

CICCARELLI
WHITE



FOURTH EDITION

psychology

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fourth edition

SAUNDRA K. CICCARELLI

Gulf Coast State College

J. NOLAND WHITE

Georgia College

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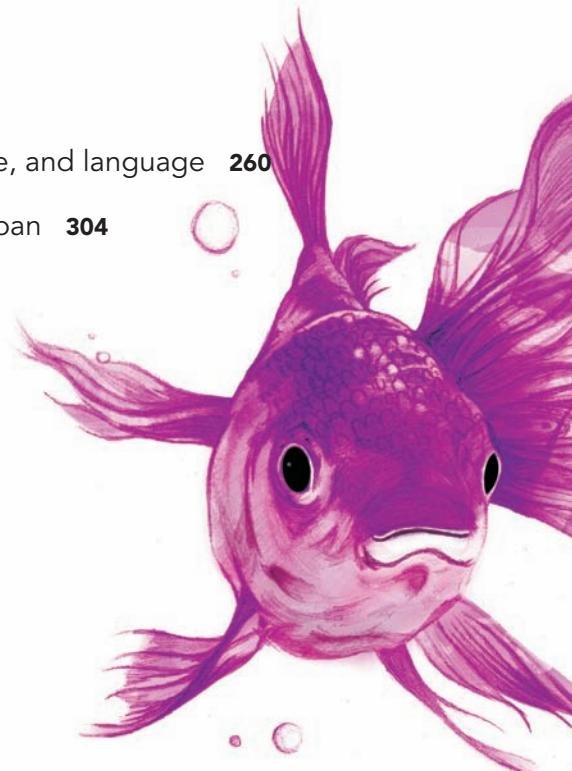
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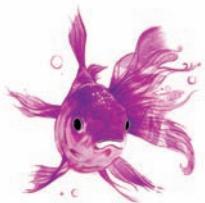
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learner-centered approach

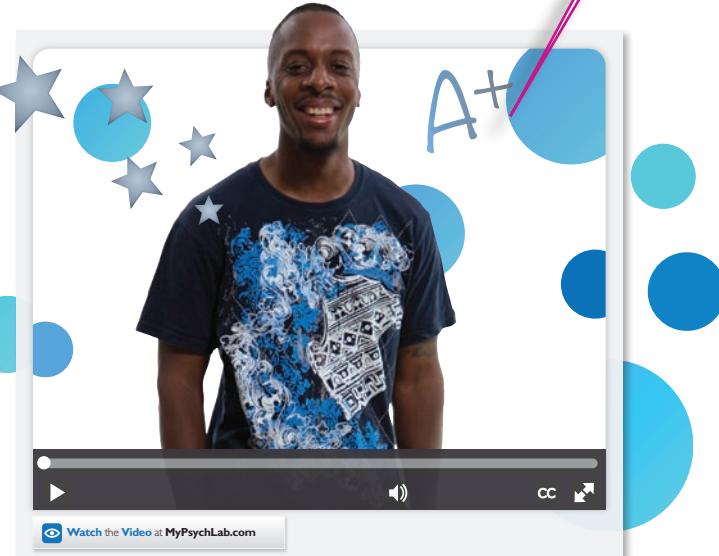
Curiosity and Dialogue

Our goal is to awaken students' curiosity and energize their desire to learn by having them read and engage with the material. We are delighted with the feedback from students and instructors who have used our text and who tell us this approach is working, and we are pleased to extend that experience in a new eText format with this edition. The new eText format helps content come alive and makes students active participants in their learning.

5 learning

Yoshiko's first-grade teacher started a reading contest. For every book read, a child would get a gold star on the reading chart, and at the end of one month the child with the most stars would get a prize. Yoshiko went to the library and checked out several books each week. At the end of the month, Yoshiko had the most gold stars and got to stand in front of her classmates to receive her prize. Would it be candy? A toy? She was so excited! Imagine her surprise and mild disappointment when the big prize turned out to be another book! Disappointing prize aside, Yoshiko's teacher had made use of a key technique of learning called *reinforcement*. Reinforcement is anything that when following a response, increases the likelihood that the response will occur again. The reinforcers of gold stars and a prize caused Yoshiko's reading to increase.

How have you used reinforcement to modify your own behavior or the behavior of others?



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Chapter opening Student Voice videos

Chapters now open with videos in which psychology students share personal stories about how the chapter theme directly applies to their lives.

Success Center

At the start of each chapter students can access Dynamic Study Modules and study tip videos. The **Dynamic Study Modules** use confidence metrics to identify what students do and don't know and deliver question and explanation sets based on individual knowledge needs. Students can study on the go by downloading the Dynamic Study Modules mobile app on their iPhone or Android device.

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Embedded Interactive Content

Interactive content has been fully incorporated into all aspects of the text, allowing students a more direct way to access and engage with the material

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Figure 5.9 A Typical Maze
This is an example of a maze such as the one used in Tolman's experiments in latent learning. A rat is placed in the start box. The trial is over when the rat gets to the end box.

certain number of trials, whereas the second and third groups seemed to wander aimlessly around the maze until accidentally finding their way out.

On the 10th day, however, something happened that would be difficult to explain using only Skinner's basic principles. The second group of rats, upon receiving the reinforcement for the first time, should have then taken as long as the first group to solve the maze. Instead, they began to solve the maze almost immediately (see Figure 5.10).

Tolman concluded that the rats in the second group, while wandering around in the first 9 days of the experiment, had indeed learned where all the blind alleys, wrong turns, and correct paths were and stored this knowledge away as a kind of "mental map," or *ognitive map* of the physical layout of the maze. The rats in the second group had learned and stored that learning away mentally but had not *demonstrated* this learning because there was no reason to do so. The cognitive map had remained hidden and latent until the rats had received the desire to use the knowledge to get to the food. Tolman called this *latent learning*. The idea that learning could happen without reinforcement, and then later affect behavior, was not something traditional operant conditioning could explain. To see a real-life example of latent learning, participate in the experiment *Learning*.

Simulate experiments right from the narrative.

Simulation

Learning

In this experiment, you will be asked to memorize a series of words presented to you one at a time. Twenty words will be flashed on the screen for a very short time and will be repeated briefly by a blank screen. After the last word is flashed on the screen, you will be asked some questions to test your recall.

Go to the Experiment ➤

Simulate the Experiment Learning on MyPsychLab

Watch **Videos** of topics as they are explained. **Interactive Figures** walk students through some of the more complex processes in psychology.

Reinforce connections across topics with **Interactive Concept Maps**.

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Explore the Concept at MyPsychLab

CONCEPT MAP

PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY

Pick the best answer.

- Kyle, age 13, has an intellectual disability complicated by multiple physical and sensory impairments that significantly impair his skills of daily living and ability to communicate. He is unable to take care of himself in any area of life. Kyle would most likely be classified with **a** intellectual disability.
 - mild
 - moderate
 - severe
 - profound
- Lewis Terman's study provided evidence that individuals with high IQs
 - are generally weaker and lack social skills.
 - show no better at excelling in their careers than others with average IQs.
 - show little to no signs of mental illness or adjustment problems.
 - have more problems with interpersonal relationships except for those with IQs over 180.
- What were some of the differences between the 100 most successful men and the 100 least successful men in Terman's study?
 - The successful men had higher IQ scores and better parental upbringing.
 - The successful men had higher IQ scores and no family history of mental illness.

c. The successful men had no family history of mental illness and were more motivated in general.
d. The successful men had clearly defined goals and more motivation to achieve them.

4. In recent studies, what do some researchers argue is a more accurate means of gauging success in relationships and careers?

- intellectual intelligence
- emotional intelligence
- hereditary influences
- stress levels

5. Which of the following would be an example of a stereotype threat?

- Josquin, who believes IQ tests are unfair to Hispanics, something that his IQ score seems to reflect.
- Jasmine, who feels she must excel on her IQ test.
- Tiana, who believes that all testing, no matter the type, is a waste of time.
- Malik, who believes that tests are equal but must excel so as not to be stereotyped by his friends

Take **Practice Quizzes** as you read.

PRACTICE QUIZ How Much Do You Remember?

Pick the best answer.

- Learning can best be described as
 - a relatively permanent change in behavior.
 - a permanent change in behavior.
 - due primarily to unconscious motives.
 - momentary changes that require biological changes from within.
- Michael noticed that whenever he moved his dog's food dish, his dog would come into the kitchen and act hungry and excited. He reasoned that because he feeds the dog using that dish, the sound of the dish had become *a(n)*
 - unconditioned stimulus.
 - conditioned stimulus.
 - unconditioned response.
 - conditioned response.
- Which of the following statements is essential to classical conditioning?
 - The CS and UCS must come close together in time.
 - The CS must come immediately after the CR.
 - The neutral stimulus and UCR must be paired several times before conditioning takes place.
 - The CS should be something highly unusual.

Correct! You answered correctly. Good job!

Writing Prompt

- ▼ Imagine you are asked by a roommate to help him devise a weight loss program to increase his chances of making the football team. Create a one month behavior modification program based on the principles of operant conditioning which will get him started towards his goal. Be sure to describe how you will measure your roommate's progress and what schedules of reinforcement will be included in your program.

teaching and learning package

Integration and Feedback

It is increasingly true today that as valuable as a good textbook is, it is still only one element of a comprehensive learning package. The teaching and learning package that accompanies *Psychology*, 4e, is the most comprehensive and integrated on the market. We have made every effort to provide high-quality instructor resources that will save you preparation time and will enhance the time you spend in the classroom.

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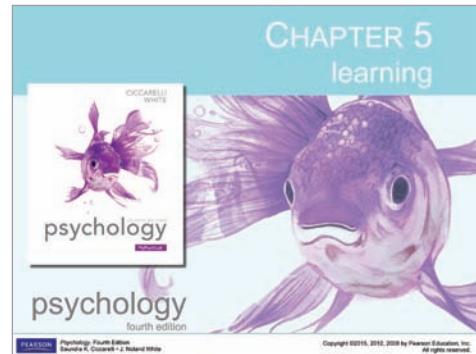
presentation and teaching resources

The Instructor's Resource Center (www.pearsonhighered.com/irc)

provides information on the following supplements and downloadable files:

Instructor's DVD (ISBN 0-205-97235-7): Bringing all of the fourth edition's instructor resources together in one place, the Instructor's DVD offers Interactive PowerPoints, standard Lecture PowerPoints, and Classroom Response System PowerPoints, along with the Test Bank, and the Instructor's Resource Manual to help instructors customize their classroom experience.

- **Interactive PowerPoint Slides** bring the Ciccarelli/White design into the classroom, drawing students into the lecture and providing appealing interactive activities, visuals, and videos. The slides are built around the text's learning objectives and offer many direct links to interactive exercises, simulations, and activities.
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- **Peer Instruction Clicker Activities** offered as a PowerPoint presentation for introductory psychology courses is also available on the Instructor's DVD.



Instructor's Resource Manual, prepared by Don Lucas, Northwest Vista College, offers detailed Chapter Lecture Outlines, chapter summaries, learning objectives, activities, exercises, assignments, handouts, and demonstrations for in-class use, as well as useful guidelines for integrating the many Pearson media resources into your classroom and syllabus.

The **Test Item File** prepared by Jason Spiegelman, Community College of Baltimore County, contains over 3,200 questions categorized by learning objective and question type (factual, conceptual, or applied). Rationales for each correct answer and the key distracter in the multiple-choice questions help instructors evaluate questions and provide more feedback to students.

Pearson MyTest (ISBN 0-205-97239-X), a powerful assessment generation program, helps instructors easily create and print quizzes and exams. Questions and tests can be authored online, allowing instructors ultimate flexibility! For more information, go to www.PearsonMyTest.com.

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Available within MyPsychLab, a unique bank of assessment items allows instructors to assess student progress against the American Psychological Association's Learning Goals and Outcomes.

Accessing All Resources

For a list of all student resources available with Ciccarelli/White, *Psychology*, 4e, go to www.mypearsonstore.com and enter the text ISBN 0-205-97224-1, and check out the "Everything That Goes with It" section under the photo of the book cover.

For access to all instructor resources for Ciccarelli/White, *Psychology*, 4e, simply go to <http://pearsonhighered.com/irc>.

For technical support for any of your Pearson products, you and your students can contact <http://247.pearsoned.com>.



learning outcomes and assessment

Goals and Standards

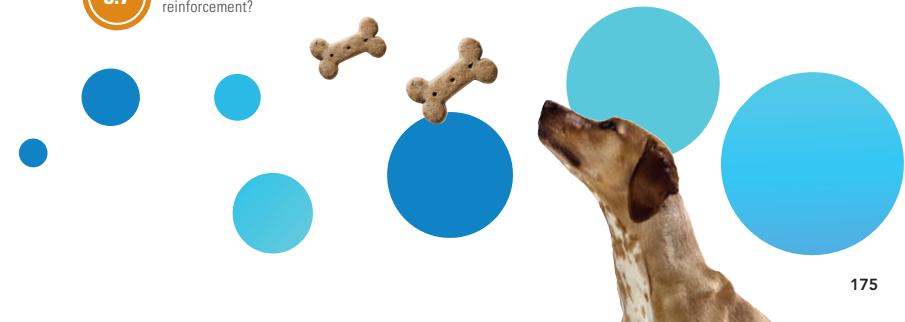
In recent years many psychology departments have been focusing on core competencies and how methods of assessment can better enhance students' learning. In response, the American Psychological Association (APA) established recommended goals for the undergraduate psychology major beginning in 2008 with a set of ten goals, and revised again in 2013 with a new set of five goals. Specific learning outcomes were established for each of the goals and suggestions were made on how best to tie assessment practices to these goals. In writing this text, we have used the APA goals and assessment recommendations as guidelines for structuring content and integrating the teaching and homework materials. For details on the APA learning goals and assessment guidelines, please see www.apa.org/.

learning objectives

Based on APA recommendations, each chapter is structured around detailed learning objectives. All of the instructor and student resources are also organized around these objectives, making the text and resources a fully integrated system of study. The flexibility of these resources allows instructors to choose which learning objectives are important in their courses as well as which content they want their students to focus on.

learning objectives

<p>5.1 What does the term <i>learning</i> really mean?</p> <p>5.2 How was classical conditioning first studied, and what are the important elements and characteristics of classical conditioning?</p> <p>5.3 What is a conditioned emotional response, and how do cognitive psychologists explain classical conditioning?</p> <p>5.4 How does operant conditioning occur, and what were the contributions of Thorndike and Skinner?</p> <p>5.5 What are the important concepts in operant conditioning?</p> <p>5.6 What are the schedules of reinforcement?</p> <p>5.7 What is punishment and how does it differ from reinforcement?</p>	<p>5.8 What are some of the problems with using punishment?</p> <p>5.9 How do operant stimuli control behavior, and what are some other concepts that can enhance or limit operant conditioning?</p> <p>5.10 What is behavior modification, and how can behavioral techniques be used to modify involuntary biological responses?</p> <p>5.11 How do latent learning, insight, and learned helplessness relate to cognitive learning theory?</p> <p>5.12 What is observational learning, and what are the four elements of modeling?</p> <p>5.13 What is a real-world example of the use of conditioning?</p>
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1**Knowledge Base in Psychology**

Students should demonstrate fundamental knowledge and comprehension of the major concepts, theoretical perspectives, historical trends, and empirical findings to discuss how psychological principles apply to behavioral phenomena. Foundation students should demonstrate breadth in their knowledge and applications of psychological ideas to simple problems; baccalaureate students should show depth in their knowledge and application of psychological concepts and frameworks to problems of greater complexity.

- 1.1 Describe key concepts, principles, and overarching themes in psychology.
- 1.2 Develop a working knowledge of psychology's content domains.
- 1.3 Describe applications that employ discipline-based problem solving.

Intro: PIA.1
Ch 1: 1.1-1.5,
Ch 2: 2.1-2.11 and Applying Psychology to Everyday Life: Paying Attention to Attention-Deficit/Hyperactivity Disorder
Ch 3: 3.1-3.11
Ch 4: 4.1-4.10
Ch 5: 5.1-5.7, 5.9-5.12
Ch 6: 6.1-6.13 and Applying Psychology to Everyday Life: Health and Memory
Ch 7: 7.1, 7.3, 7.4, 7.6-7.9
Ch 8: 8.2-8.5, 8.7-8.11
Ch 9: 9.1-9.10
Ch 10: 10.1-10.9
Ch 11: 11.1-11.9 and Issues in Psychology: Health Psychology and Stress
Ch 12: 12.1-12.13
Ch 13: 13.1-13.7, 13.9 and Applying Psychology to Everyday Life: The Biological Basis of the Big Five
Ch 14: 14.1-14.9
Ch 15: 15.1-15.10
Major concepts are reinforced with learning tools: Writing Space, Experiment Simulations, MyPsychLab Video Series, Operation ARA, Visual Brain, and instructor's teaching and assessment package.

2**Scientific Inquiry and Critical Thinking**

The skills in this domain involve the development of scientific reasoning and problem solving, including effective research methods. Foundation students should learn basic skills and concepts in interpreting behavior, studying research, and applying research design principles to drawing conclusions about behavior; baccalaureate students should focus on theory use as well as designing and executing research plans.

- 2.1 Use scientific reasoning to interpret psychological phenomena.
- 2.2 Demonstrate psychology information literacy.
- 2.3 Engage in innovative and integrative thinking and problem-solving.
- 2.4 Interpret, design, and conduct basic psychological research.
- 2.5 Incorporate sociocultural factors in scientific inquiry.

Ch 1: 1.6-1.12, 1.14
Ch 2: 2.6, 2.12 and Psychology in the News: Fact or Fiction: Focus on the Brain, but Check your Sources; Classic Studies in Psychology: Through the Looking Glass—Spatial Neglect; Applying Psychology to Everyday Life: Paying Attention to Attention-Deficit/Hyperactivity Disorder
Ch 3: Applying Psychology to Everyday Life: Beyond "Smoke and Mirrors"—The Psychological Science and Neuroscience of Magic
Ch 4: 4.10 and Psychology in the News: Murder While Sleepwalking; Applying Psychology to Everyday Life: Thinking Critically About Ghosts, Aliens, and Other Things That Go Bump in the Night
Ch 5: 5.13 and Classic Studies in Psychology: Biological Constraints of Operant Conditioning
Ch 6: Classic Studies in Psychology: Elizabeth Loftus and Eyewitnesses and Applying Psychology to Everyday Life: Health and Memory
Ch 7: 7.2-7.5 and Classic Studies in Psychology: Terman's Termites
Ch 8: 8.1, 8.6, 8.10 and Psychology in the News: Abby and Brittany Hensel, Together for Life; Classic Studies in Psychology: The Visual Cliff; Classic Studies in Psychology: Harlow and Contact Comfort
Ch 9: Psychology in the News: Cartoon Characters Influence Children's Food and Taste Preferences; Classic Studies in Psychology: The Angry/Happy Man
Ch 10: 10.6 and Issues in Psychology: Sex Differences in Science and Math: A Game Changer?; Classic Studies in Psychology: Masters and Johnson's Observational Study of the Human Sexual Response; Issues in Psychology: What is the Evolutionary Purpose of Homosexuality?
Ch 12: Psychology in the News: Anatomy of a Cult; Classic Studies in Psychology: Brown Eyes, Blue Eyes; Psychology in the News: Facing Facebook—The Social Nature of Online Networking
Ch 13: 13.8 and Classic Studies in Psychology: Geert Hofstede's Four Dimensions of Cultural Personality
Appendix A: Statistics in Psychology
Scientific methods are reinforced with learning tools: Writing Space, Experiment Simulations, MyPsychLab Video Series, Operation ARA, Visual Brain, and instructor's teaching and assessment package.

3**Ethical and Social Responsibility**

The skills in this domain involve the development of ethically and socially responsible behaviors for professional and personal settings. Foundation students should become familiar with the formal regulations that govern professional ethics in psychology and begin to embrace the values that will contribute to positive outcomes in work settings and in society. Baccalaureate students should have more direct opportunities to demonstrate adherence to professional values that will help them optimize their contributions.

- 3.1** Apply ethical standards to psychological science and practice.
- 3.2** Build and enhance interpersonal relationships.
- 3.3** Adopt values that build community at local, national, and global levels.

Ch 1: 1.13**Ch 5:** 5.8 and Issues in Psychology: The Link Between Spanking and Aggression in Young Children**Ch 7:** 7.10 and Psychology in the News: Neuropsychology Sheds Light on Head Injuries**Ch 8:** 8.11 and Issues in Psychology: The Facts and Myths About Immunizations**Ch 9:** 9.5–9.6**Ch 10:** Applying Psychology to Everyday Life: The AIDS Epidemic in Russia**Ch 11:** 11.8**Ch 12:** 12.8–12.9

Ethics and values are reinforced with learning tools: Writing Space, Experiment Simulations, MyPsychLab Video Series, Operation ARA, Visual Brain, and instructor's teaching and assessment package.

4**Communication**

Students should demonstrate competence in written, oral, and interpersonal communication skills. Foundation students should be able to write a cogent scientific argument, present information using a scientific approach, engage in discussion of psychological concepts, explain the ideas of others, and express their own ideas with clarity. Baccalaureate students should produce a research study or other psychological project, explain scientific results, and present information to a professional audience. They should also develop flexible interpersonal approaches that optimize information exchange and relationship development.

- 4.1** Demonstrate effective writing in multiple formats.
- 4.2** Exhibit effective presentation skills in multiple formats.
- 4.3** Interact effectively with others.

Intro: PIA.6**Ch 7:** 7.10**Ch 8:** 8.7, 8.11 and Applying Psychology to Everyday Life: Cross-Cultural Views on Death**Ch 10:** 10.4**Ch 11:** 11.2, 11.6, 11.8**Ch 12:** 12.2–12.3, 12.5, 12.8–12.9, 12.12 and Psychology in the News: Facing Facebook—The Social Nature of Online Networking

Communication skills are reinforced with learning tools: Writing Space, Experiment Simulations, MyPsychLab Video Series, Operation ARA, Visual Brain, and instructor's teaching and assessment package.

5

Professional Development

The skills in this domain refer to abilities that sharpen student readiness for post-baccalaureate employment, graduate school, or professional school. The emphasis in the domain involves application of psychology-specific content and skills, effective self-reflection, project management skills, teamwork skills, and career preparation. These skills can be developed and refined both in traditional academic settings and extracurricular involvement. In addition, career professionals can be enlisted to support occupational planning and pursuit.

- 5.1** Apply psychological content and skills to professional work.
- 5.2** Exhibit self-efficacy and self-regulation.
- 5.3** Refine project management skills.
- 5.4** Enhance teamwork capacity.
- 5.5** Develop meaningful professional direction for life after graduation.

Intro: PIA.1-PIA.7

Ch 1: 1.5, 1.14

Ch 4: 4.6

Ch 7: Applying Psychology to Everyday Life: Mental and Physical Exercises Com-bine for Better Cognitive Health

Ch 9: 9.1, 9.3-9.4, 9.10 and Applying Psychology to Everyday Life: When Moti-vation Is Not Enough

Ch 10: Issues in Psychology: Sex Differences in Science and Math: A Game Changer?

Ch 11: 11.6-11.9 and Applying Psychology to Everyday Life: Becoming More Optimistic

Ch 12: 12.1-12.3, 12.8-12.9

Ch 14: 14.10

Ch 15: Psychology in the News: Mental Health on Campus

Appendix B: Applied Psychology and Psychology Careers

Professional development opportunities are reinforced with learning tools: Writing Space, Experiment Simulations, MyPsychLab Video Series, Operation ARA, Visual Brain, and instructor's teaching and assessment package.



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Sandy Ciccarelli
Gulf Coast State College
Panama City, Florida
sandy243@comcast.net

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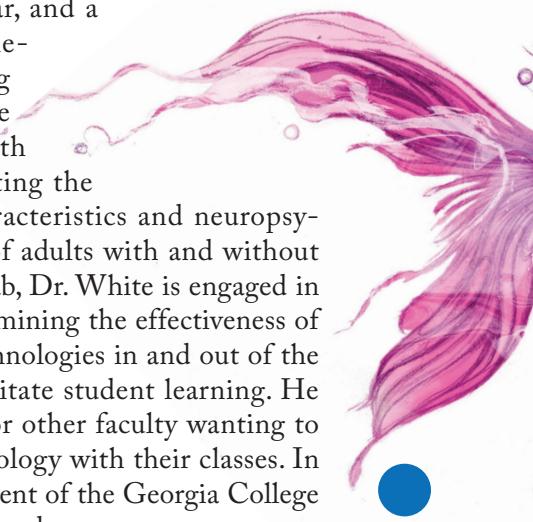
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Noland White
Georgia College
Milledgeville, Georgia
noland.white@gcsu.edu

about the authors

SAUNDRA K. CICCARELLI is a Professor Emeritus of Psychology at Gulf Coast State College in Panama City, Florida. She received her Ph.D. in Developmental Psychology from George Peabody College of Vanderbilt University, Nashville, Tennessee. She is a member of the American Psychological Association and the Association for Psychological Science. Originally interested in a career as a researcher in the development of language and intelligence in developmentally delayed children and adolescents, Dr. Ciccarelli had publications in the *American Journal of Mental Deficiency* while still at Peabody. However, she discovered a love of teaching early on in her career. This led her to the position at Gulf Coast State College, where she taught Introductory Psychology and Human Development for over 30 years. Her students loved her enthusiasm for the field of psychology and the many anecdotes and examples she used to bring psychology to life for them. Before writing this text, Dr. Ciccarelli authored numerous ancillary materials for several introductory psychology and human development texts.

J. NOLAND WHITE is an Associate Professor of Psychology at Georgia College, Georgia's Public Liberal Arts University, located in Milledgeville. He received both his B.S. and M.S. in Psychology from Georgia College and joined the faculty there in 2001 after receiving his Ph.D. in Counseling Psychology from the University of Tennessee. He is a licensed psychologist and has worked primarily with adolescents and adults, in a variety of clinical and community settings. On campus, he teaches Introductory Psychology, Psychology of Adjustment, Behavioral Neuroscience, Advanced Behavioral Neuroscience, Senior Seminar, and a section of Advanced Research Methods focusing on psychophysiology. He has an active lab and, with his students, is investigating the psychophysiological characteristics and neuropsychological performance of adults with and without ADHD. Outside of the lab, Dr. White is engaged in collaborative research examining the effectiveness of incorporating various technologies in and out of the college classroom to facilitate student learning. He also serves as a mentor for other faculty wanting to expand their use of technology with their classes. In April 2008 he was a recipient of the Georgia College Excellence in Teaching Award.



psychology in action

secrets for surviving college and improving your grades

Pamela was struggling in her psychology class. She would read the text assignments, but nothing seemed to "stick," no matter how many times she read it. She understood nearly all of what was said in class, but found it hard to listen and take notes. There was so much content to learn, how should she focus her efforts? Her grades were mediocre C's. Feeling depressed and overwhelmed, she went to the instructor to ask for advice.

Her professor suggested that Pamela go to the college's counseling center to learn about alternate ways to study. The center's guidance counselor suggested recording the lectures, so that Pamela would be able to listen without having to worry about taking notes. The counselor suggested Pamela try reciting what she has just read aloud—a text reading technique called the "SQ3R" method. After following the suggestions, all of Pamela's grades have improved to A's.

Based on what you know now, what advice would you share with a student just starting out in college?

A video player interface featuring a woman with long brown hair, wearing a black top and a blue necklace, smiling at the camera. In the background, there is a stack of books and a tablet displaying a study guide titled "Study Skills". The video player includes a play button, volume control, closed captioning (CC), and a share icon. Below the video, a button says "Watch the Video at MyPsychLab.com".

Watch the Video at [MyPsychLab.com](#)

Why study how to study?

Pamela's story is not uncommon. Many students find that they need to study in different ways, and also to use the old "listen and write notes" technique. This chapter will detail some helpful study tips as well as provide you with some good information you can use to improve your reading, writing, and memory skills.

learning objectives



What are some different methods of studying?



What are some strategies for time management?



How should you go about reading a textbook so that you get the most out of your reading efforts?



What are the best ways to take notes in class and while reading the text?



How should you approach studying for exams, and why do different kinds of test questions require different study approaches?



What are the key steps in writing papers for college?



How can you improve your memory for facts and concepts?



Success Center

 Study on MyPsychLab

Dynamic Study Modules

 Watch the Video on MyPsychLab

Study Methods

Managing Time

Reading the Text

Lecture Notes

Exam Prep

Paper Writing

Improve Memory

Many students entering college have developed a system of taking notes, reading the textbook, and reviewing for exams that may have worked pretty well in the past; but what worked in grade school and high school may not work in college, where the expectations from teachers are higher and the workload is far greater. Students should know seven things in order to do their absolute best in any college course:

1. How to identify which study methods work best for them and for different kinds of materials.
2. How to manage their time and avoid procrastination.
3. How to read a textbook and take notes that are understandable and memorable the first time.
4. How to listen and take useful notes during lectures.
5. How to study efficiently for exams.
6. How to write good term papers.
7. How to improve their memory for facts and concepts.

This introduction presents various techniques and information aimed at maximizing knowledge and skills in each of these seven areas. In addition, brief videos are available on each of these topics from the “Success Center” section located at the start of every chapter.

Study Skills



I want to make better grades, but sometimes it seems that no matter how hard I study, the test questions turn out to be hard and confusing and I end up not doing very well. Is there some trick to getting good grades?

Many students would probably say that their grades are not what they want them to be. They may make the effort, but they still don't seem to be able to achieve the higher grades that they wish they could earn. A big part of the problem is that despite many different educational experiences, students are rarely taught how to study.

STUDY METHODS: DIFFERENT STROKES FOR DIFFERENT FOLKS

What are some different methods of studying?

Most college students, at one point or another in their educational experiences, have probably run into the concept of a *learning style*, but what exactly is it? In general, a learning style is the particular way in which a person takes in, or absorbs, information (Barsch, 1996; Dunn et al., 1989, 2001; Felder & Spurlin, 2005).  **Explore the Concept, What Learning Techniques Do You Use?, at MyPsychLab**

We learn many different kinds of things during our lives, and one method of learning probably isn't going to work for everyone. Some people seem to learn better if they can read about a topic or put it into their own words (verbal learners). Others may find that looking at charts, diagrams, and figures help them more (visual learners). There are those who learn better if they can hear the information (auditory learners), and there are even people who use the motion of their own bodies to help them remember key information (action learners). While instructors would have a practical nightmare if they tried to teach to every individual student's particular learning style, students who are aware of their own style can use it to change the way they study. So instead of focusing on different learning styles, this *Psychology in Action* introduction will focus on different *study*

Teachers often use multiple methods to present a point, but trying to cover all learning methods in one lecture would not be practical.



Some students find it helpful to hear the content in addition to reading it. This is especially true when learning a new language. This woman is listening to an audio recording from her textbook as she follows along and looks at the figures and photos.

Table PIA.1**Multiple Study Methods**

VERBAL METHODS	VISUAL METHODS	AUDITORY METHODS	ACTION METHODS
Use flash cards to identify main points or key terms.	Make flash cards with pictures or diagrams to aid recall of key concepts.	Join or form a study group or find a study partner so that you can discuss concepts and ideas.	Sit near the front of the classroom and take notes by jotting down key terms and making pictures or charts to help you remember what you are hearing.
Write out or recite key information in whole sentences or phrases in your own words.	Make charts and diagrams and sum up information in tables.	While studying, speak out loud or into a digital recorder that you can play back later.	While studying, walk back and forth as you read out loud.
When looking at diagrams, write out a description.	Use different colors of highlighter for different sections of information in text or notes.	Make speeches.	Study with a friend.
Use "sticky" notes to remind yourself of key terms and information, and put them in the notebook or text or on a mirror that you use frequently.	Visualize charts, diagrams, and figures.	Record the lectures (with permission). Take notes on the lecture sparingly, using the recording to fill in parts that you might have missed.	While exercising, listen to recordings you have made of important information.
Practice spelling words or repeating facts to be remembered.	Trace letters and words to remember key facts.	Read notes or text material into a digital recorder or get study materials recorded and play back while exercising or doing chores.	Write out key concepts on a large board or poster.
Rewrite things from memory.	Redraw things from memory.	When learning something new, state or explain the information in your own words out loud or to a study partner.	Make flash cards, using different colors and diagrams, and lay them out on a large surface. Practice putting them in order.
		Use musical rhythms as memory aids, or put information to a rhyme or a tune.	Make a three-dimensional model.
			Spend extra time in the lab.
			Go to off-campus areas such as a museum or historical site to gain information.



methods. Take the opportunity to try them out and find which methods work best for you. Table PIA.1 lists just some of the ways in which you can study. All of the methods listed in this table are good for students who wish to improve both their understanding of a subject and their grades on tests. See if you can think of some other ways in which you might prefer to practice the various study methods.

WHEN AND WHERE DO YOU FIT IN TIME TO STUDY?

What are some strategies for time management?

One of the biggest failings of college students (and many others) is managing the time for all the tasks involved. Procrastination, the tendency to put off tasks until some later time that often does not arrive, is the enemy of time management. There are some strategies to defeating procrastination (The College Board, 2011):

- Make a map of your long-term goals. If you are starting here, what are the paths you need to take to get to your ultimate goal?
- Get a calendar and write down class times, work times, social engagements, everything!
- Before you go to bed, plan your next day, starting with when you get up and prioritizing your tasks for that day. Mark tasks off as you do them.
- Go to bed. Getting enough sleep is a necessary step in managing your tasks. Eating right and walking or stretching between tasks is a good idea, too.
- If you have big tasks, break them down into smaller, more manageable pieces. How do you eat an elephant? One bite at a time.



- Do small tasks, like answering emails or writing the first paragraph of a paper, in those bits of time you might otherwise dismiss: riding the bus to school or work, waiting in a doctor's office, and so on.
- Build in some play time—all work and no play pretty much insures that you will fail at keeping your schedule. Use play time as a reward for getting tasks done.
- If your schedule falls apart, don't panic—just start again the next day. Even the best time managers have days when things don't go as planned.

Another problem that often interferes with time management is the enduring myth that we can effectively multitask. In today's world of technological interconnectedness, people tend to believe that they can learn to do more than one task at a time. The fact, however, is that the human mind is not meant to multitask and trying to do so not only can lead to car wrecks and other disasters, but also may result in changes in how individuals process different types of information, and not for the better. One study challenged college students to perform experiments that involved task switching, selective attention, and working memory (Ophir et al., 2009). The expectation was that students who were experienced at multitasking would outperform those who were not, but the results were just the opposite: the "chronic multitaskers" failed miserably at all three tasks. The results seemed to indicate that frequent multitaskers use their brains less effectively, even when focusing on a single task.

Another study found that people who think they are good at multitasking are actually not (Sanbonmatsu et al., 2013), while still another study indicates that video gamers, who often feel that their success at gaming is training them to be good multitaskers in other areas of life such as texting or talking while driving, are just as unsuccessful at multitasking as nongamers (Donohue et al., 2012). In short, it's better to focus on one task and only one task for a short period of time before moving on to another than to try to do two things at once. [Watch the Video, What's In It For Me?: The Myth of Multitasking, at MyPsychLab](#)

Mastering the Course Content

It would be nice if there were a magical way to get the content of a college course into your head, but the sad fact is that you must work at learning. The two things you must do above all else: Read the textbook and attend the class lectures. The following sections give you some good tips for getting the most out of both necessary evils.

READING TEXTBOOKS: TEXTBOOKS ARE NOT MEATLOAF

How should you go about reading a textbook so that you get the most out of your reading efforts?

No matter what the study method, students must read the textbook to be successful in the course. (While that might seem obvious to some, many students today seem to think that just taking notes on lectures or slide presentations will be enough.) This section deals with how to read textbooks for understanding rather than just to "get through" the material.

Students make two common mistakes in regard to reading a textbook. The first mistake is simple: Many students don't bother to read the textbook *before* going to the lecture that will cover that material. Trying to get anything out of a lecture without having read the material first is like trying to find a new, unfamiliar place without using a GPS or any kind of directions. It's easy to get lost. This is especially true because of the assumption that most instructors make when planning their lectures: They take for granted that

the students have already read the assignment. The instructors then use the lecture to go into detail about the information the students **supposedly** got from the reading. If the students have not done the reading, the instructor's lecture isn't going to make a whole lot of sense.

The second mistake that most students make when reading textbook material is to try to read it the same way they would read a novel: They start at the first page and read continuously. With a novel, it's easy to do this because the plot is usually interesting and people want to know what happens next, so they keep reading. It isn't necessary to remember every little detail—all they need to remember are the main plot points. One could say that a novel is like meatloaf—some meaty parts with lots of filler. Meatloaf can be eaten quickly, without even chewing for very long.

With a textbook, the material may be interesting but not in the same way that a novel is interesting. A textbook is a big, thick steak—all meat, no filler. Just as a steak has to be chewed to be enjoyed and to be useful to the body, textbook material has to be “chewed” with the mind. You have to read slowly, paying attention to every **morsel** of meaning.

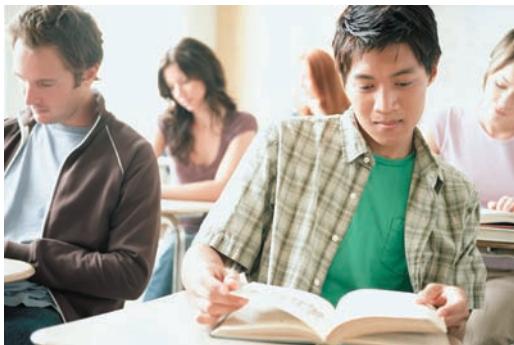
So how do you do that? Probably one of the best-known reading methods is called SQ3R, first used by F. P. Robinson in a 1946 book called *Effective Study*. The letters S-Q-R-R-R stand for:

SURVEY Look at the chapter you've been assigned to read. Read the outline, learning objectives, or other opening materials. Then flip through the chapter and read the headings of sections, and look at tables and figures. Quickly read through the chapter summary if one is provided.

It might sound like it takes too much time to do this, but you should just be skimming at this point—a couple of minutes is all it should take. Why do this at all? Surveying the chapter, or “previewing” it, as some experts call it, helps you form a framework in your head around which you can organize the information in the chapter when you read it in detail. Organization is one of the main ways to improve your memory for information.  [LINK](#) to Learning Objective 6.5.

QUESTION After previewing the chapter, read the heading for the first section. *Just* the first section! Try to think of a question based on this heading that the section should answer as you read. For example, in Chapter One there's a section titled “Pavlov, Watson, and the Dawn of Behaviorism.” You could ask yourself, “What did Pavlov and Watson do for psychology?” or “What is behaviorism?” In this text, a list of learning objectives for the key concepts in the chapter is presented in the form of questions that can be used with the SQ3R method. There are also student questions that can serve the same purpose. Now when you read the section, you aren't *just* reading—you're reading to *find an answer*. That makes the material much easier to remember later on.

READ Now read the section, looking for the answers to your questions. As you read, take notes by making an outline of the main points and terms in the section. This is another area where some students make a big mistake. They assume that using a highlighter to mark words and phrases is as good as writing notes. One of the author's former students conducted research on the difference between highlighting and note taking, and



Before reading any chapter in a text, survey the chapter by reading the outline and the section headings.

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-  PIA.2
-  PIA.3
-  PIA.4
-  PIA.5
-  PIA.6
-  PIA.7



As you read, take notes. Write down key terms and try to summarize the main points of each paragraph and section in the chapter. These notes will be useful when you later review the chapter material.

PIA.1

PIA.2

PIA.3

PIA.4

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her findings were clear: Students who wrote their own notes during the reading of a text or while listening to a lecture scored significantly higher on their exam grades than students who merely used a highlighter on the text (Boyd & Peeler, 2004). Highlighting requires no real mental effort (no “chewing,” in other words), but writing the words down yourself requires you to read the words in depth and to understand them. When we study memory, you’ll learn more about the value of processing information in depth.  to [Learning Objective 6.1](#).

RECITE It may sound silly, but reciting out loud what you can remember from the section you’ve just read is another good way to process the information more deeply and completely. How many times have you thought you understood something, only to find that when you tried to explain it to someone, you didn’t understand it at all? Recitation forces you to put the information in your own words—just as writing it in notes does. Writing it down accesses your visual memory; saying it out loud gives you an auditory memory for the same information. If you have ever learned something well by teaching it to someone else, you already know the value of recitation. If you feel self-conscious about talking to yourself, talk into a digital recorder—and it’s a great way to review later.

Now repeat the Question, Read, and Recite instructions for each section, taking a few minutes’ break after every two or three sections. Why take a break? There’s a process that has to take place in your brain when you are trying to form a permanent memory for information, and that process takes a little time. When you take a break every 10 to 20 minutes, you are giving your brain the time to accomplish this process. A break will help you avoid a common problem in reading texts—finding yourself reading the same sentence over and over again because your brain is too overloaded from trying to remember what you just read.

RECALL/REVIEW Finally, you’ve finished reading the entire chapter. If you’ve used the guidelines listed previously, you’ll only have to read the chapter as thoroughly this one time, instead of having to read it over and over throughout the semester and just before exams. Once you’ve read the chapter, take a few minutes to try to remember as much of what you learned while reading it as you can. A good way to do this is to take any practice quizzes that might be available, either in your text or in a student workbook that goes with the text. Many publishers have Web sites for their textbooks that have practice quizzes available online. For this text, we offer both practice quizzes within the text and online quizzes and study materials. If there are no quizzes, read the chapter summary in detail, making sure that you understand everything in it. If there’s anything that’s confusing, go back to that section in the chapter and read again until you understand it.

Some educators and researchers now add a fourth R: *Reflect*. To reflect means to try to think critically about what you have read by trying to tie the concepts into what you already know, thinking about how you can use the information in your own life, and deciding which of the topics you’ve covered interests you enough to look for more information on that topic (Richardson & Morgan, 1997). For example, if you have learned about the genetic basis for depression, you might better understand why that disorder seems to run in your best friend’s family.  to [Learning Objective 14.5](#).

Reading textbooks in this way means that, when it comes time for the final exam, all you will have to do is carefully review your notes to be ready for the exam—you won’t have to read the entire textbook all over again. What a time-saver! Recent research suggests that the most important steps in this method are the three R’s: Read, Recite, and Review. In two experiments with college students, researchers found that when compared with other study methods such as rereading and note-taking study strategies, the 3R strategy produced superior recall of the material (McDaniel et al., 2009).



After reading a chapter section, take time to reflect on what the information means and how it might relate to real-world situations.

GETTING THE MOST OUT OF LECTURES

What are the best ways to take notes in class and while reading the text?

As mentioned earlier, mastering course content means you have to attend the lectures. Even if lectures are online, you have to read or watch them. But just attending or reading or watching is not enough; you have to process the information just as you have to process the text material. To get the most out of lectures, you need to take notes on the content, and taking notes involves quite a bit more than just writing down the words the instructor says or printing out the PowerPoint slides.

One very important fact you must remember: PowerPoint slides are not meant to be notes at all; they are merely talking points that help the instructor follow a particular sequence in lecturing. Typically, the instructor will have more to say about each point on the slide, and that is the information students should be listening to and writing down. In Table PIA.1, the suggestion to use highlighters of different colors is not meant to replace taking notes but instead to supplement the notes you do take.

How should you take notes? As stated earlier, you should try to take notes while reading the chapter (*before* attending the lecture) by writing down the main points and the vocabulary terms *in your own words* as much as possible. This forces you to think about what you are reading. The more you think about it, the more likely it is that the concepts will become a part of your permanent memory.  to Learning Objective 6.4.

Taking notes while listening to the lecture is a slightly different procedure. First, you should have your notes from your earlier reading in front of you, and it helps to leave plenty of space between lines to add notes from the lecture. A major mistake made by many students is to come to the lecture without having read the material first. This is an EXTREMELY BAD IDEA. If you come to the lecture totally unprepared, you will have no idea what is important enough to write down and what is just the instructor's asides and commentary. Reading the material first gives you a good idea of exactly what is important in the lecture and reduces the amount of notes you must take.

There is an art to really listening to someone, too, often called *active listening*. Active listeners make eye contact with the speaker and sit facing the speaker in a place where they can easily hear and see the speaker. Active listeners focus on what is being said rather than how the speaker looks or sounds (not always an easy task) and ask questions when they do not understand something or need a clarification. Asking questions during a lecture is a good way to stay engaged in actively processing the speaker's message.

If you are like Pamela in the introduction, ask your instructor if you can bring a digital recorder to class to record the lecture. You will then be able to listen during the class and use the recording to take notes from later. Some students may prefer to jot down diagrams, charts, and other visual aids along with their written notes. When you have good notes taken while reading the text and from the lectures, you will also have ready-made study aids for preparing to take exams. The next section deals with the best ways to study for exams.



Here are two things that instructors love to see: attentive looks and note taking during the lecture. And for the student who learns better just listening, a small digital recorder (used with permission) can help for later review of the lecture. How should these students have prepared before coming to this class?

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- PIA.2
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PIA.1



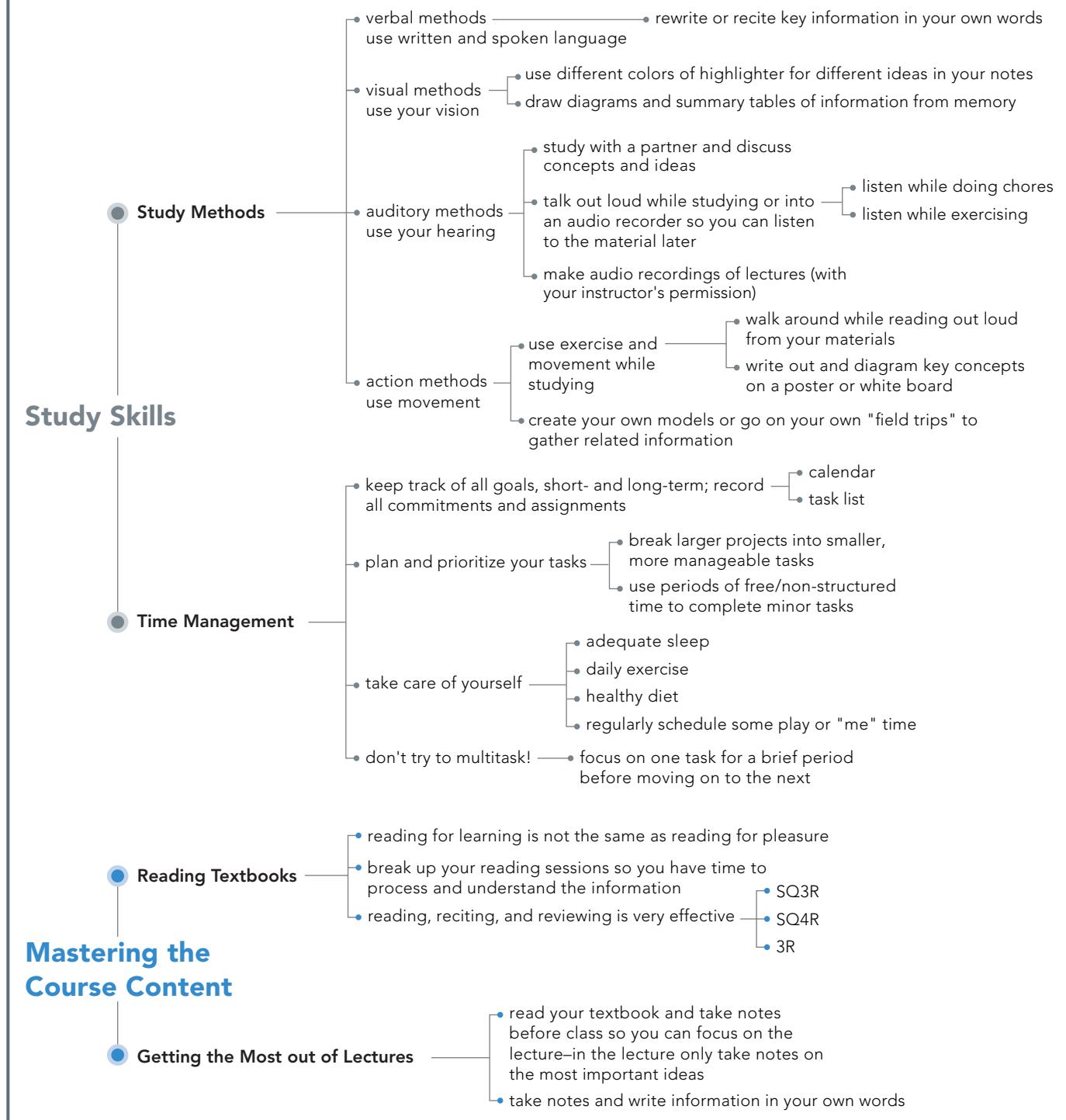
PIA.2



PIA.3



PIA.4

Explore the Concept at [MyPsychLab](#)**CONCEPT MAP**

PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. What does the research show in regards to multitasking?
 - a. Chronic multitaskers have developed strategies that allow them to use their brains more effectively.
 - b. Chronic multitasking may be related to less effective ways of processing different types of information.
 - c. Multitasking is effective, but only if you limit the number of tasks to 5 or fewer.
 - d. Video gamers are better at multitasking in all areas of life.

2. What does the "S" in SQ3R stand for?

a. survey	c. synthesize
b. study	d. stand

3. Candice has surveyed the material, developed questions to consider, and begun reading the material to find the answers to her questions. What should she do next?
 - a. Recite out loud what she can remember from the section she just read.
 - b. Re-read the material a second time.
 - c. Review the material from the chapter that she has read.
 - d. Retain the material by committing it to memory.

4. To maximize success, which method of note-taking should Juan use?
 - a. He should take notes in his own words as much as possible.
 - b. He should write down every word from the PowerPoint slides used in class.
 - c. He should highlight the text rather than writing his own notes.
 - d. He should make sure that his notes contain the exact words used by his instructor.

5. Avery maintains eye contact when listening to her instructors. She also places herself so that she can see and hear the instructors. Additionally, she works to listen to the content of the lecture instead of focusing on how they look or what they are wearing. Avery would be described as a(n)

a. accomplished student.	c. active listener.
b. passive listener.	d. social listener.

THINKING CRITICALLY:

What are some reasons why not relying on the instructor's PowerPoints might be beneficial in committing information to memory?

**Demonstrating Your Knowledge: Tests and Papers**

Inevitably, the time will come when your instructor wants some hard evidence that you have truly learned at least some of the material to which you have been exposed. Tests and paper writing are two common ways in which this evidence is gathered.

STUDYING FOR EXAMS: CRAMMING IS NOT AN OPTION

How should you approach studying for exams, and why do different kinds of test questions require different study approaches?

There is a right way to study for a test, believe it or not. Here are some good things to remember when preparing for an exam, whether it's a quiz, a unit test, a midterm, or a final (Carter et al., 2002; Reynolds, 2002):

- **Timing is everything.** One of the worst things that students can do is to wait until the last minute to study for an exam. Remember the analogy about “chewing” the steak? (Just as a steak has to be chewed to be enjoyed and to be useful to the body, textbook material has to be “chewed” with the mind.) The same concept applies to preparing for an exam: You have to give yourself enough time. If you've read your text material and taken good notes as discussed in the previous sections, you'll be able to save a lot of time in studying for the exam, but you still need to give yourself ample time to go over all of those notes. The time management tips given earlier in this chapter will help you prioritize your studying.

- **Find out as much as you can about the type of test and the material it will cover.** The type of test can affect the way in which you want to study the material. An



Could this be you? The scattered materials, the frantic phone call to a friend or professor, the tense and worried facial expression are all hallmarks of that hallowed yet useless student tradition, cramming. Don't let this happen to you.



objective test, for example, such as multiple-choice or true/false, is usually fairly close to the text material, so you'll want to be very familiar with the wording of concepts and definitions in the text, although this is not a suggestion to memorize a lot of material.

These kinds of tests can include one of three types of questions:

- **Factual:** Questions that ask you to remember a specific fact from the text material. For example, "Who built the first psychological laboratory?" requires that you recognize a person's name. (The answer is Wilhelm Wundt.)
- **Applied:** Questions that ask you to use, or apply, information presented in the text. For example, consider the following question:

Ever since she was scared by a dog as a young child, Angelica has been afraid of all dogs. The fact that she is not only afraid of the original dog but all types of dogs is an example of

- a. stimulus generalization.
- b. stimulus discrimination.
- c. spontaneous recovery.
- d. shaping.

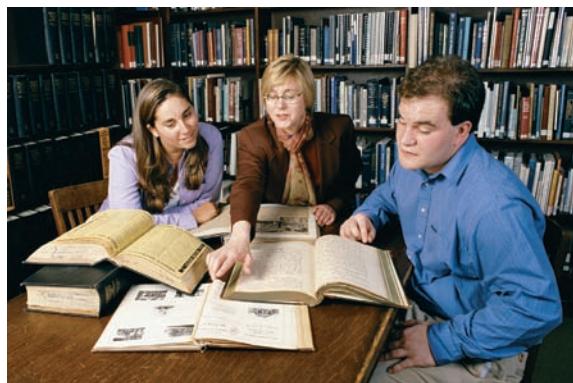
This question requires you to take a concept (in this case, generalization) and apply it to a real-world example.

- **Conceptual:** Questions that demand that you think about the ideas or concepts presented in the text and demonstrate that you understand them by answering questions like the following: "Freud is to _____ as Watson is to _____. " (The answers could vary, but a good set would be "the unconscious" and "observable behavior.")

Notice that although memorizing facts might help on the first type of question, it isn't going to help at all on the last two. Memorization doesn't always help on factual questions either, because the questions are sometimes worded quite differently from the text. It is far better to understand the information rather than be able to "spit it back" without understanding it. "Spitting it back" is memorization; understanding it is true learning. to Learning Objective 6.1. There are different levels of analysis for information you are trying to learn, and the higher the level of analysis, the more likely you are to remember (Anderson et al., 2001; Bloom, 1956). *Factual questions* are the lowest level of analysis: knowledge. *Applied questions* are a higher level and are often preferred by instructors for that reason—it's hard to successfully apply information if you don't really understand it. *Conceptual questions* are a kind of analysis, a level higher than either of the other two. Not only do you have to understand the concept, you have to understand it well enough to compare and contrast it with other concepts. They might be harder questions to answer, but in the long run, you will get more "bang for your buck" in terms of true learning.

Subjective tests, such as essay tests and short-answer exams, require that you not only are able to recall and understand the information from the course but also that you are able to organize it in your own words. To study for a subjective test means that you need to be familiar with the material *and* that you need to be able to write it down. Make outlines of your notes. Rewrite both reading and lecture notes and make flash cards, charts, and drawings. Practice putting the flash cards in order. Talk out loud or study with someone else and discuss the possible questions that could be on an essay test. You may find that only a few of these methods work best for you, but the more ways in which you try to study, the better you will be able to retrieve the information when you need it. It may sound like a big investment of your time, but most students vastly underestimate how long it takes to study—and fail to recognize that many of these techniques are doable when first reading the textbook assignment and preparing for the classroom lecture. DON'T CRAM!

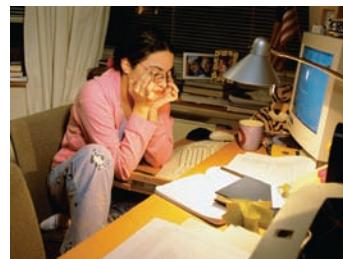
You might also look at old tests (if the instructor has made them available) to see what kinds of questions are usually asked. If this is not possible, make sure that you pay close attention to the kinds of questions asked on the first exam so that you will know how to prepare for future tests. Write out your own test questions as if you were the instructor. Not only does this force you to think about the material the way it will appear on the test, it also provides a great review tool. Other helpful advice:



Many students studying for exams ignore one of the most valuable resources to which they have access: the instructor. Most instructors are happy to answer questions or schedule time for students who are having difficulty understanding the material.

- **Use SQ3R.** You can use the same method that you used to read the text material to go over your notes. Skim through your notes, try to think of possible test questions, recite the main ideas and definitions of terms, either out loud, into a digital recorder, or to a friend or study group. Review by summarizing sections of material or by making an outline or flash cards that you can use in studying important concepts.
- **Use the concept maps if provided.** When surveying the chapter, make sure you look over any concept maps. (In this text, they are provided at the end of each major section of the chapters, just before the practice quizzes). **Concept maps** are a visual organization of the key concepts, terms, and definitions that are found in each section and are an excellent way to “see” how various concepts are linked together (Carnot et al., 2001; Novak, 1995; Wu et al., 2004). They are also a great way to review the chapter once you have finished reading it, just to check for understanding—if the concept maps don’t make sense, then you’ve missed something and need to go back over the relevant section. You can also make your own concept maps as you take notes on the chapter.
- **Take advantage of all the publisher’s test materials.** Practice does help, and most textbooks come with a study guide or a Web site (such as www.mypsychlab.com for this text; see preface). Those materials should have practice quizzes available—take them. The more types of quiz questions you try to answer, the more successful you will be at interpreting the questions on the actual exam. You’ll also get a very good idea of the areas that you need to go back and review again. And remember, retrieval practice, or actually testing your recall through tests or quizzes, is a great way to improve long-term learning (Karpicke, 2012; Karpicke & Blunt, 2011), even when just thinking about the information or rehearsing it over in your mind (Smith et al., 2013)! Retrieval practice works better than simply restudying. The key is testing your retrieval of information, not your recognition of information.
- **Make use of the resources.** If you find that you are having difficulty with certain concepts, go to the instructor well in advance of the exam for help. (This is another good reason to manage your study time so that you aren’t trying to do everything in a few hours the night before the exam.) There are help centers on most college and university campuses with people who can help you learn to study, organize your notes, or tutor you in the subject area.
- **Don’t forget your physical needs.** Studies have shown that not getting enough sleep is bad for memory and learning processes (Stickgold et al., 2001; Vecsey et al., 2009). Try to stop studying an hour or so before going to bed at a reasonable

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Holding your eyes open is not going to help you study when you are this tired. Sleep has been shown to improve memory and performance on tests, so get a good night’s sleep before every exam.

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time to give your body time to relax and unwind. Get a full night's sleep if possible. Do not take sleep-inducing medications or drink alcohol, as these substances prevent normal stages of sleep, including the stage that seems to be the most useful for memory and learning (Davis et al., 2003). Do eat breakfast; hunger is harmful to memory and mental performance. A breakfast heavy on protein and light on carbohydrates is the best for concentration and recall (Benton & Parker, 1998; Dani et al., 2005; Pollitt & Matthews, 1998; Stubbs et al., 1996).

- **Use your test time wisely.** When taking the test, don't allow yourself to get stuck on one question that you can't seem to answer. If an answer isn't clear, skip that question and go on to others. After finishing all of the questions that you can answer easily, go back to the ones you have skipped and try to answer them again. This accomplishes several things: You get to experience success in answering the questions that you can answer, which makes you feel more confident and relaxed; other questions on the test might act as memory cues for the exact information you need for one of those questions you skipped; and once you are more relaxed, you may find that the answers to those seemingly impossible questions are now clear because anxiety is no longer blocking them. This is a way of reducing stress by dealing directly with the problem, one of many ways of dealing effectively with stress.

 [LINK](#) to [Learning Objective 11.7](#).

The next section gives some helpful information about another form of assessment: the term paper.

WRITING PAPERS: PLANNING MAKES PERFECT

 **PIA.6** What are the key steps in writing papers for college?



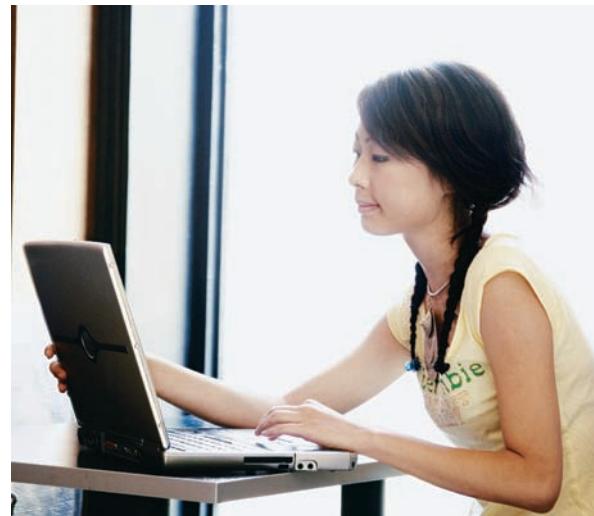
Instructors are a good source of suggestions for paper topics—they know the kind of information they want to be reading and grading in the wee hours of the night.

Several steps are involved in writing a paper, whether it be a short paper or a long one. You should begin all of these steps well in advance of the due date for the paper (not the night before):

1. **Choose a topic.** The first step is to choose a topic for your paper. In some cases, the instructor may have a list of acceptable subjects, which makes your job easier. If that is not the case, don't be afraid to go to your instructor during office hours and talk about some possible topics. Try to choose a topic that interests you, one that you would like to learn more about. The most common mistake students make is to choose subject matter that is too broad. For example, the topic "autism" could fill a book. A narrower focus might discuss a single form of autism in detail. Again, your instructor can help you narrow down your topic choices.
2. **Do the research.** Find as many sources as you can that have information about your topic. Don't limit yourself to encyclopedias or textbooks. Go to your school library and ask the librarian to point you in the direction of some good scientific journals that would have useful information on the subject. Be very careful about using the Internet to do research: Not everything on the Internet is correct or written by true experts—avoid other students' papers and "encyclopedia" Web sites that can be written and updated by darn near anyone.
3. **Take notes.** While reading about your topic, take careful notes to remember key points and write down the reference that will go along with the reading. References for psychology papers are usually going to be in APA (American Psychological Association) style, which can be found at www.apastyle.org and in MyPsychLab. Remember, taking notes helps you avoid **plagiarism**, the copying of someone else's ideas or exact words (or a close imitation of the words) and presenting them as your own. Note taking also helps you avoid using too many direct quotes—papers are supposed to be in *your* words, not someone else's, even if you give them credit.

4. Decide on the thesis.

The thesis is the central message of your paper—the message you want to communicate to your audience—which may be your instructor, your classmates, or both, depending on the nature of the assignment. Some papers are persuasive, which means the author is trying to convince the reader of a particular point of view, such as “Autism is not caused by immunizations.” Some papers are informative, providing information about a topic to an audience that may have no prior knowledge, such as “Several forms of autism have been identified.”



In earlier times, people actually had to write or type their first, second, and sometimes third drafts on real paper. The advent of computers with word-processing programs that allow simple editing and revision have no doubt saved a lot of trees from the paper mill. This also means there is no good excuse for failing to write a first draft and proofreading one's work.

5. Write an outline. Using your notes from all your readings, create an outline of your paper—a kind of “road map” of how the paper will go. Start with an introduction (e.g., a brief definition and discussion of what autism is). Then decide what the body of the paper should be. If your paper is about a specific type of autism, for example, your outline might include sections about the possible causes of that type. The last section of your outline should be some kind of conclusion. For example, you might have recommendations about how parents of a child with autism can best help that child to develop as fully as possible.

6. Write a first draft. Write your paper using the outline and your notes as guides. If using APA style, place citations with all of your statements and assertions. Failure to use citations (which point to the particular reference work from which your information came) is also a common mistake that many students make. It is very important that you avoid plagiarism, as discussed in step 3. When you use a source, you are supposed to explain the information that you are using in your own words and cite the source, as in the following example:

In one study comparing both identical and fraternal twins, researchers found that stressful life events of the kind listed in the SRRS were excellent predictors of the onset of episodes of major depression (Kendler & Prescott, 1999).

Your paper’s reference section would have the following citation: Kendler, K. S., & Prescott, C. A. (1999). A population-based twin study of lifetime major depression in men and women. *Archives of General Psychiatry*, 56(1): 39–44. [Author’s note: The number in front of the parentheses is the volume of the journal, the one inside is the issue number, and the last numbers are the page numbers of that article.]

7. Let it sit. Take a few days (if you have been good about starting the paper on time) to let the paper sit without reading it. Then go back over and mark places that don’t sound right and need more explanation, a citation, or any other changes. This is much easier to do after a few days away from the paper; the need to reword will be more obvious.

8. Write the revised draft. Some people do more than one draft, while others do only a first draft and a final. In any case, revise the draft carefully, making sure to check your citations—and your spelling!





Before we end this introduction, here are some excellent books and Web resources available for help in maximizing your studying:

Carter, C., Bishop, J., & Kravits, S. (2011). *Keys to effective learning: Study skills and habits for success* (6th ed.) Upper Saddle River, NJ: Prentice Hall.

Carter, C., Bishop, J., Kravits, S., & Block, J. (2009). *Keys to success: Building analytical, creative, and practical skills* (6th ed.). Upper Saddle River, NJ: Prentice Hall.

Sellers, D., Dochen, C. W., & Hodges, R. W. (2011). *Academic transformation: The road to college success* (2nd ed.) Upper Saddle River, NJ: Prentice Hall.

A good source created by Joe Landsberger is the Web site Study Guides and Strategies, available at www.studygs.net

A good resource for the background behind concept maps and how to use them is at cmap.ihmc.us/Publications/ResearchPapers/TheoryCmaps/TheoryUnderlyingConceptMaps.htm

MyPsychLab contains study materials, practice quizzes, and resources for doing research and writing papers.

PIA.5
PIA.6

Explore the Concept at [MyPsychLab](#)

●
Studying for Exams

●
Writing papers

CONCEPT MAP

- spacing out studying sessions (distributed practice) is more effective than cramming (massed practice); start early!
- knowing what kind of test questions to expect can help guide study efforts
- use effective time management strategies, both when studying and while taking exams
- don't forget to take care of yourself by getting enough sleep, proper nutrition, and exercise

- quality papers often require timely preparation, research, planning, and outlining. Write an initial draft followed by a revised draft
- don't forget to proofread and to use your spelling and grammar checker

PRACTICE quiz How Much Do You Remember?

Pick the best answer.
ANSWERS AVAILABLE IN ANSWER KEY.

1. Which category is the following question an example of? *True or False: Psychology is the study of behavior and mental processes.*

- factual question
- conceptual question
- applied question
- critical question

2. Which questions are the highest level of analysis and often considered the hardest to answer on a test?

- factual
- applied
- conceptual
- true/false

3. Tom is studying for his first psychology exam. What should he do to ensure he remembers all that he has studied?

- Wait until just before the scheduled exam, so that the information will be fresh in his mind.
- Study all night long before the exam—he can sleep after the test.
- Memorize as much of the information as possible.
- Begin studying many days in advance so as to give his brain time to commit the material to memory and repeatedly testing his retrieval of information.

4. What is the value of retrieval practice?

- It helps to increase long-term learning.
- It allows students more opportunities to study.
- It assists only in preparing for essay-based exams.
- No research exists to prove that retrieval practice is effective

(continued)

5. Simply spitting information back out on a test is likely more indicative of _____, while truly understanding information is more indicative of actual _____.
a. memorization; learning c. behavior; action
b. learning; memorization d. a process; a gift
6. Tamika has developed and researched a topic for her paper. What should she do next?
a. Begin writing a rough draft of her paper.
b. Begin writing as if her first draft will be her final draft.
c. Develop an outline as a road map to help her stay on track when writing her paper.
d. Let everything sit for a couple of days before beginning her rough draft.

THINKING CRITICALLY:

Many elementary and secondary school programs now offer breakfast to their students. What foods would benefit these children the most and why?



Applying Psychology to Everyday Life: Strategies for Improving Your Memory

PIA.7 How can you improve your memory for facts and concepts?

Everyone needs a little memory help now and then. Even memory experts use strategies to help them perform their unusual feats of remembering. These strategies may be unique to that individual, but there are many memory “tricks” that are quite simple and available for anyone to learn and use. A memory trick or strategy to help people remember is called a **mnemonic**, from the Greek word for memory. Here are a few of the more popular mnemonics, some of which may sound familiar:

- **Linking.** Make a list in which items to be remembered are linked in some way. If trying to remember a list of the planets in the solar system, for example, a person could string the names of the planets together like this: *Mercury* was the messenger god, who carried lots of love notes to *Venus*, the beautiful goddess who sprang from the *Earth*'s sea. She was married to *Mars*, her brother, which didn't please her father *Jupiter* or his father *Saturn*, and his uncle *Uranus* complained to the sea god, *Nep-tune*. That sounds like a lot, but once linked in this way, the names of the planets are easy to recall in proper order.
- **The peg-word method.** In this method, it is necessary to first memorize a series of “peg” words, numbered words that can be used as keys for remembering items associated with them. A typical series of peg words is:

One is a bun

Two is a shoe

Three is a tree

Four is a door

Five is a hive

Six is bricks

Seven is heaven

Eight is a gate

Nine is a line

Ten is a hen

To use this method, each item to be remembered is associated with a peg word and made into an image. For instance, if you are trying to remember the parts of the nervous system, you might picture the brain stuck inside a bun, the spinal cord growing out of a shoe or with shoes hanging off of it, and the peripheral nerves as the branches of a tree.



- **The method of loci (LOW-kee or LOW-si).** In this method, the person pictures a very familiar room or series of rooms in a house or other building. Each point of the speech is then made into an image and “placed” mentally in the room at certain locations. For example, if the first point was about military spending, the image might be a soldier standing in the doorway of the house throwing money out into the street. Each point would have its place, and all the person would need to do to retrieve the memories would be to take a “mental walk” around the house.
- **Verbal/rhythmic organization.** How do you spell relief? If, when spelling a word with an *ie* or an *ei* in it, you resort to the old rhyme “I before E except after C, or when sounded as A as in neighbor or weigh,” you have made use of a verbal/rhythmic organization mnemonic. “Thirty days hath September, April, June, and November ...” is another example of this technique. Setting information into a rhyme aids memory because it uses verbal cues, rhyming words, and the rhythm of the poem itself to aid retrieval. Sometimes this method is accomplished through making a sentence by using the first letters of each word to be remembered and making them into new words that form a sentence. The colors of the rainbow are ROY G. BIV (red, orange, yellow, green, blue, indigo, and violet). The notes on the musical staff are “Every Good Boy Does Fine.” There are countless examples of this technique.
- **Put it to music (a version of the rhythmic method).** Some people have had success with making up little songs, using familiar tunes, to remember specific information. The best example of this? The alphabet song.

This *Psychology in Action* introduction has covered several different ways to help you get more out of your psychology class as well as all of your other college course work. If you follow the advice given in this chapter for reading, taking notes, studying, writing papers, and improving your memory, you will find that making good grades will be easier than ever before and that you will actually remember a great deal of what you’ve studied long after the last final exam is over.

Questions for Further Discussion

1. The use of images appears to help form better memories. How might imagery be linked to the earliest kinds of memories we have?
2. What are some mnemonics that you or people you know have used? Which method do you think those personal mnemonics represent?

psychology in action summary

Listen to the **Audio File** of your chapter **MyPsychLab**

Study Skills

PIA.1 What are some different methods of studying?

- While students may have preferred methods of learning, research has shown that using multiple methods to study is probably more useful than trying to learn in any one particular style.

PIA.2 What are some strategies for time management?

- Making a calendar of prioritized tasks, breaking tasks down into smaller ones, and avoiding multitasking are some ways to improve time management.

Mastering Course Content

PIA.3 How should you go about reading a textbook so that you get the most out of your reading efforts?

- Textbooks must be read in a different way from novels or popular books.
- The SQ3R method is an excellent way to approach reading a textbook: survey, question, read, recite, review.

PIA.4 What are the best ways to take notes in class and while reading the text?

- Notes should be in your own words and written or typed, not highlighted in the text or on handouts.

- When taking notes from a lecture, you should be prepared by having the notes from your reading in front of you; some people may benefit from recording the lecture and taking notes afterward.

Demonstrating Your Knowledge: Tests and Papers

PIA.5 How should you approach studying for exams, and why do different kinds of test questions require different study approaches?

- Don't wait until the last minute to study.
- Find out about the types of questions on the exam.
- Use concept maps, the SQ3R method, publisher's practice-test materials.
- Engage in retrieval practice; test your recall, not just recognition, of content often.
- Get plenty of sleep and eat breakfast, preferably something with protein.

test YOURSELF

ANSWERS AVAILABLE IN ANSWER KEY.

 **Study and Review** with more quizzes and a customized study plan at [MyPsychLab](#)

Pick the best answer.

- Cody learns best whenever he can see things laid out before him. What studying aid may benefit him the most?
 - practice quizzes
 - SQ3R
 - test yourself
 - concept maps
- Scientists have developed a fourth "R" in the SQ3R sequence. What is it?
 - recite
 - re-read
 - retain
 - reflect
- What learning aid gives the student the ability to more effectively read and remember material?
 - MyPsychLab
 - content maps
 - SQ3R
 - practice quizzes
- What type of question requires that you understand the material so well that you are able to compare and contrast it to other material as well?
 - factual
 - applied
 - conceptual
 - true/false
- Joaquin is rewriting his notes and making note cards to help him thoroughly understand the material. He even talks aloud to himself as if he were lecturing to an imaginary class. Such a level of preparation is best for what type of test?
 - subjective test
 - objective test
 - true/false test
 - practice test

PIA.6 What are the key steps in writing papers for college?

- Key steps in writing a research paper are to choose a topic, read about the topic, take notes on your reading, decide upon the central message of your paper, write an outline, complete a first draft, and allow the paper to sit for a few days before going back and writing the final draft.

Applying Psychology to Everyday Life: Strategies for Improving Your Memory

PIA.7 How can you improve your memory for facts and concepts?

- There are memory strategies called mnemonics, including methods that use imagery, rhymes, linking, and even music to improve memory.

- Which resource is considered one of the most valuable yet least used by students?
 - MyPsychLab
 - PowerPoints
 - the instructor
 - lecture notes
- Your mom wants you to eat some breakfast before going off to your first psychology exam. What will you tell her?
 - No thanks. A big meal will probably put me to sleep.
 - Sounds good. Can I have some cereal and toast?
 - All I want is some coffee. Caffeine will help me do my best!
 - Thank you. Just some ham and eggs and maybe a small slice of bread.
- Tabitha is stuck on a question while taking her psychology exam. What should she do?
 - Stay on that question until she can figure out what the answer is.
 - Go on to the other questions. Maybe she can find a clue to the one she skipped.
 - Take a guess as to the correct answer. She probably will get it correct anyways.
 - Review the questions she already has answered to find a clue there.
- What is one of the most common mistakes students make when choosing a topic for a research paper?
 - The topic is too broad.
 - The topic is too narrow.
 - The topic is unclear.
 - The topic has no research to support it.
- Keela has finished a draft of her research paper almost two weeks before the date it is due. What should she do now?
 - Let it sit for a few days before reviewing it.
 - Complete the final draft immediately while the material is still fresh in her head.
 - Hand in her rough draft as if it were the final draft. Most students tend to make their paper worse when they revise it.
 - Keela needs to start again, since papers finished early tend not to be well written.

1

the science of psychology

Most people think of psychology as the study of weird people, odd behavior. But in reality, psychology is much, much more: the study of how each of us thinks, feels, and acts in our everyday life. You may not realize it, but you use psychology every day: when you correct a child's behavior, teach a pet a new trick, get a salesperson to give you what you want, or fall victim to a telemarketer's come-on. It's psychology in action when you talk with your significant other (or a friend or relative) when he or she is feeling down. Psychology is involved in both the tragedy of a person who commits an act of violence or terrorism for no apparent reason and in our reaction to that horrifying act. From everyday actions and interactions to the rarer triumphs and tragedies of life, psychology is all around us.

How would you define psychology? What do you hope to learn about psychology, yourself, and others after taking this course?

A video player interface featuring a young man with dark hair and a yellow polo shirt. He is positioned in front of a white background with a stylized brain diagram composed of colored dots and lines to his left. The video player includes a play button, volume control, closed captioning (CC), and a share icon at the bottom. A call-to-action button at the bottom left encourages users to "Watch the Video at MyPsychLab.com".

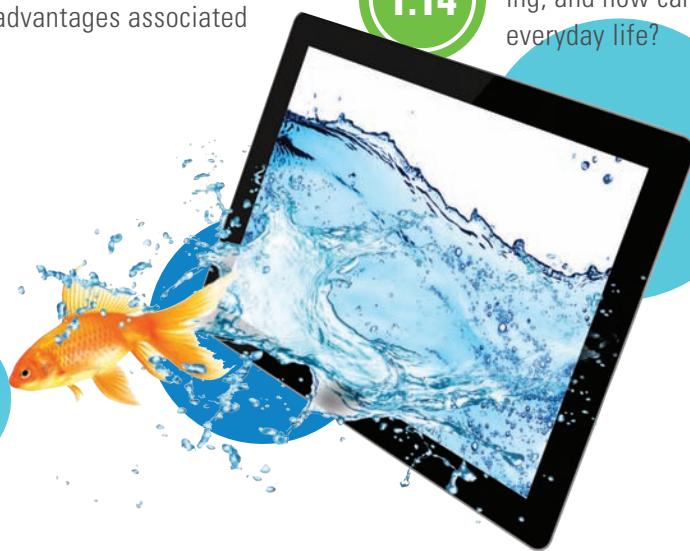
Watch the Video at [MyPsychLab.com](#)

Why study psychology?

Psychology not only helps you understand why people (and animals) do the things they do, but it also helps you better understand yourself and your reactions to others. Psychology can help you comprehend how your brain and body are connected, how to improve your learning abilities and memory, and how to deal with the stresses of life, both ordinary and extraordinary. In studying psychology, an understanding of the methods psychologists use is crucial because research can be flawed, and knowing how research should be done can bring those flaws to light. And finally, psychology and its research methods promote critical thinking, which can be used to evaluate not just research but also claims of all kinds, including those of advertisers and politicians.

Learning objectives

- 1.1** What defines psychology as a field of study, and what are psychology's four primary goals?
- 1.2** Who were some of the early pioneers in psychology, and how did structuralism and functionalism differ?
- 1.3** What were the basic ideas and who were the important people behind the early approaches known as Gestalt, psychoanalysis, and behaviorism?
- 1.4** What are the basic ideas behind the seven modern perspectives, and what were the important contributions of Skinner, Maslow, and Rogers?
- 1.5** How does a psychologist differ from a psychiatrist, and what are the other types of professionals who work in the various areas of psychology?
- 1.6** Why is psychology considered a science, and what are the steps in using the scientific method?
- 1.7** How are naturalistic and laboratory settings used to describe behavior, and what are some of the advantages and disadvantages associated with these settings?
- 1.8** How are case studies and surveys used to describe behavior, and what are some drawbacks to each of these methods?
- 1.9** What is the correlational technique, and what does it tell researchers about relationships?
- 1.10** What are the steps involved in designing an experiment?
- 1.11** How do the placebo and experimenter effects cause problems in an experiment, and what are some ways to control for these effects?
- 1.12** What are some basic elements of a real-world experiment?
- 1.13** What are some ethical concerns that can occur when conducting research with people and animals?
- 1.14** What are the basic principles of critical thinking, and how can critical thinking be useful in everyday life?



Success Center

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Dynamic Study Modules

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Study Methods

Managing Time

Reading the Text

Lecture Notes

Exam Prep

Paper Writing

Improve Memory

What Is Psychology?

What defines psychology as a field of study, and what are psychology's four primary goals?

Some people believe psychology is just the study of people and what motivates their behavior. Psychologists do study people, but they study animals as well. And to better understand what motivates behavior, psychologists study not only what people and animals do, but also what happens in their bodies and in their brains as they do it. Before examining the field of psychology, participate in the experiment *What Do You Know About Psychology?* to understand more about your own preconceived notions of people and human behavior.

Simulation

What Do You Know About Psychology?

This survey asks you about your attitudes towards and experiences with a broad range of psychological principles and theories.

Some people believe that our behaviors are mainly influenced by biology - by our genes, hormones, and brain chemistry. This is the nature perspective. Others believe that our behaviors are mainly influenced by our environment - by the rewards and punishments we receive, and by the things other people do or say to us. This is the nurture perspective. Which perspective do you agree with more strongly?

- Nature is more important.
- Nurture is more important.
- Nature and nurture are equally important.
- Not Sure

[Go to the Experiment ►](#)

Simulate the **Experiment**, *What Do You Know About Psychology?* at **MyPsychLab**

Psychology is the scientific study of behavior and mental processes. *Behavior* includes all of our outward or overt actions and reactions, such as talking, facial expressions, and movement. The term *mental processes* refers to all the internal, covert (hidden) activity of our minds, such as thinking, feeling, and remembering. Why “scientific”? To study behavior and mental processes in both animals and humans, researchers must observe them. Whenever a human being observes anyone or anything, there’s always a possibility that the observer will see only what he or she *expects* to see. Psychologists don’t want to let these possible biases* cause them to make faulty observations. They want to be precise, and to measure as carefully as they can—so they use the *scientific method* to study psychology.

PSYCHOLOGY'S GOALS

Every science has the common goal of learning how things work. The goals specifically aimed at uncovering the mysteries of human and animal behavior are description, explanation, prediction, and control.

*biases: personal judgments based on beliefs rather than facts.

DESCRIPTION: WHAT IS HAPPENING? The first step in understanding anything is to describe it. *Description* involves observing a behavior and noting everything about it: what is happening, where it happens, to whom it happens, and under what circumstances it seems to happen.

For example, a psychologist might wonder why so many computer scientists seem to be male. She makes further observations and notes that many “non-techie” stereotypically perceive the life and environment of a computer scientist as someone who lives and breathes at the computer and surrounds himself with computer games, junk food, and science-fiction gadgets—characteristics that add up to a very masculine ambiance.

That’s what *seems* to be happening. The psychologist’s observations are a starting place for the next goal: Why do females seem to avoid going into this environment?

EXPLANATION: WHY IS IT HAPPENING? Based on her observations, the psychologist might try to come up with a tentative explanation, such as “women feel they do not belong in such stereotypically masculine surroundings.” In other words, she is trying to understand or find an *explanation* for the lower proportion of women in this field. Finding explanations for behavior is a very important step in the process of forming theories of behavior. A *theory* is a general explanation of a set of observations or facts. The goal of description provides the observations, and the goal of explanation helps to build the theory.

The preceding example comes from a real experiment conducted by psychologist Sapna Cheryan and colleagues (Cheryan et al., 2009). Professor Cheryan (who teaches psychology at the University of Washington in Seattle) set up four experiments with more than 250 female and male student participants who were not studying computer science. In the first experiment, students came into a small classroom that had one of two sets of objects: either Star Trek® posters, video-game boxes, and Coke™ cans, or nature posters, art, a dictionary, and coffee mugs (among other things). Told to ignore the objects because they were sharing the room with another class, the students spent several minutes in the classroom. While still sitting in the classroom, they were asked to fill out a questionnaire asking about their attitude toward computer science. While the attitudes of male students were not different between the two environments, women exposed to the stereotypically masculine setup were less interested in computer science than those who were exposed to the nonstereotypical environment. The three other similar experiments yielded the same results.

PREDICTION: WHEN WILL IT HAPPEN AGAIN? Determining what will happen in the future is a *prediction*. In the Cheryan et al. study, the prediction is clear: If we want more women to go into computer science, we must do something to change either the environment or the perception of the environment typically associated with this field. This is the purpose of the last of the four goals of psychology: changing or modifying behavior.

CONTROL: HOW CAN IT BE CHANGED? The focus of control, or the modification of some behavior, is to change a behavior from an undesirable one (such as women avoiding a certain academic major) to a desirable one (such as more equality in career choices). Professor Cheryan suggests that changing the image of computer science may help increase the number of women choosing to go into this field.

Not all psychological investigations will try to meet all four of these goals. In some cases, the main focus might be on description and prediction, as it would be for a personality theorist who wants to know what people are like (description) and what they might do in certain situations (prediction). Some psychologists are interested in both



Is this an environment that you would want to work in? Some researchers have wondered if your answer might be influenced by your gender.

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description and explanation, as is the case with experimental psychologists who design research to find explanations for observed (described) behavior. Therapists may be more interested in controlling or influencing behavior and mental processes, although the other three goals would be important in achieving this objective.

Although these goals have not really changed over the years, in the time since psychology's beginnings, the methods of achieving them certainly have changed. In the next section, we'll take a look at the early pioneers in psychology.

Psychology Then: The History of Psychology



How long has psychology been around?

Psychology is a relatively new field in the realm of the sciences, only about 135 years old. It's not that no one thought about why people and animals do the things they do before then; on the contrary, there were philosophers,* medical doctors, and physiologists** who thought about little else—particularly with regard to people. Philosophers such as Plato, Aristotle, and Descartes tried to understand or explain the human mind and its connection to the physical body (Durrant, 1993; Everson, 1995; Kenny, 1968, 1994). Medical doctors and physiologists wondered about the physical connection between the body and the brain. For example, physician and physicist Gustav Fechner is often credited with performing some of the first scientific experiments that would form a basis for experimentation in psychology with his studies of perception (Fechner, 1860), and physician Hermann von Helmholtz (von Helmholtz, 1852, 1863) performed groundbreaking experiments in visual and auditory perception. to Learning Objectives 3.1 and 3.3.

IN THE BEGINNING: WUNDT, INTROSPECTION, AND THE LABORATORY

Who were some of the earlier pioneers in psychology, and how did structuralism and functionalism differ?

It really all started to come together in a laboratory in Leipzig, Germany, in 1879. It was here that Wilhelm Wundt (VILL-helm Voont, 1832–1920), a physiologist, attempted to apply scientific principles to the study of the human mind. In his laboratory, students from around the world were taught to study the structure of the human mind. Wundt believed that consciousness, the state of being aware of external events, could be broken down into thoughts, experiences, emotions, and other basic elements. In order to inspect these nonphysical elements, students had to learn to think objectively about their own thoughts—after all, they could hardly read someone else's mind. Wundt called this process **objective introspection**, the process of objectively examining and measuring one's own thoughts and mental activities (Rieber & Robinson, 2001). For example, Wundt might place an object, such as a rock, into a student's hand and have the student tell him everything that he was feeling as a result of having the rock in his hand—all the sensations stimulated by the rock. (Objectivity*** was—and is—important because scientists need to remain unbiased. Observations need to be clear and precise, but unaffected by the individual observer's beliefs and values.)



German physiologist Wilhelm Wundt.

*philosophers: people who seek wisdom and knowledge through thinking and discussion.

**physiologists: scientists who study the physical workings of the body and its systems.

***objectivity: expressing or dealing with facts or conditions as they really are without allowing the influence of personal feelings, prejudices, or interpretations.

This was really the first attempt by anyone to bring objectivity and measurement to the concept of psychology. This attention to objectivity, together with the establishment of the first true experimental laboratory in psychology, is why Wundt is known as the father of psychology.

TITCHENER AND STRUCTURALISM IN AMERICA

One of Wundt's students was Edward Titchener (1867–1927), an Englishman who eventually took Wundt's ideas to Cornell University in Ithaca, New York. Titchener expanded on Wundt's original ideas, calling his new viewpoint **structuralism** because the focus of study was the structure of the mind. He believed that every experience could be broken down into its individual emotions and sensations (Brennan, 2002). Although Titchener agreed with Wundt that consciousness could be broken down into its basic elements, Titchener also believed that objective introspection could be used on thoughts as well as on physical sensations. For example, Titchener might have asked his students to introspect about things that are blue rather than actually giving them a blue object and asking for reactions to it. Such an exercise might have led to something like the following: "What is blue? There are blue things, like the sky or a bird's feathers. Blue is cool and restful, blue is calm ..." and so on.

In 1894, one of Titchener's students at Cornell University became famous for becoming the first woman to receive a Ph.D. in psychology (Goodman, 1980; Guthrie, 2004). Her name was Margaret F. Washburn, and she was Titchener's only graduate student for that year. In 1908 she published a book on animal behavior that was considered an important work in that era of psychology, *The Animal Mind* (Washburn, 1908).

Structuralism was a dominant force in the early days of psychology, but it eventually died out in the early 1900s, as the structuralists were busily fighting among themselves over just which key elements of experience were the most important. A competing view arose not long after Wundt's laboratory was established, shortly before structuralism came to America.

WILLIAM JAMES AND FUNCTIONALISM

Harvard University was the first school in America to offer classes in psychology in the late 1870s. These classes were taught by one of Harvard's most illustrious instructors, William James (1842–1910). James began teaching anatomy and physiology, but as his interest in psychology developed, he began teaching it almost exclusively (Brennan, 2002). His comprehensive textbook on the subject, *Principles of Psychology*, is so brilliantly written that copies are still in print (James, 1890, 2002).

Unlike Wundt and Titchener, James was more interested in the importance of consciousness to everyday life rather than just its analysis. He believed that the scientific study of consciousness itself was not yet possible. Conscious ideas are constantly flowing in an ever-changing stream, and once you start thinking about what you were just thinking about, what you were thinking about is no longer what you *were* thinking about—it's what you *are* thinking about—and ... excuse me, I'm a little dizzy. I think you get the picture, anyway.

Instead, James focused on how the mind allows people to *function* in the real world—how people work, play, and adapt to their surroundings, a viewpoint he called **functionalism**. (He was heavily influenced by Charles Darwin's ideas about *natural selection*, in which physical traits that help an animal adapt to its environment and survive are passed on to its offspring.) If physical traits could aid in survival, why couldn't behavioral traits do the same? Animals and people whose behavior helped them to survive would pass those traits on to their offspring, perhaps by teaching or even by some mechanism of heredity.* (Remember that this was early in the days of trying to understand how heredity



Structuralists would be interested in all of the memories and sensations this woman is experiencing as she smells the rose.

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*heredity: the transmission of traits and characteristics from parent to offspring through the actions of genes.

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Mary Whiton Calkins, despite being denied a Ph.D. degree by Harvard because she was a woman, became the first female president of the American Psychological Association and had a successful career as a professor and researcher.



Francis Cecil Sumner, the first African American to receive a Ph.D. in psychology, went on to chair the psychology department at Howard University and is considered by many to be the father of African American psychology.

worked.) For example, a behavior such as avoiding the eyes of others in an elevator can be seen as a way of protecting one's personal space—a kind of territorial protection that may have its roots in the primitive need to protect one's home and source of food and water from intruders (Manusov & Patterson, 2006) or as a way of avoiding what might seem like a challenge to another person (Brown et al., 2005; Jehn et al., 1999).

It is interesting to note that one of James's early students was Mary Whiton Calkins, who completed every course and requirement for earning a Ph.D. but was denied that degree by Harvard University because she was a woman. She was allowed to take those classes as a guest only. Calkins eventually established a psychological laboratory at Wellesley College. Her work was some of the earliest research in the area of human memory and the psychology of the self. In 1905, she became the first female president of the American Psychological Association (Furumoto, 1979, 1991; Zedler, 1995). Unlike Washburn, Calkins never earned the elusive Ph.D. degree despite a successful career as a professor and researcher (Guthrie, 2004).

Women were not the only minority to make contributions in the early days of psychology. In 1920, for example, Francis Cecil Sumner became the first African American to earn a Ph.D. in psychology at Clark University. He eventually became the chair of the psychology department at Howard University and is assumed by many to be the father of African American psychology (Guthrie, 2004). Kenneth and Mamie Clark worked to show the negative effects of school segregation on African American children (Lal, 2002). In the 1940s, Hispanic psychologist George (Jorge) Sanchez conducted research in the area of intelligence testing, focusing on the cultural biases in such tests (Tevis, 1994). Since those early days, psychology has seen an increase in the contributions of all minorities, although the percentages are still small when compared to the population at large. For a summary of the contributions of African Americans to the early days of psychology, see the following section, *Issues in Psychology: Psychology's African American Roots*.



Is functionalism still an important point of view in psychology?

In the new field of psychology, functionalism offered an alternative viewpoint to the structuralists. But like so many of psychology's early ideas, it is no longer a major perspective. Instead, one can find elements of functionalism in the modern fields of *educational psychology* (studying the application of psychological concepts to education) and *industrial/organizational psychology* (studying the application of psychological concepts to businesses, organizations, and industry), as well as other areas in psychology.  to Learning Objective B.6. Functionalism also played a part in the development of one of the more modern perspectives, evolutionary psychology, discussed later in this chapter.

issues in psychology

Psychology's African American Roots



Even the Rat Was White is a book written by the late Dr. Robert V. Guthrie in 1976 and recently republished (Guthrie, 2004). It is a summary of the history of African Americans in the field of psychology. The contributions to early psychology of African American psychologists have often been ignored in textbooks. Dr. Guthrie includes in his text a detailed listing of the important African American psychologists and their contributions to the relatively new field of psychology. The following is a brief summary of just a few of these often neglected scholars and their work.

- Dr. Charles Henry Thompson (1896–1980) was the first African American to receive a doctorate in educational psychology in 1925 from the University of Chicago. For 30 years he was the editor of the *Journal of Negro Education*.
- Dr. Albert Sidney Beckham (1897–1964) received his Ph.D. in psychology in 1930 from New York University. He was senior assistant psychologist at the National Committee for Mental Hygiene at the Illinois Institute for Juvenile Research in the early 1930s; he also counseled many Black youths in his role as the psychologist at DuSable High School in Chicago. He, like Thompson, had many publications of his research in the areas of intelligence and social concerns of the African American youth of his time.
- Dr. Robert Prentiss Daniel (1902–1968) earned his Ph.D. in educational psychology from Columbia University in 1932. At one time the director of the Division of Educational Psychology and Philosophy at Virginia Union University, he became president of Shaw University in North Carolina and finally the president of Virginia State College.
- Dr. Inez Beverly Prosser (1897–1934) earned her Ph.D. in educational psychology from the University of Cincinnati in 1933 and was the first African American woman to earn this degree. Her promising teaching career met a tragic end when she died in an automobile accident only 1 year after earning her doctorate.
- Dr. Howard Hale Long (1888–1948) received his Ed.D. in educational psychology from Harvard University in 1933. After teaching psychology and doing research in educational psychology for many years, Dr. Long became dean of administration at Wilberforce State College in Ohio.
- Dr. Ruth Howard (1900–1997) is known as the first African American woman to earn a Ph.D. in psychology (not educational psychology) in 1934 from the University of Minnesota. She served with her husband, Dr. Albert Beckham, as codirector for the Center for Psychological Services and also maintained a private practice in clinical psychology.

These few African American pioneers in the field of psychology represent only a fraction of all those who made important contributions to psychology's early days.

Questions for Further Study:

1. What kind of challenges might African American women have faced in the early days of psychology?
2. Are there people or areas of study in psychology today that you think might face similar challenges?

GESTALT PSYCHOLOGY: THE WHOLE IS GREATER THAN THE SUM OF ITS PARTS

What were the basic ideas and who were the important people behind the early approaches known as Gestalt, psychoanalysis, and behaviorism?

Meanwhile, back in Germany, other psychologists were attacking the concepts of psychology in yet another way. Max Wertheimer (VERT-hi-mer), like James, objected to the structuralist point of view, but for different reasons. Wertheimer believed that psychological events such as perceiving* and sensing** could not be broken down into any smaller elements and still be properly understood. For example, you can take a smartphone apart, but then you no longer have a smartphone—you have a pile of unconnected bits and pieces. Or, just as a melody is made up of individual notes that can only be understood if the notes are in the correct relationship to one another, so perception can only

*perceiving: becoming aware of something through the senses.

**sensing: seeing, hearing, feeling, tasting, or smelling something.

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Figure 1.1 A Gestalt Perception

The eye tends to “fill in” the blanks here and sees both of these figures as circles rather than as a series of dots or a broken line.

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be understood as a whole, entire event. Hence, the familiar slogan, “The whole is greater than the sum of its parts.” Wertheimer and others believed that people naturally seek out patterns (“wholes”) in the sensory information available to them.

Wertheimer and others devoted their efforts to studying sensation and perception in this new perspective, **Gestalt psychology**. *Gestalt* (Gesh-TALT) is a German word meaning “an organized whole” or “configuration,” which fit well with the focus on studying whole patterns rather than small pieces of them. See **Figure 1.1** for an example of Gestalt perceptual patterns. Today, Gestalt ideas are part of the study of *cognitive psychology*, a field focusing not only on perception but also on learning, memory, thought processes, and problem solving; the basic Gestalt principles of perception are still taught within this newer field (Ash, 1998; Kohler, 1992; Wertheimer, 1982). [LINK](#) to Learning Objective 3.9. The Gestalt approach has also been influential in psychological therapy, becoming the basis for a therapeutic technique called *Gestalt therapy*. [LINK](#) to Learning Objective 15.3.

SIGMUND FREUD'S THEORY OF PSYCHOANALYSIS

It should be clear by now that psychology didn’t start in one place and at one particular time. People of several different viewpoints were trying to promote their own perspective on the study of the human mind and behavior in different places all over the world. Up to now, this chapter has focused on the physiologists who became interested in psychology, with a focus on understanding consciousness but little else. The medical profession took a whole different approach to psychology.



What about Freud? Everybody talks about him when they talk about psychology. Are his ideas still in use?

Sigmund Freud had become a noted physician in Austria while the structuralists were arguing, the functionalists were specializing, and the Gestaltists were looking at the big picture. Freud was a neurologist, a medical doctor who specializes in disorders of the nervous system; he and his colleagues had long sought a way to understand the patients who were coming to them for help.

Freud’s patients suffered from nervous disorders for which he and other doctors could find no physical cause. Therefore, it was thought, the cause must be in the mind, and that is where Freud began to explore. He proposed that there is an *unconscious* (un-aware) mind into which we push, or *repress*, all of our threatening urges and desires. He believed that these repressed urges, in trying to surface, created the nervous disorders in his patients (Freud et al., 1990). [LINK](#) to Learning Objective 13.2.

Freud stressed the importance of early childhood experiences, believing that personality was formed in the first 6 years of life; if there were significant problems, those problems must have begun in the early years.

Some of his well-known followers were Alfred Adler, Carl Jung, and his own daughter, Anna Freud. Anna Freud began what became known as the ego movement in psychology, which produced one of the best-known psychologists in the study of personality development, Erik Erikson. [LINK](#) to Learning Objective 8.7.

Freud’s ideas are still influential today, although in a somewhat modified form. He had a number of followers in addition to those already named, many of whom became famous by altering Freud’s theory to fit their own viewpoints, but his basic ideas are still discussed and debated. [LINK](#) to Learning Objective 13.3.

While some might think that Sigmund Freud was the first person to deal with people suffering from various mental disorders, the truth is that mental illness has a fairly long (and not very pretty) history. For more on the history of mental illness, see the [LINK](#) to Learning Objective 14.1.



Psychoanalyst Sigmund Freud walks with his daughter Anna, also a psychoanalyst.

Freudian **psychoanalysis**, the theory and therapy based on Freud's ideas, has been the basis of much modern *psychotherapy* (a process in which a trained psychological professional helps a person gain insight into and change his or her behavior), but another major and competing viewpoint has actually been more influential in the field of psychology as a whole.

PAVLOV, WATSON, AND THE DAWN OF BEHAVIORISM

Ivan Pavlov, like Freud, was not a psychologist. He was a Russian physiologist who showed that a *reflex* (an involuntary reaction) could be caused to occur in response to a formerly unrelated stimulus. While working with dogs, Pavlov observed that the salivation reflex (which is normally produced by actually having food in one's mouth), could be caused to occur in response to a totally new stimulus, in this case, the sound of a ticking metronome. At the onset of his experiment, Pavlov would turn on the metronome, give the dogs food, and they would salivate. After several repetitions, the dogs would salivate to the sound of the metronome *before* the food was presented—a learned (or “conditioned”) reflexive response (Klein & Mowrer, 1989). This process was called *conditioning*.

 to Learning Objective 5.2.

By the early 1900s, psychologist John B. Watson had tired of the arguing among the structuralists; he challenged the functionalist viewpoint, as well as psychoanalysis, with his own “science of behavior,” or **behaviorism** (Watson, 1924). Watson wanted to bring psychology back to a focus on scientific inquiry, and he felt that the only way to do that was to ignore the whole consciousness issue and focus only on *observable behavior*—something that could be directly seen and measured. He had read of Pavlov’s work and thought that conditioning could form the basis of his new perspective of behaviorism.

Watson was certainly aware of Freud’s work and his views on unconscious repression. Freud believed that all behavior stems from unconscious motivation, whereas Watson believed that all behavior is learned. Freud had stated that a *phobia*, an irrational fear, is really a symptom of an underlying, repressed conflict and cannot be “cured” without years of psychoanalysis to uncover and understand the repressed material.

Watson believed that phobias are learned through the process of conditioning and set out to prove it. Along with his colleague Rosalie Rayner, he took a baby, known as “Little Albert,” and taught him to fear a white rat by making a loud, scary noise every time the infant saw the rat, until finally, just seeing the rat caused the infant to cry and become fearful (Watson & Rayner, 1920). Even though “Little Albert” was not afraid of the rat at the start, the experiment worked very well—in fact, he later appeared to be afraid of other fuzzy things including a rabbit, a dog, and a sealskin coat.  to Learning Objective 5.3.

 This sounds really bizarre—what does scaring a baby have to do with the science of psychology?

Watson wanted to prove that all behavior was a result of a stimulus–response relationship such as that described by Pavlov. Because Freud and his ideas about unconscious motivation were becoming a dominant force, Watson felt the need to show the world that a much simpler explanation could be found. Although scaring a baby sounds a little cruel, he felt that the advancement of the science of behavior was worth the baby’s relatively brief discomfort.

A graduate student of Watson’s named Mary Cover Jones later decided to repeat Watson and Rayner’s study but added training that would “cancel out” the phobic reaction of the baby to the white rat. She duplicated the “Little Albert” study with another child, “Little Peter,” successfully conditioning Peter to be afraid of a white rabbit (Jones, 1924). She then began a process of *counterconditioning*, in which Peter was exposed to the



American psychologist John Watson is known as the father of behaviorism. Behaviorism focuses only on observable behavior.

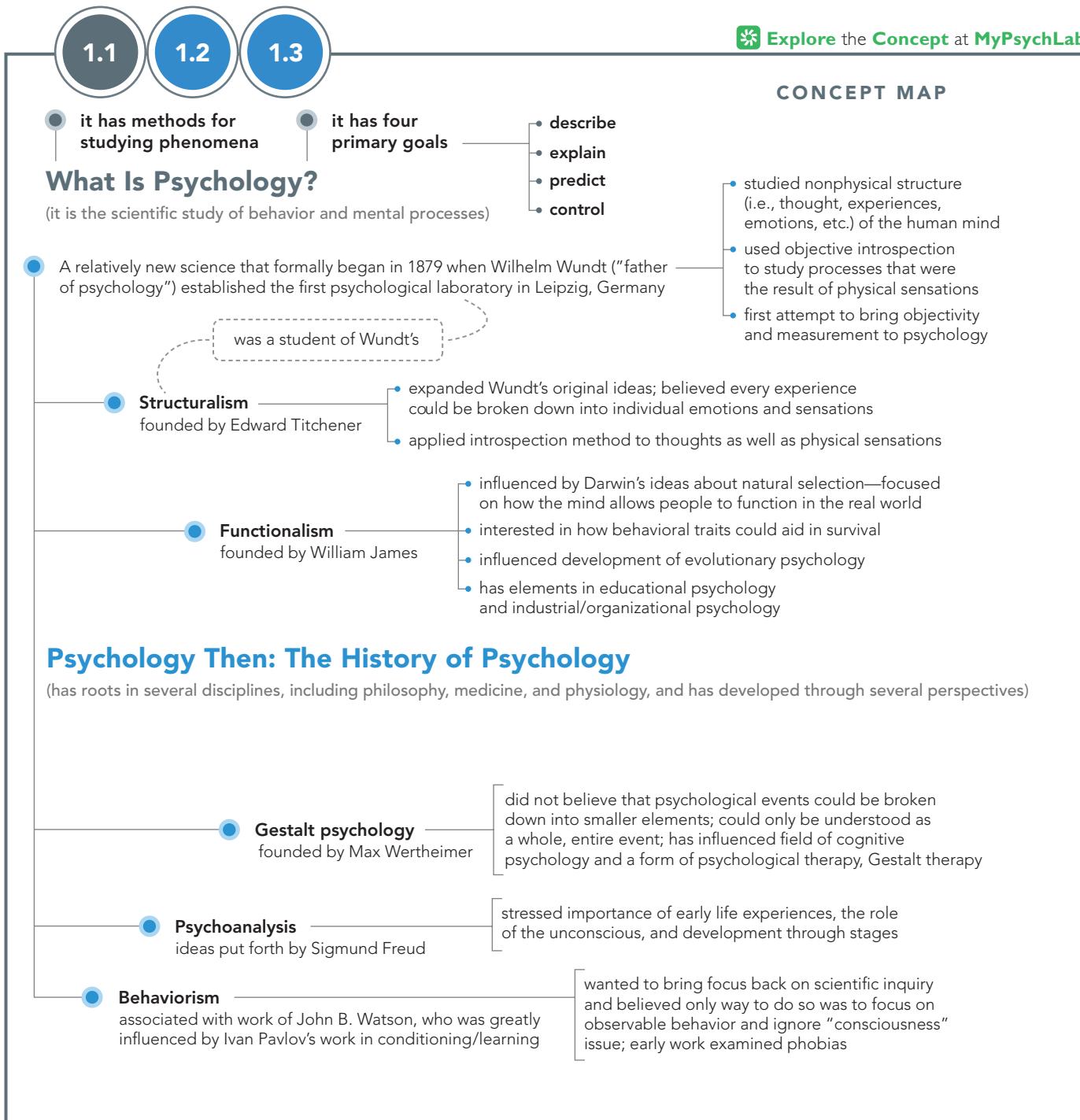
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Mary Cover Jones, one of the early pioneers of behavior therapy, earned her master’s degree under the supervision of John Watson. Her long and distinguished career also included the publication in 1952 of the first educational television course in child development (Rutherford, 2000).

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white rabbit from a distance while eating a food that he really liked. The pleasure of the food outweighed the fear of the faraway rabbit. Day by day, the situation was repeated with the rabbit being brought closer each time, until Peter was no longer afraid of the rabbit. Jones went on to become one of the early pioneers of behavior therapy. Behaviorism is still a major perspective in psychology today. It has also influenced the development of other perspectives, such as *cognitive psychology*.



PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Study Help Note: These practice quizzes are spaced throughout each chapter to give you an opportunity to check your understanding of the material in each section and to provide practice for exams.

Pick the best answer.

1. In the definition of psychology, *mental processes* means
 - a. internal, covert processes.
 - b. unconscious processes.
 - c. outward or overt actions and reactions.
 - d. only human behavior.

2. Dr. Baker designs an experiment for studying lab rats' reaction to energy drinks in relation to problem solving. Dr. Baker is most interested in the goal of
 - a. description.
 - b. explanation.
 - c. prediction.
 - d. control.

3. Results of the study by Cheryan et al. (2009) suggest that changes must occur to the perception of the computer science field. This illustrates the goal of
 - a. description.
 - b. explanation.
 - c. prediction.
 - d. control.

4. Which of the following early psychologists would have been most likely to agree with the statement, "The study of the mind should focus on how it functions in everyday life"?
 - a. Wilhelm Wundt
 - b. William James
 - c. John Watson
 - d. Sigmund Freud

5. Who was the first woman to complete the coursework for a doctorate at Harvard University?
 - a. Mary Whiton Calkins
 - b. Mary Cover Jones
 - c. Margaret Washburn
 - d. Ruth Howard

6. Which early perspective tried to return to a focus on scientific inquiry by ignoring the study of consciousness?
 - a. behaviorism
 - b. functionalism
 - c. psychoanalysis
 - d. Gestalt

THINKING CRITICALLY:

Would it be possible to do a study such as Watson and Rayner's "Little Albert" research today? Why or why not? What might justify such a study today?

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Psychology Now: Modern Perspectives

What are the basic ideas behind the seven modern perspectives, and what were the important contributions of Skinner, Maslow, and Rogers?

Even in the twenty-first century, there isn't one single perspective that is used to explain all human behavior and mental processes. There are actually seven modern perspectives, with two of those being holdovers from the early days of the field. Watch the video *The Basics: Diverse Perspectives* to get a quick overview of the perspectives before we continue on.

The video player interface includes a play button, volume control, closed captioning (CC), and a share icon.

[Watch the Video](#), *The Basics: Diverse Perspectives*, at [MyPsychLab](#)

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PSYCHODYNAMIC PERSPECTIVE

Freud's theory is still used by many professionals in therapy situations. It is far less common today than it was a few decades ago, however, and even those who use his techniques modify them for contemporary use. In the more modern **psychodynamic perspective**, the focus may still include the unconscious mind and its influence over conscious behavior and on early childhood experiences, but with less of an emphasis on sex and sexual motivations and more emphasis on the development of a sense of self, social and interpersonal relationships, and the discovery of other motivations behind a person's behavior. [LINK](#) to Learning Objective 13.3. Some modern psychodynamic practitioners have even begun to recommend that the link between neurobiology (the study of the brain and nervous system) and psychodynamic concepts should be more fully explored (Glucksman, 2006).



Behaviorist B. F. Skinner puts a rat through its paces. What challenges might arise from applying information gained from studies with animals to human behavior?

BEHAVIORAL PERSPECTIVE

Like modern psychodynamic perspectives, behaviorism is still also very influential. When its primary supporter, John B. Watson, moved on to greener pastures in the world of advertising, B. F. Skinner became the new leader of the field.

Skinner not only continued research in classical conditioning, but he also developed a theory called *operant conditioning*, to explain how voluntary behavior is learned (Skinner, 1938). In this theory, *behavioral responses* that are followed by pleasurable consequences are strengthened, or *reinforced*. For example, a child who cries and is rewarded by getting his mother's attention will cry again in the future. Skinner's work is discussed later in more depth. [LINK](#) to Learning Objective 5.4. In addition to the psychodynamic and behavioral perspectives, there are five newer perspectives that have developed within the last 50 years.

HUMANISTIC PERSPECTIVE

Often called the "third force" in psychology, humanism was really a reaction to both psychoanalytic theory and behaviorism. If you were a psychologist in the early to mid-1900s, you were either a psychoanalyst or a behaviorist—there weren't any other major viewpoints to rival those two.

In contrast to the psychoanalytic focus on sexual development and behaviorism's focus on external forces in guiding personality development, some professionals began to develop a perspective that would allow them to focus on people's ability to direct their own lives. Humanists held the view that people have *free will*, the freedom to choose their own destiny, and strive for *self-actualization*, the achievement of one's full potential. Two of the earliest and most famous founders of this view were Abraham Maslow (1908–1970) and Carl Rogers (1902–1987). Today, humanism exists as a form of psychotherapy aimed at self-understanding and self-improvement. [LINK](#) to Learning Objective 15.3.

COGNITIVE PERSPECTIVE

Cognitive psychology, which focuses on how people think, remember, store, and use information, became a major force in the field in the 1960s. It wasn't a new idea, as the Gestalt psychologists had themselves supported the study of mental processes of learning. The development of computers (which just happened to make pretty good models of human thinking) and discoveries in biological psychology all stimulated an interest in studying the processes of thought. The **cognitive perspective** with its focus on memory, intelligence, perception, thought processes, problem solving, language, and learning has become a major force in psychology. [LINK](#) to Chapter Seven: Cognition.

Within the cognitive perspective, the relatively new field of **cognitive neuroscience** includes the study of the physical workings of the brain and nervous system when

engaged in memory, thinking, and other cognitive processes. Cognitive neuroscientists use tools for imaging the structure and activity of the living brain, such as magnetic resonance imaging (MRI), functional magnetic resonance imaging (fMRI), and positron emission tomography (PET).  to [Learning Objective 2.6](#). The continually developing field of brain imaging is important in the study of cognitive processes.

SOCIOCULTURAL PERSPECTIVE

Another modern perspective in psychology is the **sociocultural perspective**, which actually combines two areas of study: *social psychology*, which is the study of groups, social roles, and rules of social actions and relationships; and *cultural psychology*, which is the study of cultural norms,* values, and expectations. These two areas are related in that they are both about the effect that people have on one another, either individually or in a larger group such as a culture (Peplau & Taylor, 1997).  to [Chapter Twelve: Social Psychology](#). Think about it: don't you behave differently around your family members than you do around your friends? Would you act differently in another country than you do in your native land? Russian psychologist Lev Vygotsky (1978) also used sociocultural concepts in forming his sociocultural theory of children's cognitive development.  to [Learning Objective 8.6](#).

The sociocultural perspective is important because it reminds people that the way they and others behave (or even think) is influenced not only by whether they are alone, with friends, in a crowd, or part of a group but also by the social norms, fads, class differences, and ethnic identity concerns of the particular culture in which they live. *Cross-cultural research* also fits within this perspective. In cross-cultural research, the contrasts and comparisons of a behavior or issue are studied in at least two or more cultures. This type of research can help illustrate the different influences of environment (culture and training) when compared to the influence of heredity (genetics, or the influence of genes on behavior).

For example, in a classic study covered in Chapter Twelve: Social Psychology, researchers Dr. John Darley and Dr. Bibb Latané (1968) found that the presence of other people actually *lessened* the chances that a person in trouble would receive help. The phenomenon is called the “bystander effect” and it is believed to be the result of *diffusion of responsibility*, which is the tendency to feel that someone else is responsible for taking action when others are present. But would this effect appear in other cultures? Lieutenant-Commander George Shorey (2001), in his discussion of the brutal beating death of a Somali prisoner in a Canadian military facility while bystanders looked on without acting, suggests that it just might. But is Canadian culture too similar to our own to lead us to this conclusion? Would another culture very different from Western culture show the same effect? This is exactly the kind of question that the sociocultural perspective asks and attempts to answer, using cross-cultural research.

BIOPSYCHOLOGICAL PERSPECTIVE

Biopsychology, or the study of the biological bases of behavior and mental processes, isn't really as new a perspective as one might think. Also known as physiological psychology, biological psychology, psychobiology, and behavioral neuroscience, biopsychology is part of the larger field of *neuroscience*: study of the physical structure, function, and development of the nervous system. Also, the previously discussed field of cognitive neuroscience often overlaps with biopsychology.

In the **biopsychological perspective**, human and animal behavior is seen as a direct result of events in the body. Hormones, heredity, brain chemicals, tumors, and diseases are some of the biological causes of behavior and mental events.  to [Chapter Two: The Biological Perspective](#). Some of the topics researched by biopsychologists include sleep, emotions, aggression, sexual behavior, and learning and memory—as well as

*norms: standards or expected behavior.

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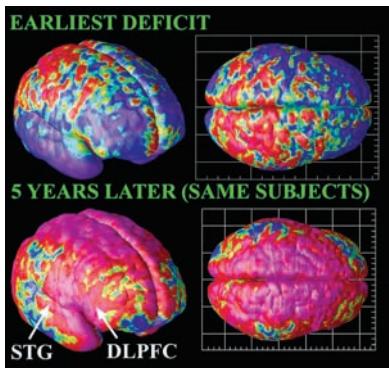
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These scans highlight gray matter loss in the brains of individuals with very early-onset, adolescent schizophrenia over a five-year period, highlighting one focus of the biological perspective.

disorders. While disorders may have multiple causes (family issues, stress, or trauma, for example), research in biopsychology points clearly to biological factors as one of those causes.

For example, evidence continues to mount for a genetic cause for *schizophrenia*, a mental disorder involving delusions (false beliefs), hallucinations (false sensory impressions), and extremely distorted thinking (Brzustowicz et al., 2004; Maziade et al., 1997; Pogue-Geile & Yokley, 2010; Zhang et al., 2012). [LINK](#) to Learning Objective 14.8. Other research suggests that human sexual orientation may be related to the developing baby's exposure in the womb to testosterone, especially in females (Breedlove, 2010; Grimbos et al., 2010), as well as the birth order of male children (Puts et al., 2006). The birth order study suggests that the more older brothers a male child has, the more likely he is to have a homosexual orientation (Puts et al., 2006). [LINK](#) to Learning Objective 10.7. Still another example of research in this field is a study finding a possible link between the tendency to lose one's train of thought in later adulthood—staring into space, unexplained excessive daytime sleepiness, and disorganized thinking, for example—and the development of Alzheimer's disease (Escandon et al., 2010). [LINK](#) to Learning Objective 6.12.

EVOLUTIONARY PERSPECTIVE

The **evolutionary perspective** focuses on the biological bases for universal mental characteristics that all humans share. It seeks to explain general mental strategies and traits, such as why we lie, how attractiveness influences mate selection, why fear of snakes is so common, or why people universally like music and dancing. This approach may also overlap with biopsychology and the sociocultural perspective.

In this perspective, the mind is seen as a set of information-processing machines, designed by the same process of natural selection that Darwin (1859) first theorized, allowing human beings to solve the problems faced in the early days of human evolution—the problems of the early hunters and gatherers. For example, *evolutionary psychologists* (psychologists who study the evolutionary origins of human behavior) would view the human behavior of not eating substances that have a bitter taste (such as poisonous plants) as an adaptive* behavior that evolved as early humans came into contact with such bitter plants. Those who ate the bitter plants would die, while those who spit them out survived to pass on their "I-don't-like-this-taste" genes to their offspring, who would pass on the genes to *their* offspring, and so on, until after a long period of time there is an entire population of humans that naturally avoids bitter-tasting substances.

That explains why people don't like bitter stuff, like the white part of an orange peel, but that's really a physical thing. How would the evolutionary perspective help us understand something psychological like relationships?

Relationships between men and women are one of the many areas in which evolutionary psychologists conduct research. For example, in one study researchers surveyed young adults about their relationships with the opposite sex, asking the participants how likely they would be to forgive either a sexual infidelity or an emotional one (Shackelford et al., 2002). Evolutionary theory would predict that men would find it more difficult to forgive a woman who had sex with someone else than a woman who was only emotionally involved with someone, because the man wants to be sure that the children the woman bears are his (Geary, 2000, 2012). Why put all that effort into providing for children who could be another man's offspring? Women, on the other hand, should find it harder to forgive an emotional infidelity, as they are always sure that their children are

*adaptive: having the quality of adjusting to the circumstances or need; in the sense used here, a behavior that aids in survival.

their own, but (in evolutionary terms, mind you) they need the emotional loyalty of the men to provide for those children (Buss et al., 1992; Daly et al., 1982; Edlund et al., 2006). The results support the prediction: Men find it harder to forgive a partner's sexual straying and are more likely to break up with the woman than if the infidelity is purely emotional; for women, the opposite results were found. Other research concerning mating has found that women seem to use a man's kissing ability to determine his worthiness as a potential mate (Hughes et al., 2007; Walter, 2008).

You may have realized as you read through the various perspectives that no one perspective has all the answers. Some perspectives are more scientific (e.g., behavioral and cognitive) while others are based more in thinking about human behavior (e.g., psychodynamic and humanistic). Some, like sociocultural, biopsychological, and evolutionary perspectives, are related to each other. Psychologists will often take an *eclectic* perspective—one that uses the “bits and pieces” of several perspectives that seem to best fit a particular situation.

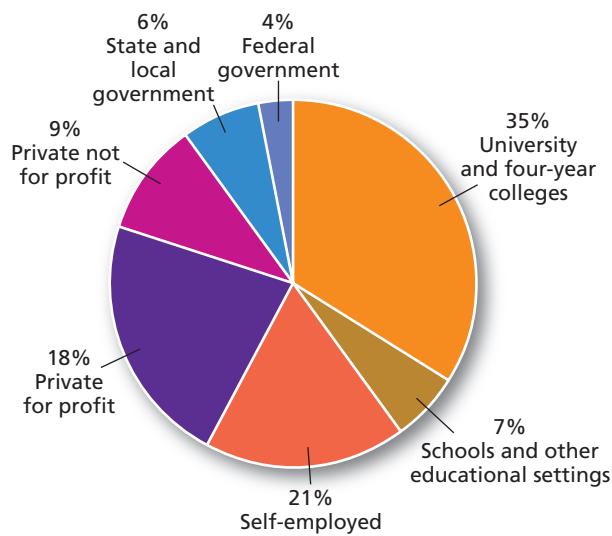
Psychological Professionals and Areas of Specialization

How does a psychologist differ from a psychiatrist, and what are the other types of professionals who work in the various areas of psychology?

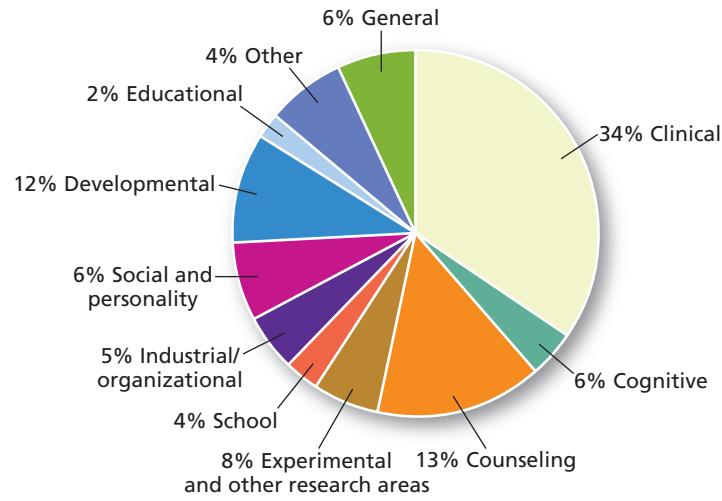
Psychology is a large field, and the many professionals working within it have different training, different focuses, and may have different goals from the typical psychologist.

 Watch the Video, *The Big Picture: Asking the Tough Questions*, at [MyPsychLab](#)

A **psychologist** has no medical training but has a doctorate degree. Psychologists undergo intense academic training, learning about many different areas of psychology before choosing a specialization. Because the focus of their careers can vary so widely, psychologists work in many different vocational* settings. **Figure 1.2a** shows the types of settings in which psychologists work. Remember, not all psychologists are trained to do counseling! Psychologists in the counseling specialization must also be licensed to practice in their states.



a. Where Psychologists Work

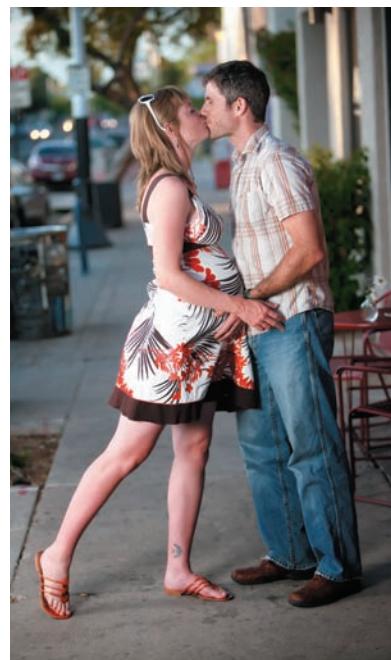


b. Subfields of Psychology

Figure 1.2 Work Settings and Subfields of Psychology

(a) There are many different work settings for psychologists. Although not obvious from the chart, many psychologists work in more than one setting. For example, a clinical psychologist may work in a hospital setting and teach at a university or college (Tsapogas et al., 2006). (b) This pie chart shows the specialty areas of psychologists who recently received their doctorates (Hoffer et al., 2007).

*vocational: having to do with a job or career.



Psychologists with an evolutionary perspective would be interested in how this couple selected each other as partners.

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In contrast, a **psychiatrist** has a medical degree and is a physician who specializes in the diagnosis and treatment (including the prescription of medications) of psychological disorders. A **psychiatric social worker** is trained in the area of social work and usually possesses a master's degree in that discipline. These professionals focus more on the environmental conditions that can have an impact on mental disorders, such as poverty, overcrowding, stress, and drug abuse.

 You said not all psychologists do counseling. But I thought that was all that psychologists do—what else is there?

Although many psychologists do participate in delivering therapy to people who need help, there is a nearly equal number of psychologists who do other tasks: researching, teaching, designing equipment and workplaces, and developing educational methods, for example. Also, not every psychologist is interested in the same area of human—or animal—behavior, and most psychologists work in several different areas of interest, as shown in **Figure 1.2b**, “Subfields of Psychology.”

Those psychologists who do research have two types of research to consider: basic research versus applied research. **Basic research** is research for the sake of gaining scientific knowledge. For example, a researcher might want to know how many “things” a person can hold in memory at any one time. The other form of research is **applied research**, which is research aimed at answering real-world, practical problems. An applied researcher might take the information from the basic researcher’s memory study and use it to develop a new study method for students. Some of the subfields in Figure 1.2b tend to do more basic research, such as experimental and cognitive psychologists, while others may focus more on applied research, such as educational, school, and industrial/organizational psychologists.

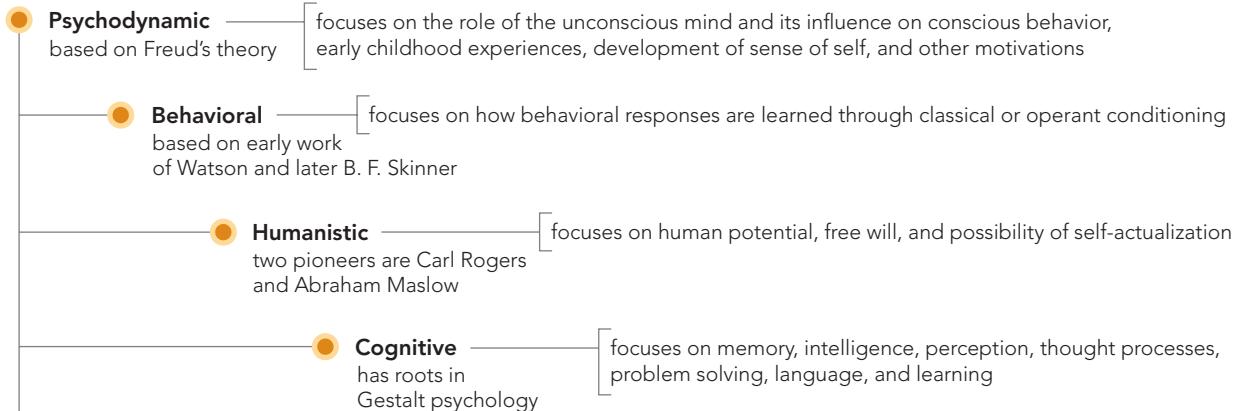
There are many other areas of specialization: Psychology can be used in fields such as health; sports performance; legal issues; business concerns; and even in the design of equipment, tools, and furniture. For a more detailed look at some of the areas in which psychological principles can be applied and a listing of careers that can benefit from a degree in psychology, see  to [Appendix B: Applied Psychology](#).



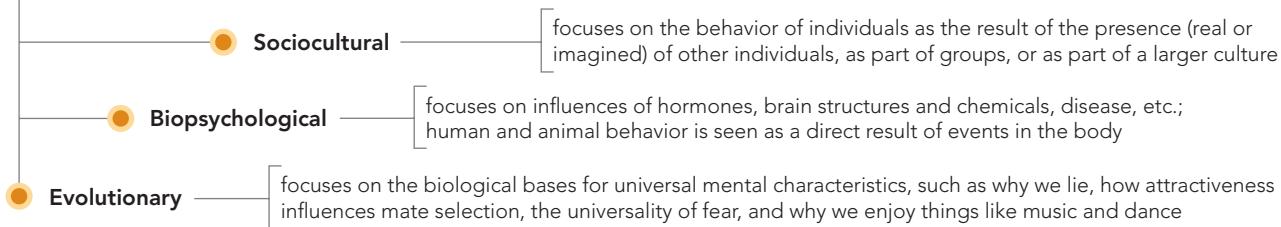
Psychiatric social workers help many kinds and ages of people. The woman on the right might be going through a divorce, dealing with the loss of a spouse, or even recovering from drug abuse.

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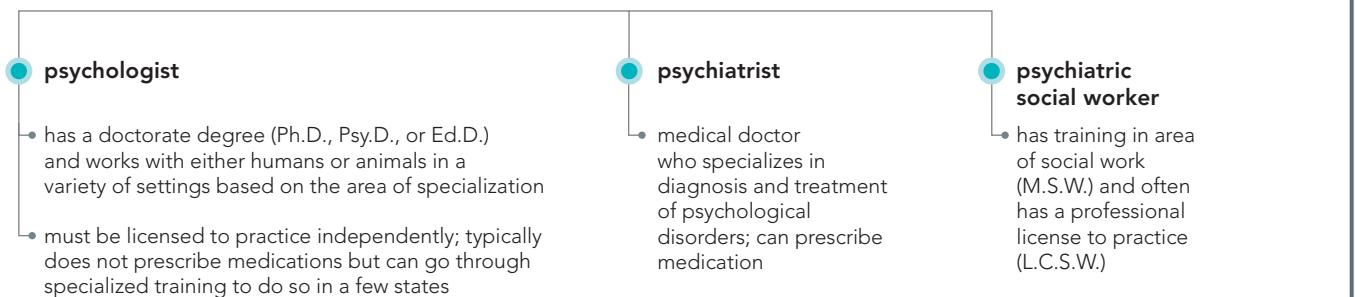
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 Explore the Concept at [MyPsychLab](#)
CONCEPT MAP**Psychology Now: Modern Perspectives**

(no one single perspective is used to explain all human behavior and processes)

**Psychological Professionals and Areas of Specialization**

(people working in the field of psychology have a variety of training experiences and different focuses)

**PRACTICE quiz How Much Do You Remember?**

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Which of the following perspectives focuses on the biological bases of universal mental characteristics?
 - a. humanistic
 - b. behavioral
 - c. psychodynamic
 - d. evolutionary
2. Which perspective offers the best explanation for schizophrenia?
 - a. psychodynamic
 - b. behavioral
 - c. biopsychological
 - d. humanistic
3. Wesley has learned that if he cries with his mother in public, she will often get him a new toy or a piece of candy so as to quiet him. Which of the following perspectives explains Wesley's behavior?
 - a. psychodynamic
 - b. cognitive
 - c. behavioral
 - d. biopsychological
4. Which perspective would a researcher be taking if she were studying a client's early childhood experiences and his resulting development of self?
 - a. psychodynamic
 - b. cognitive
 - c. behavioral
 - d. evolutionary

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5. Which of the following professionals in psychology has no medical training but has a doctoral degree?
 - a. psychiatrist
 - b. psychiatric nurse
 - c. psychiatric social worker
 - d. psychologist

6. If Dr. Swasey is like most psychologists, where does she probably work?
 - a. university/college
 - b. self-employed
 - c. federal government
 - d. state or local government

THINKING CRITICALLY:

Do you believe that violence is a part of human nature? Is violent behavior something that can someday be removed from human behavior or, at the very least, be controlled? Think about this question from each of the perspectives discussed in this chapter.

Psychology: The Scientific Methodology

Why is psychology considered a science, and what are the steps in using the scientific method?

Have you ever played the “airport game”? You sit at the airport (bus terminal, doctor’s office, or any other place where people come and go and you have a long wait) and try to guess what people do for a living based only on their appearance. Although it’s a fun game, the guesses are rarely correct. People’s guesses also sometimes reveal the biases that they may have about certain physical appearances: men with long hair are musicians, people wearing suits are executives, and so on. Psychology is about trying to determine facts and reduce uncertainty and bias.

In psychology, researchers want to see only what is really there, not what their biases might lead them to see. This can be achieved using the **scientific method**, a system for reducing bias and error in the measurement of data.

THE FIVE STEPS OF THE SCIENTIFIC METHOD

The scientific method is a way to accomplish the goals of psychology as discussed earlier: description, explanation, prediction, and control. The first step in any investigation is to have a question to investigate, right? So the first step in the scientific method is this:

1. **Perceiving the Question:** You notice something interesting happening in your surroundings for which you would like to have an explanation. An example might be that you’ve noticed that your children seem to get a little more aggressive with each other after watching a particularly violent children’s cartoon program on Saturday morning. You wonder if the violence in the cartoon could be creating the aggressive behavior in your children. This step is derived from the goal of *description*: What is happening here?

Once you have a question, you want an answer. The next logical step is to form a tentative* answer or explanation for the behavior you have seen. This tentative explanation is known as a **hypothesis**.

2. **Forming a Hypothesis:** Based on your initial observations of what’s going on in your surroundings, you form an educated guess about the explanation for your observations, putting it into the form of a statement that can be tested in some way. Going back to the previous example, you might say, “Children who watch violent cartoons will become more aggressive.” (Forming a hypothesis based on observations is related to the goals of *description* and *explanation*.)

*tentative: something that is not fully worked out or completed as yet.



The scientific method can be used to determine if children who watch violence on television are more likely to be aggressive than those who do not.

The next step is testing the hypothesis. People have a tendency to notice only things that agree with their view of the world, a kind of selective perception called *confirmation bias*. [LINK](#) to Learning Objective 7.3. For example, if a person is convinced that all men with long hair smoke cigarettes, that person will tend to notice only those long-haired men who are smoking and ignore all the long-haired men who don't smoke. The scientific method is designed to overcome the tendency to look at only the information that confirms people's biases by forcing them to actively seek out information that might *contradict* their biases (or hypotheses). So when you test your hypothesis, you are trying to determine if the factor you suspect has an effect and that the results weren't due to luck or chance. That's why psychologists keep doing research over and over—to get more evidence that hypotheses are "supported."

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3. **Testing the Hypothesis:** The method you use to test your hypothesis will depend on exactly what kind of answer you think you might get. You could make more detailed observations or do a survey in which you ask questions of a large number of people, or you might design an experiment in which you would deliberately change one thing to see if it causes changes in the behavior you are observing. In the example, the best method would probably be an experiment in which you select a group of children, show half of them a cartoon with violence and half of them a cartoon with no violence, and then find some way of measuring aggressive behavior in the two groups.

What do you do with the results of your testing? Of course, testing the hypothesis is all about the goal of getting an *explanation* for behavior, which leads to the next step.

4. **Drawing Conclusions:** Once you know the results of your hypothesis testing, you will find that either your hypothesis was supported—which means that your experiment worked, and that your measurements supported your initial observations—or that they weren't supported, which means that you need to go back to square one and think of another possible explanation for what you have observed. (Could it be that Saturday mornings make children a little more aggressive? Or Saturday breakfasts?)

The results of any method of hypothesis testing won't be just the raw numbers or measurements. Any data that come from your testing procedure will be analyzed with some kind of statistical method that helps to organize and refine the data.

[LINK](#) to Appendix A: Statistics. Drawing conclusions can be related to the goal of *prediction*: If your hypothesis is supported, you can make educated guesses about future, similar scenarios.

5. **Report Your Results:** You have come to some conclusion about your investigation's success or failure, and you want to let other researchers know what you have found.



Why tell anyone what happened if it failed?

Just because one experiment or study did not find support for the hypothesis does not necessarily mean that the hypothesis is incorrect. Your study could have been poorly designed, or there might have been factors out of your control that interfered with the study. But other researchers are asking the same kinds of questions that you might have asked. They need to know what has already been found out about the answers to those questions so that they can continue investigating and adding more knowledge about the answers to those questions. Even if your own investigation didn't go as planned, your report will tell other researchers what *not* to do in the future. So the final step in any scientific investigation is reporting the results.

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At this point, you would want to write up exactly what you did, why you did it, how you did it, and what you found. If others can **replicate** your research (meaning, do exactly the same study over again and get the same results), it gives much more support to your findings. This allows others to predict behavior based on your findings and to use the results of those findings to modify or **control** behavior, the last goal in psychology.

This might be a good place to make a distinction between questions that can be scientifically or empirically studied and those that cannot. For example, “What is the meaning of life?” is not a question that can be studied using the scientific or empirical method. Empirical questions are those that can be tested through direct observation or experience. For example, “Has life ever existed on Mars?” is a question that scientists are trying to answer through measurements, experimentation, soil samples, and other methods. Eventually they will be able to say with some degree of confidence that life could have existed or could not have existed. That is an empirical question, because it can be supported or disproved by gathering real evidence. The meaning of life, however, is a question of belief for each person. One does not need proof to *believe*, but scientists need proof (in the form of objectively gathered evidence) to *know*. Questions that involve beliefs and values are best left to philosophy and religion.

In psychology, researchers try to find the answers to empirical questions. They can use a variety of research methods depending on the scientific question to be answered as seen in the video *The Big Picture: How to Answer Psychological Questions*.

Descriptive Methods

- Naturalistic observation
- Laboratory observation
- Case studies
- Surveys

Watch the Video, *The Big Picture: How to Answer Psychological Questions*, at [MyPsychLab](#)

DESCRIPTIVE METHODS

How are naturalistic and laboratory settings used to describe behavior, and what are some of the advantages and disadvantages associated with these settings?

There are a number of different ways to investigate the answers to research questions, and which one researchers use depends on the kind of question they want to answer. If they only want to gather information about what has happened or what is happening, they would select a method that gives them a detailed description.

NATURALISTIC OBSERVATION Sometimes all a researcher needs to know is what is happening to a group of animals or people. The best way to look at the behavior of animals or people is to watch them behave in their normal environment. That's why animal researchers go to where the animals live and watch them eat, play, mate, and sleep in their own natural surroundings. With people, researchers might want to observe them in their workplaces, homes, or on playgrounds. For example, if someone wanted to know how adolescents behave with members of the opposite sex in a social setting, that researcher might go to the mall on a weekend night.



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What is the advantage of naturalistic observation? It allows researchers to get a realistic picture of how behavior occurs because they are actually watching that behavior in its natural setting. In a more controlled arranged environment, like a laboratory, they might get behavior that is contrived or artificial rather than genuine. Of course, there are precautions that must be taken. An observer should have a checklist of well-defined and specific behavior to record, perhaps using their phone, tablet computer, or a special handheld computer to log each piece of data. In many cases, animals or people who know they are being watched will not behave normally—a process called the **observer effect**—so, often the observer must remain hidden from view. When researching humans, remaining hidden is often a difficult thing to do. In the earlier example of the mall setting with the teenagers, a researcher might find that pretending to read a book is a good disguise, especially if one wears glasses to hide the movement of the eyes. Using such a scenario, researchers would be able to observe what goes on between the teens without them knowing that they were being watched. In other cases, researchers might use one-way mirrors, or they might actually become participants in a group, a technique called **participant observation**.

Are there disadvantages to this method? Unfortunately, yes. One of the disadvantages of naturalistic observation is the possibility of **observer bias**. That happens when the person doing the observing has a particular opinion about what he or she expects to see. If that is the case, sometimes that person recognizes only those actions that support the preconceived expectation and ignores actions that coincide with it. For example, if you think girls initiate flirting, you might not see the boys who initiate flirting. One way to avoid observer bias is to use *blind observers*: People who do not know what the research question is and, therefore, have no preconceived notions about what they “should” see. It’s also a good idea to have more than one observer, so that the various observations can be compared.

Another disadvantage is that each naturalistic setting is unique and unlike any other. Observations that are made at one time in one setting may not hold true for another time, even if the setting is similar, because the conditions are not going to be identical time after time—researchers don’t have that kind of control over the natural world. For example, famed gorilla researcher Diane Fossey had to battle poachers who set traps for the animals in the area of her observations (Mowat, 1988). The presence and activities of the poachers affected the normal behavior of the gorillas she was trying to observe.

LABORATORY OBSERVATION Sometimes observing behavior in animals or people is just not practical in a natural setting. For example, a researcher might want to observe the reactions of infants to a mirror image of themselves, and to record the reactions with a camera mounted behind a one-way mirror. That kind of equipment might be difficult to set up in a natural setting. In a laboratory observation, the researcher would bring the infant to the equipment, controlling the number of infants and their ages, as well as everything else that goes on in the laboratory.



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This researcher is studying the behavior of a group of meerkats. Is this naturalistic observation? Why or why not?

The researcher in the foreground is watching the children through a one-way mirror to get a description of their behavior. Observations such as these are just one of many ways that psychologists have of investigating behavior. Why is it important for the researcher to be behind a one-way mirror?

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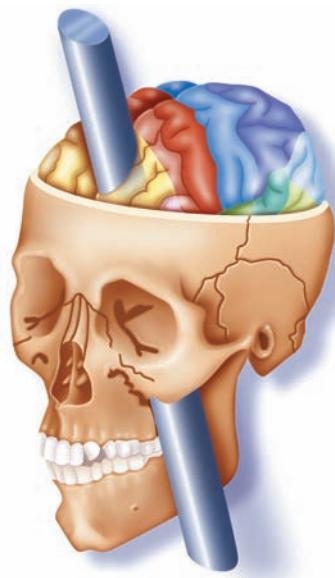
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Phineas Gage survived a steel tamping rod going through his head after some explosive powder went off unexpectedly. Visible above the left side of his mouth is the entry point of the steel rod, and the exit point is at the top of the skull.



"Next question: I believe that life is a constant striving for balance, requiring frequent tradeoffs between morality and necessity, within a cyclic pattern of joy and sadness, forging a trail of bittersweet memories until one slips, inevitably, into the jaws of death. Agree or disagree?"

© The New Yorker Collection 1989 George Price from cartoonbank.com. All Rights Reserved.

As mentioned previously, laboratory settings have the disadvantage of being an artificial situation that might result in artificial behavior—both animals and people often react differently in the laboratory than they would in the real world. The main advantage of this method is the degree of control that it gives to the observer.

Both naturalistic and laboratory observations can lead to the formation of hypotheses that can later be tested.

How are case studies and surveys used to describe behavior, and what are some drawbacks to each of these methods?

CASE STUDIES Another descriptive technique is called the **case study**, in which one individual is studied in great detail. In a case study, researchers try to learn everything they can about that individual. For example, Sigmund Freud based his entire theory of psychoanalysis on case studies of his patients in which he gathered information about their childhoods and relationships with others from the very beginning of their lives to the present. to Learning Objective 13.2.

The advantage of the case study is the tremendous amount of detail it provides. It may also be the only way to get certain kinds of information. For example, one famous case study was the story of Phineas Gage, who, in an accident, had a large metal rod driven through his head and suffered a major personality change as a result (Damasio et al., 1994). Researchers couldn't study that with naturalistic observation, and an experiment is out of the question. Imagine anyone responding to an ad in the newspaper that read:

Wanted: 50 people willing to suffer nonfatal brain damage for scientific study of the brain. Will pay all medical expenses.

It's pretty certain that anyone who actually answered such an ad might already be suffering from some rather extensive brain damage. Case studies are also good ways to study things that are rare, such as dissociative identity disorder. to Learning Objective 14.7.

The disadvantage of the case study is that researchers can't really apply the results to other similar people. In other words, they can't assume that if another person had the same kind of experiences growing up that he or she would turn out just like the person in their case study. People are unique and have too many complicating factors in their lives to be that predictable. So what researchers find in one case won't necessarily apply or generalize to others. Another weakness of this method is that case studies are a form of detailed observation and are vulnerable to bias on the part of the person conducting the case study, just as observer bias can occur in naturalistic or laboratory observation.

SURVEYS Sometimes what psychologists want to know about is pretty personal—like what people do in their sexual relationships, for example. (I'm pretty sure naturalistic observation of human sexual behavior could end in an arrest!) The only way to find out about very private (covert) behavior is to ask questions.

In the survey method, researchers will ask a series of questions about the topic they are studying. Surveys can be conducted in person in the form of interviews or on the telephone, the Internet, or with a questionnaire. The questions used in interviews or on the telephone can vary, but usually the questions in a survey are all the same for everyone answering the survey. In this way, researchers can ask lots of questions and survey literally hundreds of people. To gain a better understanding of what it is like to complete a survey, try your hand at the *Participating in a Research Survey* experiment.

Simulation

Participating in a Research Survey

This survey asks about your attitudes towards and experience with participating in research, particularly psychological research.

[Go to the Experiment ►](#)

Which of these roles have you performed in any way as part of your participation in any type of research project? (Select all that apply.)

Please check all that apply

- Participant / Subject
- Experimenter
- Confederate (someone who is "in" on the study and helps the experimenter)
- Designed a study
- Collected data for a study
- Entered data into a computer program
- Analyzed data / statistics
- Wrote up a description of the research
- Presented the research to a group of people
- Other

Simulate the Experiment, *Participating in a Research Survey*, at [MyPsychLab](#)

That is the big advantage of surveys, aside from their ability to get at private information. Researchers can get a tremendous amount of data on a very large group of people. Of course, there are disadvantages. For one, researchers have to be very careful about the group of people they survey. If they want to find out what college freshmen think about politics, for example, they can't really ask every single college freshman in the entire United States. But they can select a **representative sample** from that group. They could randomly* select a certain number of college freshmen from several different colleges across the United States, for example. Why randomly? Because the sample has to be *representative* of the **population**, which is the entire group in which the researcher is interested. If researchers selected only freshmen from Ivy League schools, for example, they would certainly get different opinions on politics than they might get from small community colleges. But if they take a lot of colleges and select their *participants* (people who are part of the study) randomly, they will be more certain of getting answers that a broad selection of college students would typically give.

That brings up the other major disadvantage of the survey technique: People aren't always going to give researchers accurate answers. The fact is, people tend to misremember things, distort the truth, and may lie outright—even if the survey is an anonymous** questionnaire. Remembering is not a very accurate process sometimes, especially when people think that they might not come off sounding very desirable or socially appropriate. Some people deliberately give the answer they think is more socially correct rather than their true opinion, so that no one gets offended, in a process called *courtesy bias*. Researchers must take their survey results with a big grain of salt†—they may not be as accurate as they would like them to be.

Both the wording of survey questions and the order in which they appear can affect the outcome. It is difficult to find a wording that will be understood in exactly the same way by all those who read the question. Questions can be worded in a way that the

*randomly: in this sense, selected so that each member of the group has an equal chance of being chosen.

**anonymous: not named or identified.

†grain of salt: a phrase meaning to be skeptical; to doubt the truth or accuracy of something.

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CORRELATIONS: FINDING RELATIONSHIPS

What is the correlational technique, and what does it tell researchers about relationships?

The methods discussed so far only provide descriptions of behavior. There are really only two methods that allow researchers to know more than just a description of what has happened: correlations and experiments. Correlation is actually a statistical technique, a particular way of organizing numerical information so that it is easier to look for patterns in the information. This method will be discussed here rather than in the statistics appendix found at the back of this text because correlation, like the experiment, is about finding relationships. In fact, the data from the descriptive methods just discussed are often analyzed using the correlational technique.

A **correlation** is a measure of the relationship between two or more variables. A *variable* is anything that can change or vary—scores on a test, temperature in a room, gender, and so on. For example, researchers might be curious to know whether or not cigarette smoking is connected to life expectancy—the number of years a person can be expected to live. Obviously, the scientists can't hang around people who smoke and wait to see when those people die. The only way (short of performing a very unethical and lengthy experiment) to find out if smoking behavior and life expectancy are related to each other is to use the medical records of people who have already died. (For privacy's sake, the personal information such as names and social security numbers would be removed, with only the facts such as age, gender, weight, and so on available to researchers.) Researchers would look for two facts from each record: the number of cigarettes the person smoked per day and the age of the person at death.

Now the researcher has two sets of numbers for each person in the study that go into a mathematical formula,  to Learning Objective A.6, to produce a number called the **correlation coefficient**. The correlation coefficient represents two things: the direction of the relationship and its strength.



Direction? How can a mathematical relationship have a direction?

Whenever researchers talk about two variables being related to each other, what they really mean is that knowing the value of one variable allows them to predict the value of the other variable. For example, if researchers found that smoking and life expectancy are indeed related, they should be able to predict how long someone might live if they know how many cigarettes a person smokes in a day. But which way does that prediction work? If a person smokes a lot of cigarettes, does that mean that he or she will live a longer life or a shorter one? Does life expectancy go up or down as smoking increases? That's what is meant by the *direction* of the relationship.

In terms of the correlation coefficient (represented by the small letter r), the number researchers get from the formula will either be a positive number or a negative number. If positive, the two variables increase in the same direction—as one goes up, the other goes up; as one decreases, the other also decreases. If negative, the two variables have an inverse* relationship—as one increases, the other decreases. If researchers find that the more cigarettes a person smoked, the younger that person was when he or she died, it would mean that the correlation between the two variables is negative. (As smoking goes up, life expectancy goes down—an inverse relationship.)

The strength of the relationship between the variables will be determined by the actual number itself. That number will always range between +1.00 and -1.00.

*inverse: opposite in order.

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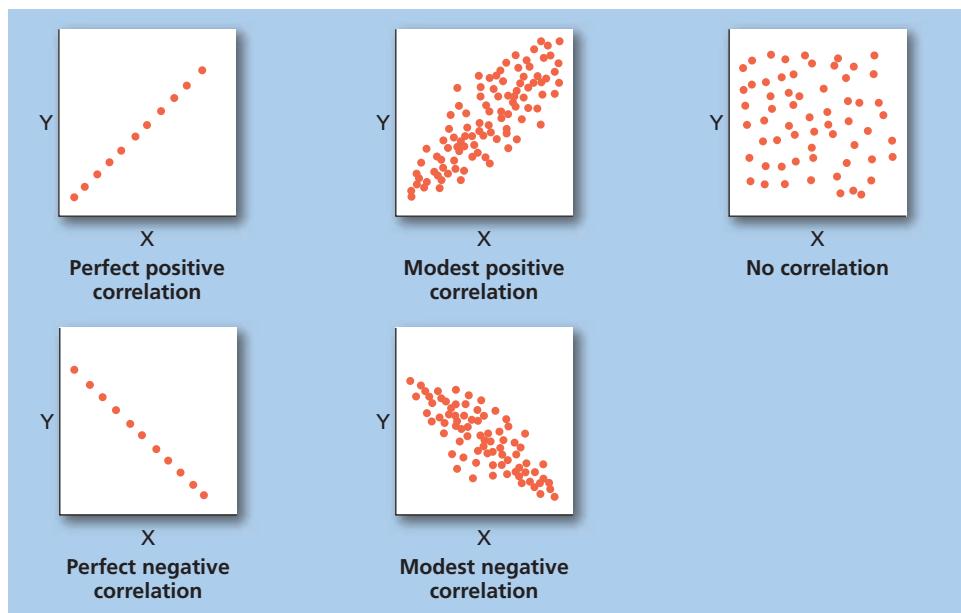


Figure 1.3 Five Scatterplots

These scatterplots show direction and strength of correlation. It should be noted that perfect correlations, whether positive or negative, rarely occur in the real world.

The reason that it cannot be greater than +1.00 or less than -1.00 has to do with the formula and an imaginary line on a graph around which the data points gather, a graph called a scatterplot (see **Figure 1.3**). If the relationship is a strong one, the number will be closer to +1.00 or to -1.00. A correlation of +.89 for example, would be a very strong positive correlation. That might represent the relationship between scores on the SAT and an IQ test, for example. A correlation of -.89 would be equally strong but negative. That would be more like the correlation researchers would probably find between smoking cigarettes and the age at which a person dies.

Notice that the closer the number is to zero, the weaker the relationship becomes. Researchers

would probably find that the correlation coefficient for the relationship between people's weight and the number of freckles they have is pretty close to zero, for example.



Go back to the cigarette thing—if we found that the correlation between cigarette smoking and life expectancy was high, does that mean that smoking causes your life expectancy to be shortened?

Not exactly. The biggest error that people make concerning correlation is to assume that it means one variable is the cause of the other. Remember that *correlation does not prove causation*. Although adverse health effects from cigarette smoking account for approximately 438,000 deaths each year in the United States alone, correlation by itself cannot be used to prove causation (Centers for Disease Control and Prevention, 2009). Just because two variables are related to each other, researchers cannot assume that one

of them causes the other one to occur. They could both be related to some other variable that is the cause of both. For example, cigarette smoking and life expectancy could be linked only because people who smoke may be less likely to take care of their health by eating right and exercising, whereas people who don't smoke may tend to eat healthier foods and exercise more than smokers do.  [Explore the Concept Correlations Do Not Show Causation, at MyPsychLab](#)

To sum up, a correlation will tell researchers if there is a relationship between the variables, how strong the relationship is, and in what direction the relationship goes. If researchers know the value of one variable, they can predict the value of the other. If they know someone's IQ score, for example, they can predict approximately what score that person should get on the SAT—not the exact score, just a reasonable estimate. Also, even though correlation does not prove causation, it can provide a starting point for examining causal relationships with another type of study, the experiment.



THE EXPERIMENT

What are the steps involved in designing an experiment?

The only method that will allow researchers to determine the cause of a behavior is the **experiment**. In an experiment, researchers deliberately manipulate (change in some purposeful way) the variable they think is causing some behavior while holding all the other variables that might interfere with the experiment's results constant and unchanging. That way, if they get changes in behavior (an effect, in other words), they know that those changes must be due to the manipulated variable. For example, remember the discussion of the steps in the scientific method. It talked about how to study the effects of watching violent cartoons on children's aggressive behavior. The most logical way to study that particular relationship is by an experiment.

SELECTION First, researchers might start by selecting the children they want to use in the experiment. The best method to do that is through random selection of a sample of children from a "population" determined by the researchers—just as a sample would be selected for a survey. Ideally, researchers would decide on the age of child they wanted to study—say, children who are 3 to 4 years old. Then researchers would go to various day care centers and randomly select a certain number of children of that age. Of course, that wouldn't include the children who don't go to a day care center. Another way to get a sample in the age range might be to ask several pediatricians to send out letters to parents of children of that age and then randomly select the sample from those children whose parents responded positively.

THE VARIABLES Another important step is to decide on the variable the researchers want to manipulate (which would be the one they think causes changes in behavior) and the variable they want to measure to see if there are any changes (this would be the effect on behavior of the manipulation). Often deciding on the variables in the experiment comes before selection of the participants or subjects.

In the example of aggression and children's cartoons, the variable that researchers think causes changes in aggressive behavior is the violence in the cartoons. Researchers would want to manipulate that in some way, and in order to do that they have to define the term *violent cartoon*. They would have to find or create a cartoon that contains violence. Then they would show that cartoon to the participants and try to measure their aggressive behavior afterwards. In measuring the aggressive behavior, the researchers would have to define exactly what they mean by "aggressive behavior" so that it can be measured. This definition is called an **operational definition** because it specifically names the operations (steps or procedures) that the experimenter must use to control or measure the variables in the experiment. An operational definition of aggressive behavior might be a checklist of very specific actions such as hitting, pushing, and so on that an observer can mark off as the children do the items on the list. If the observers were just told to look for "aggressive behavior," the researchers would probably get half a dozen or more different interpretations of what aggressive behavior is.

The name for the variable that is manipulated in any experiment is the **independent variable** because it is *independent* of anything the participants do. The participants in the study do not get to choose or vary the independent variable, and their behavior does not affect this variable at all. In the preceding example, the independent variable would be the presence or absence of violence in the cartoons.



The act of hitting each other with toy swords could be part of an operational definition of aggressive behavior.

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The response of the participants to the manipulation of the independent variable is a dependent relationship, so the response of the participants that is measured is known as the **dependent variable**. Their behavior, if the hypothesis is correct, should *depend* on whether or not they were exposed to the independent variable, and in the example, the dependent variable would be the measure of aggressive behavior in the children. The dependent variable is always the thing (response of subjects or result of some action) that is measured to see just how the independent variable may have affected it.  **Watch** the **Video**, *The Big Picture: Scientific Research Methods*, at **MyPsychLab**

THE GROUPS



If researchers do all of this and find that the children's behavior is aggressive, can they say that the aggressive behavior was caused by the violence in the cartoon?

No, what has been described so far is not enough. The researchers may find that the children who watch the violent cartoon are aggressive, but how would they know if their aggressive behavior was caused by the cartoon or was just the natural aggressive level of those particular children or the result of the particular time of day they were observed? Those sorts of *confounding variables* (variables that interfere with each other and their possible effects on some other variable of interest) are the kind researchers have to control for in some way. For example, if most children in this experiment just happened to be from a fairly aggressive family background, any effects the violent cartoon in the experiment might have had on the children's behavior could be confused (confounded) with the possible effects of the family background. The researchers wouldn't know if the children were being aggressive because they watched the cartoon or because they liked to play aggressively anyway.

The best way to control for confounding variables is to have two groups of participants: those who watch the violent cartoon, and those who watch a nonviolent cartoon for the same length of time. Then the researchers would measure the aggressive behavior in both groups. If the aggressive behavior is significantly greater in the group that watched the violent cartoon (statistically speaking), then researchers can say that in this experiment, violent cartoon watching caused greater aggressive behavior.

The group that is exposed to the independent variable (the violent cartoon in the example) is called the **experimental group**, because it is the group that receives the experimental manipulation. The other group that gets either no treatment or some kind of treatment that should have no effect (like the group that watches the nonviolent cartoon in the example) is called the **control group** because it is used to *control* for the possibility that other factors might be causing the effect that is being examined. If researchers were to find that both the group that watched the violent cartoon and the group that watched the nonviolent cartoon were equally aggressive, they would have to assume that the violent content did not influence their behavior at all.

THE IMPORTANCE OF RANDOMIZATION As mentioned previously, random selection is the best way to choose the participants for any study. Participants must then be assigned to either the experimental group or the control group. Not surprisingly, **random assignment** of participants to one or the other condition is the best way to ensure control over other interfering, or *extraneous*, variables. Random assignment means that each participant has an equal chance of being assigned to each condition. If researchers simply looked at the children and put all of the children from one day care center or one pediatrician's recommendations into the experimental group and the same for the control group, they would run the risk of biasing their research. Some day care centers may have more naturally aggressive children, for example, or some pediatricians may have a

particular client base in which the children are very passive. So researchers want to take the entire participant group and assign each person randomly to one or the other of the groups in the study. Sometimes this is as simple as picking names out of a hat.

How do the placebo and experimenter effects cause problems in an experiment, and what are some ways to control for these effects?

EXPERIMENTAL HAZARDS: THE PLACEBO EFFECT AND THE EXPERIMENTER EFFECT There are a few other problems that might arise in any experiment, even with the use of control groups and random assignment. These problems are especially likely when studying people instead of animals, because people are often influenced by their own thoughts or biases about what's going on in an experiment. For example, say there is a new drug that is supposed to improve memory in people who are in the very early stages of *Alzheimer's disease* (a form of mental deterioration that occurs in some people as they grow old). [LINK](#) to Learning Objective 6.12. Researchers would want to test the drug to see if it really is effective in helping to improve memory, so they would get a sample of people who are in the early stages of the disease, divide them into two groups, give one group the drug, and then test for improvement. They would probably have to do a test of memory both before and after the administration of the drug to be able to measure improvement.



Let me see if I've got this straight. The group that gets the drug would be the experimental group, and the one that doesn't is the control group, right?

Right, and getting or not getting the drug is the independent variable, whereas the measure of memory improvement is the dependent variable. But there's still a problem with doing it this way. What if the researchers do find that the drug group had greater memory improvement than the group that received nothing? Can they really say that the drug itself caused the improvement? Or is it possible that the participants who received the drug *knew* that they were supposed to improve in memory and, therefore, made a major effort to do so? The improvement may have had more to do with participants' *belief* in the drug than the drug itself, a phenomenon* known as the **placebo effect**: The expectations and biases of the participants in a study can influence their behavior. In medical research, the control group is often given a harmless substitute for the real drug, such as a sugar pill or an injection of salt water, and this substitute (which has no medical effect) is called the *placebo*. If there is a placebo effect, the control group will show changes in the dependent variable even though the participants in that group received only a placebo.

Another way that expectations about the outcome of the experiment can influence the results, even when the participants are animals rather than people, is called the **experimenter effect**. It has to do with the expectations of the experimenter, not the participants. As discussed earlier in the section about naturalistic observations, sometimes observers are biased—they see what they expect to see. Observer bias can also happen in an experiment. When the researcher is measuring the dependent variable, it's possible that he or she could give the participants clues about how they are supposed to respond—through the use of body language, tone of voice, or even eye contact. Although not deliberate, it does happen. It could go something like this in the memory drug example mentioned earlier: You, the Alzheimer's patient, are in the experimenter's office to

*phenomenon: an observable fact or event.



This elderly woman has Alzheimer's disease, which causes a severe loss of recent memory. If she were given a new drug in the very early stages of her disease, in the attempt to improve her memory, the researcher could not be certain that any improvement shown was caused by the drug rather than by the elderly woman's belief that the drug would work. The expectations of any person in an experimental study can affect the outcome of the study, a phenomenon known as the placebo effect.

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take your second memory test after trying the drug. The experimenter seems to pay a lot of attention to you and to every answer that you give in the test, so you get the feeling that you are supposed to have improved a lot. So you try harder, and any improvement you show may be caused only by your own increased effort, not by the drug. That's an example of the experimenter effect in action: The behavior of the experimenter caused the participant to change his or her response pattern.

SINGLE-BLIND AND DOUBLE-BLIND STUDIES Fortunately, there are ways to control these effects. The classic way to avoid the placebo effect is to give the control group an actual placebo—some kind of treatment that doesn't affect behavior at all. In the drug experiment, the placebo would have to be some kind of sugar pill or saline (salt) solution that looks like and is administered just like the actual drug. The participants in both the experimental and the control groups would not know whether or not they got the real drug or the placebo. That way, if their expectations have any effect at all on the outcome of the experiment, the experimenter will be able to tell by looking at the results for the control group and comparing them to the experimental group. Even if the control group improves a little, the drug group should improve significantly more if the drug is working. This is called a **single-blind study** because the participants are “blind” to the treatment they receive.

For a long time, that was the only type of experiment researchers carried out in psychology. But researchers Robert Rosenthal and Lenore Jacobson reported in their 1968 book, *Pygmalion in the Classroom*, that when teachers were told that some students had a high potential for success and others a low potential, the students showed significant gains or decreases in their performance on standardized tests depending on which “potential” they were supposed to have (Rosenthal & Jacobson, 1968). Actually, the students had been selected randomly and were randomly assigned to one of the two groups, “high” or “low.” Their performances on the tests were affected by the attitudes of the teachers concerning their potential. This study and similar ones after it highlighted the need for the experimenter to be “blind” as well as the participants in research. So in a **double-blind study** neither the participants nor the person or persons measuring the dependent variable know who got what. That's why every element in a double-blind experiment gets coded in some way, so that only after all the measurements have been taken can anyone determine who was in the experimental group and who was in the control group.

For a good example of a typical experiment, read the following section about stereotypes, athletes, and test grades.

issues in psychology



Stereotypes, Athletes, and College Test Performance

What are some basic elements of a real-world experiment?



It seems that many people have a negative stereotype of college athletes—that they are graded and promoted on the basis of their ability on the athletic field and not on the basis of classroom performance. Evidence does exist for poorer performance on academic tests of athletes when compared to nonathletes in college (National Collegiate Athletic Association, 2002; Purdy et al., 1982; Upthegrove et al., 1999). If you are an athlete, can that negative stereotype actually have a negative impact on your test performance? Wesleyan University researchers Matthew Jameson, Robert Diehl, and Henry Danso have some evidence that such stereotypes can have just that kind of negative impact (Jameson et al., 2007).

In their experiment, 72 male college athletes from the sports teams of the university were given an intellectual test. Half of the athletes answered a brief questionnaire before taking the test, whereas the other half received the same questionnaire after taking the test. The questionnaire asked three questions, with the third question being, "Rate your likelihood of being accepted to the university without the aid of athletic recruiting." This item was designed to bring the negative stereotype of athletes ("dumb jocks") to the forefront of students' minds, creating a "high threat" for that stereotype. This difference in threat level between the two groups before taking the intellectual test represents the *independent variable* in this experiment.

The results? Those students who answered the "high threat" question before the intellectual test (the *experimental group*) scored significantly lower on that test (the measurement of the *dependent variable*) than those who answered the question after the test (the *control group*). The researchers also found a correlation between the students' exposure to the "high threat" stereotype condition and accuracy on the intellectual test: The more students believed that they got into college primarily because of their ability in sports (based on their rating of that third question), the worse they performed on the subsequent test. Jameson and colleagues concluded that obvious negative stereotypes in higher education may be an important cause underlying the tendency of college athletes to underperform in academics.

Questions for Further Discussion

1. In this experiment, what might be some extraneous variables affecting the students' test performance?
2. What might educators do to try to prevent the effect of the "dumb jock" negative stereotype on college athletes?

Ethics of Psychological Research

What are some ethical concerns that can occur when conducting research with people and animals?



➤ The study that Dr. Watson did with "Little Albert" and the white rat seems pretty cruel, when you think about it. Do researchers today do that kind of study?

Actually, as the field and scope of psychology began to grow and more research with people was being done, psychologists began to realize that some protections had to be put in place. No one wanted to be thought of as a "mad scientist," and if studies were permitted that could actually harm people, the field of psychology might die out pretty quickly.  [Learning Objectives 5.3 and 12.3](#). Scientists in other areas of research were also realizing that ethical treatment of the participants in studies had to be ensured in some way. Ethical treatment, of course, means that people who volunteer for a study will be able to expect that no physical or psychological harm should come to them. The video *Special Topics: Ethics and Psychological Research: Research with People* explains how researchers in the field of psychology draw the line between what is ethical and what is not and explains some of the safeguards in place today.



Could knowing that other people might think your success in school is due to your athletic ability and not to your intelligence make you perform poorly on an academic test?

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Watch the [Video](#), Special Topics: Ethics and Psychological Research: Research with People, at [MyPsychLab](#)

Universities and colleges (where most psychological research is carried out) usually have *institutional review boards*, groups of psychologists or other professionals who look over each proposed study and judge it according to its safety and consideration for the research participants. These review boards look at all aspects of the projected study, from the written materials that explain the research to the potential subjects to the equipment that may be used in the study itself.

THE GUIDELINES FOR DOING RESEARCH WITH PEOPLE

There are quite a few ethical concerns when dealing with human subjects in an experiment or other type of study. Here is a list of some of the most common ethical guidelines:

1. **Rights and well-being of participants must be weighed against the study's value to science.** In other words, people come first, research second.
2. **Participants must be allowed to make an informed decision about participation.** This means that researchers have to explain the study to the people they want to include before they do anything to them or with them—even children—and it has to be in terms that the participants can understand. If researchers are using infants or children, their parents have to be informed and give their consent, a legal term known as *informed consent*. Even in single- or double-blind studies, it is necessary to tell the participants that they may be members of either the experimental or the control group—they just won't find out which group they were actually in until after the experiment is concluded.
3. **Deception must be justified.** In some cases, it is necessary to deceive the participants because the study wouldn't work any other way. For example, if you intend to give the participants a test of memory at the end, but don't want them to know about the test beforehand, you would have to withhold that part of the experiment. The participants have to be told after the study exactly why the deception was important. This is called *debriefing*.
4. **Participants may withdraw from the study at any time.** The participants must be allowed to drop out for any reason. For example, sometimes people get bored with

the study, decide they don't have the time, or don't like what they have to do. Children participating in studies often decide to stop "playing" (play is a common part of studies of children). Researchers have to release them, even if it means having to get more participants.

5. **Participants must be protected from risks or told explicitly of risks.** For example, if researchers are using any kind of electrical equipment, care must be taken to ensure that no participant will experience a physical shock from faulty electrical equipment.
6. **Investigators must debrief participants, telling the true nature of the study and expectations of results.** This is important in all types of studies but particularly in those involving a deception.
7. **Data must remain confidential.** Freud recognized the importance of confidentiality, referring to his patients in his books and articles with false names. Likewise, psychologists and other researchers today tend to report only group results rather than results for a single individual, so that no one could possibly be recognized.
8. **If for any reason a study results in undesirable consequences for the participant, the researcher is responsible for detecting and removing, or correcting, these consequences.** Sometimes people react in unexpected ways to the manipulations in an experiment, despite the researcher's best efforts to prevent any negative impact upon participants. If this happens, the researcher must find some way of helping the participant overcome that impact (American Psychological Association, 2002).

ANIMAL RESEARCH

Psychologists also study animals to find out about behavior, often drawing comparisons between what the animals do and what people might do under similar conditions.



But why not just study people in the first place?

Some research questions are extremely important but difficult or impossible to answer by using human participants. Animals live shorter lives, so looking at long-term effects becomes much easier. Animals are also easier to control—the scientist can control diet, living arrangements, and even genetic relatedness. The white laboratory rat has become a recognized species different from ordinary rats, bred with its own kind for many decades until each white rat is essentially a little genetic "twin" of all the others. Animals also engage in much simpler behavior than humans do, making it easier to see the effects of manipulations. But the biggest reason that researchers use animals in some research is that animals can be used in ways that researchers could never use people. For example, it took a long time for scientists to prove that the tars and other harmful substances in tobacco cause cancer, because they had to do correlational studies with people and experiments only with animals. There's the catch—researchers can do many things to animals that they can't do to people. That might seem cruel at first, but when you think that without animal research there would be no vaccines for deadly diseases, no insulin treatments for diabetics, no transplants, and so on, then the value of the research and its benefits to humankind far outweigh the hazards to which the research animals are exposed. Still, some animal rights activists disagree with this point of view.

There are also ethical considerations when dealing with animals in research, just as there are with humans. With animals,



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 Explore the Concept at MyPsychLab

CONCEPT MAP

Correlations

- is a measure of relationship between two or more variables (anything that can change or vary)
- produces a value called the **correlation coefficient** that represents both direction and strength of relationship
- does not prove causation—variables can be related but you can not assume that one of them causes the other to occur

Experiments

(the only research method that will allow researchers to determine the cause of a behavior by deliberately manipulating some variable and measuring changes in the variable of interest)

- **operational definition** specifically names the steps or procedures used to control or measure the variable in the experiment

- independent variable is the variable that is manipulated, it is independent of anything participants do
- dependent variable is the measure used to evaluate the manipulation of the independent variable

- **groups**
 - **experimental**: gets the independent variable or experimental manipulation
 - **control**: receives no treatment or treatment that should not have an effect

random assignment to conditions is the best way to assure control over extraneous variables or confounding variables, variables that interfere with each other, and/or on the variable of interest

- **hazards**
 - **placebo effect**: beliefs or expectations about a study can influence their behavior
 - **experimenter effect**: experimenter's biases can affect or influence participants' behavior

can be controlled through single-blind (participant "blind" to treatment/condition) and double-blind studies where the experimenter measuring the dependent variable does not know the treatment/condition associated with the data

guidelines for research with humans

- rights and well-being of participants must be weighed against the study's value to science
- participants must be allowed to make an informed decision about participating (informed consent)
- deception must be justified
- participants may withdraw from the study at any time
- participants must be protected from risks or told explicitly of risks
- investigator must debrief participants, telling the true nature of the study and expectations of results
- data must remain confidential

Ethics of Psychological Research

(psychological scientists have a primary goal of protecting the health and welfare of their animal or human participants)

- any animal research is also covered by ethical considerations; primary focus is on avoiding any unnecessary pain or suffering

- some research questions are important but can be difficult or dangerous to answer with human participants
- animals are easier to control
- animals have shorter lives; easier to study long-term effects

research with animals

- why use animals?

PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Which of the following would indicate the weakest relationship and thus be close to complete randomness?
 - a. +1.04
 - b. -0.89
 - c. +0.01
 - d. -0.98
2. In an experiment to examine the effects of sleep deprivation on completion of a puzzle, one group is allowed to sleep eight hours while another group is made to stay awake. In this experiment, the control group is
 - a. the group that gets to sleep.
 - b. the group that remains awake.
 - c. the puzzle.
 - d. the difference in time for each group to complete the puzzle.
3. In a _____ study, the participants do not know if they are part of the control group or the experimental group. Only the experimenter knows who is in each group.
 - a. placebo
 - b. single-blind
 - c. double-blind
 - d. triple-blind
4. In the "dumb jock" stereotype threat experiment, what was the independent variable?
 - a. the degree of stereotype threat
 - b. the testing room
 - c. the scores on the intellectual test
 - d. the intelligence level of the athletes

5. What is the first guideline for doing research with people?
 - a. Participants have to give informed consent.
 - b. Deception cannot be used in any studies with human beings.
 - c. The rights and well-being of the participants must come first.
 - d. Data must remain confidential.
6. What is the biggest reason why we use animals in research?
 - a. Animals have simple behavior that makes it easy to see changes.
 - b. Animals don't live as long as humans.
 - c. We can do things to animals that we can't do to people.
 - d. Animals are easier to control.

THINKING CRITICALLY:

You are testing a new drug to treat a serious, often fatal medical condition. Before your experiment is over, it becomes obvious that the drug is working so well that the people in the experimental group are going to recover completely. Should you stop the experiment to give the drug to the people in the control group?

Applying Psychology to Everyday Life: Thinking Critically About Critical Thinking

What are the basic principles of critical thinking, and how can critical thinking be useful in everyday life?

 What good is all this focus on science and research going to do for me? I live in the real world, not a laboratory.

The real world is full of opportunities for scientific thinking. Think about all the commercials on television for miracle weight loss, hair restoration, or herbal remedies for arthritis, depression, and a whole host of physical and mental problems. Wouldn't it be nice to know how many of these claims people should believe? Wouldn't you like to know how to evaluate statements like these and possibly save yourself some time, effort, and money? That's exactly the kind of "real-world" problem that critical thinking can help sort out.  [Watch the Video, Thinking Like a Psychologist:Thinking Critically, at MyPsychLab](#)

Critical thinking means making reasoned judgments (Beyer, 1995). The word *reasoned* means that people's judgments should be logical and well thought out. Critical thinking also includes the ability to ask and seek answers for critical questions at the right time (Browne & Keeley, 2009). (A relevant example of a critical question might be, "Is someone paying you to do this research, and is this a conflict of interest?" or "Do you have any good evidence for your assertions, or are you just giving your opinion?") Critical thinking can also help us avoid false beliefs that may lead to poor decisions or even prove dangerous to our mental and physical health as the video *Thinking Like a Psychologist: Debunking Myths: The Danger of False Beliefs* explains.

*criteria: standards on which a judgment or decision may be based.

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Watch the **Video**, *Thinking Like a Psychologist: Debunking Myths: The Danger of False Beliefs*, at [MyPsychLab](#)

While the word *critical* is often viewed as meaning “negative,” that is not the use of this term here. Instead, it’s more related to the word *criteria*,* as in thinking that meets certain high criteria or standards (Nosich, 2008). There are four basic criteria for critical thinking that people should remember when faced with statements about the world around them (Browne & Keeley, 2009; Gill, 1991; Shore, 1990):

1. **There are very few “truths” that do not need to be subjected to testing.** Although people may accept religious beliefs and personal values on faith, everything else in life needs to have supporting evidence. Questions that can be investigated empirically should be examined using established scientific methods. One shouldn’t accept anything at face value but should always ask, “How do you know that? What is the evidence? Can you be more specific in your terms?” (These are more examples of those important questions to ask when thinking critically.) For example, many people still believe that astrology, the study of the supposed influence of the stars and planets on the birth of an infant, can be used to make predictions about that infant’s personality and life events as he or she grows. But scientific investigations have shown us, time after time, that astrology is without any basis in truth or scientific fact (Dean & Kelly, 2000; Hines, 2003; Kelly, 1980; Wiseman, 2007).
2. **All evidence is not equal in quality.** One of the most important, often overlooked steps in critical thinking is evaluating how evidence is gathered before deciding that it provides good support for some idea. For example, there are poorly done experiments, incorrect assumptions based on correlations rather than experiments, studies that could not be replicated, and studies in which there was either no control group or no attempt made to control for placebo effects or experimenter effects. There are also studies that have been deliberately manipulated to produce the findings that the researcher (or whoever is paying the researcher) would prefer. For example, the results of a study on the effectiveness of a particular drug would be immediately suspect if the researcher is being paid by the company making the drug. As a critical thinker you should be aware that the more wild the claim, the better the evidence should be: For example, I have not yet seen any evidence that convinces me of alien visitations or abductions!

3. **Just because someone is considered to be an authority or to have a lot of expertise does not make everything that person claims automatically true.** One should always ask to see the evidence rather than just take some expert's word for anything. How good is the evidence? Are there other alternative explanations? Is the alternative explanation simpler? If there are two explanations for some phenomenon and both account for the phenomenon equally well, the *simpler* explanation is *more often* the best one—a rule of thumb known as *the law of parsimony*. For example, let's look at crop circles, those geometric patterns of flattened crop stalks that have at times been discovered in farmers' fields. Two possible explanations for crop circles exist: either they are made by aliens in space ships—as is the claim by many alleged experts—or they are made by human beings as a hoax.* Which explanation is simpler? Obviously, the hoax rationalization is the simplest, and it turned out to be correct for the crop circles that appeared in England in the late 1970s and 1980s: David Bower and Doug Chorley, two British men, confessed to creating the crop circles as a prank, thought up in a barroom and meant to make fun of people who believe in alien visitations (Nickell, 1995; M. Ridley, 2002; Schnabel, 1994).
4. **Critical thinking requires an open mind.** Although it is good to be a little skeptical, people should not close their minds to things that are truly possible. At the same time, it's good for people to have open minds but not so open that they are gullible** and apt to believe anything. Critical thinking requires a delicate balance between skepticism and willingness to consider possibilities—even possibilities that contradict previous judgments or beliefs. For example, scientists have yet to find any convincing evidence that there was once life on Mars. That doesn't mean that scientists totally dismiss the idea, just that there is no convincing evidence *yet*. I don't believe that there are Martians on Mars, but if I were shown convincing evidence, I would have to be willing to change my thinking—as difficult as that might be.



Many people believe that crop circles are created by alien visitors, despite clear evidence that crop circles are hoaxes created by ordinary people.

Questions for Further Discussion

- How might critical thinking be applied to the issue of global climate change?
- Why do you think some people (even very smart people) sometimes avoid thinking critically about issues such as politics, the existence of ESP, or the supernatural?

Writing Prompt

▼ Imagine you have been asked to create an experimental design to test the hypothesis that talking on a cell phone impairs driving skills. Explain why a control condition would be important to include in testing this hypothesis. How should subjects be assigned to conditions? How can the researchers design the experiment so that the only difference between both conditions is the use of a cell phone?

Words: 0

Print

Feedback

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*hoax: something intended to fool people, a trick or lie.

**gullible: easily fooled or cheated.

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chapter summary

 Listen to the **Audio File** of your chapter **MyPsychLab**

What Is Psychology?

1.1 What defines psychology as a field of study, and what are psychology's four primary goals?

- Psychology is the scientific study of behavior and mental processes.
- The four goals of psychology are description, explanation, prediction, and control.

Psychology Then: The History of Psychology

1.2 Who were some of the earlier pioneers in psychology, and how did structuralism and functionalism differ?

- In 1879 psychology began as a science of its own in Germany with the establishment of Wundt's psychology laboratory. He developed the technique of objective introspection.
- Titchener, a student of Wundt, brought psychology in the form of structuralism to America. Structuralism died out in the early twentieth century. Margaret F. Washburn, Titchener's student, was the first woman to receive a Ph.D. in psychology in 1894 and published *The Animal Mind*.
- William James proposed a countering point of view called functionalism, which stressed the way the mind allows us to adapt.
- Many of psychology's early pioneers were minorities such as the African Americans who, despite prejudice and racism, made important contributions to the study of human and animal behavior.
- Functionalism influenced the modern fields of educational psychology, evolutionary psychology, and industrial/organizational psychology.

1.3 What were the basic ideas and who were the important people behind the early approaches known as Gestalt, psychoanalysis, and behaviorism?

- Wertheimer and others studied sensation and perception, calling the new perspective Gestalt (an organized whole) psychology.
- Freud proposed that the unconscious mind controls much of our conscious behavior in his theory of psychoanalysis.
- Watson proposed a science of behavior called behaviorism, which focused only on the study of observable stimuli and responses.
- Watson and Rayner demonstrated that a phobia could be learned by conditioning a baby to be afraid of a white rat.
- Mary Cover Jones, one of Watson's more famous students in behaviorism and child development, later demonstrated that a learned phobia could be counterconditioned.

Psychology Now: Modern Perspectives

1.4 What are the basic ideas behind the seven modern perspectives, and what were the important contributions of Skinner, Maslow, and Rogers?

- Modern Freudians such as Anna Freud, Jung, and Adler changed the emphasis in Freud's original theory into a kind of neo-Freudianism.
- Skinner's operant conditioning of voluntary behavior became a major force in the twentieth century. He introduced the concept of reinforcement to behaviorism.
- Humanism, which focuses on free will and the human potential for growth, was developed by Maslow and Rogers, among others, as a reaction to the deterministic nature of behaviorism and psychoanalysis.
- Cognitive psychology is the study of learning, memory, language, and problem solving, and includes the field of cognitive neuroscience.
- Biopsychology emerged as the study of the biological bases of behavior, such as hormones, heredity, chemicals in the nervous system, structural defects in the brain, and the effects of physical diseases.
- The principles of evolution and the knowledge we currently have about evolution are used in the evolutionary perspective to look at the way the mind works and why it works as it does. Behavior is seen as having an adaptive or survival value.

Psychological Professionals and Areas of Specialization

1.5 How does a psychologist differ from a psychiatrist, and what are the other types of professionals who work in the various areas of psychology?

- Psychologists have academic degrees and can do counseling, teaching, and research and may specialize in any one of a large number of areas within psychology.
- There are many different areas of specialization in psychology, including clinical, counseling, developmental, social, and personality as areas of work or study.
- Psychiatrists are medical doctors who provide diagnosis and therapy for persons with mental disorders.
- Psychiatric social workers are social workers with special training in the influences of the environment on mental illness.

Psychology: The Scientific Methodology

1.6 Why is psychology considered a science, and what are the steps in using the scientific method?

- The scientific method is a way to determine facts and control the possibilities of error and bias when observing behavior. The five steps are perceiving the question, forming a hypothesis, testing the hypothesis, drawing conclusions, and reporting the results.

1.7 How are naturalistic and laboratory settings used to describe behavior, and what are some of the advantages and disadvantages associated with these settings?

- Naturalistic observations involve watching animals or people in their natural environments but have the disadvantage of lack of control.
- Laboratory observations involve watching animals or people in an artificial but controlled situation, such as a laboratory.

1.8 How are case studies and surveys used to describe behavior, and what are some drawbacks to each of these methods?

- Case studies are detailed investigations of one subject, whereas surveys involve asking standardized questions of large groups of people that represent a sample of the population of interest.
- Information gained from case studies cannot be applied to other cases. People responding to surveys may not always tell the truth or remember information correctly.

1.9 What is the correlational technique, and what does it tell researchers about relationships?

- Correlation is a statistical technique that allows researchers to discover and predict relationships between variables of interest.
- Positive correlations exist when increases in one variable are matched by increases in the other variable, whereas negative correlations exist when increases in one variable are matched by decreases in the other variable.
- Correlations cannot be used to prove cause-and-effect relationships.

1.10 What are the steps involved in designing an experiment?

- Experiments are tightly controlled manipulations of variables that allow researchers to determine cause-and-effect relationships.
- The independent variable in an experiment is the variable that is deliberately manipulated by the experimenter to see if related changes occur in the behavior or responses of the participants and is given to the experimental group.
- The dependent variable in an experiment is the measured behavior or responses of the participants.
- The control group receives either a placebo treatment or nothing.
- Random assignment of participants to experimental groups helps to control for individual differences both within and between the groups that might otherwise interfere with the experiment's outcome.

1.11 How do the placebo and experimenter effects cause problems in an experiment, and what are some ways to control for these effects?

- Experiments in which the subjects do not know if they are in the experimental or control groups are single-blind studies, whereas experiments in which neither the experimenters nor the subjects know this information are called double-blind studies.

1.12 What are some basic elements of a real-world experiment?

- An experiment studying the effect of negative stereotypes on test performance of athletes (Jameson et al., 2007) found that exposure to negative stereotypes prior to taking a test resulted in poorer performance by athletes than the performance of athletes whose exposure came after the test.

Ethics of Psychological Research

1.13 What are some ethical concerns that can occur when conducting research with people and animals?

- Ethical guidelines for doing research with human beings include the protection of rights and well-being of participants, informed consent, justification when deception is used, the right of participants to withdraw at any time, protection of participants from physical or psychological harm, confidentiality, and debriefing of participants at the end of the study. Researchers are also responsible for correcting any undesirable consequences that may result from the study.
- Animals in psychological research make useful models because they are easier to control than humans, they have simpler behavior, and they can be used in ways that are not permissible with humans.

Applying Psychology to Everyday Life: Thinking Critically About Critical Thinking

1.14 What are the basic principles of critical thinking, and how can critical thinking be useful in everyday life?

- Critical thinking is the ability to make reasoned judgments. The four basic criteria of critical thinking are that there are few concepts that do not need to be tested, evidence can vary in quality, claims by experts and authorities do not automatically make something true, and keeping an open mind is important.

test YOURSELF

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Pick the best answer.

1. In the definition of psychology, the term behavior means
 - a. internal, covert processes.
 - b. outward behavior.
 - c. overt actions and reactions.
 - d. only animal behavior.
2. A psychologist is interested in finding out why married couples seemingly begin to look like each other after several years of marriage. This psychologist is most interested in the goal of
 - a. description.
 - b. explanation.
 - c. prediction.
 - d. control.
3. Who is considered to be the father of African American psychology?
 - a. Charles Henry Thompson
 - b. Robert V. Guthrie
 - c. Francis Cecil Sumner
 - d. Howard Hale Long
4. Sigmund Freud's psychoanalysis focused on
 - a. observable behavior.
 - b. Gestalt perceptions.
 - c. introspection.
 - d. early childhood experiences.
5. Which psychologist dared to ignore the whole consciousness issue and return to a study of scientific inquiry by focusing on observable behavior?
 - a. Ivan Pavlov
 - b. John Watson
 - c. Sigmund Freud
 - d. William James
6. Which perspective is often referred to as the "third force" in psychology and focuses on a person's freedom of choice in determining their behavior?
 - a. biopsychological perspective
 - b. behaviorism
 - c. cognitive psychology
 - d. humanism
7. Which perspective best explains the bystander effect whereby individuals will be less likely to help someone in need because of the presence of others close by?
 - a. psychoanalysis
 - b. behaviorism
 - c. cognitive psychology
 - d. sociocultural
8. If Dr. Byers uses an eclectic approach in her clinical treatment of children, what is it that she is doing?
 - a. She is relying primarily on one psychological perspective to treat all her patients.
 - b. She is using medications with all her patients, especially those suffering from depression.
 - c. She relies heavily on the Freudian psychodynamic perspective to help children who show abnormal behavior.
 - d. She is using a combination of perspectives to treat different clients.
9. Dr. Colton identifies himself with the largest subfield of psychology. What kind of psychologist is he?
 - a. counseling
 - b. clinical
 - c. school
 - d. experimental
10. Micah has recently been diagnosed with a psychological disorder that is best addressed initially with medication. He would likely benefit the most by first seeing a _____.
 - a. psychiatrist
 - b. psychoanalyst
 - c. psychiatric social worker
 - d. psychologist
11. Which step in the scientific method is derived from the goal of description?
 - a. reporting your results
 - b. perceiving a question
 - c. drawing conclusions
 - d. forming a hypothesis
12. Brianne wants to find an explanation for the behavior of her lab rats in her study. Which step in the scientific method is she currently focusing on?
 - a. testing a hypothesis
 - b. perceiving the question
 - c. drawing conclusions
 - d. reporting her results
13. The famous study of Phineas Gage, who survived when a metal rod pierced his skull, is an example of a
 - a. laboratory experiment.
 - b. correlation.
 - c. case study.
 - d. survey.
14. A researcher finds that as her subjects increased the number of hours they spent exercising, the overall weight of her subjects decreased. This would be an example of a _____ correlation.
 - a. positive
 - b. negative
 - c. zero
 - d. causal

15. A researcher wants to study the effects of texting on driving. Students in Group A drive a car in a computer game and see how many virtual accidents they have. Students in Group B are asked to drive the same virtual car but they must respond to and send at least three texts. The number of virtual accidents is measured for each group. What is the independent variable?
- the virtual car
 - texting
 - the number of virtual accidents
 - the group assignment
16. A researcher asks an assistant to conduct a study on her behalf. She specifically tells her assistant only to share the results anonymously and not include the names of the students along with their scores. Such an experiment would be considered a
- double-blind experiment.
 - single-blind experiment.
 - correlational study.
 - laboratory observation.
17. Double-blind studies control for
- the placebo effect.
 - the experimenter effect.
 - the placebo effect and the experimenter effect.
 - extrinsic motivation.
18. In the stereotypes and athletes study, who was the control group?
- those students who completed the survey prior to the intelligence test
 - those students who completed the survey after the intelligence test
 - those students who were not asked to complete the intelligence test
 - those students who did not take part in the study at all
19. Dr. Calvin needs just one more participant to complete her experiment. Lisa, a student of Dr. Calvin, has almost completed the experiment when she announces she wants to quit because the experiment is boring. What options does Dr. Calvin have?
- Dr. Calvin can require that Lisa finish because students don't have the same rights to quit an experiment as the general public does.
 - Dr. Calvin can require that Lisa finish because boredom is not an acceptable excuse for quitting.
 - Dr. Calvin can make Lisa stay since she is a student of hers and she requires students to take part in her experiments.
 - Dr. Calvin must let Lisa go and find another participant.
20. A famous golfer advertises a new golf bracelet that helps minimize fatigue while playing. If Bethany decides to order the bracelet because she believes that such a well-known personality should know if it works or not, she has made an error in which of the following?
- Few "truths" do not need to be tested.
 - All evidence is not equal in quality.
 - Authority or expertise does not make the claims of the authority or expert true.
 - Critical thinking requires an open mind.

2

the biological perspective

The Ironman® competition consists of a 2.4-mile swim, a 112-mile bike ride, and a 26.2-mile run. Dick Hoyt pulls his son Rick in a boat that is attached to a bungee cord, then he peddles Rick on a special two-seater bicycle, and finally he pushes Rick across the finish line in a customized running chair.

Why the unusual approach? Rick was born with spastic quadriplegia and cerebral palsy as the result of anoxia during birth. Unable to walk or talk, Rick learned to communicate by tapping his head against a head piece on his wheelchair when specific letters of the alphabet were highlighted on a specially designed computer screen. He eventually graduated from Boston University with a degree in special education.

Current research to help individuals with brain injuries or neurological conditions has moved far beyond the computer that assisted Rick. Some of the most promising areas are in brain-computer interfaces (BCI) that use the brain's electrical activity to communicate with others. It is possible that in the future, brain activity will enable individuals to control such assistive devices as prosthetic limbs or wheelchairs.

What do you see as the brain's role in our behavior? How much do you think your behavior is influenced by hormones and chemicals in the nervous system?

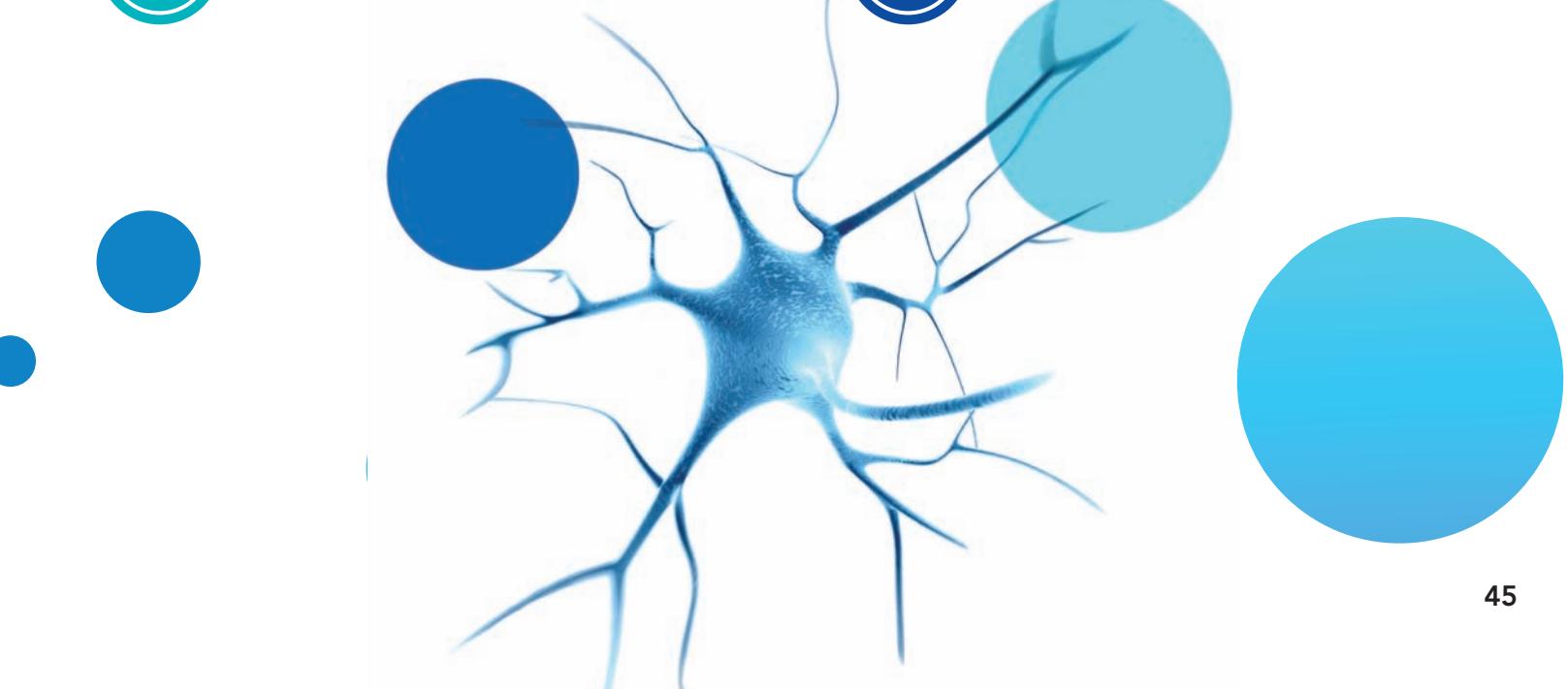
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Why study the nervous system and the glands?

How could we possibly understand any of our behavior, thoughts, or actions without knowing something about the incredible organs that allow us to act, think, and react? If we can understand how the brain, the nerves, and the glands interact to control feelings, thoughts, and behavior, we can begin to truly understand the complex organism called a human being.

Learning objectives

- 2.1** What are the nervous system, neurons, and nerves, and how do they relate to one another?
- 2.2** How do neurons use neurotransmitters to communicate with each other and with the body?
- 2.3** How do the brain and spinal cord interact, what are some misconceptions about the brain, and what is neuroplasticity?
- 2.4** How do the somatic and autonomic nervous systems allow people and animals to interact with their surroundings and control the body's automatic functions?
- 2.5** How do the hormones released by glands interact with the nervous system and affect behavior?
- 2.6** How do psychologists study the brain and how it works?
- 2.7** What are the different structures of the hindbrain and what do they do?
- 2.8** What are the structures of the brain that control emotion, learning, memory, and motivation?
- 2.9** What parts of the cortex control the different senses and the movement of the body?
- 2.10** What parts of the cortex are responsible for higher forms of thought, such as language?
- 2.11** How does the left side of the brain differ from the right side?
- 2.12** What are some potential causes of attention-deficit/hyperactivity disorder?



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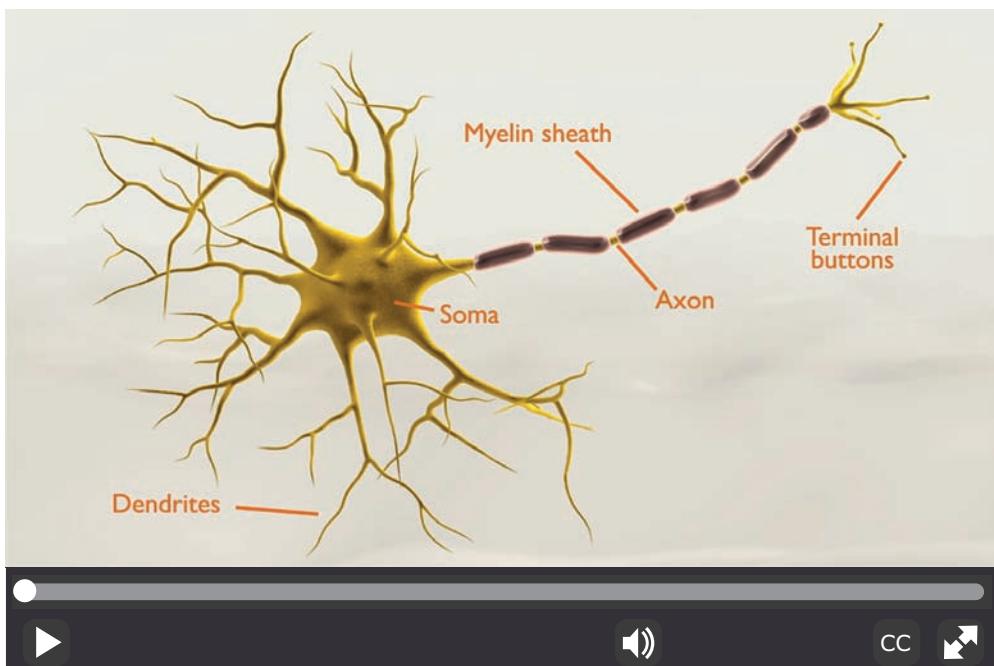
Neurons and Nerves: Building the Network

What are the nervous system, neurons, and nerves, and how do they relate to one another?

This chapter will explore a complex system of cells, chemicals, and organs that work together to produce behavior, thoughts, and actions. The first part of this complex arrangement is the **nervous system**, a network of cells that carries information to and from all parts of the body. The field of **neuroscience** is a branch of the life sciences that deals with the structure and functioning of the brain and the neurons, nerves, and nervous tissue that form the nervous system. **Biological psychology**, or **behavioral neuroscience**, is the branch of neuroscience that focuses on the biological bases of psychological processes, behavior, and learning, and it is the primary area associated with the biological perspective in psychology.

STRUCTURE OF THE NEURON: THE NERVOUS SYSTEM'S BUILDING BLOCK

In 1887, Santiago Ramón y Cajal, a doctor studying slides of brain tissue, first theorized that the nervous system was made up of individual cells (Ramón y Cajal, translation, 1995). Although the entire body is composed of cells, each type of cell has a special purpose and function and, therefore, a special structure. For example, skin cells are flat, but muscle cells are long and stretchy. Most cells have three things in common: a nucleus, a cell body, and a cell membrane holding it all together. The **neuron** is the specialized cell in the nervous system that receives and sends messages within that system. Neurons are one of the messengers of the body, and that means that they have a very special structure, which we will explore in the video *The Basics: How the Brain Works, Part 1: The Neuron*.

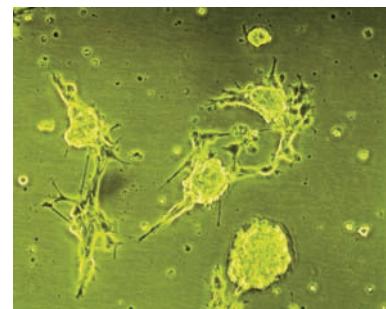


Watch the [Video](#), *The Basics: How the Brain Works, Part 1: The Neuron*, at [MyPsychLab](#)

The parts of the neuron that receive messages from other cells are called the **dendrites**. The name *dendrite* means “tree-like,” or “branch,” and this structure does indeed look like the branches of a tree. The dendrites are attached to the cell body, or **soma**, which is the part of the cell that contains the nucleus and keeps the entire cell alive and functioning. The word *soma* means “body.” The **axon** (from the Greek for “axis”) is a fiber

attached to the soma, and its job is to carry messages out to other cells. The end of the axon branches out into several shorter fibers that have swellings or little knobs on the ends called **axon terminals** (may also be called *presynaptic terminals*, *terminal buttons*, or *synaptic knobs*), which are responsible for communicating with other nerve cells. (See Figure 2.1.)

Neurons make up a large part of the brain but they are not the only cells that affect our thinking, learning, memory, perception, and all of the other facets of life that make us who we are. The other primary cells are called glia, or **glial cells**, which serve a variety of functions. Some glia serve as a sort of structure on which the neurons develop and work and that hold the neurons in place. For example, during early brain development, radial glial cells (extending from inner to outer areas like the spokes of a wheel) help guide migrating neurons to form the outer layers of the brain. Other glia are involved in getting nutrients to the neurons, cleaning up the remains of neurons that have died, communicating with neurons and other glial cells, and providing insulation for neurons. Glial cells affect both the functioning and structure of neurons and specific types also have properties similar to stem cells, which allow them to develop into new neurons, both during prenatal development and in adult mammals (Bullock et al., 2005; Kriegstein & Alvarez-Buylla, 2009). Glial cells are also being investigated for their possible role in a variety of psychiatric disorders, including *major depressive disorder* and *schizophrenia*. It appears in some areas of the brain, major depressive disorder is characterized by lower numbers of specific glial cells whereas in schizophrenia, parts of the brain have a greater number (Blank & Prinz, 2013).  to Learning Objectives 14.5 and 14.8. Recent findings also implicate glial cells in learning and behavior, both by affecting synaptic connectivity during development, and in mice transplanted with human glial cells, faster learning across a variety of learning and memory tasks (Han et al., 2013; Ji et al., 2013).



This electron micrograph shows a stem cell in the process of becoming a neuron.

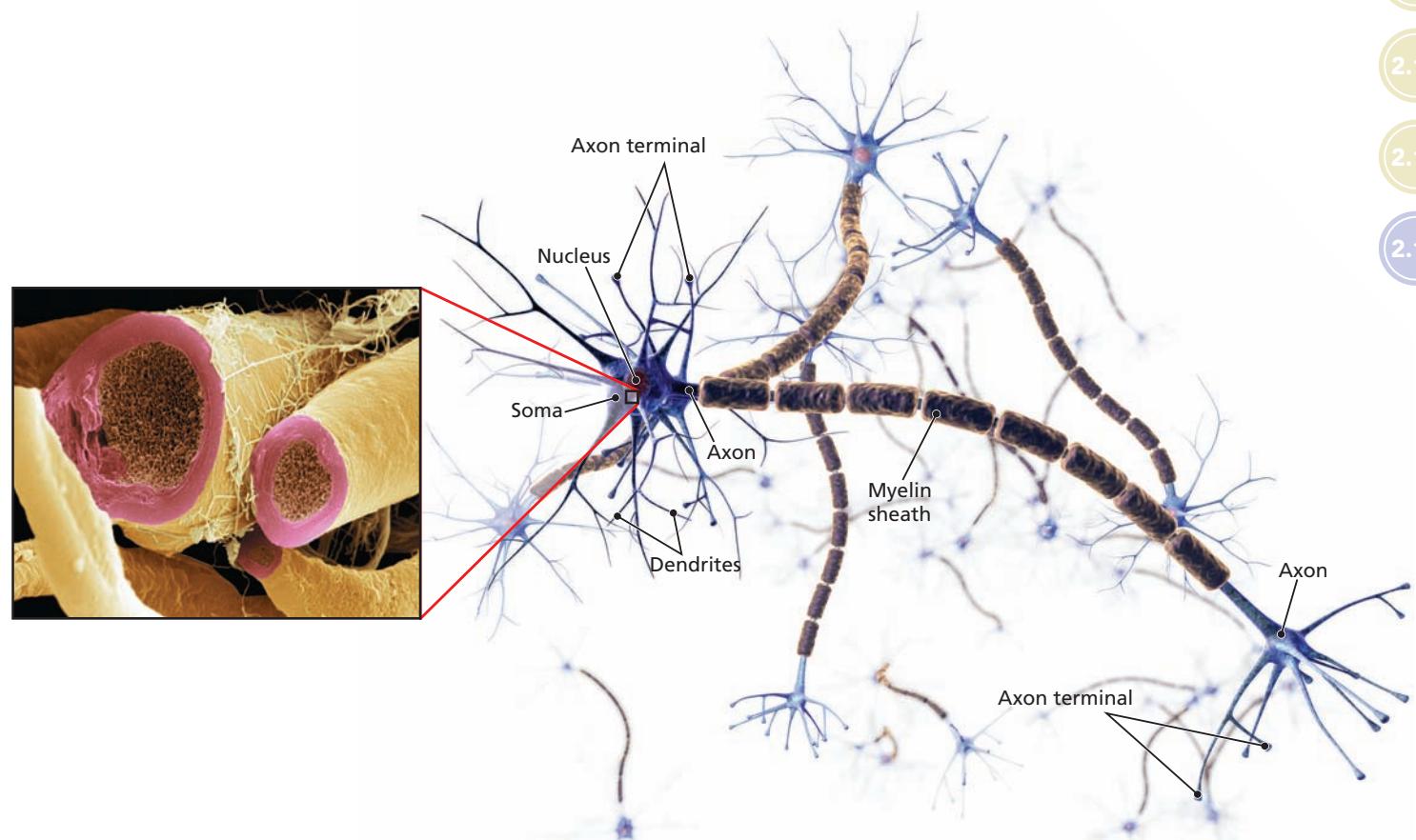


Figure 2.1 The Structure of the Neuron

The electron micrograph on the left shows myelinated axons.

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Two special types of glial cells, called *oligodendrocytes* and *Schwann cells*, generate a layer of fatty substances called **myelin**. Oligodendrocytes produce myelin for the neurons in the brain and spinal cord (the central nervous system); Schwann cells produce myelin for the neurons of the body (the peripheral nervous system). Myelin wraps around the shaft of the axons, forming an insulating and protective sheath. Bundles of myelin-coated axons travel together as “cables” in the central nervous system called *tracts*, and in the peripheral nervous system bundles of axons are called **nerves**. Myelin from Schwann cells has a unique feature that can serve as a tunnel through which damaged nerve fibers can reconnect and repair themselves. That’s why a severed toe might actually regain some function and feeling if sewn back on in time. Unfortunately, myelin from oligodendrocytes covering axons in the brain and spinal cord does not have this feature, and these axons are more likely to be permanently damaged.

The myelin sheath is a very important part of the neuron. It not only insulates and protects the neuron, it also speeds up the neural message traveling down the axon. As shown in Figure 2.1, sections of myelin bump up next to each other on the axon, similar to the way sausages are linked together. The places where the myelin seems to bump are actually small spaces on the axon called nodes, which are not covered in myelin. Myelinated and unmyelinated sections of axons have slightly different electrical properties. There are also far more ion channels at each node. Both of these features affect the speed the electrical signal is conducted down the axon. When the electrical impulse that is the neural message travels down an axon coated with myelin, the electrical impulse is regenerated at each node and appears to “jump” or skip rapidly from node to node down the axon (Koester & Siegelbaum, 2013; Schwartz et al., 2013). That makes the message go much faster down the coated axon than it would down an uncoated axon of a neuron in the brain. In the disease called *multiple sclerosis* (MS), the myelin sheath is destroyed (possibly by the individual’s own immune system), which leads to diminished or complete loss of neural functioning in those damaged cells. Early symptoms of MS may include fatigue, changes in vision, balance problems, and numbness, tingling, or muscle weakness in the arms or legs.



Exactly how does this “electrical message” work inside the cell?

GENERATING THE MESSAGE WITHIN THE NEURON: THE NEURAL IMPULSE

A neuron that’s at rest—not currently firing a neural impulse or message—is actually electrically charged. Inside and outside of the cell is a semiliquid (jelly-like) solution in which there are charged particles, or *ions*. Although both positive and negative ions are located inside and outside of the cell, the relative charge of ions inside the cell is mostly negative, and the relative charge of ions outside the cell is mostly positive due to both **diffusion**, the process of ions moving from areas of high concentration to areas of low concentration, and *electrostatic pressure*, the relative electrical charges when the ions are at rest. The cell membrane itself is *semipermeable*. This means some substances that are outside the cell can enter through tiny protein openings, or *channels*, in the membrane, while other substances in the cell can go outside. Many of these channels are gated—they open or close based on the electrical potential of the membrane—more about that in a minute. Inside the cell is a concentration of both smaller positively charged potassium ions and larger negatively charged protein ions. The negatively charged protein ions, however, are so big that they can’t get out, which leaves the inside of the cell primarily negative when at rest. Outside the cell are lots of positively charged sodium ions and negatively charged chloride ions, but they are unable to enter the cell membrane when the cell is at rest because the ion channels that would allow them in are closed. But because the outside sodium ions are positive and the inside ions are negative, and because opposite electrical charges attract each other, the sodium ions will cluster around the membrane. This difference in charges creates an electrical potential. **Watch the Video**, *The Basics: How the Brain Works, Part I: Action Potential*, at **MyPsychLab**

Think of the ions inside the cell as a baseball game inside a stadium (the cell walls). The sodium ions outside the cell are all the fans in the area, and they want to get inside to see the game. When the cell is resting (the electrical potential is in a state called the **resting potential**, because the cell is at rest), the fans are stuck outside. The sodium ions cannot enter when the cell is at rest, because even though the cell membrane has all these channels, the *particular channels* for the big sodium ions aren't open yet. But when the cell receives a strong enough stimulation from another cell (meaning that the dendrites are activated), the cell membrane opens up those particular channels, one after the other, all down its surface, allowing the sodium ions (the "fans") to rush into the cell. That causes the inside of the cell to become mostly positive and the outside of the cell to become mostly negative, because many of the positive sodium ions are now inside the cell—at the point where the first ion channel opened. This electrical charge reversal will start at the part of the axon closest to the soma, the *axon hillock*, and then proceed down the axon in a kind of chain reaction. (Picture a long hallway with many doors in which the first door opens, then the second, and so on all the way down the hall.) This electrical charge reversal is known as the **action potential** because the electrical potential is now in action rather than at rest. Each action potential sequence takes about one thousandth of a second, so the neural message travels very fast—from 2 miles per hour in the slowest, shortest neurons to 270 miles per hour in other neurons. (See **Figure 2.2** on the next page.)

Now the action potential is traveling down the axon. When it gets to the end of the axon, something else happens: the message will get transmitted to another cell (that step will be discussed momentarily). Meanwhile, what is happening to the parts of the cell that the action potential has already left behind? How does the cell get the "fans" back outside? Remember, the action potential means that the cell is now positive inside and negative outside at the point where the channel opened. Several things happen to return the cell to its resting state. First, the sodium ion channels close immediately after the action potential has passed, allowing no more "fans" (sodium ions) to enter. The cell membrane also literally pumps the positive sodium ions back outside the cell, kicking the "fans" out until the next action potential opens the ion channels again. This pumping process is a little slow, so another type of ion gets into the act. Small, positively charged potassium ions inside the neuron move rapidly out of the cell after the action potential passes, helping to more quickly restore the inside of the cell to a negative charge. Now the cell becomes negative inside and positive outside, and the neuron is capable of "firing off" another message. Once the sodium pumps finish pumping out the sodium ions, the neuron can be said to have returned to its full resting potential, poised and ready to do it all again.

To sum all that up, when the cell is stimulated, the first ion channel opens and the electrical charge *at that ion channel* is reversed. Then the next channel opens and *that* charge is reversed, but in the meantime the *first* ion channel has been closed and the charge is returning to what it was when it was at rest. The action potential is the *sequence* of ion channels opening all down the length of the cell's axon.

So if the stimulus that originally causes the neuron to fire is very strong, will the neuron fire more strongly than it would if the stimulus were weak?

Neurons actually have a threshold for firing, and all it takes is a stimulus that is just strong enough to get past that threshold to make the neuron fire. Here's a simple version of how this works: Each neuron is receiving many signals from other neurons. Some of these signals are meant to cause the neuron to fire, whereas others are meant to prevent the neuron from firing. The neuron constantly adds together the effects of the "fire" messages and subtracts the "don't fire" messages, and if the fire messages are great enough, the threshold is crossed and the neuron fires. When a neuron does fire, it fires in an **all-or-none** fashion. That is, neurons are either firing at full strength or not firing at

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Figure 2.2 The Neural Impulse Action Potential

In the graph, voltage readings are shown at a given place on the neuron over a period of 20 or 30 milliseconds (thousandths of a second). At first the cell is resting; it then reaches threshold and an action potential is triggered. After a brief hyperpolarization period, the cell returns to its resting potential.

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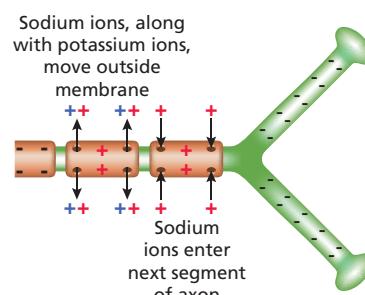
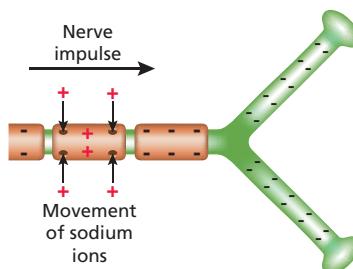
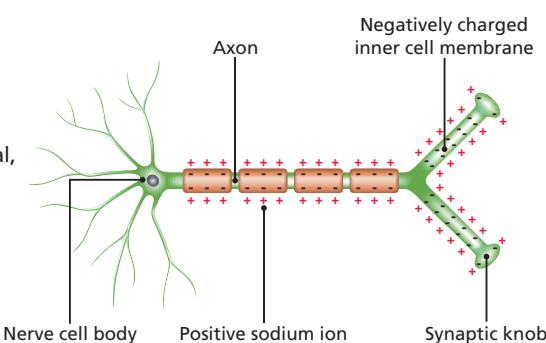
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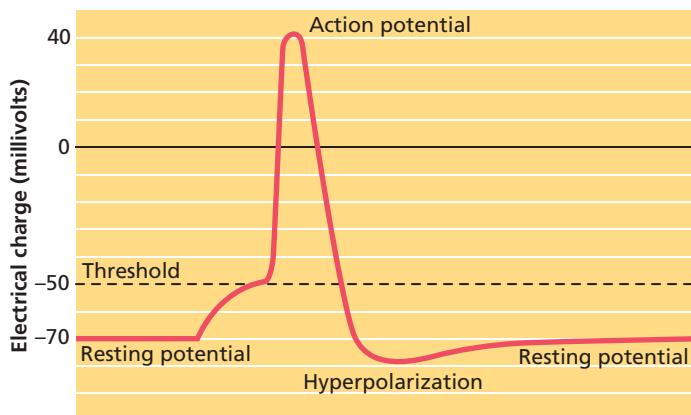
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The Neuron at Rest
During the resting potential, the neuron is negatively charged inside and positively charged outside.



The Neural Impulse
The action potential occurs when positive sodium ions enter into the cell, causing a reversal of the electrical charge from negative to positive.

The Neural Impulse Continues
As the action potential moves down the axon toward the axon terminals, the cell areas behind the action potential return to their resting state of a negative charge as the positive sodium ions are pumped to the outside of the cell, and the positive potassium ions rapidly leave.



all—there's no such thing as "partial" firing of a neuron. It would be like turning on a light switch—it's either on or it's off. Once the switch is turned to the on position, the light will come on. When it's turned to the off position, the light is off.

So, what's the difference between strong stimulation and weak stimulation? A strong message will cause the neuron to fire repeatedly (as if someone flicked the light switch on and off as quickly as possible), and it will also cause more neurons to fire (as if there were a lot of lights going on and off instead of just one).

Now that we know how the message travels within the axon of the cell, what is that "something else" that happens when the action potential reaches the end of the axon?

SENDING THE MESSAGE TO OTHER CELLS: THE SYNAPSE

How do neurons use neurotransmitters to communicate with each other and with the body?

Look once again at the axon terminals in Figure 2.1. Figure 2.3 shows an axon terminal enlarged to giant scale. Notice that the presynaptic terminal is not empty. It has a number of little sac-like structures in it called **synaptic vesicles**. The word *vesicle* is Latin and means a “little blister” or “fluid-filled sac.”

Inside the synaptic vesicles are chemicals suspended in fluid, which are molecules of substances called **neurotransmitters**. The name is simple enough—they are inside a neuron and they are going to transmit a message. (Neurons have traditionally been viewed as containing a single type of neurotransmitter but it is now accepted that neurons may release more than one neurotransmitter. For simplicity and unless otherwise specified, our discussion throughout the text will assume a single, predominant neurotransmitter is being released.) Next to the axon terminal is the dendrite of another neuron (see Figure 2.3). Between them is a fluid-filled space called the **synapse** or the **synaptic gap**. Instead of an electrical charge, the vesicles at the end of the axon (also called the pre-synaptic membrane) contain the molecules of neurotransmitters, and the surface of the dendrite next to the axon (the post-synaptic membrane) contains ion channels that have **receptor sites**, proteins that allow only particular molecules of a certain shape to fit into it, just as only a particular key will fit into a keyhole.

How do the neurotransmitters get across the gap? Recall the action potential making its way down the axon after the neuron has been stimulated. When that action potential, or electrical charge, reaches the synaptic vesicles, the synaptic vesicles release their neurotransmitters into the synaptic gap. The molecules then float across the synapse and many of them fit themselves into the receptor sites, opening the ion channels and allowing sodium to rush in, activating the next cell. It is this very activation that stimulates, or releases, the action potential in that cell. It is important to understand that the “next cell” may be a neuron, but it may also be a cell on a muscle or a gland. Muscles and glands have special cells with receptor sites on them, just like on the dendrite of a neuron.

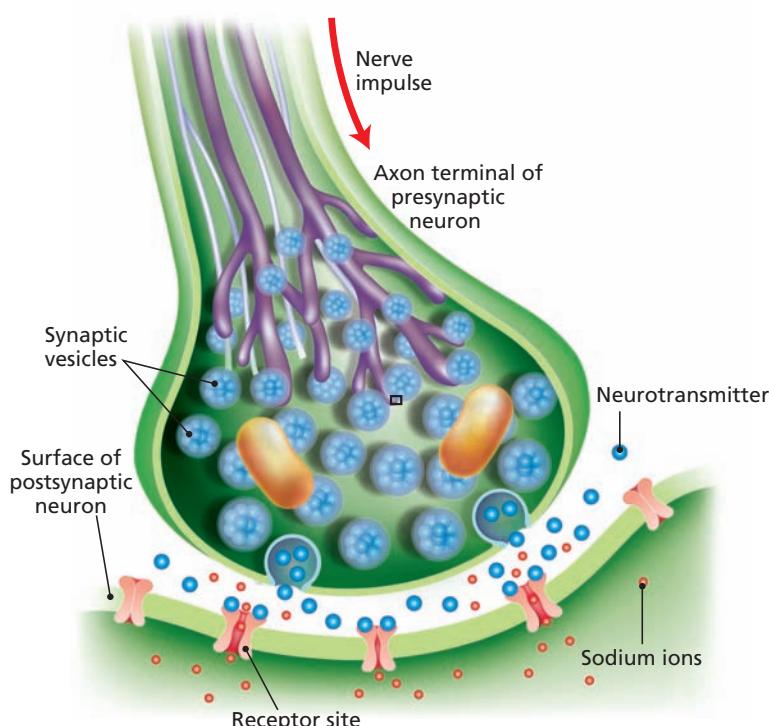
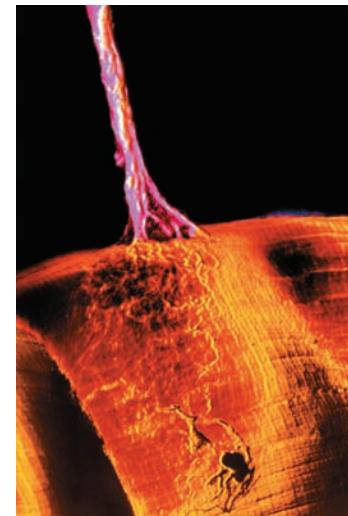


Figure 2.3 The Synapse

The nerve impulse reaches the axon terminal, triggering the release of neurotransmitters from the synaptic vesicles. The molecules of neurotransmitter cross the synaptic gap to fit into the receptor sites that fit the shape of the molecule, opening the ion channel and allowing sodium ions to rush in.



This electron micrograph shows a motor neuron making contact with muscle fibers.

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So far, we've been talking about the synapse as if neurotransmitters always cause the next cell to fire its action potential (or, in the case of a muscle or gland, to contract or start secreting its chemicals). But the neurons must have a way to be turned *off* as well as on. Otherwise, when a person burns a finger, the pain signals from those neurons would not stop until the burn was completely healed. Muscles are told to contract or relax, and glands are told to secrete or stop secreting their chemicals. The neurotransmitters found at various synapses around the nervous system can either turn cells on (called an *excitatory* effect) or turn cells off (called an *inhibitory* effect), depending on exactly what synapse is being affected. Although some people refer to neurotransmitters that turn cells on as *excitatory* neurotransmitters and the ones that turn cells off as *inhibitory* neurotransmitters, it's really more correct to refer to **excitatory synapses** and **inhibitory synapses**. In other words, it's not the neurotransmitter itself that is excitatory or inhibitory, but rather it is the effect of that neurotransmitter that is either excitatory or inhibitory at the receptor sites of a particular synapse.

NEUROTRANSMITTERS: MESSENGERS OF THE NETWORK

The first neurotransmitter to be identified was named *acetylcholine* (ACh). It is found at the synapses between neurons and muscle cells. Acetylcholine stimulates the skeletal muscles to contract but actually slows contractions in the heart muscle. If acetylcholine receptor sites on the muscle cells are blocked in some way, then the acetylcholine can't get to the site and the muscle will be incapable of contracting—paralyzed, in other words. This is exactly what happens when *curare*, a drug used by South American Indians on their blow darts, gets into the nervous system. Curare's molecules are just similar enough to fit into the receptor site without actually stimulating the cell, making curare an **antagonist** (a chemical substance that blocks or reduces the effects of a neurotransmitter) for ACh.

What would happen if the neurons released too much ACh? The bite of a black widow spider does just that. Its venom stimulates the release of excessive amounts of ACh and causes convulsions and possible death. Black widow spider venom is an **agonist** (a chemical substance that mimics or enhances the effects of a neurotransmitter) for ACh.

ACh also plays a key role in memory, arousal, and attention. For example, ACh is found in the hippocampus, an area of the brain that is responsible for forming new memories, and low levels of ACh have been associated with Alzheimer's disease, the most common type of dementia.  to [Learning Objective 6.12](#). We will focus more on agonists and antagonists later in the chapter.

Dopamine (DA) is a neurotransmitter found in the brain, and like some of the other neurotransmitters, it can have different effects depending on the exact location of its activity. For example, if too little DA is released in a certain area of the brain, the result is Parkinson's disease—the disease currently being battled by former boxing champ Muhammad Ali and actor Michael J. Fox (Ahlskog, 2003). If too much DA is released in other areas, the result is a cluster of symptoms that may be part of schizophrenia (Akil et al., 2003).  to [Learning Objective 14.8](#).  [Watch the Video](#), *In the Real World: Neurotransmitters*, at [MyPsychLab](#)

Serotonin (5-HT) is a neurotransmitter originating in the lower part of the brain that can have either an excitatory or inhibitory effect, depending on the particular synapses being affected. It is associated with sleep, mood, anxiety, and appetite. For example, low levels of 5-HT activity have been linked to depression.  to [Learning Objective 14.5](#).

Although ACh was the first neurotransmitter found to have an excitatory effect at the synapse, the nervous system's major excitatory neurotransmitter is *glutamate*. Like ACh, glutamate plays an important role in learning and memory, and may also be involved in the development of the nervous system and in synaptic plasticity (the ability of the



The venom of the black widow spider causes a flood of acetylcholine to be released into the body's muscle system, causing convulsions.

brain to change connections among its neurons). However, an excess of glutamate results in overactivation and neuronal damage, and may be associated with the cell death that occurs after stroke, head injury, or in degenerative diseases like Alzheimer's disease and Huntington disease (Julien et al., 2011; Siegelbaum et al., 2013).

Another neurotransmitter is *gaba-aminobutyric acid* or GABA. Whereas glutamate is the major neurotransmitter with an excitatory effect, GABA is the most common neurotransmitter producing inhibition in the brain. GABA can help to calm anxiety, for example, by binding to the same receptor sites that are affected by tranquilizing drugs and alcohol. In fact, the effect of alcohol is to enhance the effect of GABA, which causes the general inhibition of the nervous system associated with getting drunk. This makes alcohol an agonist for GABA.  to Learning Objective 4.8. (See Table 2.1 for a list of some neurotransmitters and their functions.)

A group of substances known as *neuropeptides* can serve as neurotransmitters, hormones, or influence the action of other neurotransmitters (Schwartz & Javitch, 2013). You may have heard of the set of neuropeptides called *endorphins*—pain-controlling chemicals in the body. When a person is hurt, a neurotransmitter that signals pain is released. When the brain gets this message, it triggers the release of endorphins. The endorphins bind to receptors that open the ion channels on the axon. This causes the cell to be unable to fire its pain signal and the pain sensations eventually lessen. For example, you might bump your elbow and experience a lot of pain at first, but the pain will quickly subside to a much lower level. Athletes may injure themselves during an event and yet not feel the pain until after the competition is over, when the endorphin levels go down.

The name *endorphin* comes from the term *endogenous morphine*. (*Endogenous* means “native to the area”—in this case, native to the body.) Scientists studying the nervous system found receptor sites that fit morphine molecules perfectly and decided that there must be a natural substance in the body that has the same effect as morphine. Endorphins are one reason that heroin and the other drugs derived from opium are so addictive—when people take morphine or heroin, their bodies neglect to produce endorphins. When the drug wears off, they are left with no protection against pain at all, and *everything* hurts. This pain is one reason why most people want more heroin, creating an addictive cycle of abuse.  to Learning Objective 4.8.

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Table 2.1

Some Neurotransmitters and Their Functions

NEUROTRANSMITTERS	FUNCTIONS
Acetylcholine (ACh)	Excitatory or inhibitory; involved in arousal, attention, memory, and controls muscle contractions
Norepinephrine (NE)	Mainly excitatory; involved in arousal and mood
Dopamine (DA)	Excitatory or inhibitory; involved in control of movement and sensations of pleasure
Serotonin (5-HT)	Excitatory or inhibitory; involved in sleep, mood, anxiety, and appetite
Gaba-aminobutyric acid (GABA)	Major inhibitory neurotransmitter; involved in sleep and inhibits movement
Glutamate	Major excitatory neurotransmitter; involved in learning, memory formation, nervous system development, and synaptic plasticity
Endorphins	Inhibitory neural regulators; involved in pain relief

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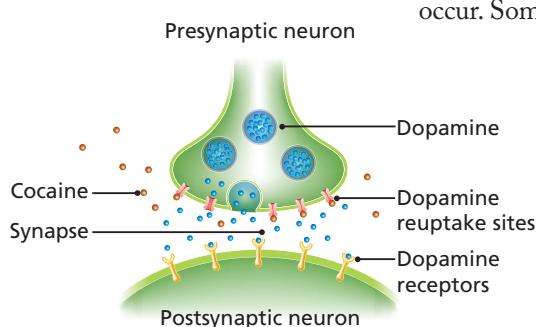


Figure 2.4 Reuptake of Dopamine

Dopamine is removed from the synapse by reuptake sites. Cocaine acts by blocking dopamine reuptake sites, allowing dopamine to remain active in the synapse longer.

If the neurotransmitters are out there in the synaptic gap and in the receptor sites, what happens to them when they aren't needed anymore?

CLEANING UP THE SYNAPSE: REUPTAKE AND ENZYMES

The neurotransmitters have to get out of the receptor sites before the next stimulation can occur. Some just drift away through the process of diffusion, but most will end up back in the synaptic vesicles in a process called **reuptake**. (Think of a little suction tube, sucking the chemicals back into the vesicles.) That way, the synapse is cleared for the next release of neurotransmitters. Some drugs, like cocaine, affect the nervous system by blocking the reuptake process. See Figure 2.4 for a visual representation of how dopamine is affected by cocaine.

There is one neurotransmitter that is not taken back into the vesicles, however. Because ACh is responsible for muscle activity, and muscle activity needs to happen rapidly and continue happening, it's not possible to wait around for the "sucking up" process to occur. Instead, an enzyme* specifically designed to break apart ACh clears the synaptic gap very quickly (a process called **enzymatic degradation**.) There are enzymes that break down other neurotransmitters as well.

I think I understand the synapse and neurotransmitters now, but how do I relate that to the real world?

Knowing how and why drugs affect us can help us understand why a doctor might prescribe a particular drug or why certain drugs are dangerous and should be avoided. Because the chemical molecules of various drugs, if similar enough in shape to the neurotransmitters, can fit into the receptor sites on the receiving neurons just like the neurotransmitters do, drugs can act as agonists or antagonists. Drugs acting as agonists, for example, can mimic or enhance the effects of neurotransmitters on the receptor sites of the next cell. This can result in an increase or decrease in the activity of the receiving cell, depending on what the effect of the original neurotransmitter (excitatory or inhibitory) was going to be. So if the original neurotransmitter was excitatory, the effect of the agonist will be to increase that excitation. If it was inhibitory, the effect of the agonist will be to increase that inhibition. Another deciding factor is the nervous system location of the neurons that use a specific neurotransmitter. Watch the Video, *What's In It For Me?: Your Brain on Drugs*, at [MyPsychLab](#)

For example, some antianxiety medications, such as diazepam (Valium®), are classified as benzodiazepines (to Learning Objective 15.8.) and are agonists for GABA, the primary inhibitory neurotransmitter in the brain. Areas of the brain that you will learn about later that play a role in controlling anxiety, agitation, and fear include the amygdala, orbitofrontal cortex, and the insula (LeDoux & Damasio, 2013; Zilles & Amunts, 2012). By increasing the inhibitory (calming) action of GABA, the benzodiazepines directly calm these specific brain areas (Julien et al., 2011; Preston et al., 2008).

Other drugs act as antagonists, blocking or reducing a cell's response to the action of other chemicals or neurotransmitters. Although an antagonist might sound like it has only an inhibitory effect, it is important to remember that if the neurotransmitter that the antagonist affects is inhibitory itself, the result will actually be an *increase* in the activity of the cell that would normally have been inhibited; the antagonist *blocks* the inhibitory effect.

Lastly, some drugs yield their agonistic or antagonistic effects by impacting the amount of neurotransmitter in the synapse. They do so by interfering with the regular reuptake or enzymatic degradation process. Remember that the neurotransmitter serotonin helps regulate and adjust people's moods, but in some people the normal process of

*enzyme: a complex protein that is manufactured by cells.

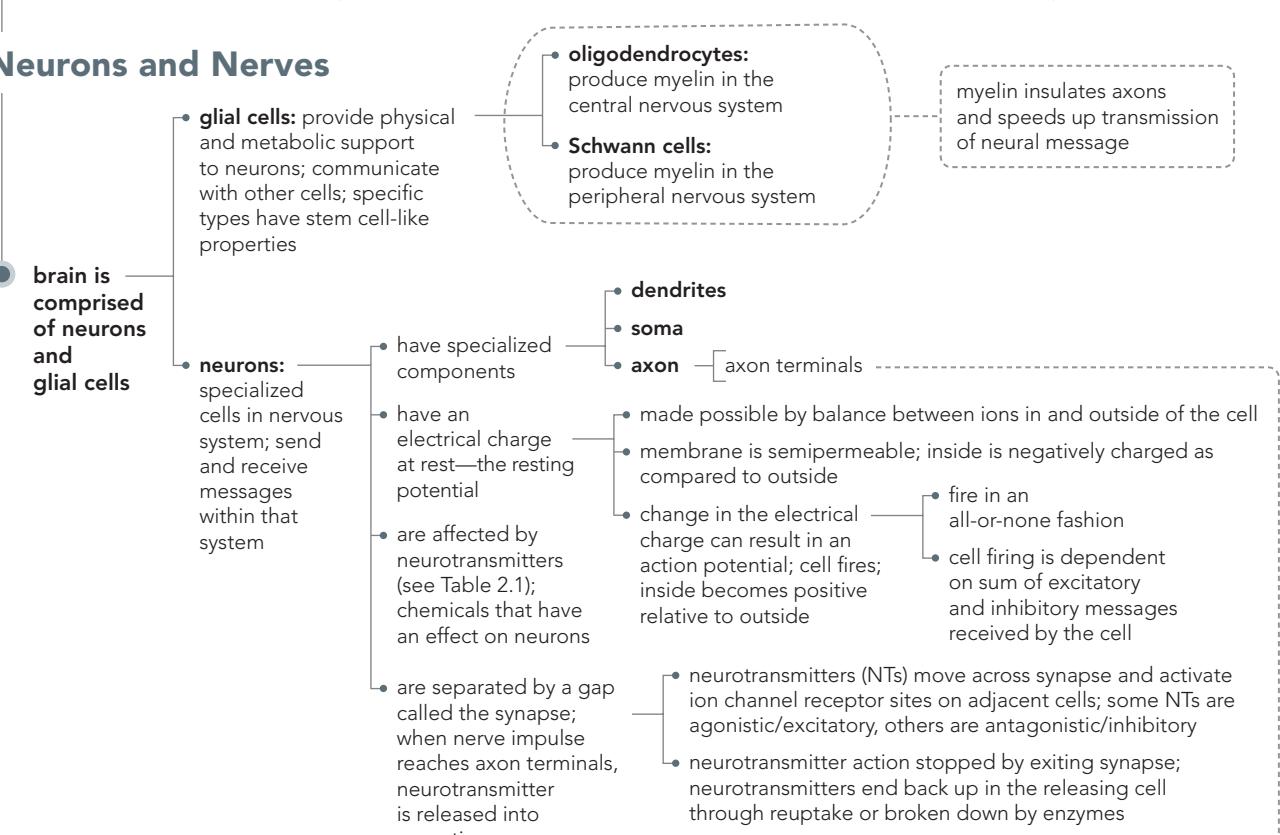
adjustment is not working properly. Some of the drugs used to treat depression are called SSRIs (selective serotonin reuptake inhibitors). SSRIs block the reuptake of serotonin, leaving more serotonin available in the synapse to bind with receptor sites. Over several weeks, the individual's mood improves. Although the reason for this improvement is not as simple as once believed (i.e., low levels of serotonin = low levels of mood) or fully understood, SSRIs are effective for depression, anxiety, and obsessive-compulsive disorder (Hyman & Cohen, 2013; Julien et al., 2011; Stahl, 2013).

This section covered the neuron and how neurons communicate. The next section looks at the bigger picture—the nervous system itself.

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 Explore the Concept at MyPsychLab

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CONCEPT MAP



```

graph TD
    NS["The nervous system is a network of cells that carries information to and from all parts of the body; neuroscience is the field of study that deals with the structure of the brain and components of the nervous system"] --- BC["brain is comprised of neurons and glial cells"]
    BC --- GC["glial cells: provide physical and metabolic support to neurons; communicate with other cells; specific types have stem cell-like properties"]
    BC --- N["neurons: specialized cells in nervous system; send and receive messages within that system"]
    GC --- OC["oligodendrocytes: produce myelin in the central nervous system"]
    GC --- SC["Schwann cells: produce myelin in the peripheral nervous system"]
    OC --- MI["myelin insulates axons and speeds up transmission of neural message"]
    N --- DC["dendrites"]
    N --- S["soma"]
    N --- A["axon"]
    A --- AT["axon terminals"]
    S --- RP["have an electrical charge at rest—the resting potential"]
    A --- AP["made possible by balance between ions in and outside of the cell"]
    A --- MP["membrane is semipermeable; inside is negatively charged as compared to outside"]
    A --- CP["change in the electrical charge can result in an action potential; cell fires; inside becomes positive relative to outside"]
    A --- FP["fire in an all-or-none fashion"]
    A --- DPM["cell firing is dependent on sum of excitatory and inhibitory messages received by the cell"]
    N --- NT["neurotransmitters (NTs) move across synapse and activate ion channel receptor sites on adjacent cells; some NTs are agonistic/excitatory, others are antagonistic/inhibitory"]
    N --- RNT["neurotransmitter action stopped by exiting synapse; neurotransmitters end back up in the releasing cell through reuptake or broken down by enzymes"]
  
```

Neurons and Nerves

- **glial cells:** provide physical and metabolic support to neurons; communicate with other cells; specific types have stem cell-like properties
- **neurons:** specialized cells in nervous system; send and receive messages within that system
 - have specialized components
 - have an electrical charge at rest—the resting potential
 - are affected by neurotransmitters (see Table 2.1); chemicals that have an effect on neurons
 - are separated by a gap called the synapse; when nerve impulse reaches axon terminals, neurotransmitter is released into synaptic space

Explore the Concept at MyPsychLab

PRACTICE QUIZ How Much Do You Remember?

PICK THE BEST ANSWER.

- Which part of the neuron carries messages to other cells?
 - axon
 - dendrite
 - soma
 - myelin
- Which one of the following is NOT a function of glial cells?
 - getting nutrients to the neurons
 - generating action potentials
 - cleaning up the remains of dead neurons
 - providing insulation
- When a neuron's resting potential is occurring, the neuron is _____ charged on the inside.
 - positively
 - negatively
 - both positively and negatively
 - neutrally
- Neurotransmitters must pass from an axon terminal to the next dendrite by crossing a fluid-filled space called the
 - synaptic gap.
 - reuptake inhibitor.
 - neuron.
 - glial cell.
- The venom of a black widow spider acts like a(n) _____ by mimicking the effects of acetylcholine.
 - agonist
 - antagonist
 - protagonist
 - glial cell
- Which of the following is associated with pain relief?
 - acetylcholine
 - glutamate
 - serotonin
 - endorphins

ANSWERS AVAILABLE IN ANSWER KEY.

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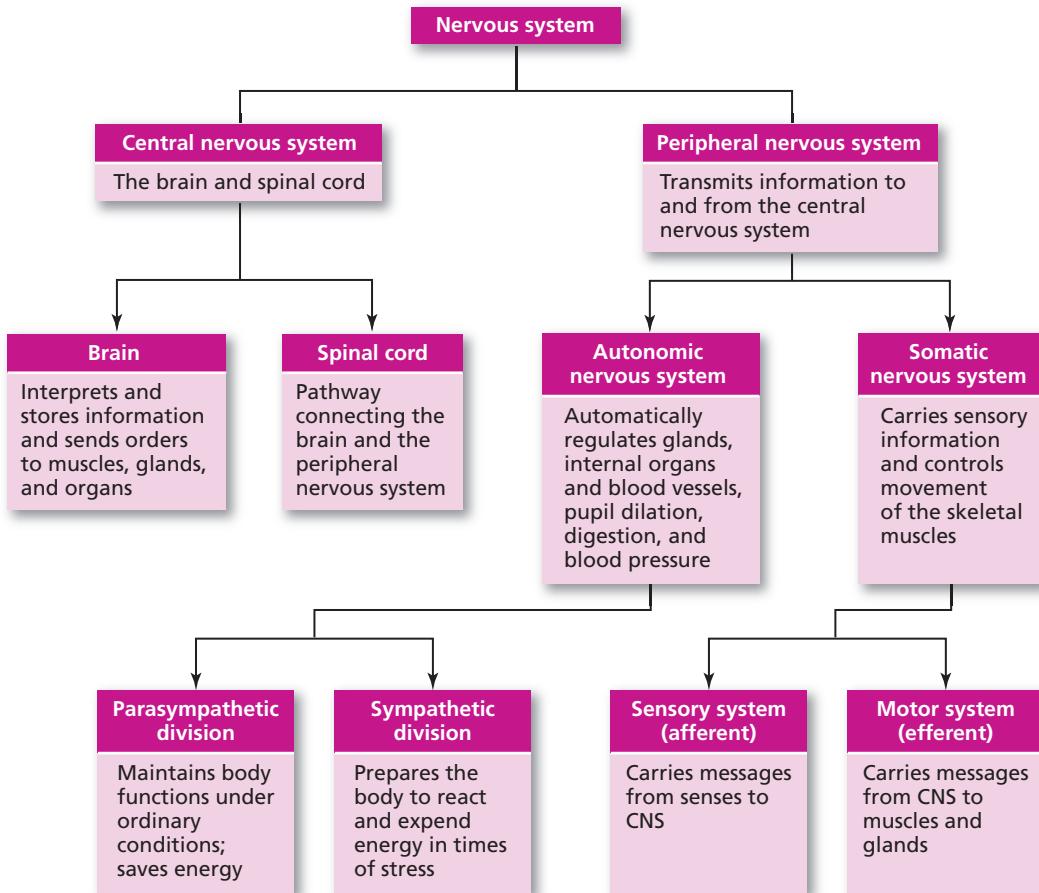
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An Overview of the Nervous System

Now that we have looked at the cells that make up the nervous system and ways in which they process and communicate information, take a look at Figure 2.5. This figure shows the organization of the various parts of the nervous system and will help in understanding how all the different parts work together in controlling the way people and animals think, act, and feel.  [Watch the Video, The Basics: How the Brain Works, Part 2: Nervous System, at MyPsychLab](#)

Figure 2.5 An Overview of the Nervous System



THE CENTRAL NERVOUS SYSTEM: THE “CENTRAL PROCESSING UNIT”

2.3

How do the brain and spinal cord interact, what are some misconceptions about the brain, and what is neuroplasticity?

The **central nervous system (CNS)** is composed of the brain and the spinal cord. Both the brain and the spinal cord are composed of neurons and glial cells that control the life-sustaining functions of the body as well as all thought, emotion, and behavior.

THE BRAIN The brain is the core of the nervous system, the part that makes sense of the information received from the senses, makes decisions, and sends commands out to the muscles and the rest of the body, if needed. Many different areas of the brain are involved in preparing us for an appropriate response to the information received, and the brain is responsible for cognition and thoughts, including learning, memory, and language. Later parts of this chapter will cover the brain in more detail, but for now, you should know the brain is organized into different regions, each with primary functions. While the neurons in each of the different areas work in much the same way, it is the groups of cells and the connections between them and other

parts of the brain or components of the nervous system, and our experiences, that influence the various functions found in specific brain areas (Amaral & Strick, 2013; Heimer, 1995; Squire & Kandel, 2009).

THE SPINAL CORD The **spinal cord** is a long bundle of neurons that serves two vital functions for the nervous system. Look at the cross-section of the spinal cord in **Figure 2.6**. Notice that it seems to be divided into two areas, a lighter outer section and a darker inner section. If it were a real spinal cord, the outer section would appear to be white and the inner section would seem gray. That's because the outer section is composed mainly of myelinated axons and nerves, which appear white, whereas the inner section is mainly composed of cell bodies of neurons, which appear gray. The purpose of the outer section is to carry messages from the body up to the brain and from the brain down to the body. It is simply a message "pipeline."

The inside section, which is made up of cell bodies separated by glial cells, is actually a primitive sort of "brain." This part of the spinal cord is responsible for certain reflexes—very fast, lifesaving reflexes. To understand how the spinal cord reflexes work, it is important to know there are three basic types of neurons: **afferent (sensory) neurons** that carry messages from the senses to the spinal cord, **efferent (motor) neurons** that carry messages from the spinal cord to the muscles and glands, and **interneurons** that connect the afferent neurons to the motor neurons (and make up the inside of the spinal cord and much of the brain itself). (See Figure 2.6.) Touch a flame or a hot stove with your finger, for example, and an afferent neuron will send the pain message up to the spinal column where it enters into the central area of the spinal cord. The interneuron in that central area will then receive the message and send out a response along an efferent neuron, causing your finger to pull back. This all happens very quickly. If the pain message had to go all the way up to the brain before a response could be made, the response time would be greatly increased and more damage would be done to your finger. So having this kind of **reflex arc** controlled by the spinal cord alone allows for very fast response times. (A good way to avoid mixing up the terms *afferent* and *efferent* is to remember "afferent neurons access the spinal cord, efferent neurons exit." The pain message does eventually get to the brain, where other motor responses may be triggered, like saying "Ouch!" and putting the finger in your mouth.

 **Explore the Concept** *The Nerve Impulse in Afferent and Efferent Neurons*, at [MyPsychLab](#)



The look on this young woman's face clearly indicates that she has experienced pain in her finger. Pain is a warning signal that something is wrong—in this case that touching the thorns on the stem of the rose was a bad idea. What might be some of the problems encountered by a person who could feel no pain at all?

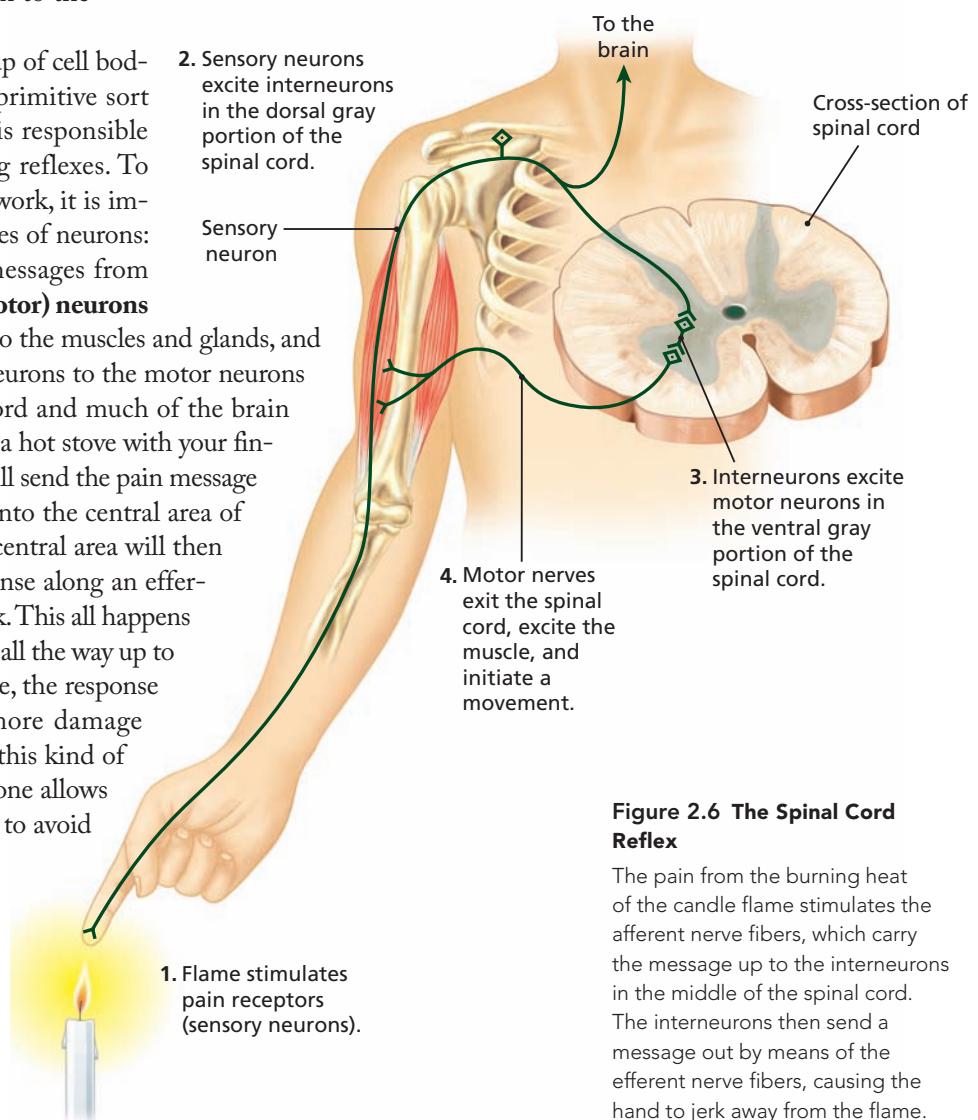


Figure 2.6 The Spinal Cord Reflex

The pain from the burning heat of the candle flame stimulates the afferent nerve fibers, which carry the message up to the interneurons in the middle of the spinal cord. The interneurons then send a message out by means of the efferent nerve fibers, causing the hand to jerk away from the flame.

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psychology in the news

Fact or Fiction: Focus on the Brain, but Check Your Sources!



As stressed in Chapter One, critical thinking is a valuable skill and one that is very useful in the study of psychology. One of the basic points highlighted was that not all evidence is equal in quality. to [Learning Objective 1.14](#). Have you ever heard a claim about the brain that you were not sure was true?

Whether you get your news from blogs or Web sites, listen to podcasts, or watch the local or national news on your television, computer, or smartphone, you have probably read/heard/seen a segment that addresses some aspect of the human brain. Some recent and not-so-recent brain-related news items have included:

"Older brains can't make new cells"

"Listening to classical music makes you smarter—also known as The Mozart Effect"

"Autism is caused by childhood vaccinations"

"People only use 10 percent of their brain"

Items adapted from Neuromyths, BrainFacts.org, Society for Neuroscience.
Available at <http://www.brainfacts.org/neuromyths/>

Do any of the above "headlines" look familiar? Given the inherent interest in many of these topics and the number of people who reportedly "know" these facts, they have often been considered the truth. But in fact, all of the above items have been found to be *false* or have not been supported by conclusive, scientific evidence. So how do you go about evaluating brain-related news the next time it flashes across the headlines or shows up on your news feed?

Think back to the research methods and discussed in Chapter One. to [Learning Objectives 1.6–1.11](#). Did the news item provide details about the actual study? If it did, what were the data collection methods used in the study? Do the methods used support the reported findings? Was a representative sample used? Did the researchers conduct an experiment or did the news item confuse correlation with causation?

Some of the best sources are the original research studies, assuming the researchers collected data in an unbiased manner and followed established research methods. Findings that are published in peer-reviewed journals (where research is reviewed by other experts in that area) are especially helpful, as are edited books with contributions by experts in the associated field. The challenge for students early in their psychological studies is that it is not so easy to fully understand the methods, statistics, or terminology used in the studies.

For students, aside from your textbooks and professors, other good resources are the educational materials provided by professional organizations. For psychology in general, the American Psychological Association (APA) and the Association for Psychological Science (APS) are two great sources of information. In addition to various peer-reviewed journals and other educational publications, they both have informative Web sites.

For information more specifically related to the brain and neuroscience, one of the best sources of research and educational material is the Society for Neuroscience (SfN). The four misconceptions mentioned earlier are based on eight myths about the brain that are covered in one of their educational Web sites, *Neuromyths*, and can be viewed on their Web site, <http://www.brainfacts.org/neuromyths/>

So the next time you see a news item about the brain, check your sources and remain mindful that some sources are certainly more helpful than others.

Useful Web sites:

American Psychological Association (APA)—www.apa.org

Association for Psychological Science (APS)—www.psychologicalscience.org

Society for Neuroscience (SfN)—www.sfn.org

BrainFacts.org—www.brainfacts.org

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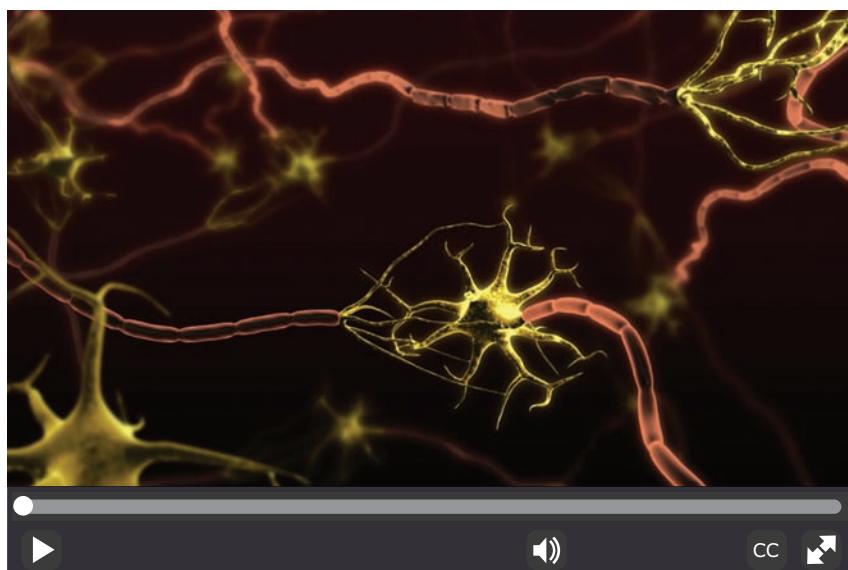
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Questions for Further Discussion

1. How might your personal experience with a brain-related disorder (e.g., grandparent with Alzheimer's disease) affect your ability to critically evaluate a claim related to the disorder (e.g., "Cure for Alzheimer's Found!")?
2. As a student in psychological science, how would you explain the need for replicability in research to a family member that is not as familiar with the scientific method?

 If the spinal cord is such an important link between the body and the brain, what happens if it is damaged?

DAMAGE TO THE CENTRAL NERVOUS SYSTEM Damage to the central nervous system was once thought to be permanent. Neurons in the brain and spinal cord were not seen as capable of repairing themselves. When people recovered from a stroke, for example, it was assumed that it was primarily due to healthy brain cells taking over the functions of the damaged ones. Scientists have known for a while now that some forms of central nervous system damage can be repaired by the body's systems, and in recent years great strides have been made in repairing spinal cord damage. The brain actually exhibits a great deal of **neuroplasticity**, the ability to constantly change both the structure and function of many cells in the brain in response to experience and even trauma (Neville & Bavelier, 2000; Rossini et al., 2007; Sanders et al., 2008). The video, *Special Topics: The Plastic Brain: Overview of Neuroplasticity* explains this process in more detail.



 [Watch the Video](#), *Special Topics: The Plastic Brain: Overview of Neuroplasticity* at [MyPsychLab](#)

Scientists have been able to *implant* nerve fibers from outside the spinal cord onto a damaged area and then "coax" the damaged spinal nerves to grow through these "tunnels" of implanted fibers (Cheng et al., 1996). Researchers are also examining the effects of implanting Schwann cells from the peripheral nervous system to the central nervous system to aid in treating spinal cord injuries (Deng et al., 2013). The brain can change itself quite a bit by adapting neurons to serve new functions when old neurons die or are damaged. Dendrites grow and new synapses are formed in at least some areas of the brain, as people learn new things throughout life (Sanes & Jessell, 2013a, 2013b).

Researchers are constantly looking for new ways to repair the brain. One avenue of research has involved scientists investigating the possibility of transplanting **stem cells** to

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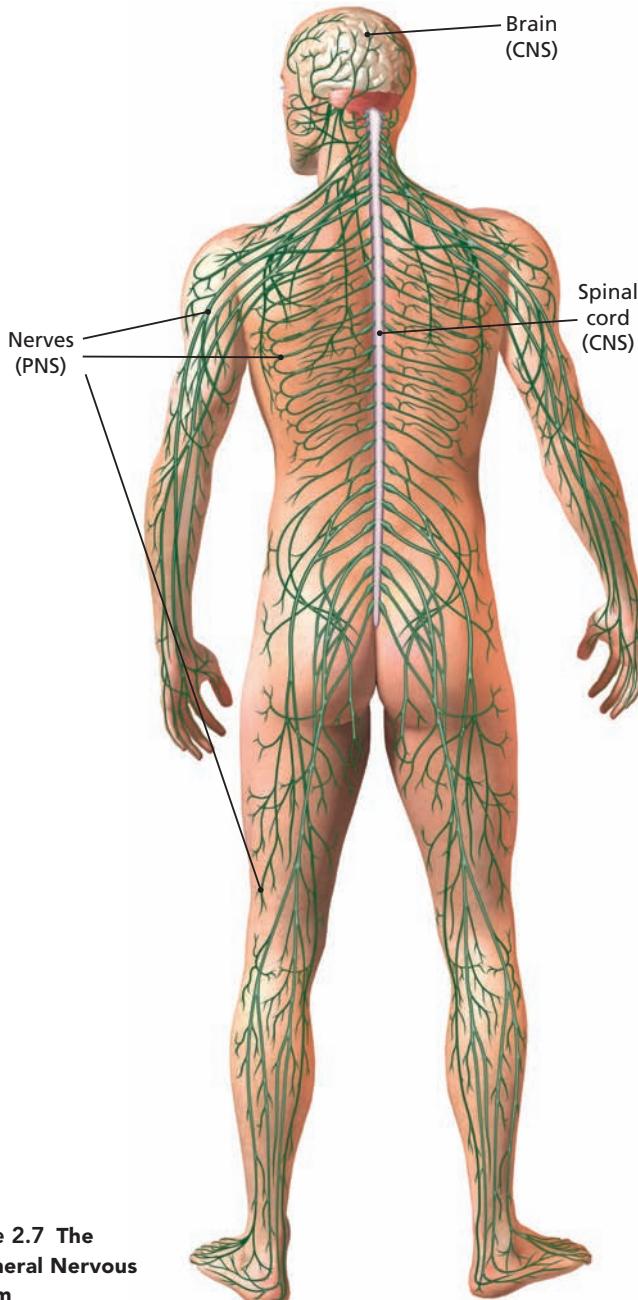
repair damaged or diseased brain tissue. Stem cells can become any cell in the body and may offer promise for addressing diseases such as Parkinson's and Alzheimer's, or the repair of damaged spinal cords or brain tissue. If stem cells can be implanted into areas that have been damaged, the newly developed neurons may assume the roles that the original (now damaged) neurons can no longer perform.

Okay, that takes care of the central nervous system, except for the detail on the brain. How does the central nervous system communicate with the rest of the body?

THE PERIPHERAL NERVOUS SYSTEM: NERVES ON THE EDGE

2.4

How do the somatic and autonomic nervous systems allow people and animals to interact with their surroundings and control the body's automatic functions?



The term *peripheral* refers to things that are not in the center or that are on the edges of the center. The **peripheral nervous system** or PNS (see Figure 2.7 and also refer back to Figure 2.5) is made up of all the nerves and neurons that are not contained in the brain and spinal cord. It is this system that allows the brain and spinal cord to communicate with the sensory systems of the eyes, ears, skin, and mouth and allows the brain and spinal cord to control the muscles and glands of the body. The PNS can be divided into two major systems: the **somatic nervous system**, which consists of nerves that control the voluntary muscles of the body, and the **autonomic nervous system (ANS)**, which consists of nerves that control the involuntary muscles, organs, and glands.

THE SOMATIC NERVOUS SYSTEM One of the parts of a neuron is the soma, or cell body (remember that the word *soma* means “body”). The somatic nervous system is made up of the **sensory pathway**, which comprises all the nerves carrying messages from the senses to the central nervous system (those nerves containing afferent neurons), and the **motor pathway**, which is all of the nerves carrying messages from the central nervous system to the voluntary, or skeletal,* muscles of the body—muscles that allow people to move their bodies (those nerves composed of efferent neurons). When people are walking, raising their hands in class, lifting a flower to smell, or directing their gaze toward the person they are talking to or to look at a pretty picture, they are using the somatic nervous system. (As seen in the discussion of spinal cord reflexes, although these muscles are called the “voluntary muscles,” they can move involuntarily when a reflex response occurs. They are called “voluntary” because they *can* be moved at will but are not limited to only that kind of movement.)

Involuntary** muscles, such as the heart, stomach, and intestines, together with glands such as the adrenal glands and the pancreas, are all controlled by clumps of neurons located on or near the spinal column. (The words *on* or *near* are used quite deliberately here. The neurons *inside* the spinal column

Figure 2.7 The Peripheral Nervous System

*skeletal: having to do with the bones of the body, or skeleton.

**involuntary: not under deliberate control.

are part of the central nervous system, not the peripheral nervous system.) These large groups of neurons near the spinal column make up the *autonomic nervous system*.

THE AUTONOMIC NERVOUS SYSTEM The word *autonomic* suggests that the functions of this system are more or less automatic, which is basically correct. Whereas the somatic division of the peripheral nervous system controls the senses and voluntary muscles, the autonomic division controls everything else in the body—organs, glands, and involuntary muscles. The autonomic nervous system is divided into two systems, the *sympathetic division* and the *parasympathetic division*. (See Figure 2.8 on the next page.) (For a schematic representation of how all the various sections of the nervous system are organized, look back at Figure 2.5.)

The Sympathetic Division The **sympathetic division** of the autonomic nervous system is primarily located on the middle of the spinal column—running from near the top of the ribcage to the waist area. It may help to think of the name in these terms: The *sympathetic* division is in *sympathy* with one's emotions. In fact, the sympathetic division is usually called the “fight-or-flight system” because it allows people and animals to deal with all kinds of stressful events.  [LINK](#) to Learning Objective 11.4. Emotions during these events might be anger (hence, the term *fight*) or fear (that's the “flight” part, obviously) or even extreme joy or excitement. Yes, even joy can be stressful. The sympathetic division’s job is to get the body ready to deal with the stress. Many of us have experienced a fight-or-flight moment at least once in our lives. Participate in the experiment *Do You Fly or Fight?* to learn more about how your body responds.



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These young soccer players are using their senses and voluntary muscles controlled by the somatic division of the peripheral nervous system. What part of the autonomic nervous system are these girls also using at this time?

Simulation

Do You Fly or Fight?

This survey asks you about your experiences with and reactions towards stressful events, particularly those that stimulate your Autonomic Nervous System (ANS).

“Fight or flight” is a catchphrase used to describe the way we react to stressful events, particularly fear. Some research suggests that there are actually four stages to the “fight or flight” response. Thinking of the “fight or flight” moments you have experienced, how often have you experienced each of these stages? Fright/Tonic Immobility (frozen stiff, can't move, “deer in headlights” feeling)

- Never
- Seldom
- Sometimes
- Often
- Prefer not to state

[Go to the Experiment ►](#)

 [Simulate the Experiment, Do You Fly or Fight?, on MyPsychLab](#)

What are the specific ways in which this division readies the body to react? (See Figure 2.8.) The pupils seem to get bigger, perhaps to let in more light and, therefore, more information. The heart starts pumping faster and harder, drawing blood away from nonessential organs such as the skin (so at first the person may turn pale) and sometimes even away from the brain itself (so the person might actually faint). Blood needs lots of oxygen before it goes to the muscles, so the lungs work overtime, too (the person may begin to breathe faster). One set of glands in particular receives special instructions. The adrenal glands will be stimulated to release certain stress-related chemicals (members of a class of chemicals released by glands called *hormones*) into the bloodstream. These stress hormones will travel to all parts of the body, but they will only affect certain target organs. Just as a

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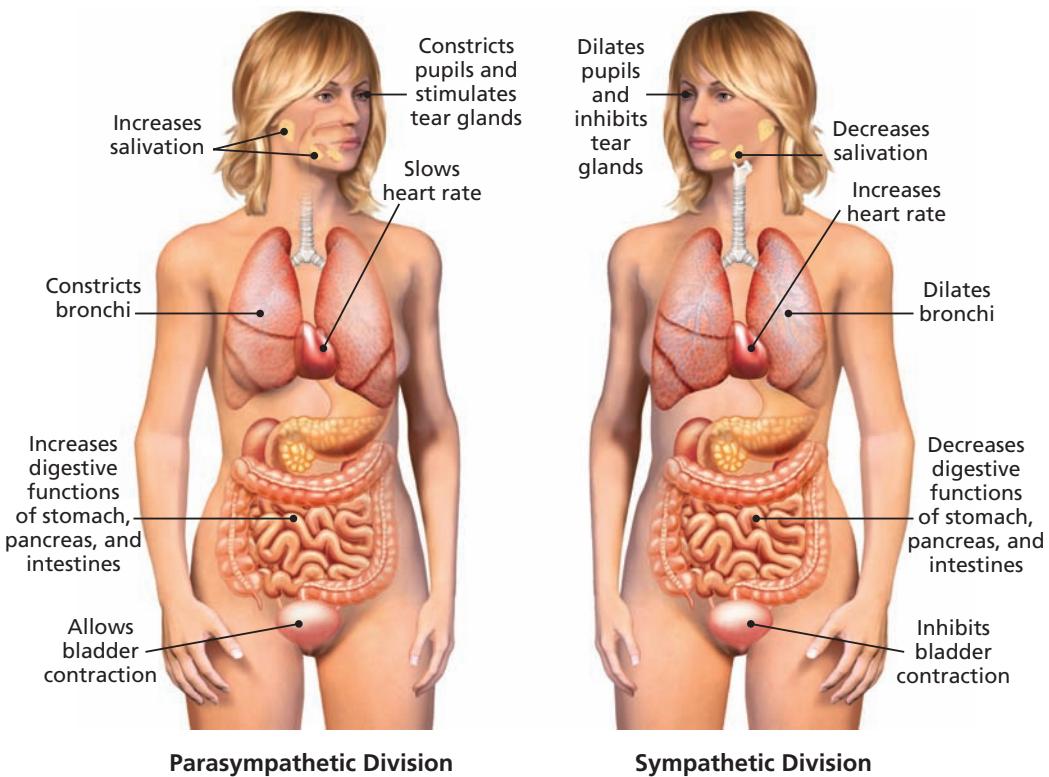
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Figure 2.8 Functions of the Parasympathetic and Sympathetic Divisions of the Nervous System

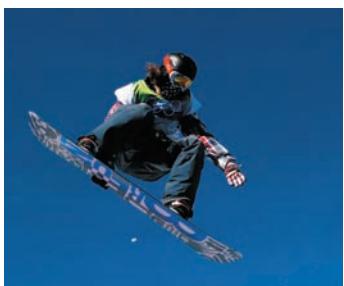


neurotransmitter fits into a receptor site on a cell, the molecules of the stress hormones fit into receptor sites at the various target organs—notably, the heart, muscles, and lungs. This further stimulates these organs to work harder. But not every organ or system will be stimulated by the activation of the sympathetic division. Digestion of food and excretion* of waste are not necessary functions when dealing with stressful situations, so these systems tend to be shut down or inhibited. Saliva, which is part of digestion, dries right up (ever try whistling when you're scared?). Food that was in the stomach sits there like a lump. Usually, the urge to go to the bathroom will be suppressed, but if the person is really scared the bladder or bowels may actually empty (this is why people who die under extreme stress, such as hanging or electrocution, will release their urine and waste). The sympathetic division is also going to demand that the body burn a tremendous amount of fuel, or blood sugar.

Now, all this bodily arousal is going on during a stressful situation. If the stress ends, the activity of the sympathetic division will be replaced by the activation of the parasympathetic division. If the stress goes on too long or is too intense, the person might actually collapse (as a deer might do when being chased by another animal). This collapse occurs because the parasympathetic division overresponds in its inhibition of the sympathetic activity. The heart slows, blood vessels open up, blood pressure in the brain drops, and fainting can be the result.

The Parasympathetic Division If the sympathetic division can be called the fight-or-flight system, the **parasympathetic division** might be called the “eat-drink-and-rest” system. The neurons of this division are located at the top and bottom of the spinal column, on either side of the sympathetic division neurons (*para* means “beyond” or “next to” and in this sense refers to the neurons located on either side of the sympathetic division neurons).

In looking at Figure 2.8, it might seem as if the parasympathetic division does pretty much the opposite of the sympathetic division, but it's a little more complex than that. The parasympathetic division's job is to return the body to normal functioning after a stressful situation ends. It slows the heart and breathing, constricts the pupils, and reactivates digestion and excretion. Signals to the adrenal glands stop because the



Snowboarder Shaun White of the U.S.A. 2010 Olympics Team won the gold medal in the halfpipe competition in Vancouver. What part of the autonomic nervous system is likely to be working as Shaun flies through the air, as in this picture?

*excretion: in this sense, the act of eliminating waste products from the body.

parasympathetic division isn't connected to the adrenal glands. In a sense, the parasympathetic division allows the body to restore all the energy it burned—which is why people are often very hungry *after* the stress is all over.

The parasympathetic division does more than just react to the activity of the sympathetic division. It is the parasympathetic division that is responsible for most of the ordinary, day-to-day bodily functioning, such as regular heartbeat and normal breathing and digestion. People spend the greater part of their 24-hour day eating, sleeping, digesting, and excreting. So it is the parasympathetic division that is typically active. At any given moment, then, one or the other of these divisions, sympathetic or parasympathetic, will determine whether people are aroused or relaxed.



How do the glands fit into all of this? Aren't there more glands than just the adrenal glands? How do they affect our behavior?

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Distant Connections: The Endocrine Glands

2.5 How do the hormones released by glands interact with the nervous system and affect behavior?

Earlier we addressed neurons and the neurotransmitters and how they release into the synapse to communicate with postsynaptic neurons. This type of chemical communication is fairly specific, primarily affecting neurons in the immediate vicinity of the originating neuron, and also very fast (almost immediate). Other structures also use chemical communication but do so at a different rate and act in a more far-reaching manner. For example, glands are organs in the body that secrete chemicals. Some glands, such as salivary glands and sweat glands, secrete their chemicals directly onto the body's tissues through tiny tubes, or ducts. This kind of gland affects the functioning of the body but doesn't really affect behavior. Other glands, called **endocrine glands**, have no ducts and secrete their chemicals directly into the bloodstream (see Figure 2.9 on the next page). The chemicals secreted by this type of gland are called **hormones**. As mentioned earlier in the chapter when talking about the sympathetic division of the autonomic nervous system, these hormones flow into the bloodstream, which carries them to their target organs. The molecules of these hormones then fit into receptor sites on those organs to fulfill their function, affecting behavior as they do so. As compared to synaptic communication, endocrine communication is generally slower due to the time it takes hormones to travel to target organs, and the behaviors and responses they affect may not occur until hours, weeks, or years later.

The hormones affect behavior and emotions by stimulating muscles, organs, or other glands of the body. Some theories of emotion state that the surge in certain hormones actually triggers the emotional reaction (Izard, 1988; Zajonc, 1980, 1984).

 [Learning Objective 9.8](#). Some of the hormones produced by endocrine glands also influence the activity of the brain, producing excitatory or inhibitory effects (Schwartz & Javitch, 2013).

THE PITUITARY: MASTER OF THE HORMONAL UNIVERSE

The **pituitary gland** is located in the brain itself, just below the hypothalamus. The hypothalamus controls the glandular system by influencing the pituitary. That is because the pituitary gland is the *master gland*, the one that controls or influences all of the other endocrine glands. One part of the pituitary controls things associated with pregnancy and levels of water in the body.

The hormone that controls aspects of pregnancy is called **oxytocin**, and it is involved in a variety of ways with both reproduction and parental behavior. It stimulates contractions of the uterus in childbirth. The word itself comes from the Greek word *oxyz*, meaning

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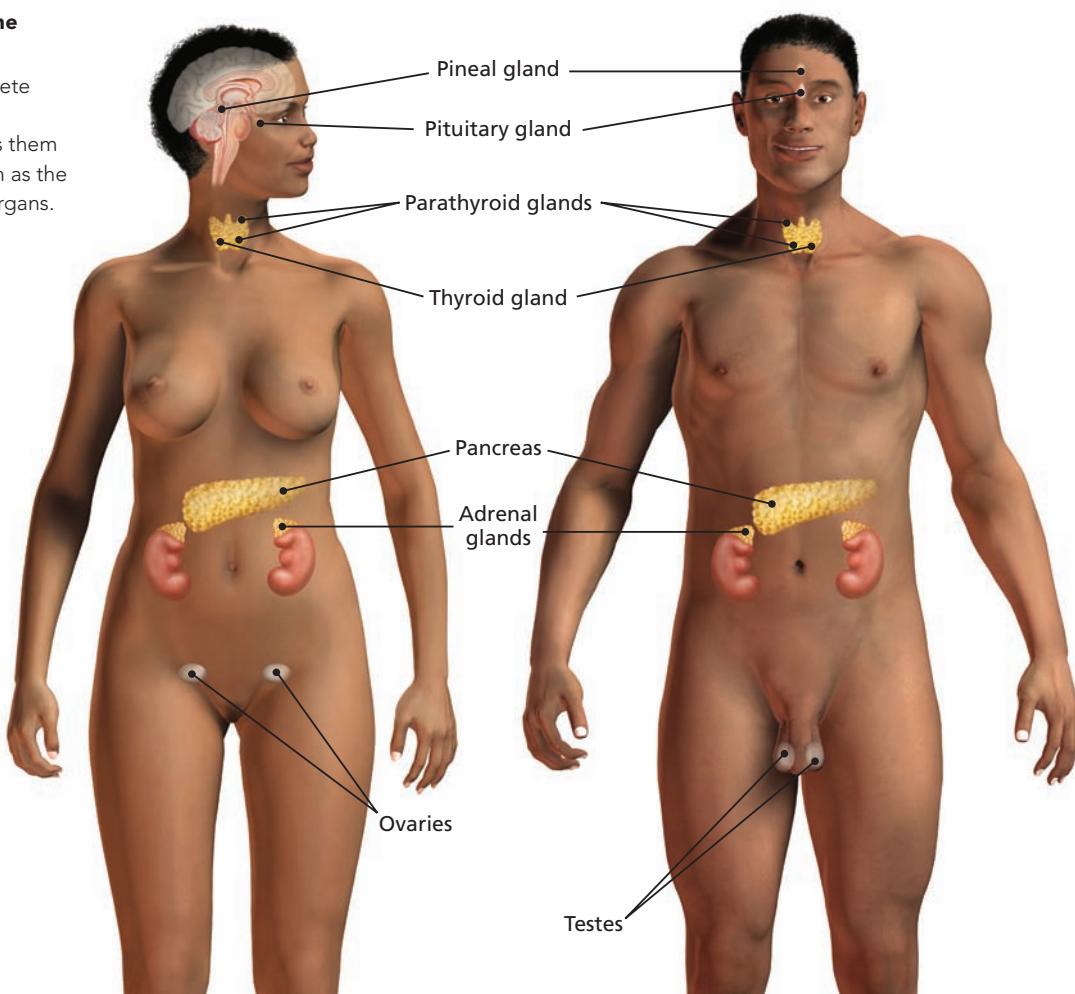
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Figure 2.9 The Endocrine Glands

The endocrine glands secrete hormones directly into the bloodstream, which carries them to organs in the body, such as the heart, pancreas, and sex organs.



“rapid,” and *tokos*, meaning “childbirth,” and injections of oxytocin are frequently used to induce or speed up labor and delivery. It is also responsible for the *milk letdown reflex*, which involves contraction of the mammary gland cells to release milk for the nursing infant. The hormone that controls levels of water in our body is called *vasopressin*, and it essentially acts as an antidiuretic, helping the body to conserve water.

Another part of the pituitary secretes several hormones that influence the activity of the other glands. One of these hormones is a *growth hormone* that controls and regulates the increase in size as children grow from infancy to adulthood. There are also hormones that stimulate the gonads (ovaries and testes) to release female or male sex hormones, which in turn influence the development and functioning of the reproductive organs, development of secondary sex characteristics in puberty, and reproductive behavior in general. [LINK](#) to Learning Objective 10.1.

You may have seen oxytocin covered in the news lately, as its role in human social behavior has been making headlines. Sometimes referred to in the media as the “love hormone,” it is prompting a great deal of research. While the role of oxytocin and vasopressin has been demonstrated in the formation of social bonds in nonhuman animals such as prairie voles, the exact role of these hormones in human social behavior is still under investigation (Ferguson et al., 2001; Lim & Young, 2006; Miller, 2013; Stoesz et al., 2013; Winslow et al., 1993).

From investigations of receptor genes to direct impact on social behaviors, both of these hormones are gathering a lot of attention (Donaldson & Young, 2008; Poulin et al., 2012; Scheele et al., 2012). A recent study suggested that men in monogamous relationships were more likely to keep a greater distance between themselves and an attractive female during their first meeting after receiving oxytocin (Scheele et al., 2012). The result suggested may help men in heterosexual monogamous relationships remain faithful to their partners.

There is additional evidence that oxytocin may have different effects for different individuals, under different conditions. Men less socially proficient at recognizing social cues performed better on a task of empathetic accuracy after receiving nasal administration of oxytocin, whereas more socially proficient males did not (Bartz et al., 2010). Especially in light of growing interest in the potential role of oxytocin as a treatment for a variety of psychiatric behaviors where social behavior is impacted (e.g., autism, social anxiety), researchers need to be aware of the different impacts oxytocin may have on different individuals, in different situations (Bartz et al., 2011).

As the master gland, the pituitary forms a very important part of a feedback system, one that includes the hypothalamus and the organs targeted by the various hormones. The balance of hormones in the entire endocrine system is maintained by feedback from each of these “players” to the others.

THE PINEAL GLAND

The **pineal gland** is also located in the brain, near the back, directly above the brain stem. It plays an important role in several biological rhythms. The pineal gland secretes a hormone called *melatonin*, which helps track day length (and seasons). In some animals, this influences seasonal behaviors such as breeding and molting. In humans, melatonin levels are more influential in regulating the sleep–wake cycle.  to [Learning Objective 4.2](#).

THE THYROID GLAND

The **thyroid gland** is located inside the neck and secretes hormones that regulate growth and metabolism. One of these, a hormone called *thyroxin*, regulates metabolism (how fast the body burns its available energy). As related to growth, the thyroid plays a crucial role in body and brain development.

PANCREAS

The **pancreas** controls the level of blood sugar in the body by secreting *insulin* and *glucagon*. If the pancreas secretes too little insulin, it results in *diabetes*. If it secretes too much insulin, it results in *hypoglycemia*, or low blood sugar, which causes a person to feel hungry all the time and often become overweight as a result.  to [Learning Objective 9.5](#).

THE GONADS

The **gonads** are the sex glands, including the **ovaries** in the female and the **testes** in the male. They secrete hormones that regulate sexual behavior and reproduction. They do not control all sexual behavior, though. In a very real sense, the brain itself is the master of the sexual system—human sexual behavior is not controlled totally by instincts and the actions of the glands as in some parts of the animal world, but it is also affected by psychological factors such as attractiveness.  to [Learning Objective 10.1](#).

THE ADRENAL GLANDS

Everyone has two **adrenal glands**, one on top of each kidney. The origin of the name is simple enough; *renal* comes from a Latin word meaning “kidney” and *ad* is Latin for “to,” so *adrenal* means “to or on the kidney.” Each adrenal gland is actually divided into two sections, the *adrenal medulla* and the *adrenal cortex*. It is the adrenal medulla that releases epinephrine and norepinephrine, when people are under stress, and aids in sympathetic arousal.

The adrenal cortex produces over 30 different hormones called *corticoids* (also called steroids) that regulate salt intake, help initiate* and control stress reactions, and also provide a source of sex hormones in addition to those provided by the gonads. One of the most important of these adrenal hormones is *cortisol*, released when the body experiences stress, both physical stress (such as illness, surgery, or extreme heat or cold) and psychological stress (such as an emotional upset). Cortisol is important in the release of glucose into the bloodstream during stress, providing energy for the brain itself, and the release of fatty acids from the fat cells that provide the muscles with energy.

*initiate: begin or start.

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When the pancreas does not secrete enough insulin, the result is diabetes. Many diabetic people must give themselves insulin shots to supply enough of the hormone.

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 Explore the Concept at MyPsychLab

The Central Nervous System

(comprised of the brain and spinal cord)

brain

true core of nervous system: takes information from senses, processes it, makes decisions, sends commands to rest of body

spinal cord

long bundle of neurons that carries information to and away from the brain; helps control pain response

- spinal cord reflexes involve several different neurons (sensory neurons, interneurons, and motor neurons)
- spinal reflexes enable fast, often lifesaving, actions that do not require conscious thought

The Peripheral Nervous System

(comprised of the nerves and neurons not contained in the brain and spinal cord; allows the brain and spinal cord to communicate with the sensory systems and to control the muscles and glands of the body; divided into somatic and autonomic nervous systems)

somatic nervous system

controls the voluntary muscles of the body; involves the sensory pathway (sensory neurons carrying information to spinal cord and/or brain) and the motor pathway (nerves that carry information to voluntary skeletal muscles)

autonomic nervous system

controls automatic functions of the body (organs, glands, involuntary muscles)

- sympathetic division:** "fight-or-flight" functions—reacts to stressful events and bodily arousal
- parasympathetic division:** "eat-drink-and-rest" functions—restores body to normal functioning after arousal and is responsible for day-to-day functioning of glands and organs



glands are organs in the body that secrete chemicals; some affect functioning of the body but not behavior; others have widespread influence on the body and behavior

Distant Connections: The Endocrine Glands



endocrine glands secrete chemicals called hormones into bloodstream; affect behavior and emotions by influencing the activity of the brain and by controlling muscles and organs such as the heart, pancreas, and sex organs

- pituitary gland
- pineal gland
- thyroid gland
- pancreas
- gonads
- adrenal glands

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

- If you touch a hot stove, your spinal cord can prompt you to withdraw your hand without having to send the message all the way to the brain. This is due to what scientists call
 - the reflex arc.
 - neuroplasticity.
 - the parasympathetic nervous system.
 - the sympathetic nervous system.
- What is the process whereby the structure and function of brain cells change in response to trauma, damage, or even learning?
 - shallow lesioning
 - deep lesioning
 - cell regeneration
 - neuroplasticity
- The neurons of the sensory pathway contain
 - efferent neurons.
 - afferent neurons.
 - both efferent and afferent neurons.
 - voluntary muscle fibers.
- Yvonne's ability to reach for and pick up her book is largely due to the functions of the _____ pathway of the _____ nervous system.
 - sensory; somatic
 - motor; somatic
 - autonomic; peripheral
 - parasympathetic; autonomic
- Which of the following would be active if you have just had an automobile accident?
 - sympathetic division
 - parasympathetic division
 - somatic division
 - motor division
- Andrew has always been thin. In fact, he often seems to be able to eat whatever he wants without gaining weight. The doctor told his parents that Andrew's _____ gland is the cause of his fast metabolism.
 - pituitary
 - adrenal
 - thyroid
 - pancreas

Looking Inside the Living Brain

How do psychologists study the brain and how it works?

Scientists can't be sure what brain tissue really looks like when it's inside the skull of a living person—nor can they be certain that it looks identical to that of a brain sitting on a dissecting table. How can scientists find out if the brain is intact, if parts are missing or damaged, or what the various parts of the brain do?

LESIONING STUDIES

One way to get some idea of the functions that various areas of the brain control is to study animals or people with damage in those areas. In animals, that may mean researchers will deliberately damage a part of the brain, after which, they test the animal to see what has happened to its abilities. In such an experiment, once the test animal is anesthetized and given medication for pain, an electrode, which is a thin wire or probe insulated everywhere but at its tip, is surgically inserted into the brain. An electrical current strong enough to kill off the target neurons is sent through the tip of the wire. This procedure is called **lesioning**.

It should be obvious that researchers cannot destroy areas of brains in living human beings. One method they can use is to study and test people who already have brain damage. However, this is not an ideal way to study the brain. No two case studies of humans are likely to present damage in exactly the same area of the brain, nor would the cases involve exactly the same amount of damage.

BRAIN STIMULATION

In contrast to lesioning, a less harmful way to study the brain is to temporarily disrupt or enhance the normal functioning of specific brain areas through electrical stimulation, and then study the resulting changes in behavior or cognition. The procedure of stimulating a specific area of the brain is much the same as in lesioning, but the much milder current in this research does no damage to the neurons. It does cause the neurons to react as if they had received a message. This is called *electrical stimulation of the brain*, or *ESB*. It has become an important technique in psychology, as its use in animals (and humans under very special circumstances such as testing before surgery to address seizure disorders) has informed us in many areas of investigation, including new directions for therapy.

INVASIVE TECHNIQUES: STIMULATING FROM THE INSIDE A specific type of ESB called *deep brain stimulation (DBS)* has been shown to be very helpful in some disorders in humans. In this procedure, neurosurgeons place electrodes in specific deep-brain areas and then route the electrode wires to a pacemaker-like device called an impulse generator that is surgically implanted under the collarbone. The impulse generator then sends impulses to the implanted electrodes, stimulating the specific brain areas of interest. Deep brain stimulation has been widely used as a treatment for Parkinson's disease and may play an important role in the treatment of seizure disorder, chronic pain, and possibly some psychiatric disorders (Fisher et al., 2010; Rabins et al., 2009; Weaver et al., 2009), among other areas. Also, using DBS for specific disorders allows researchers to learn about other effects DBS may have on the brain such as affecting an individual's mood or memory. It should be noted that invasive techniques such as DBS are typically only used after all other less intrusive treatments have been shown to be ineffective or whose side effects have been deemed undesirable. For example, DBS is being investigated for the treatment of anorexia nervosa in individuals where other treatments have not been effective (Lipsman et al., 2013).

NONINVASIVE TECHNIQUE: STIMULATING FROM THE OUTSIDE There are also noninvasive techniques for stimulating the brain that contribute to research and our knowledge of the

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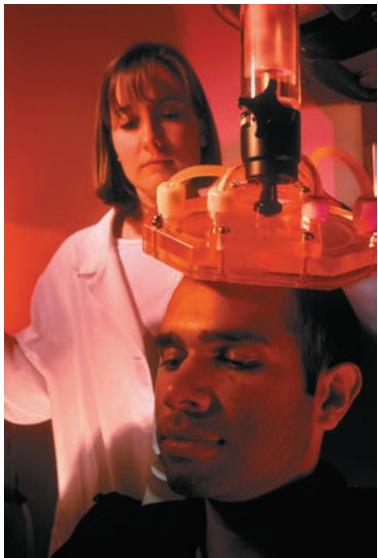
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A doctor at the National Institute of Mental Health in Bethesda, Maryland, uses an electromagnet as part of an experimental treatment for depression. This treatment, called repetitive transcranial magnetic stimulation (rTMS), excites neurons in the brain, triggering activity.

brain in a variety of areas. In *transcranial magnetic stimulation* (TMS), magnetic pulses are applied to the cortex using special copper wire coils that are positioned over the head. The resulting magnetic fields stimulate neurons in the targeted area of the cortex. Longer lasting stimulation results when the pulses are administered in a repetitive fashion, and is referred to as *repetitive TMS* (rTMS). Another procedure, called *transcranial direct current stimulation* (tDCS), uses scalp electrodes to pass very low amplitude direct current to the brain to change the excitability of cortical neurons directly below the electrodes. Both rTMS and tDCS are being evaluated as research tools in studies of cognition such as memory retrieval and decision making (Boggio et al., 2010; Boggio, et al., 2009) and as possible treatment options for a variety of psychological disorders including posttraumatic stress disorder (PTSD) and depression, and physical disorders due to suffering a stroke (Boggio, Rocha, et al., 2009; Nitsche et al., 2009; Williams et al., 2010).

Bear in mind that stimulating the cortex may facilitate specific functions or behaviors but impair others. For example, if someone is counting from 1 to 20 and the brain is stimulated in the correct location of the motor cortex, the person's speech would be disrupted, but perhaps stimulating in other areas of the frontal lobe may assist the person in attending to the counting task. Furthermore, the brain has widespread connections, so stimulation in one area is likely to affect other areas. In one recent study, inhibitory stimulation of the left prefrontal cortex resulted in reduced blood oxygenation on both the left and right sides of the prefrontal cortex (Tupak et al., 2013).

Note: tDCS is NOT the same as electroconvulsive therapy, which uses much higher levels of current through the entire brain, resulting in a grand mal seizure and changes in the brain chemistry associated with depression. [LINK](#) to Learning Objective 15.9.

All of these methods of stimulation yield important information about the brain and behavior, but they do not allow us to see what is going on with the brain as a whole. Instead, various neuroimaging techniques can do this, either by directly imaging the brain's structure (the different parts) or its function (how the parts work). These methods also vary in their degree of spatial resolution (ability to see fine detail) and temporal resolution (ability to time lock a recorded event).

MAPPING STRUCTURE

As hinted at earlier, aside from observing the person's behavior, scientists had to wait until a person died to fully investigate if there were changes or damage to the individual's brain. Fortunately modern neuroimaging allows us to image the brain's structure while the person is still alive.

COMPUTED TOMOGRAPHY (CT) Scientists have several ways to look inside the human brain without causing harm to the person. One way is to take a series of X-rays of the brain, aided by a computer. This is accomplished during a CT scan (**computed tomography** involves mapping "slices" of the brain by computer). CT scans can show stroke damage, tumors, injuries, and abnormal brain structure. (See Figure 2.10a.) A CT scan is also the structural imaging method of choice when there is metal in the body (e.g., a bullet or surgical clips) and useful for imaging possible skull fractures. (See Figure 2.10b.)

MAGNETIC RESONANCE IMAGING (MRI) As useful as a CT scan can be for imaging the skull, it doesn't show very small details within the brain. The relatively newer technique of **magnetic resonance imaging**, or **MRI**, provides much more detail (see Figure 2.10c, 2.10d and 2.10e), even allowing doctors to see the effects of very small strokes. The person getting an MRI scan is placed inside a machine that generates a powerful magnetic field to align hydrogen atoms in the brain tissues (these normally spin in a random fashion); then radio pulses are used to make the atoms spin at a particular frequency and direction. The time it takes for the atoms to return to their normal spin allows a computer to create a three-dimensional image of the brain and display "slices" of that image on a screen.

Using MRI as a basis, several techniques have been developed that allow us to study other aspects of the brain. *MRI spectroscopy* allows researchers to estimate the concentration

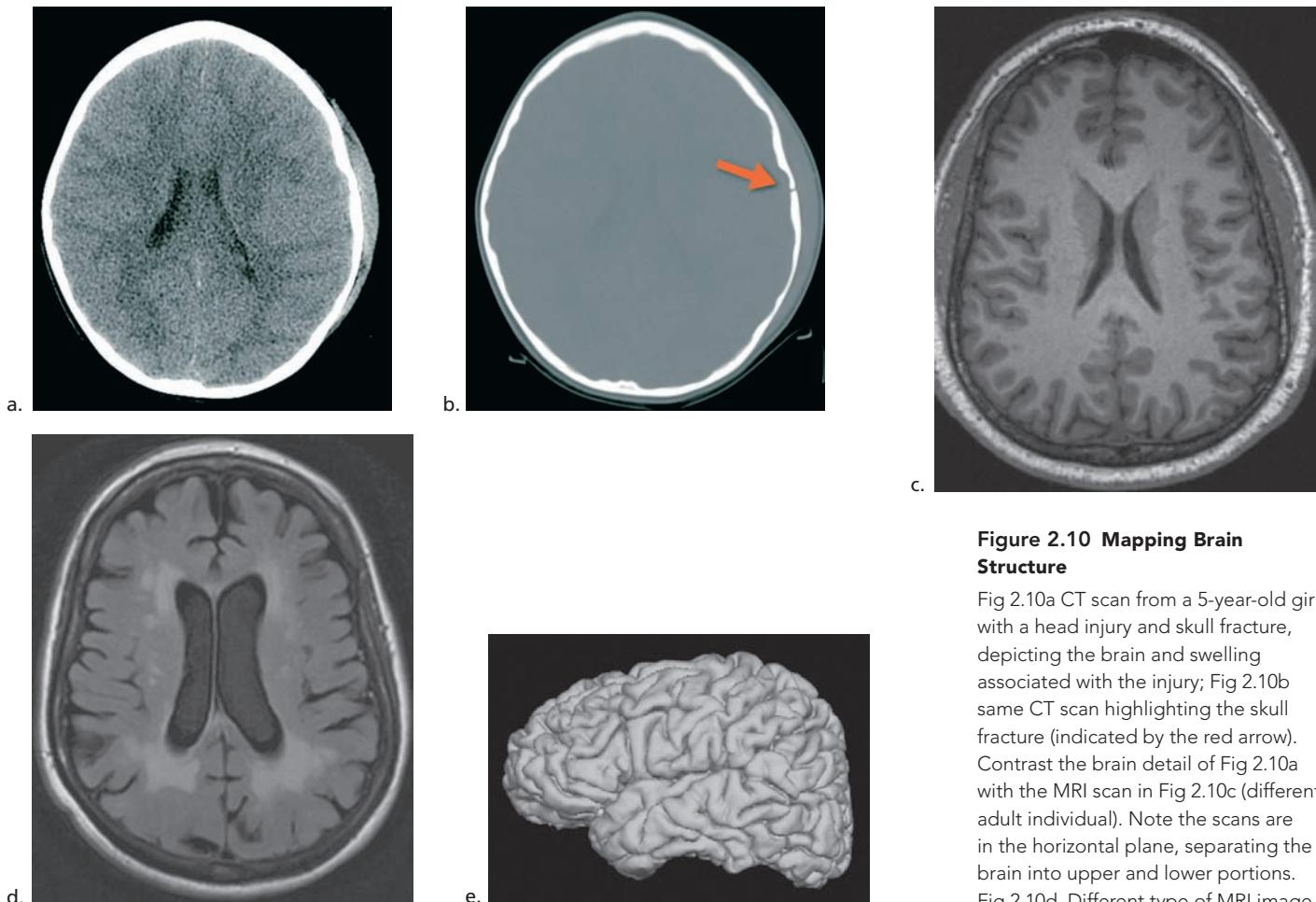


Figure 2.10 Mapping Brain Structure

Fig 2.10a CT scan from a 5-year-old girl with a head injury and skull fracture, depicting the brain and swelling associated with the injury; Fig 2.10b same CT scan highlighting the skull fracture (indicated by the red arrow). Contrast the brain detail of Fig 2.10a with the MRI scan in Fig 2.10c (different, adult individual). Note the scans are in the horizontal plane, separating the brain into upper and lower portions. Fig 2.10d. Different type of MRI image from an older adult, with cortical cell loss (atrophy) and white matter changes. Notice the enlarged ventricles and widening of the grooves (sulci) in the outer cortex as compared to 2.10c. Fig 2.10e uses the same MRI data as 2.10c to provide an estimate of what the left external surface of the brain looks like. Fig 2.10a, b, c and d images created with OsiriX software; 2.10e cortical reconstruction was performed with the Freesurfer image analysis suite.

of specific chemicals and neurotransmitters in the brain. Another fascinating technique is called *DTI*, or *diffusion tensor imaging*. The brain has two distinct color regions, *gray matter*, the outer areas consisting largely of neurons with unmyelinated axons, and *white matter*, the fiber tracts consisting of myelinated axons (the myelin is responsible for the lighter color). DTI uses MRI technology to provide a way to measure connectivity in the brain by imaging these white matter tracts. DTI has been used to investigate many disorders and conditions including multiple sclerosis, dementia, and schizophrenia, and to help researchers understand how differences in white matter tracts in the corpus callosum influence everyday skills such as hand coordination (Assaf & Pasternak, 2008; Catani & Thiebaut de Schotten, 2012; Gooijers et al., 2013; Ulmer et al., 2006; Voineskos et al., 2010).

MAPPING FUNCTION

In addition to imaging the different parts of the brain to understand what may or may not be present, examining the function of the brain is also important in understanding behavior and mental processes.

THE ELECTROENCEPHALOGRAM (EEG) As important as imaging brain structure is, it is sometimes important to know how different brain areas function. A fairly harmless way to study the activity of the living brain is to record the electrical activity of the cortex just below the skull using a device called an **electroencephalograph**. The first **electroencephalogram (EEG)** recording in humans was accomplished in 1924 by Hans Berger (Niedermeyer, 2005). Recording the EEG involves using small metal disks or sponge-like electrodes placed directly on the scalp, and a special solution to help conduct the electrical signals from the cortex just below. These electrodes are connected to an amplifier and then to a computer to view the information. The resulting electrical output

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forms waves that indicate many things, such as stages of sleep, seizures, and even the presence of tumors. The EEG can also be used to help determine which areas of the brain are active during various mental tasks that involve memory and attention. EEG activity can be classified according to appearance and frequency, and different waves are associated with different brain activity. For example, *alpha waves* in the back of the brain are one indication of relaxed wakefulness (seen in bottom two lines in Figure 2.11a). EEG waveforms are covered in more detail in Chapter Four. [LINK](#) to Learning Objective 4.2.

Another common EEG-based technique focuses on *event-related potentials*, or *ERPs*. In ERP studies, multiple presentations of a stimulus are measured during an EEG and then averaged to remove variations in the ongoing brain activity that is normally recorded during the EEG. The result is a measurement of the response of the brain related to the stimulus event itself, or an event-related potential. ERPs allow the study of different stages of cognitive processing. For example, one recent study has investigated differences in brain processing associated with the recognition of facial expression of emotion in individuals with and without schizophrenia (Lee et al., 2010); in other studies ERPs are being studied as a possible method of lie detection (Hu et al., 2013; Rosenfeld et al., 2008).

MAGNETOENCEPHALOGRAPHY (MEG) While the EEG alone does not allow for the direct identification of areas of brain activation, a closely related technique does. *Magnetoencephalography* (MEG) uses devices that are very sensitive to magnetic fields called superconducting quantum interference devices, which are contained in a helmet-like device that is placed over the individual's head. MEG has many applications and is being used to differentiate dementia disorders and to explore cognitive processes in autism (M. A. Williams & Sachdev, 2010).

POSITRON EMISSION TOMOGRAPHY (PET) The functional neuroimaging methods discussed so far rely on the electrical activity of the brain. Other techniques make use of other indicators of brain activity, including energy consumption or changes in blood oxygen levels (if areas of the brain are active, they are likely using fuel and oxygen). In **positron emission tomography (PET)**, the person is injected with a radioactive glucose (a kind of sugar). The computer detects the activity of the brain cells by looking at which cells are using up the radioactive glucose and projecting the image of that activity onto a monitor. The computer uses colors to indicate different levels of brain activity, with lighter colors indicating greater activity. (See Figure 2.11b.) With this method, researchers can actually have the person perform different tasks while the computer shows what

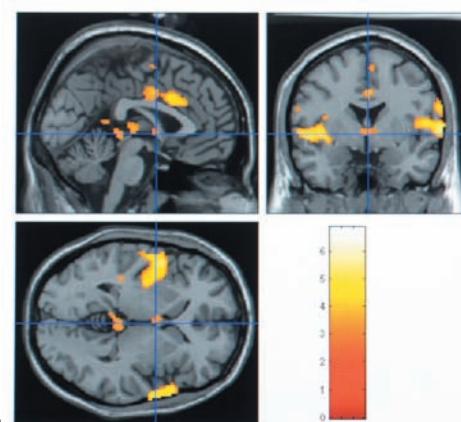
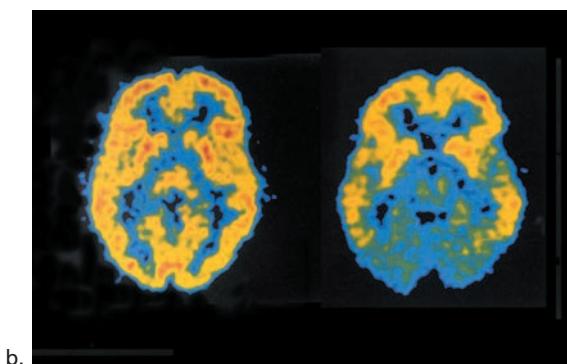
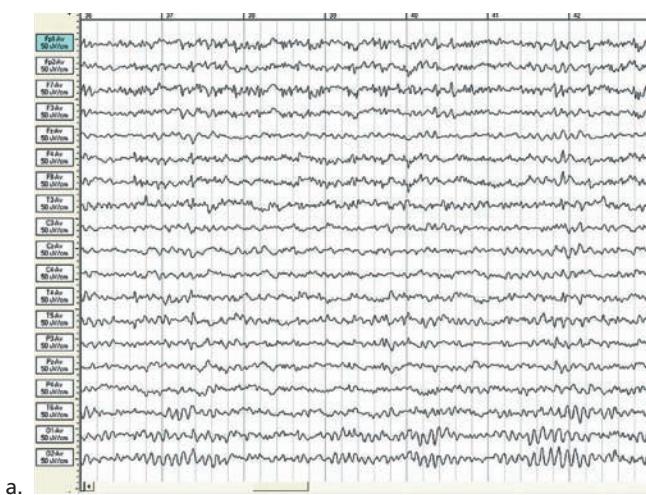


Figure 2.11 Mapping Brain Function

Various methods for mapping brain function. An EEG record is shown in 2.11a, a PET scan image in 2.11b, and an image from an fMRI study in 2.11c.

his or her brain is doing during the task. A related technique is *single photon emission computed tomography (SPECT)*, which measures brain blood flow and takes advantage of more easily obtainable radioactive tracers than those used for PET (Bremmer, 2005).

FUNCTIONAL MRI (fMRI) Although traditional MRI scans only show structure, **functional MRI (fMRI)**, in which the computer tracks changes in the oxygen levels of the blood (see Figure 2.11c), provides information on the brain's function as well. By superimposing information about where oxygen is being used in the brain over an image of the brain's structure, researchers can identify what areas of the brain are most active during specific tasks. By combining such images taken over a period of time, a sort of "movie" of the brain's functioning can be made (Lin et al., 2007). Functional MRIs can give more detail, tend to be clearer than PET scans, and are an incredibly useful tool for research into the workings of the brain. For example, fMRI has been used to demonstrate that older adults with a genetic risk for Alzheimer's disease show greater activation in brain areas associated with semantic knowledge and word retrieval when compared to older adults without that genetic risk. This finding may one day help clinicians and researchers identify individuals at risk for Alzheimer's much earlier in the disease process (Wierenga et al., 2010). There is also exciting research suggesting individuals can use fMRI to learn how to regulate their own brain processes. Individuals with schizophrenia were able to use real-time fMRI (rtfMRI) to learn how to control a portion of their brain that assists in recognition of facial emotions, which is a common deficit in schizophrenia (Ruiz et al., 2013).



Okay, now I understand a little more about how we look inside the brain. What exactly IS inside the brain?

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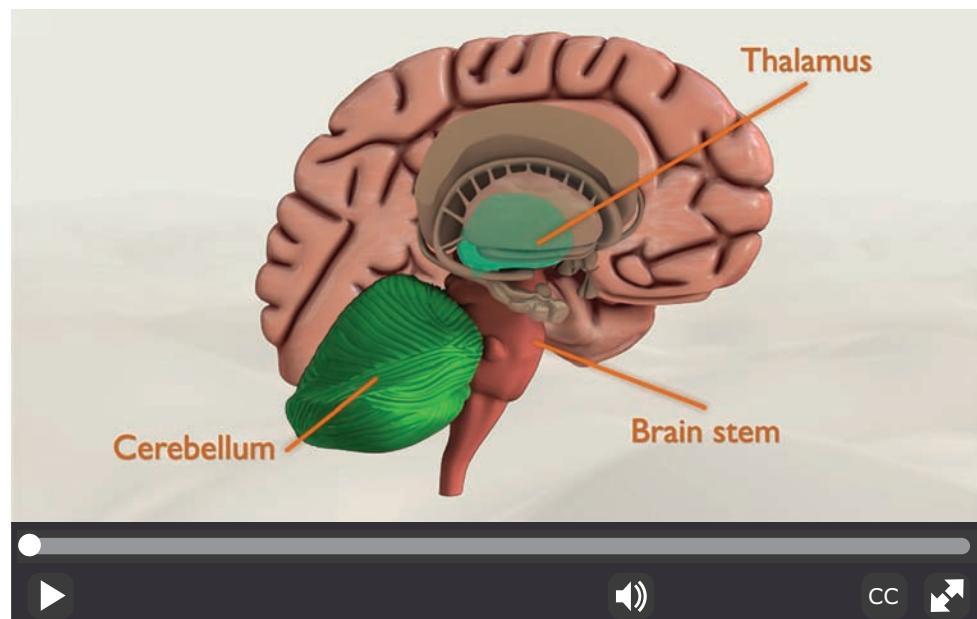
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From the Bottom Up: The Structures of the Brain

Now it's time to look at the various structures of the brain, starting from the bottom and working up to the top. The video *The Basics: How the Brain Works, Part 2: Parts of the Brain* describes the major parts of the brain and their functions. This text won't be discussing every single part of the brain, only major areas of interest to psychologists as explorers of behavior. Many areas also have multiple roles, but a full understanding of the brain is not possible within one chapter of an introductory psychology text.



Watch the Video, *The Basics: How the Brain Works, Part 2: Parts of the Brain* at [MyPsychLab](#)

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THE HINDBRAIN

2.7 What are the different structures of the hindbrain and what do they do?

The brain can be divided into three main divisions early in our development that later subdivide into smaller divisions. The three primary divisions are the forebrain, the midbrain, and the hindbrain. The forebrain includes the cortex, basal ganglia, and the limbic system. The midbrain is important for both sensory and motor functions. The hindbrain includes the medulla, pons, and cerebellum.

MEDULLA The **medulla** is located at the top of the spinal column. In Figure 2.12, it is the first “swelling” at the top of the spinal cord, just at the very bottom of the brain. This is the part of the brain that a person would least want to have damaged, as it controls life-sustaining functions such as heartbeat, breathing, and swallowing. It is in the medulla that the sensory nerves coming from the left and right sides of the body cross over, so that sensory information from the left side of the body goes to the right side of the brain and vice versa.

PONS The **pons** is the larger “swelling” just above the medulla. This term means “bridge,” and the pons is indeed the bridge between the lower parts of the brain and the upper sections. As in the medulla, there is a crossover of nerves, but in this case it is the motor nerves carrying messages from the brain to the body. This allows the pons to coordinate the movements of the left and right sides of the body. (It will be useful to remember these nerve crossovers when reading about the functions of the left and right sides of the brain in a later part of this chapter.) The pons also influences sleep, dreaming, and arousal. The role that the pons plays in sleep and dreams will be discussed in more detail in Chapter Four.  to Learning Objective 4.5.

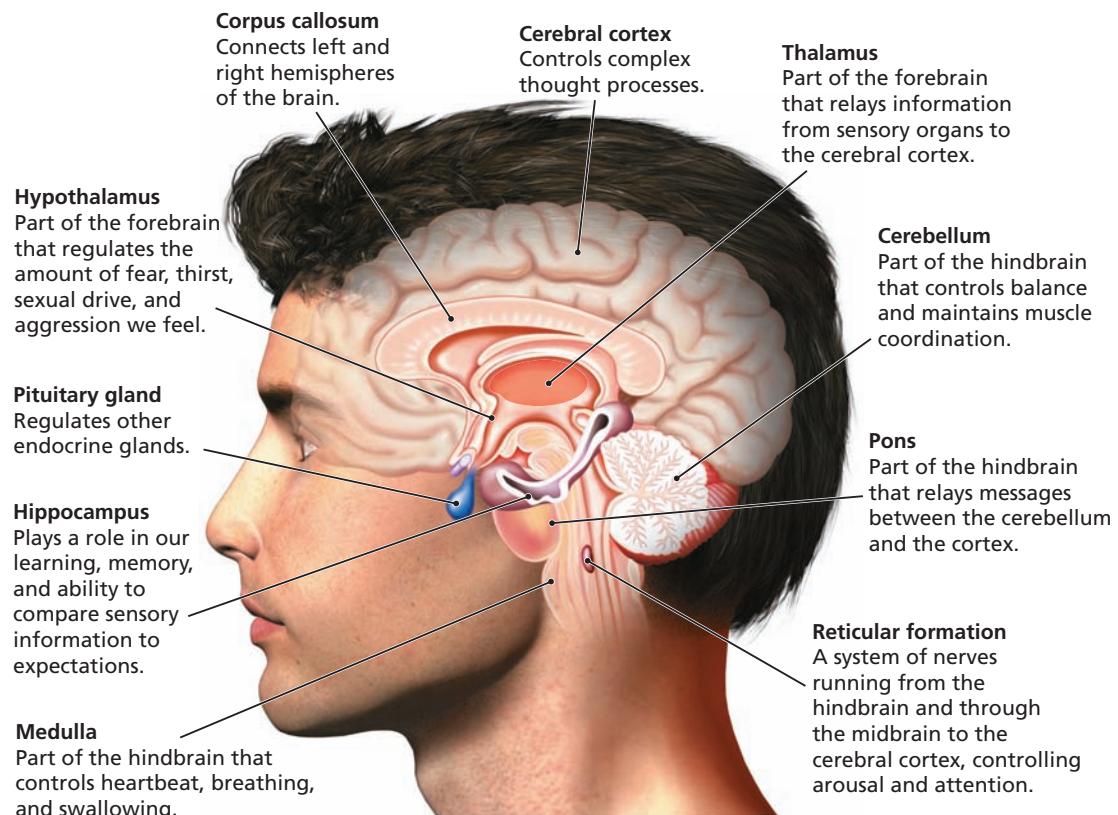


Figure 2.12 Major Structures of the Human Brain

THE RETICULAR FORMATION The **reticular formation (RF)** is a network of neurons running through the middle of the medulla and the pons and slightly beyond. These neurons are responsible for people's ability to generally attend to certain kinds of information in their surroundings. Basically, the RF allows people to ignore constant, unchanging information (such as the noise of an air conditioner) and become alert to changes in information (for example, if the air conditioner stopped, most people would notice immediately).

The reticular formation is also the part of the brain that helps keep people alert and aroused. One part of the RF is called the *reticular activating system* (RAS), and it stimulates the upper part of the brain, keeping people awake and alert. When a person is driving and someone suddenly pulls out in front of the vehicle, it is the RAS that brings that driver to full attention. It is also the system that lets a mother hear her baby cry in the night, even though she might sleep through other noises. The RAS has also been suggested by brain-scanning studies as a possible area involved in attention-deficit/hyperactivity disorder, in which children or adults have difficulty maintaining attention to a single task (Durston, 2003).

Studies have shown that when the RF of rats is electrically stimulated while they are sleeping, they immediately awaken. If the RF is destroyed (by deep lesioning, for example), they fall into a sleeplike coma from which they never awaken (Moruzzi & Magoun, 1949; Steriade & McCarley, 1990). The RF is also implicated in comas in humans (Plum & Posner, 1985).

CEREBELLUM At the base of the skull, behind the pons and below the main part of the brain, is a structure that looks like a small brain. This is the **cerebellum** (meaning "little brain"). The cerebellum is the part of the lower brain that controls all involuntary, rapid, fine motor movement. People can sit upright because the cerebellum controls all the little muscles needed to keep them from falling out of their chair. It also coordinates voluntary movements that have to happen in rapid succession, such as walking, skating, dancing, playing a musical instrument, and even the movements of speech. Learned reflexes, skills, and habits are also stored here, which allows them to become more or less automatic. Because of the cerebellum, people don't have to consciously think about their posture, muscle tone, and balance.

So if your cerebellum is damaged, you might be very uncoordinated?

Yes. In fact, this happens in a disease called *spinocerebellar degeneration*, where the first symptoms of cerebellum deterioration are tremors, an unsteady walk, slurred speech, dizziness, and muscle weakness. The person suffering from this disease will eventually be unable to walk, stand, or even get a spoon to his or her own mouth (Schöls et al., 1998). These symptoms are similar to what one might see in a person who is suffering from alcohol intoxication.

Just like we are starting to better understand the various roles of glial cells, researchers and scientists are still working to better understand other functions of the cerebellum. Research suggests the cerebellum is involved in much more than motor control and may be involved with a variety of higher functions, with parts of the cerebellum activated during sensorimotor tasks and other parts involved in cognitive or emotional tasks (Stoodley & Schmahmann, 2009). Research continues to investigate the role of the cerebellum in these and other tasks once believed to be the domain of other lobes of the brain, in a large part by examining the connections between the cerebellum and other functional areas, and patterns of brain activation during specific tasks (Strick et al., 2009; Voogd & Ruigrok, 2012). Recent fMRI studies have investigated such higher-level cognitive



This pitcher must count on his cerebellum to help him balance and coordinate the many fine motor commands that allow him to pitch the baseball accurately and swiftly. What other kinds of professions depend heavily on the activity of the cerebellum?

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functions as language and working memory, and the timing of perceptual tasks like visual attention (Kellermann et al., 2012; Stoodley et al., 2012).

STRUCTURES UNDER THE CORTEX: THE LIMBIC SYSTEM

What are the structures of the brain that control emotion, learning, memory, and motivation?

The forebrain includes the two cerebral hemispheres of the brain, including the cortex, which is discussed in detail later in this chapter, and a number of important structures located under the cortex in each hemisphere. These subcortical structures (the prefix *sub* means “under” or “below”) play a part in our thinking and behavior. While there are subcortical structures that influence motor control and the learning of motor skills, the *basal ganglia*, and white matter fiber pathways that connect the cortex to other parts of the brain and spinal cord, we will focus on the subcortical structures that have been collectively referred to as the *limbic system*. (See Figure 2.13.)

The **limbic system** (the word *limbic* means “marginal” and these structures are found in the inner margin of the upper brain) includes the thalamus, hypothalamus, hippocampus, amygdala, and the cingulate cortex. In general, the limbic system is involved in emotions, motivation, memory, and learning.

THALAMUS The **thalamus** (“inner chamber”) is in some ways similar to a triage* nurse. This somewhat round structure in the center of the brain acts as a kind of relay station for incoming sensory information. Like a nurse, the thalamus might perform some processing of that sensory information before sending it on to the part of the cortex that

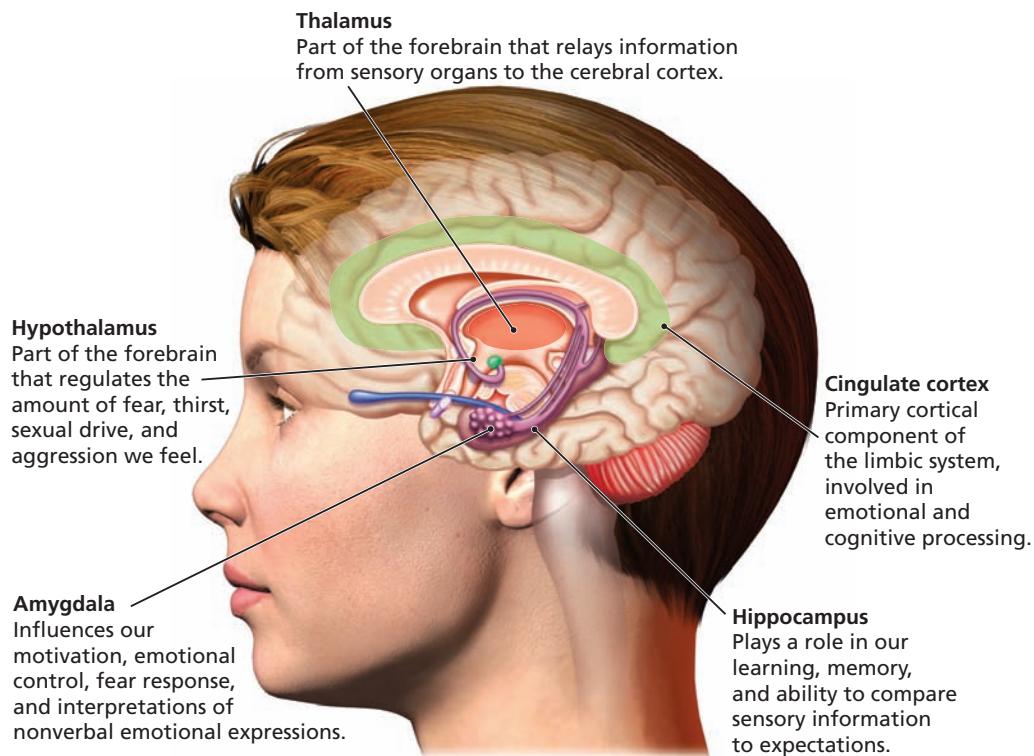


Figure 2.13 The Limbic System

*triage: a process for sorting injured people into groups based on their need for, or likely benefit from, immediate medical treatment.

deals with that kind of sensation—hearing, sight, touch, or taste. Damage to the thalamus might result in the loss or partial loss of any or all of those sensations.

The sense of smell is unique in that signals from the neurons in the sinus cavity go directly into special parts of the brain called **olfactory bulbs**, just under the front part of the brain. Smell is the only sense that does not have to first pass through the thalamus.

HYPOTHALAMUS A very small but extremely powerful part of the brain is located just below and in front of the thalamus (see Figure 2.13). The **hypothalamus** (“below the inner chamber”) regulates body temperature, thirst, hunger, sleeping and waking, sexual activity, and emotions. It sits right above the pituitary gland. The hypothalamus controls the pituitary, so the ultimate regulation of hormones lies with the hypothalamus.

HIPPOCAMPUS Like many structures in the brain, the **hippocampus** was named based on its appearance. Hippocampus is the Greek word for “seahorse” and it was given to this brain structure because the first scientists who dissected the brain thought it looked like a seahorse. The hippocampus is located within the medial temporal lobe on each side of the brain (medial means “toward the middle”). Research has shown that the hippocampus is instrumental in forming long-term (permanent) declarative memories that are then stored elsewhere in the brain (Squire & Kandel, 2009).

LINK to Learning Objective 6.11. As mentioned earlier, ACh, the neurotransmitter involved in muscle control, is also involved in the memory function of the hippocampus. People who have Alzheimer’s disease, for example, have much lower levels of ACh in that structure than is normal, and the drugs given to these people boost the levels of ACh.

AMYGDALA The **amygdala** (“almond”) is another area of the brain named for its shape and appearance. It is located near the hippocampus. The amygdala is involved in fear responses and memory of fear. Information from the senses goes to the amygdala before the upper part of the brain is even involved, so that people can respond to danger very quickly, sometimes before they are consciously aware of what is happening. In 1939 researchers found that monkeys with large amounts of their temporal lobes removed—including the amygdala—were completely unafraid of snakes and humans, both normally fear-provoking stimuli (Klüver & Bucy, 1939). This effect came to be known as the *Klüver-Bucy syndrome*. Rats that have damaged amygdala structures will also show no fear when placed next to a cat (Maren & Fanselow, 1996). Case studies of human with damage to the amygdala also show a link to decreased fear response (Adolphs et al., 2005). Although the amygdala plays a vital role in forming emotional memories, it is still unclear if the memories are stored in the amygdala (Squire & Kandel, 2009).

CINGULATE CORTEX The *cingulate cortex* is the limbic structure that is actually found in the cortex. It is found right above the corpus callosum in the frontal and parietal lobes and plays an important role in both emotional and cognitive processing. The cingulate cortex can be divided into up to four regions that play different roles in processing emotional, cognitive, and autonomic information (Vogt & Palomero-Gallagher, 2012). It has been shown to be active during a variety of cognitive tasks such as selective attention, written word recognition, and working memory (Cabeza & Nyberg, 2000) and has been implicated in a variety of psychological and mental disorders including attention-deficit/hyperactivity disorder (Bush et al., 1999; Bush et al., 2008), schizophrenia, major depressive disorder, and bipolar disorder (Fornito et al., 2009; Maletic et al., 2007). The next section further explores the cortex and its functions.



This young woman’s thirst is regulated by her hypothalamus.

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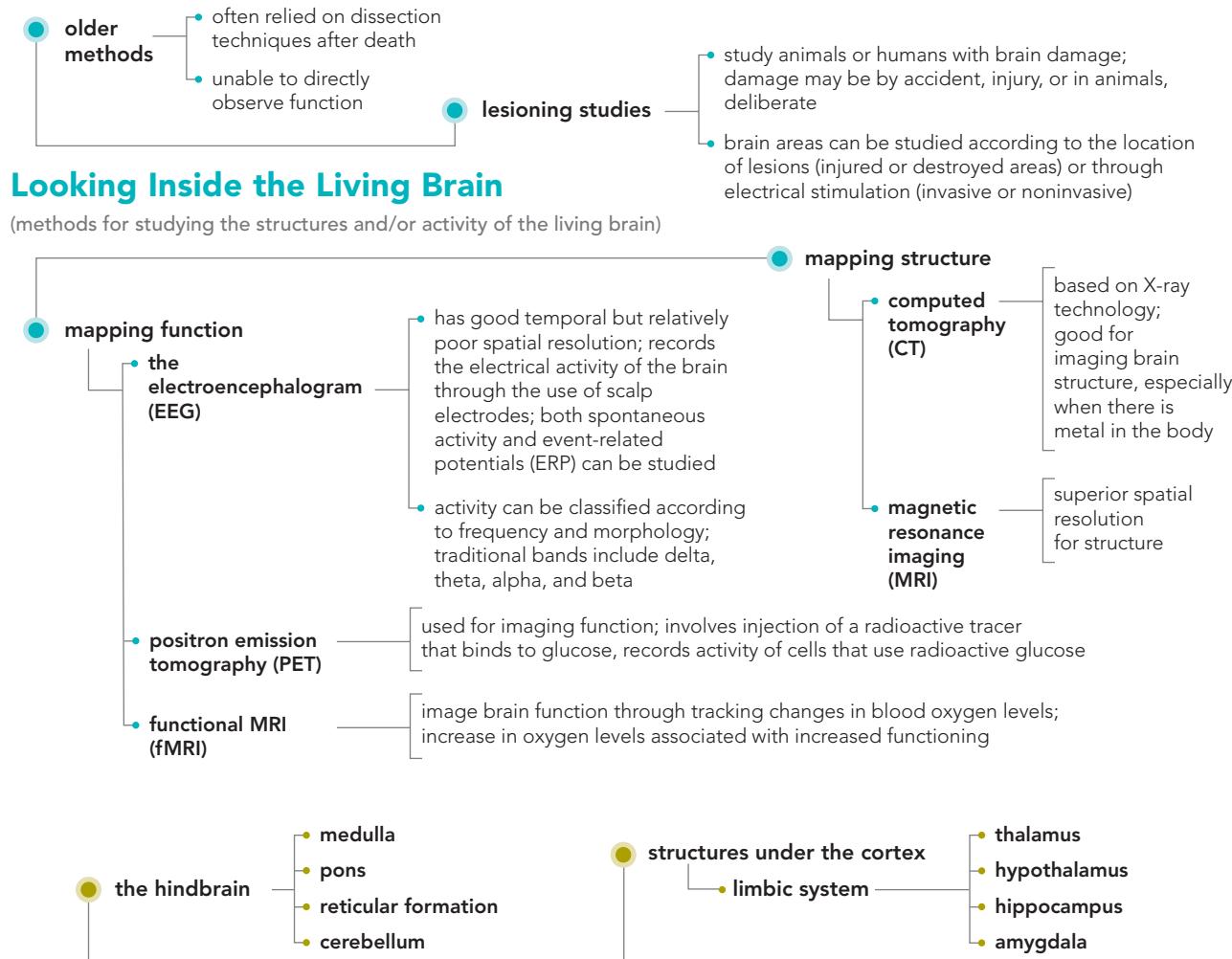
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 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP



From the Bottom Up: The Structures of the Brain

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

- Which of the following techniques analyzes blood oxygen levels to look at the functioning of the brain?
 - EEG
 - CT
 - fMRI
 - PET
- Which brain structure allows us to pay attention to certain stimuli while ignoring others?
 - medulla
 - cerebellum
 - reticular formation
 - pons
- Which brain structure relays incoming sensory information?
 - thalamus
 - hypothalamus
 - reticular formation
 - pons
- If you were to develop a rare condition in which you were not able to remember to be afraid of certain situations, animals, or events, which part of the brain would most likely be damaged?
 - cingulate cortex
 - hypothalamus
 - thalamus
 - amygdala
- If your roommate has a problem paying attention, it may be due to damage to this part of the limbic system.
 - hippocampus
 - hypothalamus
 - cerebellum
 - cingulate cortex

THE CORTEX

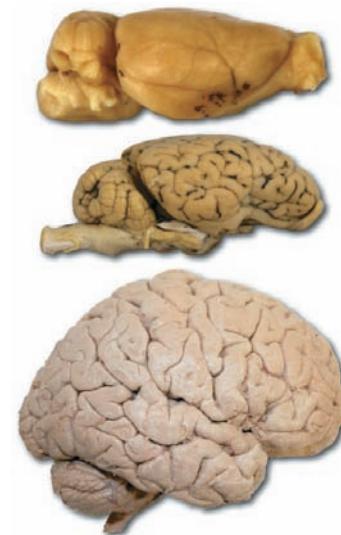
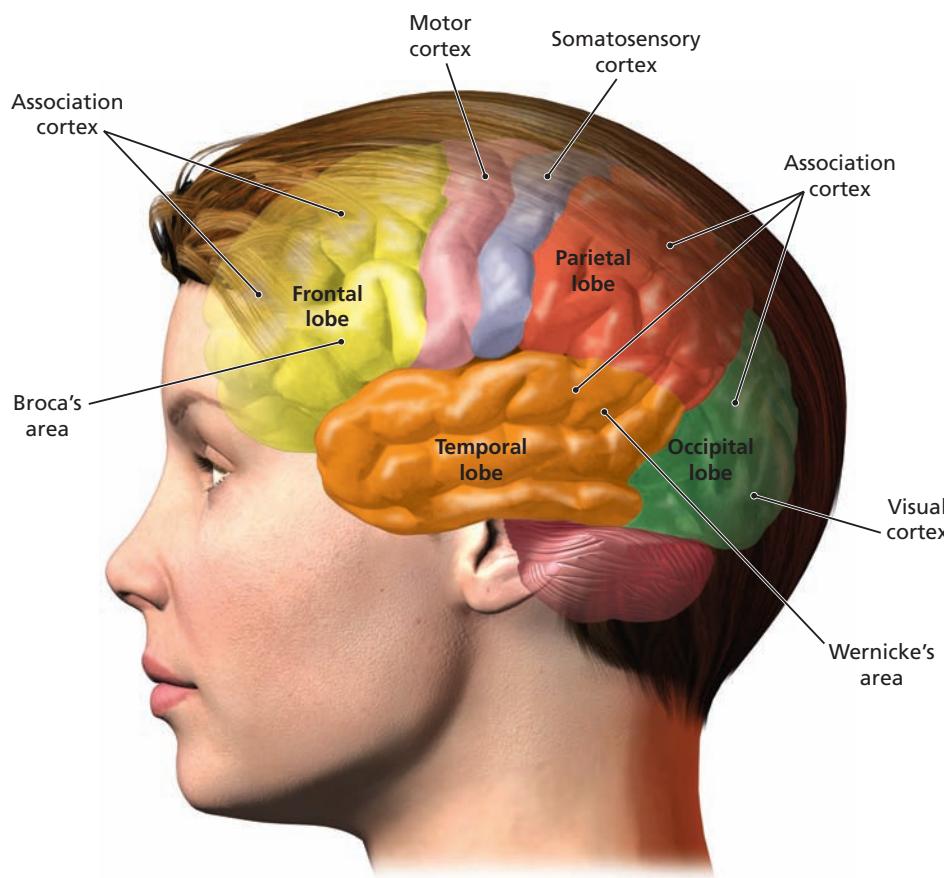
What parts of the cortex control the different senses and the movement of the body?

As stated earlier, the **cortex** (“rind” or outer covering) is the outermost part of the brain, which is the part of the brain most people picture when they think of what the brain looks like. It is made up of tightly packed neurons and actually is only about one tenth of an inch thick on average (Fischl et al., 2001; MacDonald et al., 2000; Zilles, 1990). The cortex is very recognizable surface anatomy because it is full of wrinkles.

Why is the cortex so wrinkled?

The wrinkling of the cortex allows a much larger area of cortical cells to exist in the small space inside the skull. If the cortex were to be taken out, ironed flat, and measured, it would be about 2 to 3 square feet. (The owner of the cortex would also be dead, but that’s fairly obvious, right?) As the brain develops before birth, it forms a smooth outer covering on all the other brain structures. This will be the cortex, which will get more and more wrinkled as the brain increases in size and complexity. This increase in wrinkling is called “corticalization.”

CEREBRAL HEMISPHERES The cortex is divided into two sections called the **cerebral hemispheres**, which are connected by a thick, tough band of neural fibers (axons) called the **corpus callosum** (literally meaning “hard body,” as calluses on the feet are hard). (Refer back to Figure 2.12.) The corpus callosum allows the left and right hemispheres to communicate with each other. Each hemisphere can be roughly divided into four sections or lobes by looking at the deeper wrinkles, or fissures, in its surface. The lobes are named for the skull bones that cover them (see Figure 2.14).



From top to bottom, a rat brain, sheep brain, and human brain (not to scale!). Note the differences in the amount of corticalization, or wrinkling, of the cortex between these three brains. Greater amounts of corticalization are associated with increases in size and complexity.

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Figure 2.14 The Lobes of the Brain: Frontal, Temporal, Parietal, and Occipital

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Another organizational feature of the cortex is that for specific regions, each hemisphere is responsible for the opposite side of the body, either for control, or for receiving information. For example, the motor cortex controls the muscles on the opposite side of the body. If we are writing with our right hand, the motor cortex in the left hemisphere is responsible for controlling those movements. This feature, referred to as *contralateral organization*, plays a role in information coming from many of the sense organs to the brain, and in the motor commands originating in the brain going to the rest of the body.

Information from our body can also be transmitted to both sides of the brain, or *bilaterally* (as in hearing and vision), or to only one side of the brain, or *ipsilaterally* (as in taste and olfaction). These aspects are also important in the study of *brain lateralization*, which we will come back to later in the chapter. Why do we have this arrangement for some functions and not for others? No one really knows, but at least for some information, it assists with identifying where information from the environment is coming from. For auditory information from the ears, having sensory information projected to both hemispheres allows us to localize sounds by comparing the slightly different information coming from each ear.

OCCIPITAL LOBES At the base of the cortex, toward the back of the brain, is an area called the **occipital lobe**. This area processes visual information from the eyes in the *primary visual cortex*. The *visual association cortex*, also in this lobe and in parts of the temporal and parietal lobes, helps identify and make sense of the visual information from the eyes. The famed neurologist Oliver Sacks once had a patient who had a tumor in his right occipital lobe area. He could still see objects and even describe them in physical terms, but he could not identify them by sight alone. When given a rose, the man began to describe it as a “red inflorescence” of some type with a green tubular projection. Only when he held it under his nose (stimulating the sense of smell) did he recognize it as a rose (Sacks, 1990). Each area of the cortex has these association areas that help people make sense of sensory information.  Watch the [Video](#), *The Big Picture: My Brain Made Me Do It: Association Areas*, at [MyPsychLab](#)

PARIETAL LOBES The **parietal lobes** are at the top and back of the brain, just under the parietal bone in the skull. This area contains the **somatosensory cortex**, an area of neurons (see **Figure 2.15**) at the front of the parietal lobes on either side of the brain. This area processes information from the skin and internal body receptors for touch, temperature, and body position. The somatosensory cortex is laid out in a rather interesting way—the cells at the top of the brain receive information from the bottom of the body, and as one moves down the area, the signals come from higher and higher in the body. It’s almost as if a little upside-down person were laid out along this area of cells.

TEMPORAL LOBES The beginning of the **temporal lobes** are found just behind the temples of the head. These lobes contain the *primary auditory cortex* and the *auditory association area*. Also found in the left temporal lobe is an area that in most people is particularly involved with language. We have already discussed some of the medial structures of the temporal lobe, the amygdala and hippocampus, that are involved in aspects of learning and memory. There are also parts of the temporal lobe that help us process visual information.

FRONTAL LOBES These lobes are at the front of the brain, hence, the name **frontal lobes**. (It doesn’t often get this easy in psychology; feel free to take a moment to appreciate it.) Here are found all the higher mental functions of the brain—planning, personality, memory storage, complex decision making, and (again in the left hemisphere in most people) areas devoted to language. The frontal lobe also helps in controlling emotions by means of its connection to the limbic system. The

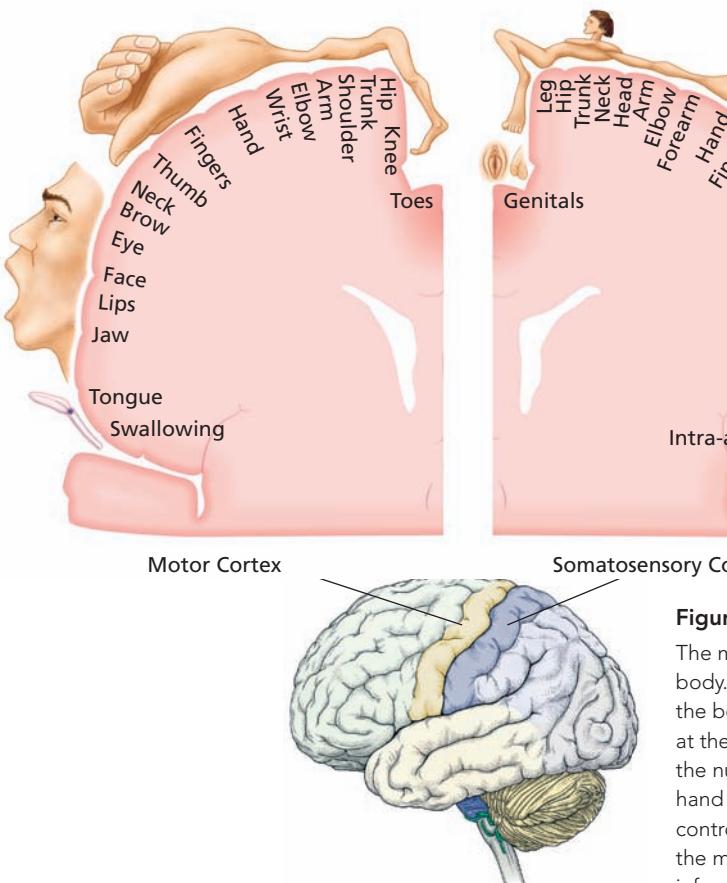


Figure 2.15 The Motor and Somatosensory Cortex

The motor cortex in the frontal lobe controls the voluntary muscles of the body. Cells at the top of the motor cortex control muscles at the bottom of the body, whereas cells at the bottom of the motor cortex control muscles at the top of the body. Body parts are drawn larger or smaller according to the number of cortical cells devoted to that body part. For example, the hand has many small muscles and requires a larger area of cortical cells to control it. The somatosensory cortex, located in the parietal lobe just behind the motor cortex, is organized in much the same manner and receives information about the sense of touch and body position.

most forward part of the frontal lobes is called the prefrontal cortex. The middle area toward the center (medial prefrontal cortex) and bottom surface above the eyes (orbitofrontal prefrontal cortex—right above the orbits of the eye) have strong connections to the limbic system. Phineas Gage, who was mentioned in Chapter One, suffered damage to his frontal lobe. He lacked emotional control because of the damage to his prefrontal cortex and the connections with limbic system structures. Overall, he had connections damaged from the left frontal cortex to many other parts of the brain (Van Horn et al., 2012). People with damage to the frontal lobe may also experience problems with performing mental or motor tasks, such as getting stuck on one step in a process or on one wrong answer in a test and repeating it over and over again, or making the same movement over and over, a phenomena called *perseveration* (Asp & Tranel, 2013; Luria, 1965). [Watch the Video](#), Thinking Like a Psychologist: The Pre-Frontal Cortex, at [MyPsychLab](#)

The frontal lobes also contain the **motor cortex**, a band of neurons located at the back of each lobe. (See Figure 2.15.) These cells control the movements of the body's voluntary muscles by sending commands out to the somatic division of the peripheral nervous system. The motor cortex is laid out just like the somatosensory cortex, which is right next door in the parietal lobes.

This area of the brain has been the focus of a great deal of recent research, specifically as related to the role of a special type of neuron. These neurons are called **mirror neurons**, which fire when an animal performs an action—but they also fire when an animal observes that same action being performed by another. Previous brain-imaging studies in humans suggested that we, too, have mirror neurons in this area of the brain (Buccino et al., 2001; Buccino et al., 2004; Iacoboni et al., 1999). However,



This boxer must rely on his parietal lobes to sense where his body is in relation to the floor of the ring and the other boxer, his occipital lobes to see his target, and his frontal lobes to guide his hand and arm into the punch.

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As this boy imitates the motions his father goes through while shaving, certain areas of his brain are more active than others, areas that control the motions of shaving. But even if the boy were only watching his father, those same neural areas would be active—the neurons in the boy's brain would *mirror* the actions of the father he is observing.

single-cell and multi-cell recordings in humans have demonstrated that neurons with mirroring functions are not only found in motor regions but also in parts of the brain involved in vision and memory, suggesting such neurons provide much more information than previously thought about our own actions as compared to the actions of others (Mukamel et al., 2010). These findings may have particular relevance for better understanding or treating specific clinical conditions that are believed to involve a faulty mirror system in the brain, such as autism (Oberman & Ramachandran, 2007; Rizzolatti et al., 2009). [LINK](#) to Learning Objective 8.6.

You've mentioned association cortex a few times. Do the other lobes of the brain contain association cortex as well?

THE ASSOCIATION AREAS OF THE CORTEX

What parts of the cortex are responsible for higher forms of thought, such as language?

Association areas are made up of neurons in the cortex that are devoted to making connections between the sensory information coming into the brain and stored memories, images, and knowledge. In other words, association areas help people make sense of the incoming sensory input. Although association areas in the occipital and temporal lobes have already been mentioned, much of the brain's association cortex is in the frontal lobes. Furthermore, some special association areas are worth talking about in more detail.

[Watch the Video](#), *The Basics: How the Brain Works, Part 2: Association Areas*, at [MyPsychLab](#)

BROCA'S AREA In the left frontal lobe of most people is an area of the brain devoted to the production of speech. (In a small portion of the population, this area is in the right frontal lobe.) More specifically, this area allows a person to speak smoothly and fluently. It is called *Broca's area* after nineteenth-century neurologist Paul Broca, who first studied people with damage to this area (Leonard, 1997). Damage to Broca's area causes a person to be unable to get words out in a smooth, connected fashion. People with this condition may know exactly what they want to say and understand what they hear others say, but they cannot control the actual production of their own words. Speech is halting and words are often mispronounced, such as saying "cot" instead of "clock" or "non" instead of "nine." Some words may be left out entirely, such as "the" or "for." This is called **Broca's aphasia**. *Aphasia* refers to an inability to use or understand either written or spoken language (Goodglass et al., 2001). (Stuttering is a somewhat different problem in getting words *started*, rather than mispronouncing them or leaving them out, but may also be related to Broca's area.)

WERNICKE'S AREA In the left temporal lobe (again, in most people) is an area called *Wernicke's area*, named after the physiologist and Broca's contemporary, Carl Wernicke, who first studied problems arising from damage in this location. This area of the brain appears to be involved in understanding the meaning of words (Goodglass et al., 2001).

A person with **Wernicke's aphasia** would be able to speak fluently and pronounce words correctly, but the words would be the wrong ones entirely. For example, Elsie suffered a stroke to the temporal lobe, damaging this area of the brain. As the ER nurse inflated a blood pressure cuff, Elsie said, "Oh, that's so Saturday hard." Elsie *thought* she was making sense. She also had trouble understanding what the people around her were saying to her. In another instance, Ernest suffered a stroke at the age of 80 and also showed signs of Wernicke's aphasia. For example, he asked his wife to get him some milk out of the air conditioner. Right idea, wrong word.

classic studies in psychology

Through the Looking Glass—Spatial Neglect

Dr. V. S. Ramachandran reported in his fascinating book, *Phantoms in the Brain* (Ramachandran & Blakeslee, 1998), the case of a woman with an odd set of symptoms. When Ellen's son came to visit her, he was shocked and puzzled by his formerly neat and fastidious* mother's appearance. The woman who had always taken pride in her looks, who always had her hair perfectly done and her nails perfectly manicured, looked messy and totally odd. Her hair was uncombed on the left side. Her green shawl was hanging neatly over her right shoulder but hanging onto the floor on the left. Her lipstick was neatly applied to the right side of her lips, and *only to the right side—the left side of her face was completely bare of makeup!* Yet her eyeliner, mascara, and blush were all neatly applied to the right side of her face.

What was wrong? The son called the doctor and was told that his mother's stroke had left her with a condition called **spatial neglect**, or unilateral neglect, in which a person with damage to the right parietal and occipital lobes of the cortex will ignore everything in the left visual field. Damage to areas of the frontal and temporal lobes may also play a part along with the parietal damage. Spatial neglect can affect the left hemisphere, but this condition occurs less frequently and in a much milder form than right-hemisphere neglect (Corbetta et al., 2005; Heilman et al., 1993; Springer & Deutsch, 1998).

When the doctor examined this woman, he tried to get her to notice her left side by holding up a mirror (remember, she was not blind—she just would not notice anything on her left side unless her attention was specifically called to it). She responded correctly when asked what the mirror was and she was able to describe her appearance correctly, but when an assistant held a pen just within the woman's reach, reflected in the mirror on her left side, she tried to reach *through the mirror* to get the pen with her good right hand. When the doctor told her that he wanted her to grab the real object and not the image of it in the mirror, she told him that the pen was *behind* the mirror and even tried to reach around to get it.

Clearly, persons suffering from spatial neglect can no longer perceive the world in the same way as other people do. For these people, the left sides of objects, bodies, and spaces are somewhere "through the looking glass."

Questions for Further Discussion

1. If a person with spatial neglect only eats the food on the right side of the plate, what could caregivers do to help that person get enough to eat?
2. What other odd things might a person with spatial neglect do that a person with normal functioning would not? What other things might a person with spatial neglect fail to do?

*fastidious: having demanding standards, difficult to please.

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As this woman brushes the right side of her hair, is she really "seeing" the left side? If she has spatial neglect, the answer is "no." While her eyes work just fine, her damaged right hemisphere refuses to notice the left side of her visual field.

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I've heard that some people are right-brained and some are left-brained.
Are the two sides of the brain really that different?

THE CEREBRAL HEMISPHERES: ARE YOU IN YOUR RIGHT MIND?

2.11 How does the left side of the brain differ from the right side?

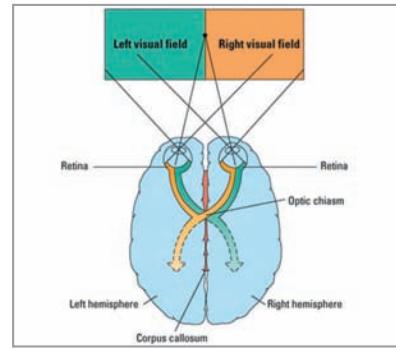
Most people tend to think of the two cerebral hemispheres as identical twins. Both sides have the same four lobes and are arranged in much the same way. But language seems to be confined to only the left hemisphere in about 90 percent of the population (Toga & Thompson, 2003). What other special tasks do the two halves of the **cerebrum** (the upper part of the brain consisting of the two hemispheres and the structures connecting them) engage in, and how do researchers know about such functions? Participate in the experiment *Hemispheric Specialization* to test the language abilities of the two hemispheres.

Simulation

Hemispheric Specialization

This experiment tests the language abilities of the two hemispheres of the brain. By exposing the two hemispheres to a language test we can determine if the left hemisphere is dominant in language function.

[Go to the Experiment ►](#)



☞ Simulate the Experiment, Hemispheric Specialization, at [MyPsychLab](#)

SPLIT-BRAIN RESEARCH Roger Sperry was a pioneer in the field of hemisphere specialization. He won a Nobel Prize for his work in demonstrating that the left and right hemispheres of the brain specialize in different activities and functions (Sperry, 1968). In looking for a way to cure epilepsy (severe muscle spasms or seizures resulting from brain damage), Sperry cut through the corpus callosum, the thick band of neural fibers that joins the two hemispheres. In early research with animals, this technique worked and seemed to have no side effects. The first people to have this procedure done also experienced relief from their severe epileptic symptoms, but testing found that (in a sense) they now had two brains in one body.

The special testing involves sending messages to only one side of the brain, which is now possible because the connecting tissue, the corpus callosum, has been cut. Remember that each hemisphere is largely responsible for controlling, or receiving information from, the opposite side of the body. Figure 2.16 shows what happens with a typical split-brain patient.

In a split-brain patient, if a picture of a ball is flashed to the right side of the screen, the image of the ball will be sent to the left occipital lobe. The person will be able to say that he or she sees a ball. If a picture of a hammer is flashed to the left side of the screen, the person will not be able to *verbally* identify the object or be able to state with any certainty that something was seen. But if the left *hand* (controlled by the right hemisphere) is used, the person can point to the hammer he or she “didn’t see.” The right occipital lobe clearly saw the hammer, but the person could not *verbalize* that fact (Sperry, 1968). By doing studies such as these, researchers have found that the left hemisphere specializes in language, speech, handwriting, calculation (math), sense of time and rhythm (which is mathematical in nature), and basically any kind of thought requiring analysis. The right hemisphere appears to specialize in more global (widespread) processing involving perception, visualization, spatial perception, recognition of patterns, faces, emotions, melodies, and expression of emotions. It also comprehends simple language but does not produce speech. (See Table 2.2.)

In general, the left hemisphere processes information in a sequence and is good at breaking things down into smaller parts, or performing analysis (Springer & Deutsch, 1998). The right hemisphere, by contrast, processes information all at once and simultaneously, a more global or holistic* style of processing. Remember the discussion in Chapter One of the early days of psychology, the structuralists, and the Gestalt psychologists? One could almost say that the left hemisphere of the brain is a structuralist who wants to break everything down into its smallest parts, and the right side of the brain is a Gestaltist, who wants to study only the whole.

 So there really are left-brained and right-brained people?

Actually, unless one is a split-brain patient, the two sides of the brain are always working together as an integrated whole. For example, the right

Table 2.2
Specialization of the Two Hemispheres

LEFT HEMISPHERE	RIGHT HEMISPHERE
Controls the right hand	Controls the left hand
Spoken language	Nonverbal
Written language	Visual-spatial perception
Mathematical calculations	Music and artistic processing
Logical thought processes	Emotional thought and recognition
Analysis of detail	Processes the whole
Reading	Pattern recognition
	Facial recognition

*holistic: relating to or concerned with complete systems or wholes.

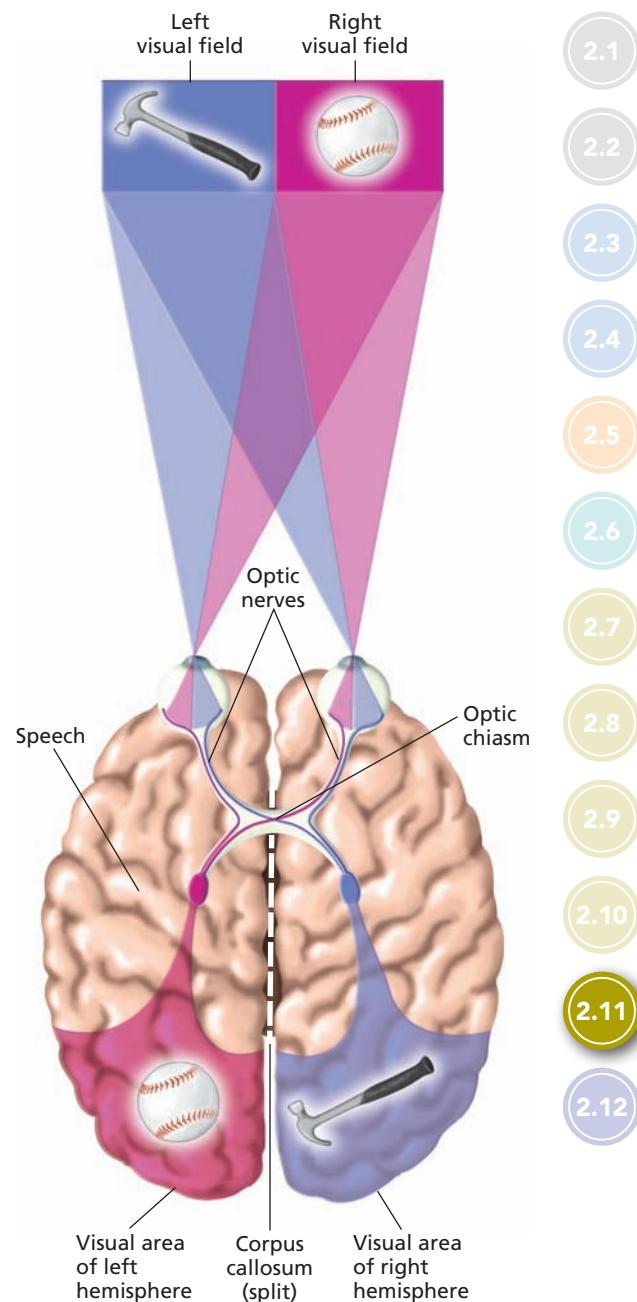


Figure 2.16 The Split-Brain Experiment

Roger Sperry created this experiment to demonstrate the specialization of the left and right hemispheres of the brain.

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side might recognize someone's face, while the left side struggles to recall the person's name. People aren't really left- or right-brained, they are "whole-brained." Michael Gazzaniga was one of Roger Sperry's students, his collaborator, and is a long-time researcher in the area of brain asymmetry and cognitive neuroscience. Gazzaniga's continuing work in brain lateralization has led to insights of the integrated mind, and he continues to work in related areas including human consciousness, perception, and neuroethics (Gazzaniga, 2006, 2009).

HANDEDNESS The separate functions of the left and right sides of the brain are often confused with handedness, or the tendency to use one hand for most fine motor skills. While most right-handed people also have their left hemisphere in control of their other fine motor skills, such as speech, a few right-handers actually have their language functions in the right hemisphere, in spite of the dominance of the left hemisphere for controlling the right hand. Among left-handed people, there are also many who, although right-brain dominant for motor control, still have their language functions on the left side of the brain. Why? Unfortunately, there are far too many theories of why we use one hand over the other for us to cover in the scope of this text.

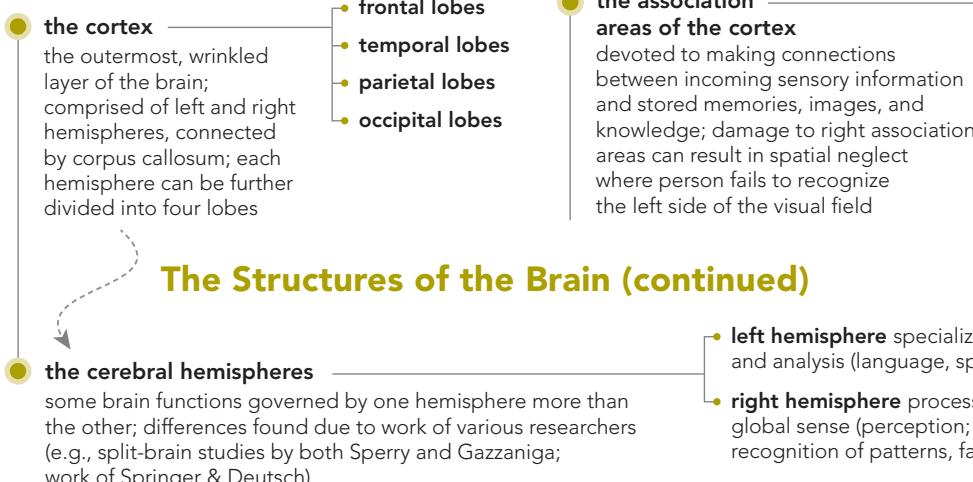
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 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP



- **Broca's area:** found in left frontal lobe; devoted to speech production; damage to this area can result in Broca's aphasia
- **Wernicke's area:** found in the left temporal lobe; plays a role in understanding the meaning of words

The Structures of the Brain (continued)

- **left hemisphere** specializes in tasks that involve sequence and analysis (language, speech, handwriting, math)
- **right hemisphere** processes information in a more global sense (perception; visualization; spatial perception; recognition of patterns, faces, and emotional expression)

PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. What part of the brain can sometimes be referred to as the "rind" or outer covering?
 - a. thalamus
 - b. medulla
 - c. corpus callosum
 - d. cortex
2. In which of the following lobes of the cortex would you find the primary visual cortex?
 - a. frontal
 - b. temporal
 - c. occipital
 - d. parietal

3. The ability to detect changes in temperature, pressure, and body position is due in part to the functions of the _____ lobe.
- a. frontal
 - b. parietal
 - c. temporal
 - d. corpus
4. You have a dream in which you wake up to find that people around you are using words that make no sense. What's more, your friends don't seem to understand you when you speak. At one point in your dream, your mom tells you that you almost forgot your tree limb today. When you give her a puzzled look, she holds up your lunchbox and repeats, "You know, your tree limb." Your predicament in your dream is most like which of the following disorders?
- a. Wernicke's aphasia
 - b. Broca's aphasia
 - c. apraxia
 - d. spatial neglect

5. Which part of the brain tends to process information globally?
- a. left hemisphere
 - b. right hemisphere
 - c. corpus callosum
 - d. cerebellum

THINKING CRITICALLY:

Phineas Gage went from a mild-mannered railroad worker to a short-tempered and highly aggressive individual after a spike was driven through his frontal lobe. Discuss the extent to which his injuries and subsequent behavior change were a result of the biological changes or if they could be due to other "social" causes.

Applying Psychology to Everyday Life: Paying Attention to Attention-Deficit/Hyperactivity Disorder

What are some potential causes of attention-deficit/hyperactivity disorder?

Attention-deficit/hyperactivity disorder (ADHD) is a developmental disorder involving behavioral and cognitive aspects of inattention, impulsivity, and hyperactivity. Previously referred to as attention deficit disorder (ADD), there are currently three diagnostic categories for this disorder in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. These include ADHD predominantly hyperactive/impulsive presentation, ADHD predominantly inattentive presentation, and ADHD combined presentation (American Psychiatric Association, 2013). Although ADHD is most commonly diagnosed in children, the disorder tends to persist into adolescence and adulthood. Inattention and impulsivity are often reported in adults, whereas symptoms of hyperactivity tend to decline with age. The ADHD-related problems in adults can range from strained relations with family, friends, or a significant other to problems with substance abuse, traffic accidents, or job stability (Barkley et al., 2008). A recent longitudinal study found a group of males diagnosed with ADHD in childhood were more likely to have issues across a variety of domains when followed up with as adults. At a mean age of 41, the men with ADHD had significantly worse educational, occupational, economic, and social outcomes, and more divorces than non-ADHD comparisons (Klein et al., 2012).

There are not only ongoing issues from the disorder itself, but also with the medications used to treat it. In the United States there is a growing concern over the misuse of prescription drugs on college campuses, for example, by students without ADHD in the attempt to improve their attention or concentration when studying. And for some students, the most common source of the medication is a friend with a prescription (Garnier-Dykstra et al., 2012). Furthermore, an ongoing increase in the number of ADHD diagnoses and prescriptions for stimulant medications appears to coincide with the use of ADHD medications as "neuroenhancers" in otherwise healthy children and adolescents, and has prompted the American Academy of Neurology to publish a position paper against such practices (Graf et al., 2013).

The brain areas involved in the behavioral and cognitive characteristics of ADHD are typically divided into those responsible for regulating attention and cognitive control and those responsible for alertness and motivation (Nigg, 2010). Cortical and subcortical

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brain areas involved, and found to be smaller in neuroimaging studies of ADHD, are the prefrontal cortex (primarily on the right side), basal ganglia (subcortical structures involved in response control), cerebellum, and corpus callosum (Nigg, 2006).

Since ADHD involves a variety of behaviors and cognitive aspects, research has often looked for specific markers that may lead to the actual causes of the disorder. These markers may be biological, cognitive, or behavioral measures (Nigg, 2010). To assess individual markers, researchers may combine neuroimaging and electrophysiological studies of individuals with ADHD while at rest or while they perform specific cognitive tasks (like various tests of attention). Some studies use EEG or ERPs (Clarke et al., 2007; Loo et al., 2009; Missonnier et al., 2013; van der Stelt et al., 2010; White et al., 2005) whereas others use MRI, fMRI, or PET (Bush et al., 2008; Volkow et al., 2007).

Much of the research over the past 10 years has focused on the cognitive markers for ADHD, such as attention problems, that may or may not be combined with neuroimaging (Nigg, 2010). More recent research suggests that some aspects of attention are actually normal in individuals with ADHD. The aspect of attention with which individuals with ADHD do have problems is vigilance (being able to “watch out” for something important). Another cognitive area that appears to be impaired is being able to effectively control one’s own cognitive processes such as staying on task, maintaining effort, or engaging in self-control (Nigg, 2010).

These findings have prompted researchers to reexamine the causes of ADHD and have highlighted the likelihood of more than one cause and more than one brain route to ADHD. Current research is looking at a variety of areas including environmental factors such as low-level lead exposure, genetic influences, the role of heredity and familial factors, and personality factors (Nigg, 2010). Furthermore, causes for the prevalence of ADHD continue to be examined, with variables ranging from the impact of sleep, circadian rhythms, and environmental light exposure (Arns et al., 2013) to the manner in which ADHD symptoms are characterized and diagnosed. While some of these areas of investigation are not completely new and have been examined before, the possibility of multiple causes and interactions between these causes has not been examined as closely as it is being examined in current ADHD research.

Questions for Further Discussion

1. How might a psychology professional help parents or teachers understand the neuroimaging techniques and brain areas associated with ADHD?
2. If a college student has ADHD, what aspects of their school or personal lives might be impacted by problems with vigilance or cognitive control?
3. What kinds of problems may arise in individuals taking ADHD medications when they do not have the actual symptoms of the disorder?

Writing Prompt

- ▼ Your best friends invite you over for pizza and a friendly game of cards. Describe how the following parts of the brain are involved during your evening of eating pizza, socializing, and playing cards: Broca's area, hippocampus, hypothalamus, and occipital lobe.

Words: 0

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chapter summary

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Neurons and Nerves: Building the Network

2.1 What are the nervous system, neurons, and nerves, and how do they relate to one another?

- The nervous system is a complex network of cells that carries information to and from all parts of the body.
- The brain is made up of two types of cells, neurons and glial cells.
- Neurons have four primary components: dendrites that receive input, a soma or cell body, axons that carry the neural message to other cells, and axon terminals that are the site of neurotransmitter release.
- Glial cells separate, support, and insulate the neurons from each other and influence thinking, memory, and other forms of cognition.
- Myelin insulates and protects the axons of neurons that travel in the body. These axons bundle together in “cables” called nerves. Myelin also speeds up the neural message.
- A neuron contains charged particles called ions. When at rest, the neuron is negatively charged on the inside and positively charged on the outside. When stimulated, this reverses the charge by allowing positive sodium ions to enter the cell. This is the action potential.
- Neurons fire in an all-or-nothing manner. It is the speed and number of neurons firing that tell researchers the strength of the stimulus.

2.2 How do neurons use neurotransmitters to communicate with each other and with the body?

- Synaptic vesicles in the end of the axon terminal release neurotransmitter chemicals into the synapse, or gap, between one cell and the next. The neurotransmitter molecules fit into receptor sites on the next cell, stimulating or inhibiting that cell's firing. Neurotransmitters may be either excitatory or inhibitory.
- The first known neurotransmitter was acetylcholine. It stimulates muscles, helps in memory formation, and plays a role in arousal and attention.
- GABA is the major inhibitory neurotransmitter; high amounts of GABA are released when drinking alcohol.
- Serotonin is associated with sleep, mood, and appetite.
- Dopamine is associated with Parkinson's disease and schizophrenia.
- Endorphins are neural regulators that control our pain response.
- Most neurotransmitters are taken back into the synaptic vesicles in a process called reuptake.
- Acetylcholine is cleared out of the synapse by enzymes that break up the molecules.

An Overview of the Nervous System

2.3 How do the brain and spinal cord interact, what are some misconceptions about the brain, and what is neuroplasticity?

- The central nervous system consists of the brain and the spinal cord.
- The spinal cord serves two functions. The outer part of the cord transmits messages to and from the brain, whereas the inner part controls lifesaving reflexes such as the pain response.

- Spinal cord reflexes involve afferent neurons, interneurons, and efferent neurons, forming a simple reflex arc.
- The peripheral nervous system is all the neurons and nerves that are not part of the brain and spinal cord and that extend throughout the body.
- There are two systems within the peripheral nervous system, the somatic nervous system and the autonomic nervous system.
- Some common misconceptions about the brain are that older brains can't make new cells and that people use only 10 percent of their brain. It is important to use critical thinking skills to evaluate news stories about the brain.
- Neuroplasticity refers to the brain's ability to modify its structure and function as the result of experience or injury; researchers are examining ways to capitalize on this feature to assist individuals with brain injury or disease.

2.4 How do the somatic and autonomic nervous systems allow people and animals to interact with their surroundings and control the body's automatic functions?

- The somatic nervous system contains the sensory pathway, or neurons carrying messages to the central nervous system, and the motor pathway, or neurons carrying messages from the central nervous system to the voluntary muscles.
- The autonomic nervous system consists of the parasympathetic division and the sympathetic division. The sympathetic division is our fight-or-flight system, reacting to stress, whereas the parasympathetic division is our eat-drink-and-rest system that restores and maintains normal day-to-day functioning of the organs.

Distant Connections: The Endocrine Glands

2.5 How do the hormones released by glands interact with the nervous system and affect behavior?

- Endocrine glands secrete chemicals called hormones directly into the bloodstream, influencing the activity of the muscles and organs.
- The pituitary gland is found in the brain just below the hypothalamus. Among its many functions, it helps us conserve water and controls oxytocin, a hormone involved in the onset of labor and lactation. The pituitary also regulates growth hormone and influences the activity of the other glands.
- The pineal gland is also located in the brain. It secretes melatonin, a hormone that regulates the sleep-wake cycle, in response to changes in light.
- The thyroid gland is located inside the neck. It controls metabolism (the burning of energy) by secreting thyroxin.
- The pancreas controls the level of sugar in the blood by secreting insulin and glucagons. Too much insulin produces hypoglycemia, whereas too little causes diabetes.
- The gonads are the ovaries in women and testes in men. They secrete hormones to regulate sexual growth, activity, and reproduction.
- The adrenal glands, one on top of each kidney, control the stress reaction through the adrenal medulla's secretion of epinephrine and norepinephrine. The adrenal cortex secretes over 30 different corticoids (hormones), controlling salt intake, stress, and sexual development.

Looking Inside the Living Brain

2.6 How do psychologists study the brain and how it works?

- We can study the brain by using lesioning techniques to destroy certain areas of the brain in laboratory animals or by electrically stimulating those areas (ESB).
- We can use case studies of human brain damage to learn about the brain's functions but cannot easily generalize from one case to another.
- rTMS and tDCS are noninvasive methods for stimulating the brain.
- Different neuroimaging methods allow scientists to investigate the structure or the function of the living brain.
- The electroencephalograph allows researchers to look at the electroencephalogram (EEG), or electrical activity of the surface of the brain, through the use of electrodes placed on the scalp that are then amplified and viewed using a computer. ERPs allow researchers to look at the timing and progression of cognitive processes.
- CT scans are computer-aided X-rays of the brain and show the skull and brain structure.
- MRI scans use a magnetic field, radio pulses, and a computer to give researchers an even more detailed look at the structure of the brain.
- fMRI allows researchers to look at the activity of the brain over a time period.
- PET scans use a radioactive sugar injected into the bloodstream to track the activity of brain cells, which is enhanced and color-coded by a computer. SPECT allows for the imaging of brain blood flow.

From the Bottom Up: The Structures of the Brain

2.7 What are the different structures of the hindbrain and what do they do?

- The medulla is at the very bottom of the brain and at the top of the spinal column. It controls life-sustaining functions such as breathing and swallowing. The nerves from each side of the body also cross over in this structure to opposite sides.
- The pons is above the medulla and acts as a bridge between the lower part of the brain and the upper part. It influences sleep, dreaming, arousal, and coordination of movement on the left and right sides of the body.
- The reticular formation runs through the medulla and the pons and controls our general level of attention and arousal.
- The cerebellum is found at the base and back of the brain and coordinates fine, rapid motor movement, learned reflexes, posture, and muscle tone. It may also be involved in some cognitive and emotional functions.

2.8 What are the structures of the brain that control emotion, learning, memory, and motivation?

- The limbic system consists of the thalamus, hypothalamus, hippocampus, and amygdala.
- The thalamus is the relay station that sends sensory information to the proper areas of the cortex.
- The hypothalamus controls hunger, thirst, sexual behavior, sleeping and waking, and emotions. It also controls the pituitary gland.

- The hippocampus is the part of the brain responsible for the formation of long-term declarative memories.

- The amygdala controls our fear responses and memory of fearful stimuli.

2.9 What parts of the cortex control the different senses and the movement of the body?

- The cortex is the outer covering of the cerebrum and consists of a tightly packed layer of neurons about one tenth of an inch in thickness. Its wrinkles, or corticalization, allow for greater cortical area and are associated with greater brain complexity.
- The cortex is divided into two cerebral hemispheres connected by a thick band of neural fibers called the corpus callosum.
- The occipital lobes at the back and base of each hemisphere process vision and contain the primary visual cortex.
- The parietal lobes at the top and back of the cortex contain the somatosensory area, which processes our sense of touch, temperature, and body position.
- The temporal lobes contain the primary auditory area and are also involved in understanding language.
- The frontal lobes contain the motor cortex, which controls the voluntary muscles, and are also where all the higher mental functions occur, such as planning, language, and complex decision making.

2.10 What parts of the cortex are responsible for higher forms of thought, such as language?

- Association areas of the cortex are found in all the lobes but particularly in the frontal lobes. These areas help people make sense of the information they receive from primary sensory areas and the lower areas of the brain.
- A region called Broca's area in the left frontal lobe is responsible for producing fluent, understandable speech. If damaged, the person has Broca's aphasia, in which words will be halting and pronounced incorrectly.
- An area called Wernicke's area in the left temporal lobe is responsible for the understanding of language. If damaged, the person has Wernicke's aphasia, in which speech is fluent but nonsensical. The wrong words are used.

2.11 How does the left side of the brain differ from the right side?

- Studies with split-brain patients, in which the corpus callosum has been severed to correct epilepsy, reveal that the left side of the brain seems to control language, writing, logical thought, analysis, and mathematical abilities. The left side also processes information sequentially.
- The right side of the brain processes information globally and controls emotional expression, spatial perception, recognition of faces, patterns, melodies, and emotions. Information presented only to the left hemisphere can be verbalized, but information only sent to the right cannot.

Applying Psychology to Everyday Life: Paying Attention to Attention-Deficit/ Hyperactivity Disorder

2.12 What are some potential causes of attention-deficit/hyperactivity disorder?

- ADHD is often diagnosed in children but may persist into adulthood. Multiple causes are possible including genetic, environmental, and several differences in brain structure and function.

test YOURSELF

ANSWERS AVAILABLE IN ANSWER KEY.

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Chapter Test:

- 1.** In the structure of the neuron, the _____ receives messages from other cells.
a. axon **c.** soma
b. dendrite **d.** myelin
- 2.** Oligodendrocytes and Schwann cells generate a fatty substance known as
a. glial. **c.** myelin.
b. soma. **d.** neurilemma.
- 3.** Which of the following insulates and protects a neuron's axon, as well as helps to speed along electrical impulses?
a. synaptic knobs **c.** myelin sheath
b. receptor sites **d.** neuromodulators
- 4.** When a neuron is in the resting potential state, the neuron is negatively charged on the _____ and positively charged on the _____.
a. inside; outside **c.** top; bottom
b. outside; inside **d.** bottom; top
- 5.** Which neurotransmitter stimulates muscle cells to contract but slows contractions in the heart?
a. acetylcholine **c.** serotonin
b. GABA **d.** endorphin
- 6.** Heroin mimics the actions of endorphins, inhibiting pain signals and creating a "high" feeling. Heroin is an example of a(n):
a. protagonist. **c.** agonist.
b. antagonist. **d.** glial cell.
- 7.** Involuntary muscles are controlled by the _____ nervous system.
a. somatic **c.** sympathetic
b. autonomic **d.** parasympathetic
- 8.** As you take notes, your heart beats at a normal rate. Your breathing is normal and your stomach slowly digests your earlier meal. What division of the peripheral nervous system is currently in action?
a. sympathetic **c.** autonomic
b. parasympathetic **d.** somatic
- 9.** Robert has had difficulty sleeping for the past 6 months and his body seemingly no longer differentiates between night and day. His doctor believes the problem lies with Robert's endocrine system. What gland will Robert's physician focus on?
a. pituitary **c.** thyroid
b. adrenal **d.** pineal
- 10.** Which gland(s) is/are known to influence all other glands within the endocrine system?
a. pineal gland **c.** thyroid gland
b. pituitary gland **d.** adrenal glands
- 11.** Bailey is a subject in a study on memory and problem solving. The researcher is applying magnetic pulses to her brain through copper wire coils positioned directly above her scalp. Bailey's study would best be described as a(n)
a. invasive stimulation technique.
b. noninvasive stimulation technique.
c. EEG technique.
d. PET technique.
- 12.** Which technique of studying the brain involves injecting the patient with radioactive glucose?
a. EEG **c.** MRI
b. CT **d.** PET
- 13.** Maria often sleeps soundly and rarely awakens to any outside noise. However, the cries of Maria's baby can awaken her immediately. What part of the brain is responsible for this reaction?
a. medulla **c.** reticular formation
b. pons **d.** cerebellum
- 14.** Alexis and Theresa are synchronized swimmers for their college swim team. They often work long hours to ensure the movements in their routine are perfectly timed. What part of their brains must Alexis and Theresa rely most upon?
a. medulla **c.** reticular formation
b. pons **d.** cerebellum
- 15.** Your psychology professor refers to this as the great relay station of the brain. What part is he or she referring to?
a. thalamus **c.** hippocampus
b. hypothalamus **d.** amygdala
- 16.** Which part of the brain is involved in the creation of memories and is often linked to Alzheimer's disease?
a. hippocampus **c.** thalamus
b. thalamus **d.** hypothalamus
c. hypothalamus **d.** amygdala
- 17.** Jessica has suffered a severe blow to the back of her head when she was thrown from her horse. Subsequently, her occipital lobe has been injured. Which of her senses has the highest chance of being affected?
a. hearing **c.** taste and smell
b. touch **d.** vision
- 18.** Jaime's grandfather recently suffered a stroke and has had difficulty with language production ever since. Most likely, he has experienced damage to the _____ area of his brain.
a. right rear **c.** left frontal
b. left frontal **d.** left rear
c. left rear **d.** right frontal
- 19.** Felicia is recovering from a brain injury. She is able to speak fluently but often uses incorrect words in a sentence. In one instance at a friend's birthday party, she said, "I would like something to drink. Can I have some battery?" Felicia's problem is known as
a. spatial neglect.
b. visual agnosia.
c. Broca's aphasia.
d. Wernicke's aphasia.
- 20.** Although the brain works largely as a whole, which of the following is not a correct pairing of hemisphere and function?
a. left; control of right-handed motor functions
b. right; control of right-handed motor functions
c. right; recognition of faces
d. left; reading

3

sensation and perception

Taria Camerino is a pastry chef who experiences music, colors, shapes, and emotions as taste, Jamie Smith is a sommelier, or wine steward, who experiences smells as colors and shapes, and James Wannerton is an information technology consultant who experiences sounds, words, and colors as tastes and textures (Carlsen, 2013, March 18). All three of these individuals have a condition known as **synesthesia**, which literally means “joined sensation.” Recent studies suggest roughly 2%–4% of the population may experience some form of synesthesia. While the causes of synesthesia are still being investigated, it appears in some forms that signals that come from the sensory organs, such as the eyes or the ears, go to places in the brain where they weren’t originally meant to be or are processed differently. Overall, there is increased communication between sensory regions that results in synesthetes experiencing the world differently than others.

Which of your sensory abilities do you rely on most during a typical day? Are certain senses more important than others depending on the social context or setting?

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Why study sensation and perception?

Without sensations to tell us what is outside our own mental world, we would live entirely in our own minds, separate from one another and unable to find food or any other basics that sustain life. Sensations are the mind's window to the world that exists around us.

Without perception, we would be unable to understand what all those sensations mean—perception is the process of interpreting the sensations we experience so that we can act upon them.

Learning objectives

- 3.1** How does sensation travel through the central nervous system, and why are some sensations ignored?
- 3.2** What is light, and how does it travel through the various parts of the eye?
- 3.3** How do the eyes see, and how do the eyes see different colors?
- 3.4** What is sound, and how does it travel through the various parts of the ear?
- 3.5** Why are some people unable to hear, and how can their hearing be improved?
- 3.6** How do the senses of taste and smell work, and how are they alike?
- 3.7** What allows people to experience the sense of touch, pain, motion, and balance?
- 3.8** What are perception and perceptual constancies?
- 3.9** What are the Gestalt principles of perception?
- 3.10** What is depth perception and what kind of cues are important for it to occur?
- 3.11** What are visual illusions and how can they and other factors influence and alter perception?



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The ABCs of Sensation

How does sensation travel through the central nervous system, and why are some sensations ignored?



 How do we get information from the outside world into our brains?

Information about the world has to have a way to get into the brain, where it can be used to determine actions and responses. The way into the brain is through the sensory organs and the process of sensation.

WHAT IS SENSATION?

Sensation occurs when special receptors in the sense organs—the eyes, ears, nose, skin, and taste buds—are activated, allowing various forms of outside stimuli to become neural signals in the brain. This process of converting outside stimuli, such as light, into neural activity is called **transduction**.  [Watch the Video, The Big Picture: Taking in the World Around Us, at MyPsychLab](#)

The *sensory receptors* are specialized forms of neurons, the cells that make up the nervous system. Instead of receiving neurotransmitters from other cells, these receptor cells are stimulated by different kinds of energy—for example, the receptors in the eyes are stimulated by light, whereas the receptors in the ears are activated by vibrations. Touch receptors are stimulated by pressure or temperature, and the receptors for taste and smell are triggered by chemical substances. Each receptor type transduces the physical information into electrical information in different ways, which then either depolarizes or hyperpolarizes the cell, causing it to fire more or to fire less based on the timing and intensity of information it is detecting from the environment (Gardner & Johnson, 2013).



In some parts of the United States, “coffee regular” refers to coffee with two creams and two sugars. How much more sugar would you need to add to taste a difference?

SENSORY THRESHOLDS

Ernst Weber (1795–1878) did studies trying to determine the smallest difference between two weights that could be detected. His research led to the formulation known as Weber’s law of **just noticeable differences (jnd, or the difference threshold)**. A jnd is the smallest difference between two stimuli that is detectable 50 percent of the time, and Weber’s law simply means that whatever the difference between stimuli might be, it is always a *constant*. If to notice a difference the amount of sugar a person would need to add to a cup of coffee that is already

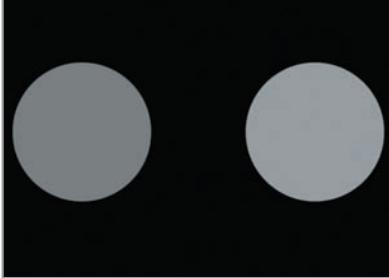
sweetened with 5 teaspoons is 1 teaspoon, then the percentage of change needed to detect a just noticeable difference is one fifth, or 20 percent. So if the coffee has 10 teaspoons of sugar in it, the person would have to add another 20 percent, or 2 teaspoons, to be able to taste the difference half of the time. Most people would not typically drink a cup of coffee with 10 teaspoons of sugar in it, let alone 12 teaspoons, but you get the point. To see a visual example of this, participate in the experiment *Weber's Law* and discover the amount of change needed to detect a just noticeable difference between two circles of light.

Simulation

Weber's Law

In this experiment, you will be presented a series of boxes containing two circles of light. In each presentation, the circles will either be the same brightness or color saturation or they will vary in brightness or color saturation. Your task is to decide if the two circles appear to have the same brightness or different brightness.

[Go to the Experiment ▶](#)



Simulate the Experiment, Weber's Law, on [MyPsychLab](#)

Gustav Fechner (1801–1887) expanded on Weber's work by studying something he called the **absolute threshold** (Fechner, 1860). An absolute threshold is the lowest level of stimulation that a person can consciously detect 50 percent of the time the stimulation is present. (Remember, the jnd is detecting a difference *between two* stimuli.) For example, assuming a very quiet room and normal hearing, how far away can someone sit and you might still hear the tick of their analog watch on half of the trials? For some examples of absolute thresholds for various senses, see Table 3.1.

Table 3.1

Examples of Absolute Thresholds

SENSE	THRESHOLD
Sight	A candle flame at 30 miles on a clear, dark night
Hearing	The tick of a watch 20 feet away in a quiet room
Smell	One drop of perfume diffused throughout a three-room apartment
Taste	1 teaspoon of sugar in 2 gallons of water
Touch	A bee's wing falling on the cheek from 1 centimeter above

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 I've heard about people being influenced by stuff in movies and on television, things that are just below the level of conscious awareness. Is that true?

Stimuli that are below the level of conscious awareness are called *subliminal stimuli*. (The word *limin* means “threshold,” so *sublimin* means “below the threshold.”) These stimuli are just strong enough to activate the sensory receptors but not strong enough for people to be consciously aware of them. Many people believe that these stimuli act upon the unconscious mind, influencing behavior in a process called *subliminal perception*.

At one time, many people believed that a market researcher named James Vicary had demonstrated the power of subliminal perception in advertising. In 1957, Vicary claimed that over a 6-week period, 45,699 patrons at a movie theater in Fort Lee, New Jersey, were shown two advertising messages, *Eat Popcorn* and *Drink Coca-Cola*, while they watched the film *Picnic*. According to Vicary, these messages were flashed for 3 milliseconds once every 5 seconds. Vicary claimed that over the 6-week period the sales of popcorn rose 57.7 percent and the sales of Coca-Cola rose 18.1 percent. It was 5 years before Vicary finally admitted that he had never conducted a real study (Merikle, 2000; Pratkanis, 1992). Furthermore, many researchers have gathered scientific evidence that subliminal perception does not work in advertising (Bargh et al., 1996; Broyles, 2006; Moore, 1988; Pratkanis & Greenwald, 1988; Trappey, 1996; Vokey & Read, 1985).

This is not to say that subliminal perception does not exist—there is a growing body of evidence that we process some stimuli without conscious awareness, especially stimuli that are fearful or threatening (LeDoux & Phelps, 2008; Öhman, 2008). In this effort, researchers have used *event-related potentials* (ERPs) and functional magnetic resonance imaging (fMRI) to verify the existence of subliminal perception and associated learning in the laboratory (Babiloni et al., 2010; Bernat et al., 2001; Fazel-Rezai & Peters, 2005; Sabatini et al., 2009).  to Learning Objective 2.6. The stimuli used in these studies are detectable by our sensory systems but below the level of full conscious perception. Participants are not aware or conscious that they have been exposed to the stimuli due to masking or manipulation of attention. Furthermore, the stimuli typically influence automatic reactions (such as an increase in facial tension) rather than direct voluntary behaviors (such as going to buy something suggested by advertising).

HABITUATION AND SENSORY ADAPTATION

Some of the lower centers of the brain filter sensory stimulation and “ignore” or prevent conscious attention to stimuli that do not change. The brain is primarily interested in changes in information. That’s why people don’t really “hear” the noise of the air conditioner unless it suddenly cuts off, or the noise made in some classrooms, unless it gets very quiet or someone else directs their attention toward it. Although they actually are *hearing* it, they aren’t paying attention to it. This is called **habituation**, and it is the way the brain deals with unchanging information from the environment.  to Learning Objective 2.7.

 Sometimes I can smell the odor of the garbage can in the kitchen when I first come home, but after a while the smell seems to go away—is this also habituation?

Although different from habituation, **sensory adaptation** is another process by which constant, unchanging information from the sensory receptors is effectively



This young woman does not feel the piercings on her ear and nose because sensory adaptation allows her to ignore a constant, unchanging stimulation from the metal rings. What else is she wearing that would cause sensory adaptation?

ignored. In habituation, the sensory receptors are still responding to stimulation but the lower centers of the brain are not sending the signals from those receptors to the cortex. The process of sensory adaptation differs because the receptor cells *themselves* become less responsive to an unchanging stimulus—garbage odors included—and the receptors no longer send signals to the brain.

For example, when you eat, the food that you put in your mouth tastes strong at first, but as you keep eating the same thing, the taste does fade somewhat, doesn't it? Generally speaking, all of our senses are subject to sensory adaptation.

You might think, then, that if you stare at something long enough, it would also disappear, but the eyes are a little different. Even though the sensory receptors in the back of the eyes adapt to and become less responsive to a constant visual stimulus, under ordinary circumstances the eyes are never entirely still. There's a constant movement of the eyes, tiny little vibrations called "microsaccades" or "saccadic movements" that people don't consciously notice. These movements keep the eyes from adapting to what they see. (That's a good thing, because otherwise many students would no doubt go blind from staring off into space.)

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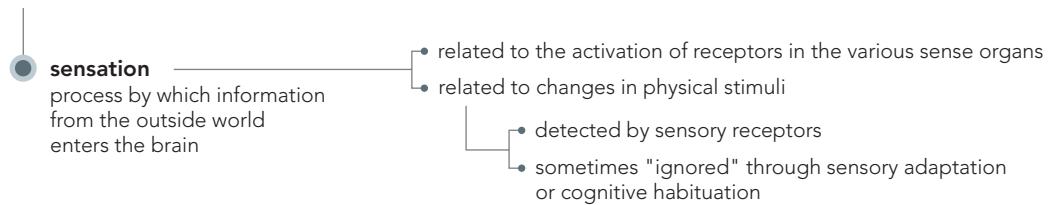
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3.1**The ABCs of Sensation**
 Explore the Concept at [MyPsychLab](#)
CONCEPT MAP**PRACTICE QUIZ** How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. _____ involves the detection of physical stimuli from our environment and is made possible by the activation of specific receptor cells.
 - a. Perception
 - b. Sublimination
 - c. Adaptation
 - d. Sensation
2. The lowest level of stimulation that a person can consciously detect 50 percent of the time the stimulation is present is called
 - a. absolute threshold.
 - b. just noticeable difference.
 - c. sensation.
 - d. sensory adaptation.
3. After being in class for a while, _____ is a likely explanation for not hearing the sound of the lights buzzing above you until someone says something about it.
 - a. accommodation
 - b. adaptation
 - c. sublimination
 - d. habituation
4. You are drinking a strong cup of coffee that is particularly bitter. After a while, the coffee doesn't taste as strong as it did when you first tasted it. What has happened?
 - a. sensory adaptation
 - b. subliminal perception
 - c. habituation
 - d. perceptual defense

THINKING CRITICALLY:

Do you think subliminally presented stimuli could cause someone to buy a particular product? Why or why not?

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The Science of Seeing

 I've heard that light is waves, but I've also heard that light is made of particles—which is it?

Light is a complicated phenomenon. Although scientists have long argued over the nature of light, they finally have agreed that light has the properties of both waves and particles. The following section gives a brief history of how scientists have tried to “shed light” on the mystery of light.

PERCEPTUAL PROPERTIES OF LIGHT: CATCHING THE WAVES

What is light, and how does it travel through the various parts of the eye?

It was Albert Einstein who first proposed that light is actually tiny “packets” of waves. These “wave packets” are called *photons* and have specific wavelengths associated with them (Lehnert, 2007; van der Merwe & Garuccio, 1994).

When people experience the physical properties of light, they are not really aware of its dual, wavelike and particle-like, nature. With regard to its psychological properties, there are three aspects to our perception of light: *brightness*, *color*, and *saturation*.

Brightness is determined by the amplitude of the wave—how high or how low the wave actually is. The higher the wave, the brighter the light appears to be. Low waves are dimmer. *Color*, or hue, is largely determined by the length of the wave. Long wavelengths (measured in nanometers) are found at the red end of the *visible spectrum* (the portion of the whole spectrum of light that is visible to the human eye; see Figure 3.1), whereas shorter wavelengths are found at the blue end.

Saturation refers to the purity of the color people perceive: A highly saturated red, for example, would contain only red wavelengths, whereas a less-saturated red might contain a mixture of wavelengths. For example, when a child is using the red paint from a set of poster paints, the paint on the paper will look like a pure red, but if the child mixes in some white paint, the paint will look pink. The hue is still red but it will be less of a saturated red because of the presence of white wavelengths. Mixing in black or gray would also lessen the saturation. (Note that when combining different colors, light works differently than pigments or paint. We will look at this distinction when we examine perception of color).

THE STRUCTURE OF THE EYE

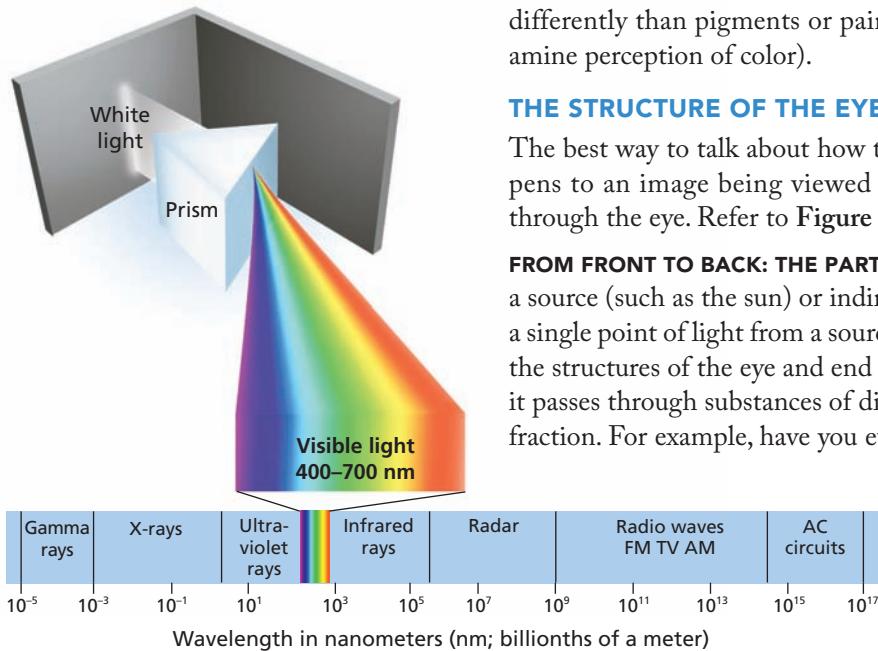
The best way to talk about how the eye processes light is to talk about what happens to an image being viewed as the photons of light from that image travel through the eye. Refer to Figure 3.2 to follow the path of the image.

FROM FRONT TO BACK: THE PARTS OF THE EYE Light enters the eye directly from a source (such as the sun) or indirectly by reflecting off of an object. To see clearly, a single point of light from a source or reflected from an object must travel through the structures of the eye and end up on the retina as a single point. Light bends as it passes through substances of different densities, through a process known as refraction. For example, have you ever looked at a drinking straw in a glass of water

through the side of the glass? It appears that the straw bends, or is broken, at the surface of the water. That optical illusion is due to the refraction of light. The structures of the eye play a vital role in both collecting and focusing of light so we can see clearly.

Figure 3.1 The Visible Spectrum

The wavelengths that people can see are only a small part of the whole electromagnetic spectrum.



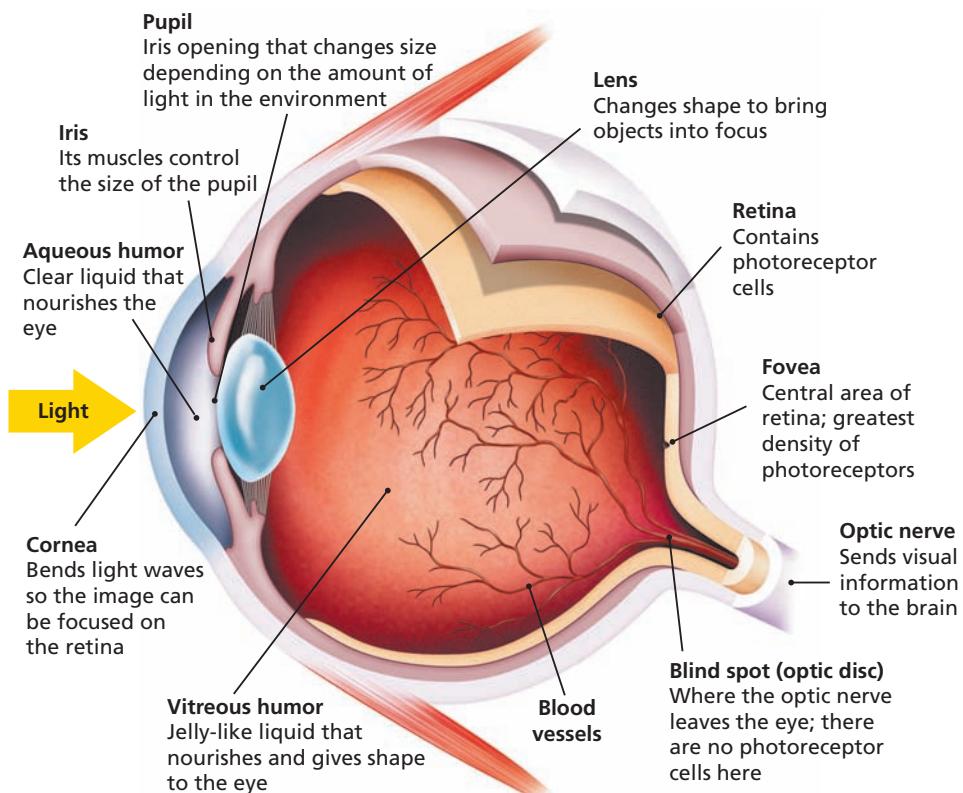


Figure 3.2 Structure of the Eye

Light enters the eye through the cornea and pupil. The iris controls the size of the pupil. From the pupil, light passes through the lens to the retina, where it is transformed into nerve impulses. The nerve impulses travel to the brain along the optic nerve.

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The surface of the eye is covered in a clear membrane called the *cornea*. The cornea not only protects the eye but also is the structure that focuses most of the light coming into the eye. The cornea has a fixed curvature, like a camera that has no option to adjust the focus. However, this curvature can be changed somewhat through vision-improving techniques that change the shape of the cornea. For example, ophthalmologists, physicians who specialize in medical and surgical treatment of eye problems, can use both *photoreactive keratectomy (PRK)* and *laser-assisted in situ keratomileusis (LASIK)* procedures to remove small portions of the cornea, changing its curvature, and thus the focus in the eye.

The next visual layer is a clear, watery fluid called the *aqueous humor*. This fluid is continually replenished and supplies nourishment to the eye. The light from the visual image then enters the interior of the eye through a hole, called the *pupil*, in a round muscle called the *iris* (the colored part of the eye). The iris can change the size of the pupil, letting more or less light into the eye. That also helps focus the image; people try to do the same thing by squinting.

Behind the iris, suspended by muscles, is another clear structure called the *lens*. The flexible lens finishes the focusing process begun by the cornea. In a process called **visual accommodation**, the lens changes its shape from thick to thin, enabling it to focus on objects that are close or far away. The variation in thickness allows the lens to project a sharp image on the retina. People lose this ability as the lens hardens through aging (a disorder called *presbyopia*). Although people try to compensate* for their inability to focus on things that are close to them, eventually they usually need bifocals because their arms just aren't long enough anymore. In nearsightedness, or *myopia*, visual accommodation may occur but the shape of the eye causes the focal point to fall short of the retina. In farsightedness, or *hyperopia*, the focus point is behind the retina (see Figure 3.3 on the next page). Glasses, contacts, or corrective surgery like LASIK or PRK can correct these issues.

*compensate: to correct for an error or defect.



This photo illustrates an optical illusion caused by the refraction of light. The straw is not really broken although it appears that way.

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Figure 3.3 Nearsightedness and Farsightedness

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Once past the lens, light passes through a large, open space filled with a clear, jelly-like fluid called the *vitreous humor*. This fluid, like the aqueous humor, also nourishes the eye and gives it shape.

RETINA, RODS, AND CONES The final stop for light within the eye is the *retina*, a light-sensitive area at the back of the eye containing three layers: ganglion cells, bipolar cells, and the **rods** and **cones**, special receptor cells (*photoreceptors*) that respond to the various wavelengths of light. (See Figures 3.4a and b.) While the retina is responsible for absorbing and processing light information, the rods and the cones are the business end of the retina—the part that actually receives the photons of light and turns them into neural signals for the brain, sending them first to the *bipolar cells* (a type of interneuron; called bipolar or “two-ended” because they have a single dendrite at one end and a single axon on the other; [LINK](#) to Learning Objective 2.3) and then to the retinal *ganglion cells* whose axons form the optic nerve. (See Figure 3.4a.)

The rods and cones are responsible for different aspects of vision. There are 6 million cones in each eye; of these, 50,000 have a private line to the optic nerve (one bipolar cell for each cone). This means that the cones are the receptors for visual acuity, or ability, to see fine detail. Cones are located all over the retina but are more concentrated at its very center where there are no rods (the area called the *fovea*). (See Figure 3.4a.) Cones also need a lot more light to function than the rods do, so cones work best in bright light, which is also when people see things most clearly. Cones are also sensitive to different wavelengths of light, so they are responsible for color vision.

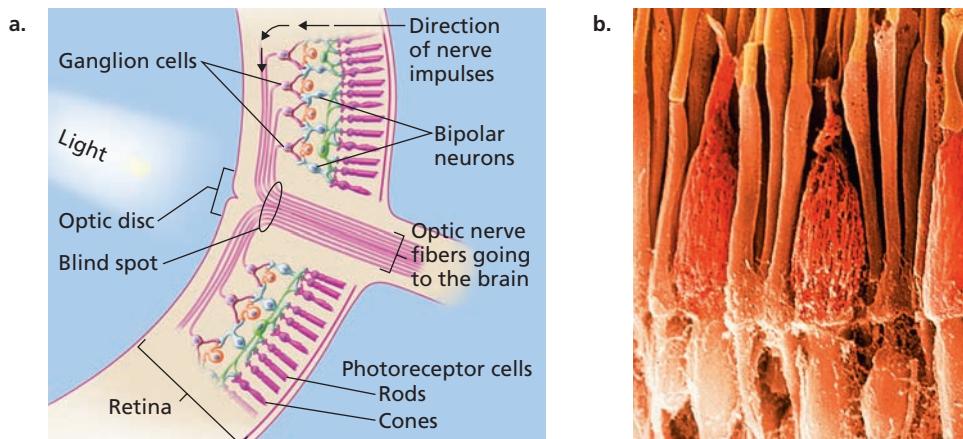


Figure 3.4 The Parts of the Retina

(a) Light passes through ganglion and bipolar cells until it reaches and stimulates the rods and cones. Nerve impulses from the rods and cones travel along a nerve pathway to the brain. (b) On the right of the figure is a photomicrograph of the long, thin rods and the shorter, thicker cones; the rods outnumber the cones by a ratio of about 20 to 1. (c) The blind spot demonstration. Hold the book in front of you. Close your right eye and stare at the picture of the dog with your left eye. Slowly bring the book closer to your face. The picture of the cat will disappear at some point because the light from the picture of the cat is falling on your blind spot. If you cannot seem to find your blind spot, try moving the book more slowly.

The rods (about 100 million of them in each eye) are found all over the retina except the *fovea*, but are concentrated in the periphery. Rods are sensitive to changes in brightness but not to a variety of wavelengths, so they see only in black and white and shades of gray. They can be very sensitive because many rods are connected to a single bipolar cell, so that if even only one rod is stimulated by a photon of light, the brain perceives the whole area of those rods as stimulated. But because the brain doesn't know exactly what part of the area (which rod) is actually sending the message, the visual acuity (sharpness) is quite low. That's why things seen in low levels of light, such as twilight or a dimly lit room, are fuzzy and grayish. Because rods are located on the periphery of the retina, they are also responsible for peripheral vision.

THE BLIND SPOT The eyes don't adapt to constant stimuli under normal circumstances because of saccadic movements. But if people stare with one eye at one spot long enough, objects that slowly cross their visual field may at one point disappear briefly because there is a "hole" in the retina—the place where all the axons of those ganglion cells leave the retina to become the optic nerve, the *optic disk*. There are no rods or cones here, so this is referred to as the **blind spot**. You can demonstrate the blind spot for yourself by following the directions in Figure 3.4c.

HOW THE EYE WORKS

How do the eyes see, and how do the eyes see different colors?

You may want to first look at Figure 3.5 for a moment before reading this section. Light entering the eyes can be separated into the left and right visual fields. Light from the right visual field falls on the left side of each eye's retina; light from the left visual field falls on the right side of each retina. Light travels in a straight line through the cornea and lens, resulting in the image projected on the retina actually being upside down and reversed from left to right as compared to the visual fields. Thank goodness our brains can compensate for this!

The areas of the retina can be divided into halves, with the halves toward the temples of the head referred to as the temporal retinas and the halves toward the center, or

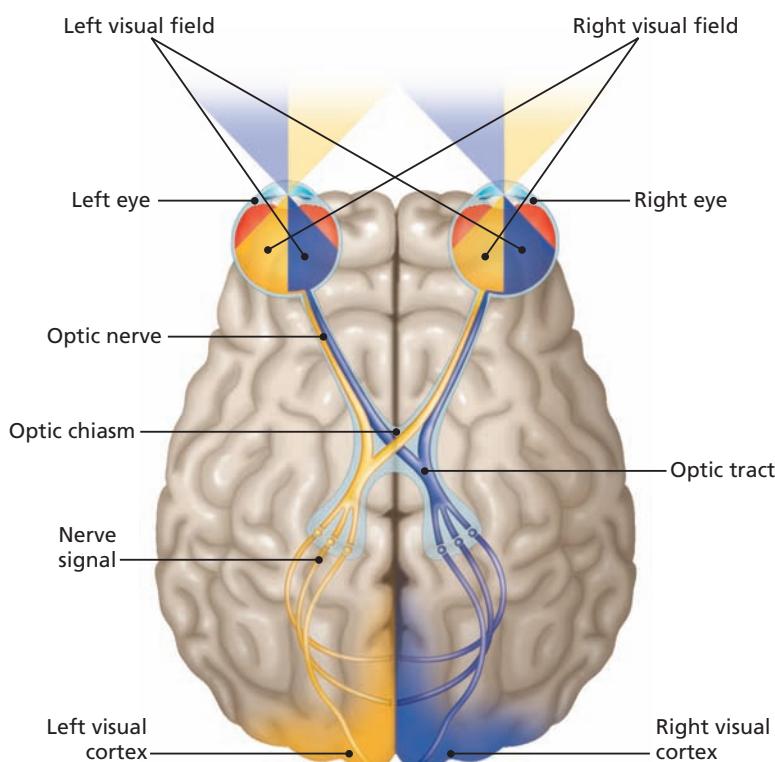


Figure 3.5 Crossing of the Optic Nerve

Light falling on the left side of each eye's retina (from the right visual field, shown in yellow) will stimulate a neural message that will travel along the optic nerve to the thalamus, and then on to the visual cortex in the occipital lobe of the left hemisphere. Notice that the message from the temporal half of the left retina goes to the left occipital lobe, while the message from the nasal half of the right retina crosses over to the left hemisphere (the optic chiasm is the point of crossover). The optic nerve tissue from both eyes joins together to form the left optic tract before going on to the thalamus and the left occipital lobe. For the left visual field (shown in blue), the messages from both right sides of the retinas will travel along the right optic tract to the right visual cortex in the same manner.

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While this deer may seem to see relatively well at night, the oncoming headlights of a car will briefly blind it. It may only take a few seconds for light adaption to occur, but until it does, the deer is unable to fully see, so it does not move.

nose, called the nasal retinas. Look at Figure 3.5 again. Notice that the information from the left visual field (falling on the right side of each retina) goes to the right visual cortex, while the information from the right visual field (falling on the left side of each retina) goes to the left visual cortex. This is because the axons from the temporal halves of each retina project to the visual cortex on the same side of the brain while the axons from the nasal halves cross over to the visual cortex on the opposite side of the brain. The optic chiasm is the point of crossover.

Because rods work well in low levels of light, they are also the cells that allow the eyes to adapt to low light. **Dark adaptation** occurs as the eye recovers its ability to see when going from a brightly lit state to a dark state. (The light-sensitive pigments that allow us to see are able to regenerate or “recharge” in the dark.) The brighter the light was, the longer it takes the rods to adapt to the new lower levels of light (Bartlett, 1965). This is why the bright headlights of an oncoming car can leave a person less able to see for a while after that car has passed. Fortunately, this is usually a temporary condition because the bright light was on so briefly and the rods readapt to the dark night relatively quickly. Full dark adaptation, which occurs when going from more constant light to darkness, such as turning out one’s bedroom lights, takes about 30 minutes. As people get older this process takes longer, causing many older persons to be less able to see at night and in darkened rooms (Klaver et al., 1998). This age-related change can cause *night blindness*, in which a person has difficulty seeing well enough to drive at night or get around in a darkened room or house. Some research indicates that taking supplements such as vitamin A can reverse or relieve this symptom in some cases (Jacobsen et al., 1995). When going from a darkened room to one that is brightly lit, the opposite process occurs. The cones have to adapt to the increased level of light, and they accomplish this **light adaptation** much more quickly than the rods adapt to darkness—it takes a few seconds at most (Hood, 1998).

PERCEPTION OF COLOR

Earlier you said the cones are used in color vision. There are so many colors in the world—are there cones that detect each color? Or do all cones detect all colors?

Although experts in the visual system have been studying color and its nature for many years, at this point in time there is an ongoing theoretical discussion about the role the cones play in the sensation of color.

TRICHROMATIC THEORY Two theories about how people see colors were originally proposed in the 1800s. The first is called the **trichromatic (“three colors”) theory**. First proposed by Thomas Young in 1802 and later modified by Hermann von Helmholtz in 1852, this theory proposed three types of cones: red cones, blue cones, and green cones, one for each of the three primary colors of light.

Most people probably think that the primary colors are red, yellow, and blue, but these are the primary colors when talking about *painting*—not when talking about *light*. Paints reflect light, and the way reflected light mixes is different from the way direct light mixes. For example, if an artist were to blend red, yellow, and blue paints together, the result would be a mess—a black mess. The mixing of paint (reflected light) is subtractive, removing more light as you mix in more colors. As all of the colors are mixed, more light waves are absorbed and we see black. But if the artist were to blend a red, green, and blue light together by focusing lights of those three colors on one common spot, the result would be white, not black. The mixing of direct light is additive, resulting in lighter colors, more light, and when mixing red, blue, and green, we see white, the reflection of the entire visual spectrum.

In the trichromatic theory, different shades of colors correspond to different amounts of light received by each of these three types of cones. These cones then fire their message to the brain’s vision centers. It is the combination of cones and the rate at which they are firing that determine the color that will be seen. For example, if the

red and green cones are firing in response to a stimulus at fast enough rates, the color the person sees is yellow. If the red and blue cones are firing fast enough, the result is magenta. If the blue and green cones are firing fast enough, a kind of cyan color (blue-green) appears.

Paul K. Brown and George Wald (1964) identified three types of cones in the retina, each sensitive to a range of wavelengths, measured in nanometers (nm), and a peak sensitivity that roughly corresponds to three different colors (although hues/colors can vary depending on brightness and saturation). The peak wavelength of light the cones seem to be most sensitive to turns out to be just a little different from Young and von Helmholtz's original three corresponding colors: Short wavelength cones detect what we see as blue-violet (about 420 nm), medium wavelength cones detect what we see as green (about 530 nm), and long wavelength cones detect what we see as green-yellow (about 560 nm). Interestingly, none of the cones identified by Brown and Wald have a peak sensitivity to light where most of us see red (around 630 nm). Keep in mind, though, each cone responds to light across a range of wavelengths, not just its wavelength of peak sensitivity. Depending on the intensity of the light, both the medium and long wavelength cones respond to light that appears red.

OPPONENT-PROCESS THEORY The trichromatic theory would, at first glance, seem to be more than adequate to explain how people perceive color. But there's an interesting phenomenon that this theory cannot explain. If a person stares at a picture of the American flag for a little while—say, a minute—and then looks away to a blank white wall or sheet of paper, that person will see an afterimage of the flag. **Afterimages** occur when a visual sensation persists for a brief time even after the original stimulus is removed. The person would also notice rather quickly that the colors of the flag in the afterimage are all wrong—green for red, black for white, and yellow for blue. If you follow the directions for **Figure 3.6**, in which the flag is yellow, green, and black, you should see a flag with the usual red, white, and blue.



Hey, now the afterimage of the flag has normal colors! Why does this happen?

The phenomenon of the color afterimage is explained by the second theory of color perception, called the **opponent-process theory** (De Valois & De Valois, 1993; Hurvich & Jameson, 1957), based on an idea first suggested by Edwald Hering in 1874 (Finger, 1994). In opponent-process theory, there are four primary colors: red, green, blue, and yellow. The colors are arranged in pairs, with each member of the pair as opponents. Red is paired with its opponent green, and blue is paired with its opponent yellow. If one member of a

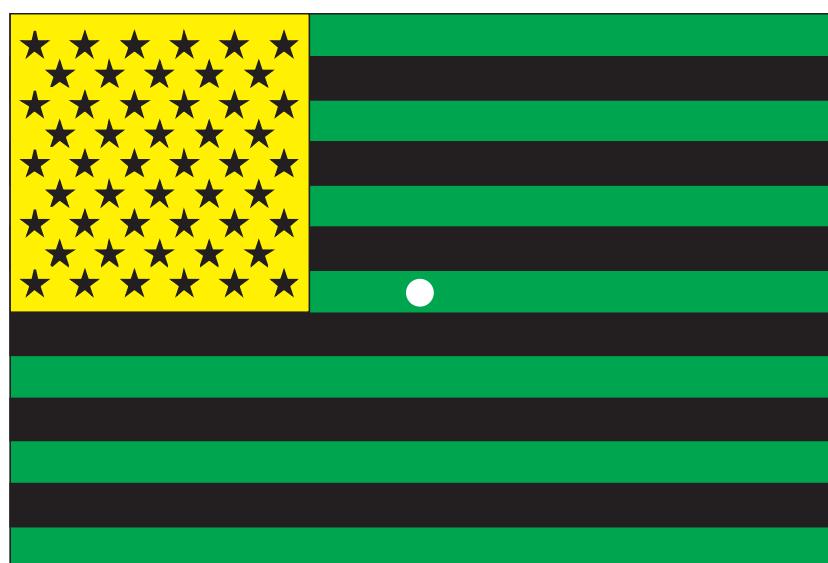


In trichromatic theory, the three types of cones combine to form different colors much as these three colored lights combine.

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Figure 3.6 Color Afterimage

Stare at the white dot in the center of this oddly colored flag for about 30 seconds. Now look at a white piece of paper or a white wall. Notice that the colors are now the normal, expected colors of the American flag. They are also the primary colors that are opposites of the colors in the picture and provide evidence for the opponent-process theory of color vision.



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pair is strongly stimulated, the other member is inhibited and cannot be working—so there are no reddish-greens or bluish-yellows.

So how can this kind of pairing cause a color afterimage? From the level of the bipolar and ganglion cells in the retina, all the way through the thalamus, and on to the visual cortical areas in the brain, some neurons (or groups of neurons) are stimulated by light from one part of the visual spectrum and inhibited by light from a different part of the spectrum. For example, let's say we have a red-green ganglion cell in the retina whose baseline activity is rather weak when we expose it to white light. However, the cell's activity is increased by red light, so we experience the color red. If we stimulate the cell with red light for a long enough period of time, the cell becomes fatigued. If we then swap out the red light with white light, the fatigued cell responds even less than the original baseline. Now we experience the color green, because green is associated with a decrease in the responsiveness of this cell.

So which theory is the right one? Both theories play a part in color vision. Trichromatic theory can explain what is happening with the raw stimuli, the actual detection of various wavelengths of light. Opponent-process theory can explain afterimages and other aspects of visual perception that occur after the initial detection of light from our environment. In addition to the retinal bipolar and ganglion cells, opponent-process cells are contained inside the thalamus in an area called the lateral geniculate nucleus (LGN). The LGN is part of the pathway that visual information takes to the occipital lobe. It is when the cones in the retina send signals through the retinal bipolar and ganglion cells that we see the red versus green pairings and blue versus yellow pairings. Together with the retinal cells, the cells in the LGN appear to be the ones responsible for opponent-processing of color vision and the afterimage effect.

So which theory accounts for color blindness? I've heard that there are two kinds of color blindness, when you can't tell red from green and when you can't tell blue from yellow.

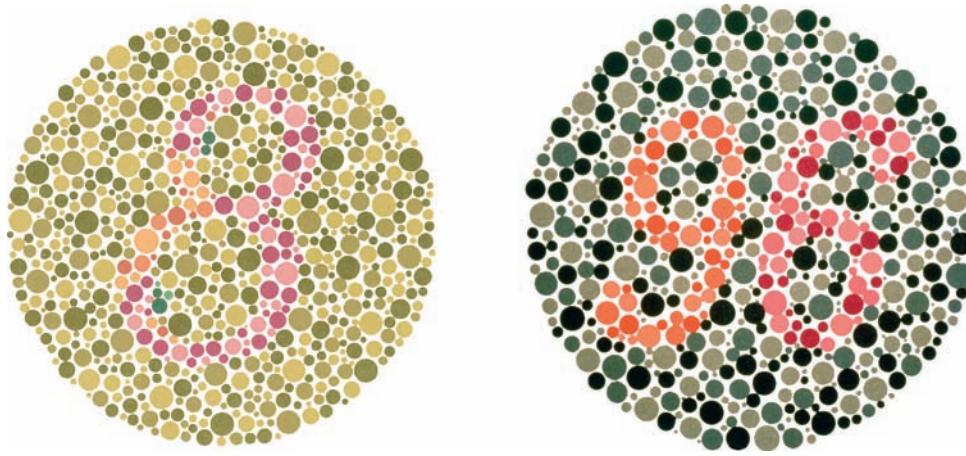
COLOR BLINDNESS From the mention of red-green and yellow-blue color blindness, one might think that the opponent-process theory explains this problem. But in reality “color blindness” is caused by defective cones in the retina of the eye and, as a more general term, *color-deficient vision* is more accurate, as most people with “color blindness” have two types of cones working and can see many colors.

There are really three kinds of color-deficient vision. In a very rare type, *monochrome color blindness*, people either have no cones or have cones that are not working at all. Essentially, if they have cones, they only have one type and, therefore, everything looks the same to the brain—shades of gray. The other types of color-deficient vision, or *dichromatic vision*, are caused by the same kind of problem—having one cone that does not work properly. So instead of experiencing the world with normal vision based on combinations of three cones or colors, trichromatic vision, individuals with dichromatic vision experience the world with essentially combinations of two cones or colors. Red-green color deficiency is due to the lack of functioning red or green cones. In both of these, the individual confuses reds and greens, seeing the world primarily in blues, yellows, and shades of gray. A lack of functioning blue cones is much less common and causes blue-yellow color deficiency. These individuals see the world primarily in reds, greens, and shades of gray. To get an idea of what a test for color-deficient vision is like, look at Figure 3.7.



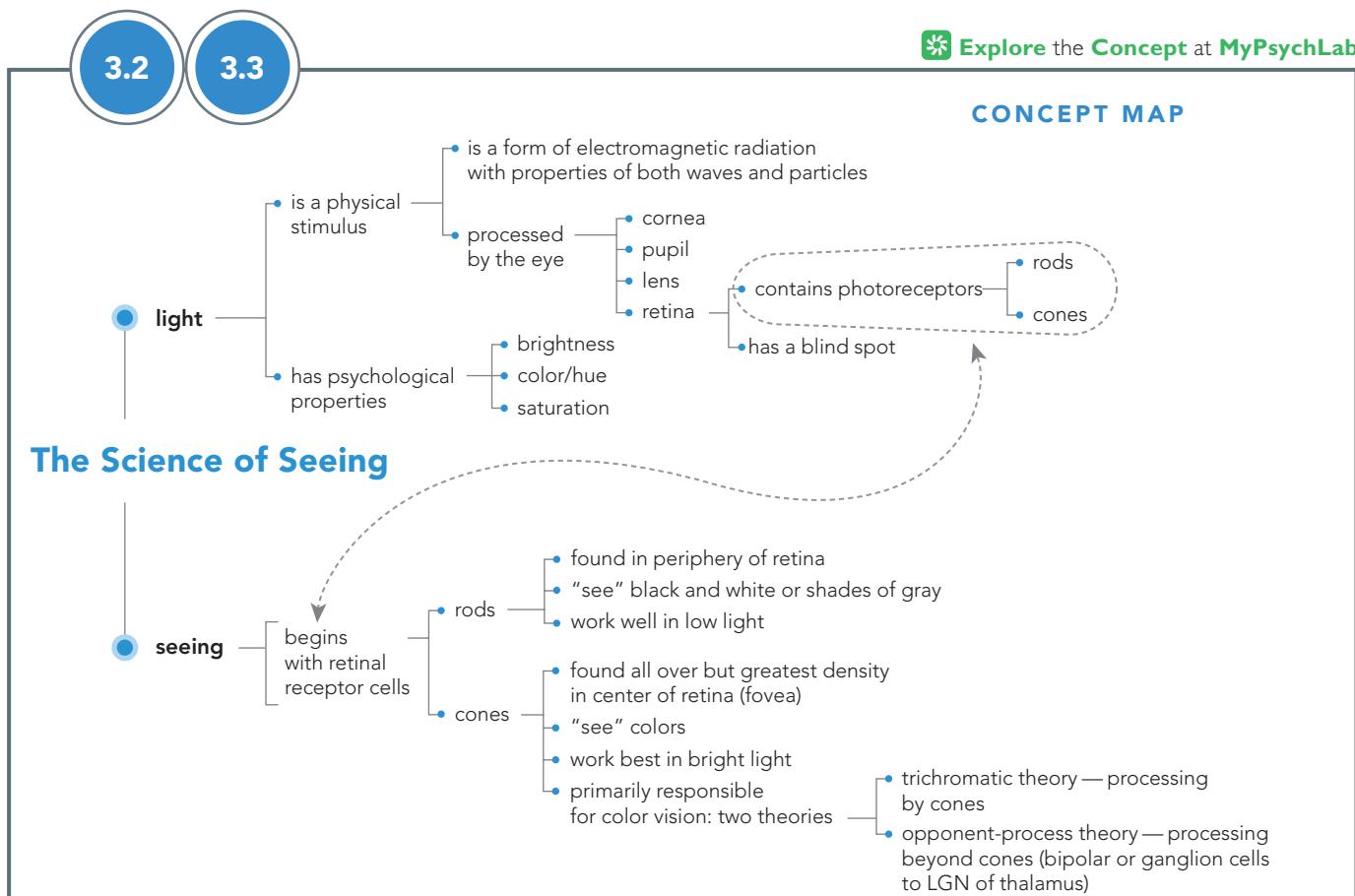
Why are most of the people with color-deficient vision men?

Color-deficient vision involving one set of cones is inherited in a pattern known as *sex-linked inheritance*. The gene for color-deficient vision is *recessive*. To inherit a recessive

**Figure 3.7 The Ishihara Color Test**

In the circle on the left, the number 8 is visible only to those with normal color vision. In the circle on the right, people with normal vision will see the number 96, while those with red-green color blindness will see nothing but a circle of dots.

trait, you normally need two of the genes, one from each parent. [LINK](#) to Learning Objective 8.3. But the gene for color-deficient vision is attached to a particular chromosome (a package of genes) that helps to determine the sex of a person. Men have one X chromosome and one smaller Y chromosome (named for their shapes), whereas women have two X chromosomes. The smaller Y has fewer genes than the larger X, and one of the genes missing is the one that would suppress the gene for color-deficient vision. For a woman to have color-deficient vision, she must inherit two recessive genes, one from each parent, but a man only needs to inherit *one* recessive gene—the one passed on to him on his mother's X chromosome. His odds are greater; therefore, more males than females have color-deficient vision.



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PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Which of the following is largely determined by the length of a light wave?
 - a. color
 - b. brightness
 - c. saturation
 - d. duration

 2. Aside from the lens, damage to the _____ can affect the eye's ability to focus light.
 - a. iris
 - b. cornea
 - c. pupil
 - d. retina

 3. In farsightedness, also known as _____, the focal point is _____ the retina.
 - a. presbyopia; above
 - b. myopia; below
 - c. hyperopia; behind
 - d. presbyopia; in front of

 4. Colleen stares at a fixed spot in her bedroom using only one eye. After a while, what might happen to her vision?
 - a. Any object that slowly crosses her visual field may at one point disappear.
- b. Any object that she focuses on will begin to rotate, first clockwise, then counterclockwise.
 - c. Objects will become more focused the longer she looks at them.
 - d. Objects will become more distorted the longer she looks at them.
5. What are the three primary colors as proposed by the trichromatic theory?
 - a. red, yellow, blue
 - b. red, green, blue
 - c. white, black, brown
 - d. white, black, red

 6. Which of the following best explains afterimages?
 - a. trichromatic theory
 - b. opponent-process theory
 - c. color-deficient vision
 - d. monochrome color blindness

The Hearing Sense: Can You Hear Me Now?

 If light works like waves, then do sound waves have similar properties?

The properties of sound are indeed similar to those of light, as both senses rely on waves. But the similarity ends there, as the physical properties of sound are different from those of light.

PERCEPTION OF SOUND: GOOD VIBRATIONS

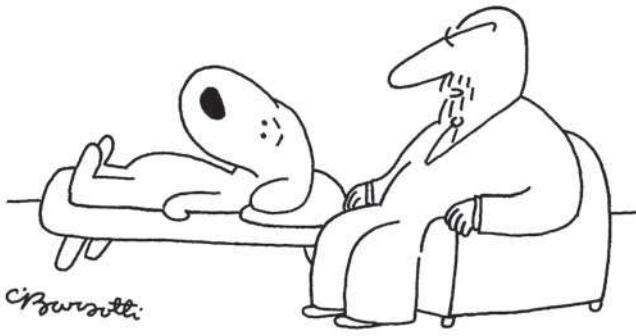
What is sound, and how does it travel through the various parts of the ear?

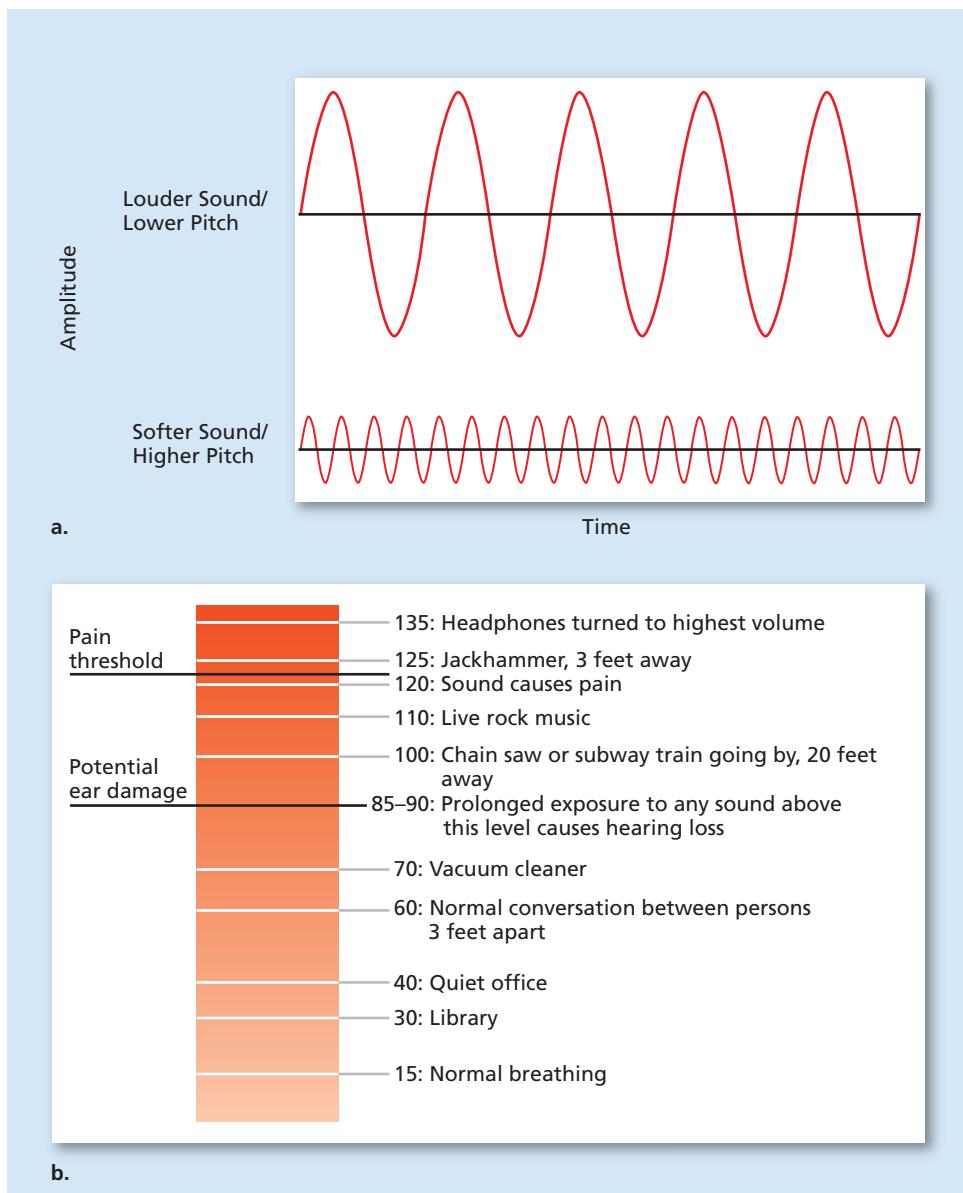
Sound waves do not come in little packets the way light comes in photons. Sound waves are simply the vibrations of the molecules of air that surround us. Sound waves do have

the same properties of light waves though—wavelength, amplitude, and purity. Wavelengths are interpreted by the brain as frequency or *pitch* (high, medium, or low). Amplitude is interpreted as *volume*, how soft or loud a sound is. (See Figure 3.8.) Finally, what would correspond to saturation or purity in light is called *timbre* in sound, a richness in the tone of the sound. And just as people rarely see pure colors in the world around us, they also seldom hear pure sounds. The everyday noises that surround people do not allow them to hear many pure tones.

Just as a person's vision is limited by the visible spectrum of light, a person is also limited in the range of frequencies he or she can hear. Frequency is measured in cycles (waves) per second, or **hertz (Hz)**.

Human limits are between 20 and 20,000 Hz, with the most sensitivity from about 2000 to 4000 Hz, very important for conversational speech. (In comparison, dogs can hear between 50 and 60,000 Hz, and dolphins can hear up to 200,000 Hz.)



**Figure 3.8 Sound Waves and Decibels**

(a) Two sound waves. The higher the wave, the louder the sound; the lower the wave, the softer the sound. If the waves are close together in time (high frequency), the pitch will be perceived as a high pitch. Waves that are farther apart (low frequency) will be perceived as having a lower pitch. (b) Decibels of various stimuli. A decibel is a unit of measure for loudness. Psychologists study the effects that noise has on stress, learning, performance, aggression, and psychological and physical well-being.

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To hear the higher and lower frequencies of a piece of music on their iPod® or iPhone®, for example, a person would need to increase the amplitude or volume—which explains why some people like to “crank it up.”

THE STRUCTURE OF THE EAR: FOLLOW THE VIBES

The ear is a series of structures, each of which plays a part in the sense of hearing, as shown in **Figure 3.9** on the next page.

THE OUTER EAR The **pinna** is the visible, external part of the ear that serves as a kind of concentrator, funneling* the sound waves from the outside into the structure of the ear. The pinna is also the entrance to the **auditory canal** (or ear canal), the short tunnel that runs down to the **tympanic membrane**, or eardrum. When sound waves hit the eardrum, they cause three tiny bones in the middle ear to vibrate.

THE MIDDLE EAR: HAMMER, ANVIL, AND STIRRUP The three tiny bones in the middle ear are known as the hammer (*malleus*), anvil (*incus*), and stirrup (*stapes*), each name stem-

*funneling: moving to a focal point.

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Figure 3.9 The Structure of the Ear

(a) This drawing shows the entire ear, beginning with the outer ear (pinna, ear canal, and eardrum). The vestibular organ includes the semicircular canals and the otolith organs (inside the round structures just above the cochlea). (b) The middle ear. Sound waves entering through the ear canal cause the eardrum to vibrate, which causes each of the three bones of the middle ear to vibrate, amplifying the sound. The stirrup rests on the oval window, which transmits its vibration to the fluid in the inner ear. (c) The inner ear. Large spaces are filled with fluid (shown in purple) that vibrates as the oval window vibrates. A thin membrane suspended in this fluid is called the basilar membrane, which contains the organ of Corti, the structure composed of the hairlike cells that send signals via the auditory nerve to the thalamus, which then relays information to the auditory cortex. (d) A close-up view of the basilar membrane (in dark pink) with the hair cells of the organ of Corti (in lighter pink). Notice the axons (small green lines) leaving the hair cells to form the auditory nerve.

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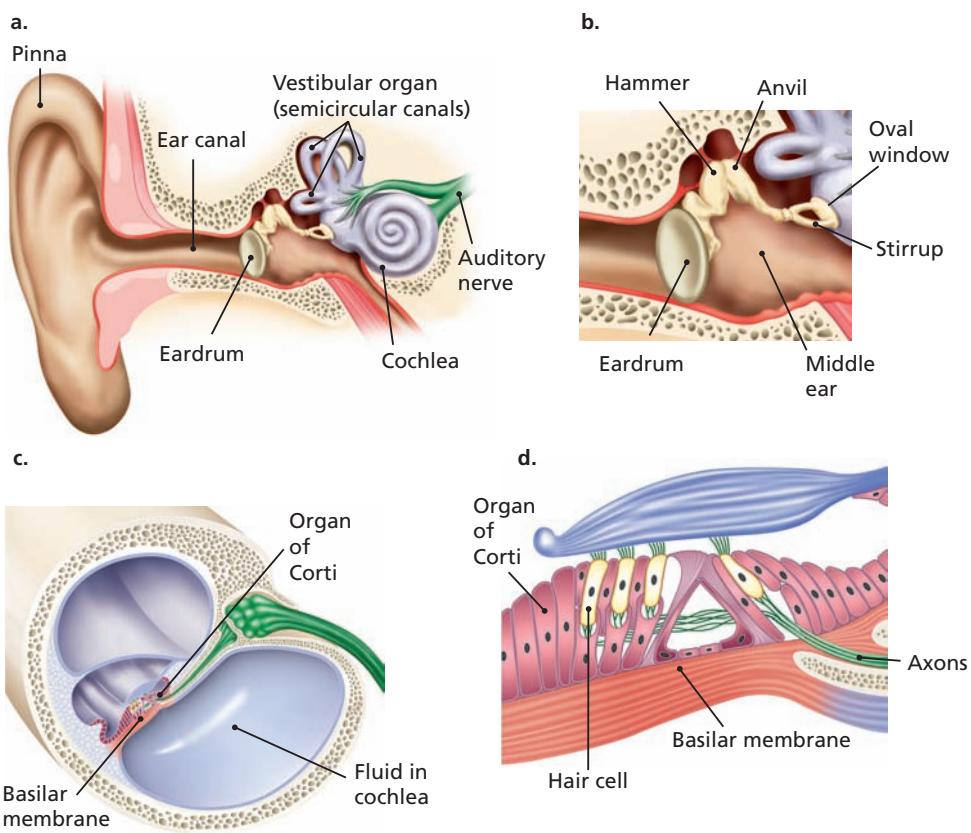
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ming from the shape of the respective bone. Collectively they are referred to as the *ossicles* and they are the smallest bones in the human body. The vibration of these three bones amplifies the vibrations from the eardrum. The stirrup, the last bone in the chain, causes a membrane covering the opening of the inner ear to vibrate.

THE INNER EAR This membrane is called the *oval window*, and its vibrations set off another chain reaction within the inner ear. The inner ear is a snail-shaped structure called the **cochlea**, which is filled with fluid. When the oval window vibrates, it causes the fluid in the cochlea to vibrate. This fluid surrounds a membrane running through the middle of the cochlea called the *basilar membrane*.

The *basilar membrane* is the resting place of the *organ of Corti*, which contains the receptor cells for the sense of hearing. When the basilar membrane vibrates, it vibrates the organ of Corti, causing it to brush against a membrane above it. On the organ of Corti are special cells called *hair cells*, which are the receptors for sound. When these auditory receptors or hair cells are bent up against the other membrane, it causes them to send a neural message through the **auditory nerve** (which contains the axons of all the receptor neurons) and into the brain, where after passing through the thalamus, the auditory cortex will interpret the sounds (the transformation of the vibrations of sound into neural messages is transduction). The louder the sound in the outside world, the stronger the vibrations that stimulate more of those hair cells—which the brain interprets as loudness.

I think I have it straight—but all of that just explains how soft and loud sounds get to the brain from the outside. How do we hear different kinds of sounds, like high pitches and low pitches?

PERCEIVING PITCH

Pitch refers to how high or low a sound is. For example, the bass beats in the music pounding through the wall of your apartment from the neighbors next door are low

pitch, whereas the scream of a 2-year-old child is a very high pitch. *Very high.* There are three primary theories about how the brain receives information about pitch.

The oldest of the three theories, **place theory**, is based on an idea proposed in 1863 by Hermann von Helmholtz and elaborated on and modified by Georg von Békésy, beginning with experiments first published in 1928 (Békésy, 1960). In this theory, the pitch a person hears depends on where the hair cells that are stimulated are located on the organ of Corti. For example, if the person is hearing a high-pitched sound, all of the hair cells near the oval window will be stimulated, but if the sound is low pitched, all of the hair cells that are stimulated will be located farther away on the organ of Corti.

Frequency theory, developed by Ernest Rutherford in 1886, states that pitch is related to how fast the basilar membrane vibrates. The faster this membrane vibrates, the higher the pitch; the slower it vibrates, the lower the pitch. (In this theory, all of the auditory neurons would be firing at the same time.)

So which of these first two theories is right? It turns out that both are right—up to a point. For place theory to be correct, the basilar membrane has to vibrate unevenly—which it does when the frequency of the sound is *above* 1000 Hz. For the frequency theory to be correct, the neurons associated with the hair cells would have to fire as fast as the basilar membrane vibrates. This only works up to 1000 Hz, because neurons don't appear to fire at exactly the same time and rate when frequencies are faster than 1000 times per second. Not to mention the maximum firing rate for neurons is approximately 1000 times per second due to the refractory period.

The frequency theory works for low pitches, and place theory works for moderate to high pitches. Is there another explanation? Yes, and it is a third theory, developed by Ernest Wever and Charles Bray, called the **volley principle** (Wever, 1949; Wever & Bray, 1930), which appears to account for pitches from about 400 Hz up to about 4000. In this explanation, groups of auditory neurons take turns firing in a process called *volleying*. If a person hears a tone of about 3000 Hz, it means that three groups of neurons have taken turns sending the message to the brain—the first group for the first 1000 Hz, the second group for the next 1000 Hz, and so on.

TYPES OF HEARING IMPAIRMENTS

Why are some people unable to hear, and how can their hearing be improved?

Hearing impairment is the term used to refer to difficulties in hearing. A person can be partially hearing impaired or totally hearing impaired, and the treatment for hearing loss will vary according to the reason for the impairment.

CONDUCTION HEARING IMPAIRMENT *Conduction hearing impairment*, or conductive hearing loss, refers to problems with the mechanics of the outer or middle ear and means that sound vibrations cannot be passed from the eardrum to the cochlea. The cause might be a damaged eardrum or damage to the bones of the middle ear (usually from an infection). In this kind of impairment the causes can often be treated, for example, hearing aids may be of some use in restoring hearing.

NERVE HEARING IMPAIRMENT In *nerve hearing impairment*, or sensorineural hearing loss, the problem lies either in the inner ear or in the auditory pathways and cortical areas of the brain. This is the most common type of permanent hearing loss. Normal aging causes loss of hair cells in the cochlea, and exposure to loud noises can damage hair cells. *Tinnitus* is a fancy word for an extremely annoying ringing in one's ears, and it can also be caused by infections or loud noises—including loud music in headphones. Prolonged exposure to loud noises further leads to permanent damage and hearing loss, so you might want to turn down that stereo or personal music player!

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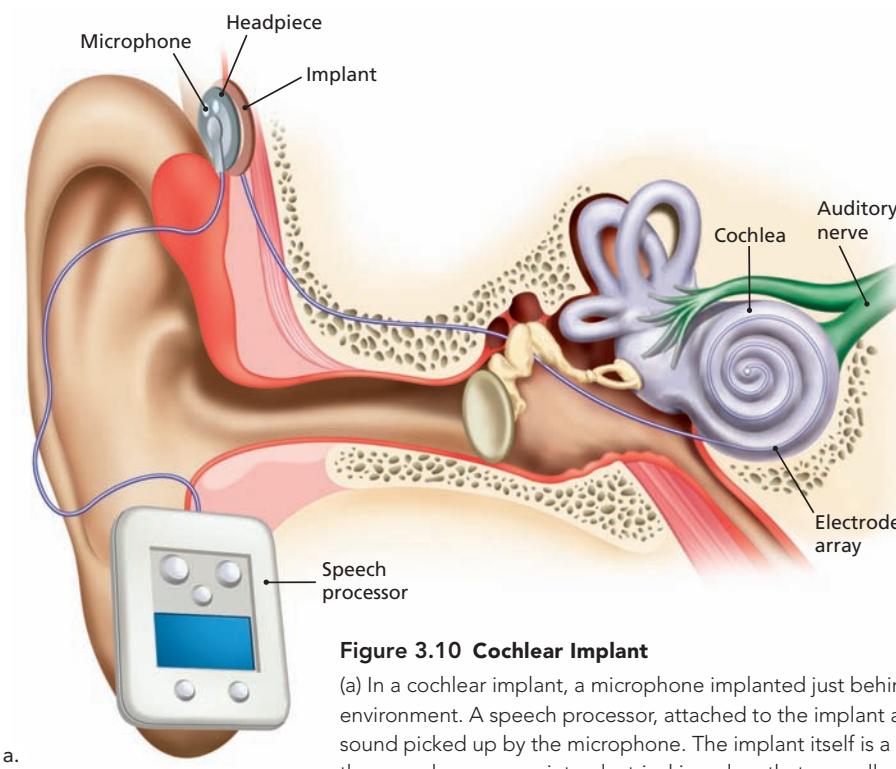


Figure 3.10 Cochlear Implant

(a) In a cochlear implant, a microphone implanted just behind the ear picks up sound from the surrounding environment. A speech processor, attached to the implant and worn outside the body, selects and arranges the sound picked up by the microphone. The implant itself is a transmitter and receiver, converting the signals from the speech processor into electrical impulses that are collected by the electrode array in the cochlea and then sent to the brain. (b) This child is able to hear with the help of a cochlear implant. Hearing spoken language during the early years of a child's life helps in the development of the child's own speech.

Because the damage is to the nerves or the brain, nerve hearing impairment cannot typically be helped with ordinary hearing aids, which are basically sound amplifiers, or the hearing aids are not enough. A technique for restoring some hearing to those with irreversible nerve hearing impairment makes use of an electronic device called a *cochlear implant*. This device sends signals from a microphone worn behind the ear to a sound processor worn on the belt or in a pocket, which then translates those signals into electrical stimuli that are sent to a series of electrodes implanted directly into the cochlea, allowing transduction to take place and stimulating the auditory nerve. (See Figure 3.10.) The brain then processes the electrode information as sound.

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Explore the Concept at MyPsychLab

The Hearing Sense

- sound
 - is a physical stimulus
 - composed of sound waves
 - processed by the ear
 - outer ear
 - middle ear
 - inner ear
 - processing can be impaired
- has psychological properties
 - frequency or pitch
 - shorter wavelengths = more waves per second = higher frequencies
 - volume
 - larger wave amplitudes associated with louder volume
 - timbre
 - increase in number of sounds results in greater richness

CONCEPT MAP

- have wavelengths and wavelike properties that can be measured
- result of vibrations of air molecules

- shorter wavelengths = more waves per second = higher frequencies
- theories of pitch perception
 - place theory
 - frequency theory
 - volley theory

- larger wave amplitudes associated with louder volume
- increase in number of sounds results in greater richness

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. The part of the ear that can be seen is also called the
 - a. pinna.
 - b. oval window.
 - c. organ of Corti.
 - d. cochlea.
2. The oval window is found in what part of the ear?
 - a. outer ear
 - b. middle ear
 - c. inner ear
 - d. The oval window is not a structure of the ear.
3. Which theory cannot adequately account for pitches above 1000hz?
 - a. place
 - b. frequency
 - c. volley
 - d. adaptive
4. Ethan has suffered minor damage to the bones in his left middle ear. What treatment, if any, might help to restore his hearing?
 - a. a hearing aid
 - b. a cochlear implant
 - c. Both a hearing aid and a cochlear implant will be needed.
 - d. Such damage is permanent and cannot be remedied.
5. Which is considered the most common type of permanent hearing loss?
 - a. psychological hearing loss
 - b. conductive hearing loss
 - c. frequency-based hearing loss
 - d. sensorineural hearing loss

THINKING CRITICALLY:

How might someone who has had total hearing loss from birth react to being able to hear?

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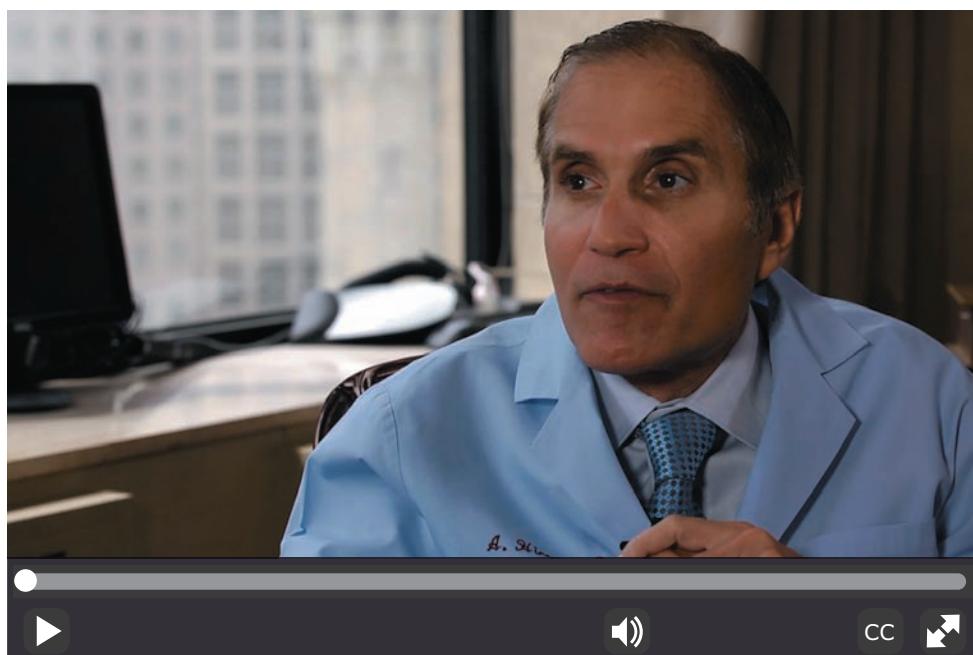
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Chemical Senses: It Tastes Good and Smells Even Better

How do the senses of taste and smell work, and how are they alike?

The sense of taste (taste in food, not taste in clothing or friends) and the sense of smell are very closely related. As Dr. Alan Hirsch, a researcher on smell and taste, explains in the video *The Basics: In Full Appreciation of the Cookie: Smell and Taste*, about 90% of what we deem taste is really smell. Have you ever noticed that when your nose is all stopped up, your sense of taste is affected, too? That's because the sense of taste is really a combination of taste and smell. Without the input from the nose, there are actually only four, or possibly five, kinds of taste sensors in the mouth.



Watch the Video, *The Basics: In Full Appreciation of the Cookie: Smell and Taste*, at [MyPsychLab](#)

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GUSTATION: HOW WE TASTE THE WORLD

Our food preferences, or aversions, start to form very early in life, very early! Taste is one of our earliest developed senses. Research suggests developing babies are exposed to substances the mother inhales or digests and these impart flavor to the amniotic fluid, which the baby also ingests. Along with exposure to different flavors early in life after we are born, these experiences may affect food choices and nutritional status, that is, picking certain foods over others, for a long time to come (Beauchamp & Mennella, 2011; Mennella & Trabulsi, 2012).

TASTE BUDS *Taste buds* are the common name for the taste receptor cells, special kinds of neurons found in the mouth that are responsible for the sense of taste, or **gustation**. Most taste buds are located on the tongue, but there are a few on the roof of the mouth, the cheeks, under the tongue, and in the throat as well. How sensitive people are to various tastes depends on how many taste buds they have; some people have only around 500, whereas others have 20 times that number. The latter are called “supertasters” and need far less seasoning in their food than those with fewer taste buds (Bartoshuk, 1993).



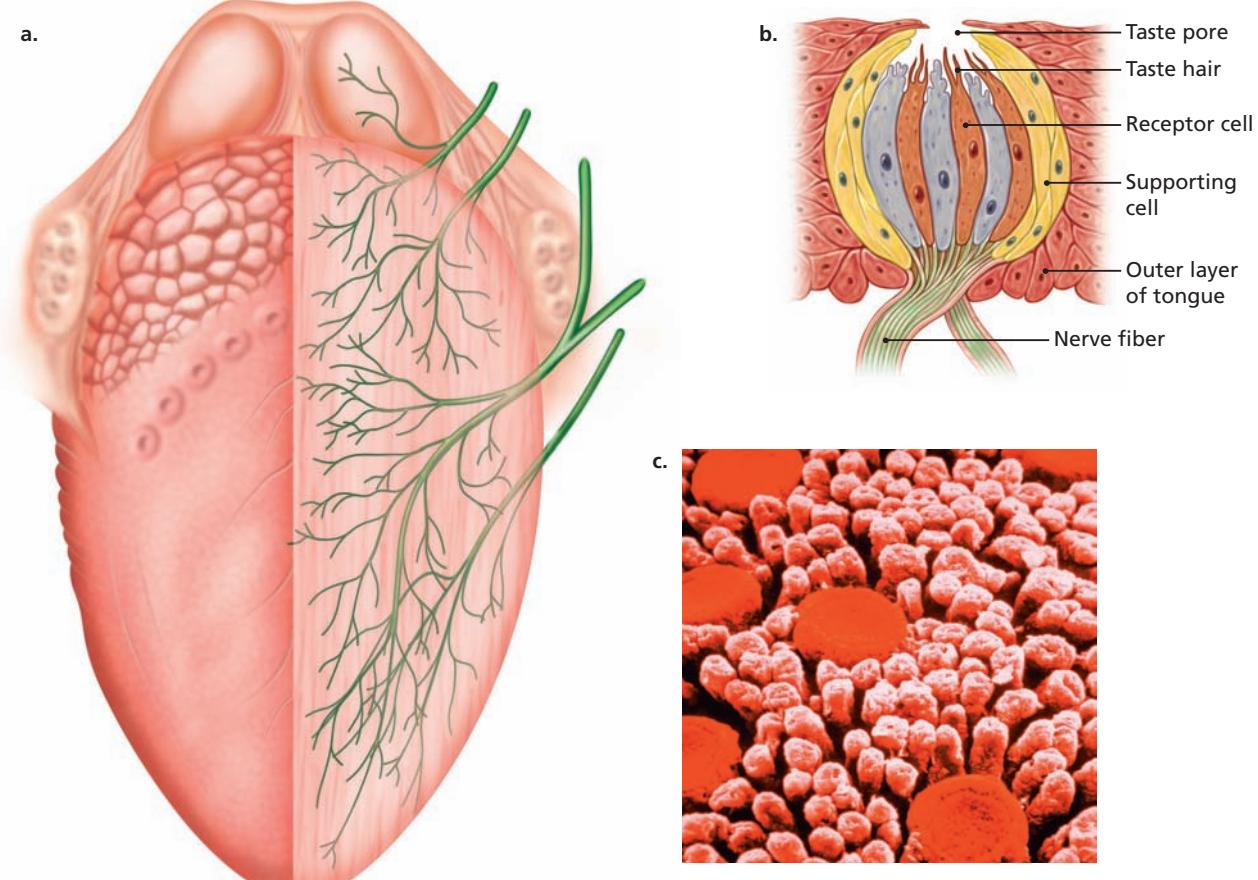
So taste buds are those little bumps I can see when I look closely at my tongue?

No, those “bumps” are called *papillae*, and the taste buds line the walls of these papillae. (See **Figure 3.11**.)

Each taste bud has about 20 receptors that are very similar to the receptor sites on receiving neurons at the synapse. [LINK](#) to Learning Objective 2.2. In fact, the receptors on taste buds work exactly like receptor sites on neurons—they receive molecules of various substances that fit into the receptor like a key into a lock. Taste is often called a chemical sense because it works with the molecules of foods people eat in the same way

Figure 3.11 The Tongue and Taste Buds—A Crosscut View of the Tongue

(a) The right side of this drawing shows the nerves in the tongue’s deep tissue. (b) The taste bud is located inside the papillae and is composed of small cells that send signals to the brain when stimulated by molecules of food. (c) Microphotograph of the surface of the tongue, showing two different sizes of papillae. The taste buds are located under the surface of the larger red papillae, whereas the smaller and more numerous papillae form a touch-sensitive rough surface that helps in chewing and moving food around the mouth.



the neural receptors work with neurotransmitters. When the molecules (dissolved in saliva) fit into the receptors, a signal is fired to the brain, which then interprets the taste sensation.

What happens to the taste buds when I burn my tongue? Do they repair themselves? I know when I have burned my tongue, I can't taste much for a while, but the taste comes back.

In general, the taste receptors get such a workout that they have to be replaced every 10 to 14 days (McLaughlin & Margolskee, 1994). And when the tongue is burned, the damaged cells no longer work. As time goes on, those cells get replaced and the taste sense comes back.

THE FIVE BASIC TASTES In 1916 a German psychologist named Hans Henning proposed that there are four primary tastes: sweet, sour, salty, and bitter. Lindemann (1996) supported the idea that there is a fifth kind of taste receptor that detects a pleasant “brothy” taste associated with foods like chicken soup, tuna, kelp, cheese, and soy products, among others. Lindemann proposed that this fifth taste be called *umami*, a Japanese word first coined in 1908 by Dr. Kikunae Ikeda of Tokyo Imperial University to describe the taste. Dr. Ikeda had succeeded in isolating the substance in kelp that generated the sensation of umami—glutamate (Beyreuther et al., 2007).  to Learning Objective 2.2. Glutamate exists not only in the foods listed earlier, but is also present in human breast milk and is the reason that the seasoning MSG—monosodium glutamate—adds a pleasant flavor to foods.

Although researchers used to believe that certain tastes were located on certain places on the tongue, it is now known that all of the taste sensations are processed all over the tongue (Bartoshuk, 1993). The taste information is sent to the gustatory cortex, found in the front part of the *insula* and the *frontal operculum*. (See Figure 3.12.) These areas are involved in the conscious perception of taste whereas the texture, or “mouth-feel,” of foods is processed in the somatosensory cortex of the parietal lobe (Buck & Bargmann, 2013; Pritchard, 2012; Shepherd, 2012). The five taste sensations work together, along with the sense of smell and the texture, temperature, and “heat” of foods, to produce thousands of taste sensations, which are further affected by our culture, personal expectations, and past learning experiences. For example, boiled peanuts are not an uncommon snack in parts of the southern United States, but the idea of a warm, soft and mushy, slightly salty peanut may not be appealing in other parts of the country. The cortical taste areas also project to parts of the limbic system, which helps explain why tastes can be used for both positive and negative reinforcement (Pritchard, 2012).  to Learning Objective 5.5.

Just as individuals and groups can vary on their food preferences, they can also vary on level of perceived sweetness. For example, obese individuals have been found to experience less sweetness than individuals who are not obese; foods that are both sweet and high in fat tend to be especially attractive to individuals who are obese (Bartoshuk et al., 2006). Such differences (as well as genetic variations like the supertasters) complicate direct comparison of food preferences. One possible solution is to have individuals rate taste in terms of an unrelated “standard” sensory experience of known intensity, such as the brightness of a light or loudness of a sound or preference in terms of all pleasurable experiences, and not just taste (Bartoshuk et al., 2005; Snyder & Bartoshuk, 2009).

Turning our attention back to how things taste for us as individuals, have you ever noticed that when you have a cold, food tastes very bland? Everything becomes bland or muted because you can taste only sweet, salty, bitter, sour, and umami—and because your nose is stuffed up with a cold, you don’t get all the enhanced variations of those tastes that come from the sense of smell.

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Figure 3.12 The Gustatory Cortex

The gustatory cortex is found in the anterior insula and frontal operculum. The insula is an area of cortex covered by folds of overlying cortex, and each fold is an operculum. In the coronal section of a human brain above, the gustatory cortex is found in the regions colored a light red.

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THE SENSE OF SCENTS: OLFACTION

Like the sense of taste, the sense of smell is a chemical sense. The ability to smell odors is called **olfaction**, or the **olfactory sense**.

The outer part of the nose serves the same purpose for odors that the pinna and ear canal serve for sounds: Both are merely ways to collect the sensory information and get it to the part of the body that will translate it into neural signals.

The part of the olfactory system that transduces odors—turns odors into signals the brain can understand—is located at the top of the nasal passages. This area of olfactory receptor cells is only about an inch square in each cavity yet contains about 10 million olfactory receptors. (See Figure 3.13.)

OLFACTORY RECEPTOR CELLS The *olfactory receptor cells* each have about a half dozen to a dozen little “hairs,” called *cilia*, that project into the cavity. Like taste buds, there are receptor sites on these hair cells that send signals to the brain when stimulated by the molecules of substances that are in the air moving past them.



Wait a minute—you mean that when I can smell something like a skunk, there are little particles of skunk odor IN my nose?

Yes. When a person is sniffing something, the sniffing serves to move molecules of whatever the person is trying to smell into the nose and into the nasal cavities. That's okay when it's the smell of baking bread, apple pie, flowers, and the like, but when it's skunk, rotten eggs, dead animals—well, try not to think about it too much.

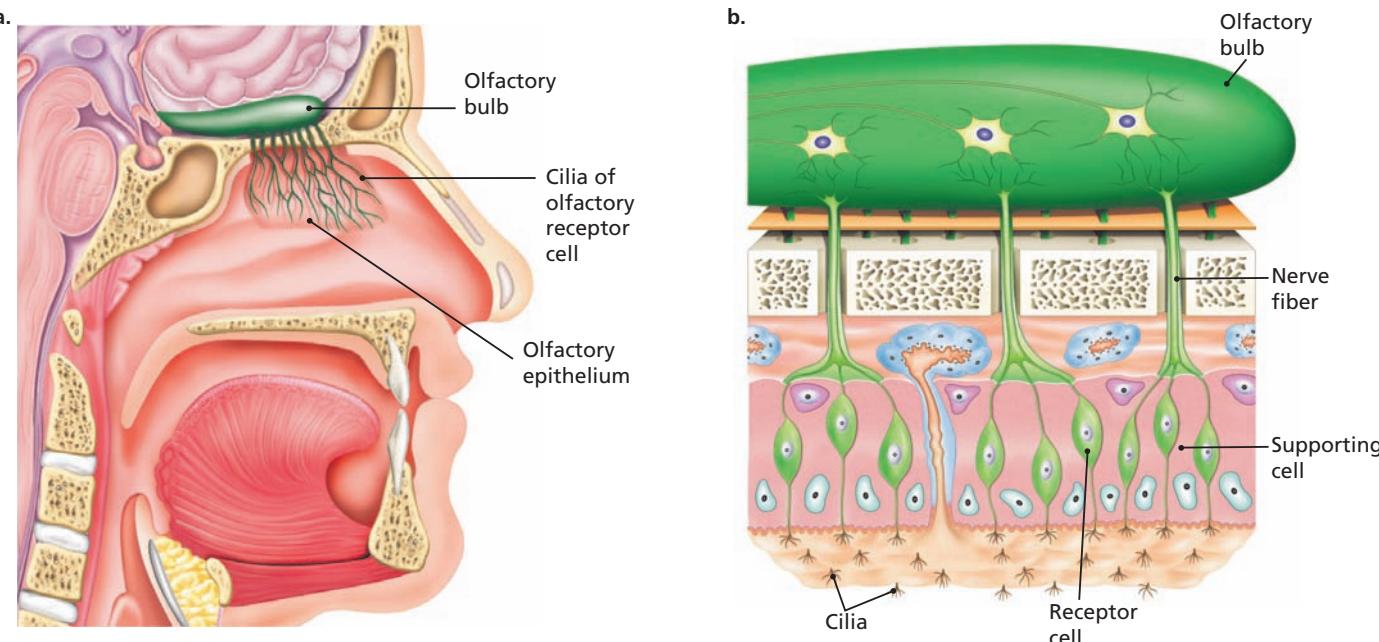
Olfactory receptors are like taste buds in another way, too. Olfactory receptors also have to be replaced as they naturally die off, about every 5 to 8 weeks. Unlike the taste buds, there are many more than 5 types of olfactory receptors—in fact, there are at least 1,000 of them.

Signals from the olfactory receptors in the nasal cavity do not follow the same path as the signals from all the other senses. Vision, hearing, taste, and touch all pass through the thalamus and then on to the area of the cortex that processes that particular sensory information. But the sense of smell has its own special place in the brain—the olfactory bulbs.

THE OLFACTORY BULBS The **olfactory bulbs** are located right on top of the sinus cavity on each side of the brain directly beneath the frontal lobes. (Refer back to Figure 3.13.) The olfactory receptors send their neural signals directly up to these bulbs, bypassing the thalamus, the relay center for all other sensory information. The olfactory information is then sent from the olfactory bulbs to higher cortical areas, including the primary

Figure 3.13 The Olfactory Receptors

(a) A cross section of the nose and mouth. This drawing shows the nerve fibers inside the nasal cavity that carry information about smell directly to the olfactory bulb just under the frontal lobe of the brain (shown in green). (b) A diagram of the cells in the nose that process smell. The olfactory bulb is on top. Notice the cilia, tiny hairlike cells that project into the nasal cavity. These are the receptors for the sense of smell.



olfactory cortex (the *piriform cortex*), the orbitofrontal cortex, and the amygdala (remember from Chapter Two that the orbitofrontal cortex and amygdala play important roles in emotion). [LINK](#) to Learning Objectives 2.8 and 2.9. [WATCH](#) the Video, Thinking Like a Psychologist: Can Smells Alter Mood and Behavior?, at [MyPsychLab](#)

Somesthetic Senses: What the Body Knows

What allows people to experience the sense of touch, pain, motion, and balance?

So far, this chapter has covered vision, hearing, taste, and smell. That leaves touch. What is thought of as the sense of touch is really several sensations, originating in several different places in—and on—the body. It's really more accurate to refer to these as the body senses, or **somesthetic senses**. The first part of that word, *soma*, means "body," as mentioned in Chapter Two. The second part, *esthetic*, means "feeling," hence, the name. There are three somesthetic sense systems, the **skin senses** (having to do with touch, pressure, temperature, and pain), the **kinesthetic sense** (having to do with the location of body parts in relation to each other), and the **vestibular senses** (having to do with movement and body position).

PERCEPTION OF TOUCH, PRESSURE, TEMPERATURE, AND PAIN

Here's a good trivia question: What organ of the body is about 20 square feet in size? The answer is the skin. Skin is an organ. Its purposes include more than simply keeping bodily fluids in and germs out; skin also receives and transmits information from the outside world to the central nervous system (specifically, to the somatosensory cortex). [LINK](#) to Learning Objective 2.9. Information about light touch, deeper pressure, hot, cold, and even pain is collected by special receptors in the skin's layers.

TYPES OF SENSORY RECEPTORS IN THE SKIN There are about half a dozen different receptors in the layers of the skin. (See Figure 3.14.) Some of them will respond to only one kind of sensation. For example, the *Pacinian corpuscles* are just beneath the skin and respond to changes in pressure. There are nerve endings that wrap around the ends of the hair follicles, a fact people may be well aware of when they tweeze their eyebrows, or when someone pulls their hair. These nerve endings are sensitive to both pain and touch. There are *free nerve endings* just beneath the uppermost layer of the skin that respond to changes in temperature and to pressure—and to pain.



How exactly does pain work? Why is it that sometimes I feel pain deep inside? Are there pain receptors there, too?

Yes, there are pain nerve fibers in the internal organs as well as receptors for pressure. How else would people have a stomachache or intestinal* pain—or get that full feeling of pressure when they've eaten too much or their bladder is full?

There are actually different types of pain. There are receptors that detect pain (and pressure) in the organs, a type of pain called *visceral pain*. Pain sensations in the skin, muscles, tendons, and joints are carried on large nerve fibers and are called *somatic pain*. Somatic pain is the body's warning system that something is being, or is about to be,

*intestinal: having to do with the tubes in the body that digest food and process waste material.



Her sense of touch is allowing this blind girl to "read" a Braille book with her fingers. The fingertips are extremely sensitive to fine differences in texture, allowing her to distinguish between small dots representing the different letters of the alphabet.

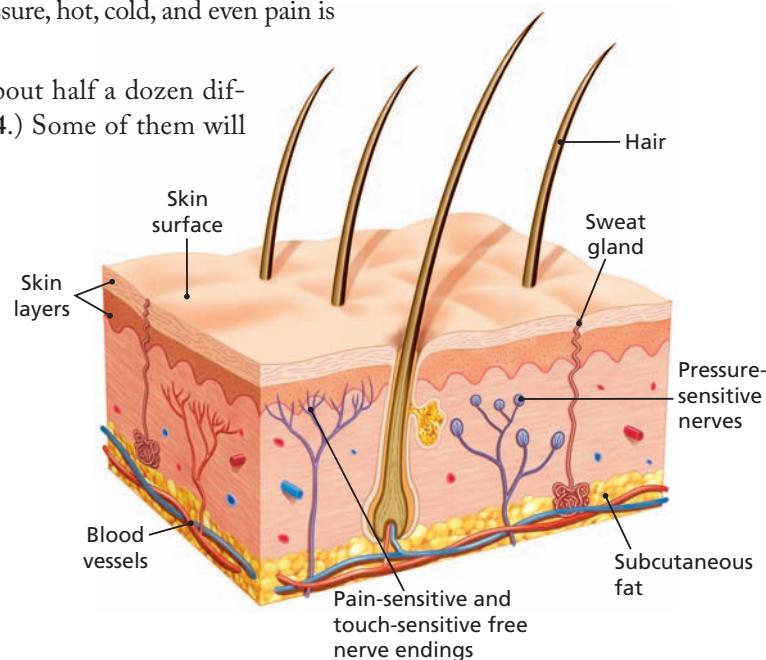


Figure 3.14 Cross Section of the Skin and Its Receptors

The skin is composed of several types of cells that process pain, pressure, and temperature. Some of these cells are wrapped around the ends of the hairs on the skin and are sensitive to touch on the hair itself, whereas others are located near the surface, and still others just under the top layer of tissue.

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Congenital insensitivity to pain with anhidrosis (CIPA) is a rare genetic disorder that makes 5-year-old Ashlyn unable to feel pain. She must be examined carefully for scrapes and cuts after recess at school because she cannot feel when she hurts herself, putting her at risk for infection. What are some of the problems that Ashlyn and her parents may face as she grows older?

ing trial for the parents and teachers of such a child. These disorders affect the neural pathways that carry pain, heat, and cold sensations. (Those with CIPA have an additional disruption in the body's heat–cold sensing perspiration system [anhidrosis], so that the person is unable to cool off the body by sweating.)

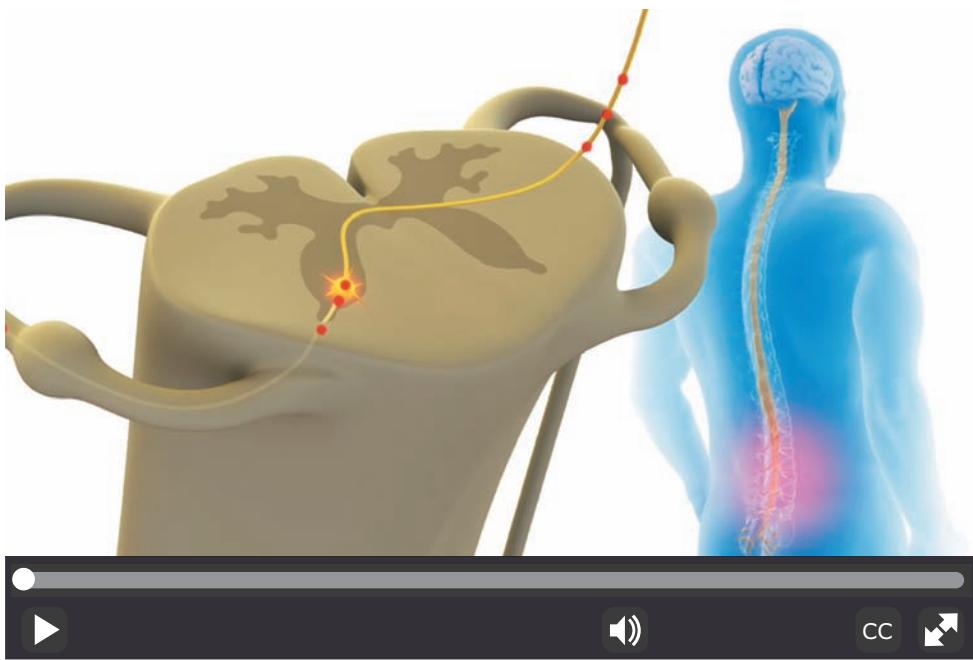
A condition called *phantom limb pain* occurs when a person who has had an arm or leg removed sometimes “feels” pain in the missing limb (Nikolajsen & Jensen, 2001; Woodhouse, 2005). As many as 50 to 80 percent of people who have had amputations experience various sensations: burning, shooting pains, or pins-and-needles sensations where the amputated limb used to be. Once believed to be a psychological problem, some now believe that it is caused by the traumatic injury to the nerves during amputation (Ephraim et al., 2005).

PAIN: GATE-CONTROL THEORY

One explanation for how the sensation of pain works is called *gate-control theory*, first proposed by Ronald Melzack and Patrick Wall (1965) and later refined and expanded (Melzack & Wall, 1996). In this theory, the pain signals must pass through a “gate” located in the spinal cord. The activity of the gate can be closed by nonpain signals coming into the spinal cord from the body and by signals coming from the brain. The gate is not a physical structure but instead represents the relative balance in neural activity of cells in the spinal cord that receive information from the body and then send information to the brain. Additional research has revealed that the activity of relay centers in the brain can also be influenced and the exact locations and mechanisms are still being investigated. The video *In the Real World: Managing Pain: Gate Control Theory* provides a simulation of how pain signals travel along the spinal cord.

damaged and tends to be sharp and fast. Another type of somatic pain is carried on small nerve fibers and is slower and more of a general ache. This somatic pain acts as a kind of reminder system, keeping people from further injury by reminding them that the body has already been damaged. For example, if you hit your thumb with a hammer, the immediate pain sensation is of the first kind—sharp, fast, and bright. But later the bruised tissue simply aches, letting you know to take it easy on that thumb.

PAIN DISORDERS People may not like pain, but its function as a warning system is vitally important. There are people who are born without the ability to feel pain, rare conditions called *congenital analgesia* and *congenital insensitivity to pain with anhidrosis (CIPA)*. Children with these disorders cannot feel pain when they cut or scrape themselves, leading to an increased risk of infection when the cut goes untreated (Mogil, 1999). They fear nothing—which can be a horrifying



Watch the Video. In the Real World: Managing Pain: Gate Control Theory, at [MyPsychLab](#)

Stimulation of the pain receptor cells releases a neuromodulator called *substance P* (for “pain,” naturally). Substance P released into the spinal cord activates other neurons that send their messages through spinal gates (opened by the pain signal). From the spinal cord, the message goes to the brain, activating cells in the thalamus, somatosensory cortex, areas of the frontal lobes, and the limbic system. The brain then interprets the pain information and sends signals that either open the spinal gates farther, causing a greater experience of pain, or close them, dampening the pain. Of course, this decision by the brain is influenced by the psychological aspects of the pain-causing stimulus. Anxiety, fear, and helplessness intensify pain, whereas laughter, distraction, and a sense of control can diminish it. (This is why people might bruise themselves and not know it if they were concentrating on something else.) Pain can also be affected by competing signals from other skin senses, which is why rubbing a sore spot can reduce the feeling of pain.

Those same psychological aspects can also influence the release of the *endorphins*, the body’s natural version of morphine. [LINK](#) to Learning Objective 2.2. Endorphins can inhibit the transmission of pain signals in the brain, and in the spinal cord they can inhibit the release of substance P.



I’ve always heard that women are able to stand more pain than men. Is that true?

On the contrary, research has shown that women apparently feel pain more intensely than do men, and they also report pain more often than men do (Chesterton et al., 2003; Faucett et al., 1994; Norrbrink et al., 2003). Men have been shown to cope better with many kinds of pain, possibly because men are often found to have a stronger belief than women that they can (or should) control their pain by their own efforts (Jackson et al., 2002).

THE KINESTHETIC SENSE

Special receptors located in the muscles, tendons, and joints are part of the body’s sense of movement and position in space—the movement and location of the arms, legs, and so

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This tightrope-walking violinist is performing an amazing feat of coordination and muscular control. He must not only use his vestibular organs to help maintain his balance, but also his kinesthetic sense to be aware of exactly where each foot is in relation to the rope.

forth in relation to one another. This sense is called *kinesthesia*, from the Greek words *kinē* (“to move”) and *aesthesia* (“sensation”). When you close your eyes and raise your hand above your head, you know where your hand is because these special receptors, called proprioceptors, tell you about joint movement or the muscles stretching or contracting.

If you have ever gotten sick from traveling in a moving vehicle, you might be tempted to blame these proprioceptors. Actually, it’s not the proprioceptors in the body that make people get sick. The culprits are special structures in the ear that tell us about the position of the body in relation to the ground and movement of the head that make up the *vestibular sense*—the sense of balance.

THE VESTIBULAR SENSE

The name of this particular sense comes from a Latin word that means “entrance” or “chamber.” The structures for this sense are located in the innermost chamber of the ear. There are two kinds of vestibular organs, the otolith organs and the semicircular canals.

The *otolith organs* are tiny sacs found just above the cochlea. These sacs contain a gelatin-like fluid within which tiny crystals are suspended (much like pieces of fruit in a bowl of Jell-O®). The head moves and the crystals cause the fluid to vibrate, setting off some tiny hairlike receptors on the inner surface of the sac, telling the person that he or she is moving forward, backward, sideways, or up and down. (It’s pretty much the way the cochlea works but with movement being the stimulus instead of sound vibrations.)

The *semicircular canals* are three somewhat circular tubes that are also filled with fluid that will stimulate hairlike receptors when rotated. Having three tubes allows one to be located in each of the three planes of motion. Remember learning in geometry class about the *x*-, *y*-, and *z*-axes? Those are the three planes through which the body can rotate, and when it does, it sets off the receptors in these canals. When you spin around and then stop, the fluid in the horizontal canal is still rotating and will make you feel dizzy because your body is telling you that you are still moving, but your eyes are telling you that you have stopped.

This disagreement between what the eyes say and what the body says is pretty much what causes *motion sickness*, the tendency to get nauseated when in a moving vehicle, especially one with an irregular movement. Normally, the vestibular sense coordinates with the other senses. But for some people, the information from the eyes may conflict a little too much with the vestibular organs, and dizziness, nausea, and disorientation are the result. This explanation of motion sickness is known as **sensory conflict theory** (Oman, 1990; Reason & Brand, 1975). The dizziness is the most likely cause of the nausea. Many poisons make a person dizzy, and the most evolutionarily adaptive thing to do is to expel the poison. Even without any poison in a case of motion sickness, the nausea occurs anyway (Treisman, 1977).

One way some people overcome motion sickness is to focus on a distant point or object. This provides visual information to the person about how he or she is moving, bringing the sensory input into agreement with the visual input. This is also how ballerinas and ice skaters manage not to get sick when turning rapidly and repeatedly—they focus their eyes at least once on some fixed object every so many turns.

Astronauts, who travel in low-gravity conditions, can get a related condition called space motion sickness (SMS). This affects about 60 percent of those who travel in space, typically for about the first week of space travel. After that time of adjustment, the astronauts are able to adapt and the symptoms diminish. Repeated exposure to some environment that causes motion sickness—whether it is space, a car, a train, or some other vehicle—is actually one of the best ways to overcome the symptoms (Hu & Stern, 1999).

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 Explore the Concept at [MyPsychLab](#)
CONCEPT MAP**smell/olfaction**

- called a chemical sense because substance molecules are suspended in the air, carried to the nasal cavity, and fit into receptor sites
- nose serves as a collection device
- unique in that signals do not first travel to the thalamus before going to the brain

Chemical Senses**taste/gustation**

- made possible largely through the role of taste buds (taste receptor cells)
- five basic tastes (receptor types)
- called a chemical sense because food molecules dissolve in saliva, which then fits into receptor sites

- sweet
- sour
- salty
- bitter
- umami

Somesthetic Senses**skin senses**

- processed by the skin
- is an organ—receives and transmits information from the outside world to the somatosensory cortex of the brain
- sensitive to touch, pressure, temperature
- pain

kinesthetic sense

- processed by proprioceptors in skin, joints, muscles, and tendons

vestibular sense

- processed by vestibular organs
- convey information about movement and body position
- found in the inner ear
- responsible for motion sickness
- otolith organs
- semicircular canals

PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Taste is often called a _____ sense because it works with the molecules of foods that people eat.
 - a. physical
 - b. psychological
 - c. chemical
 - d. electrical
2. Research has found that taste information is sent to the
 - a. pons and medulla.
 - b. suprachiasmatic nucleus.
 - c. cerebellum and parietal lobe.
 - d. insula and frontal operculum.
3. How often are olfactory receptors replaced by new olfactory receptors?
 - a. every 12–24 hours
 - b. every 2–3 days
 - c. every 30 days
 - d. every 5–8 weeks
4. Olfactory receptors project directly to the _____, and are unique in that signals do not first connect to the thalamus.
 - a. occipital lobe
 - b. olfactory bulbs
 - c. hypothalamus
 - d. gustatory cortex
5. In gate-control theory, substance P
 - a. opens the spinal gates for pain.
 - b. closes the spinal gates for pain.
 - c. is unrelated to pain.
 - d. is similar in function to endorphins.
6. Motion sickness often results from conflicting signals sent from the _____ and from the _____.
 - a. eyes; vestibular organs
 - b. brain; internal organs
 - c. conscious; unconscious
 - d. extremities; brain

THINKING CRITICALLY:

What kinds of changes in your life would you have to make if you suddenly could not feel pain?

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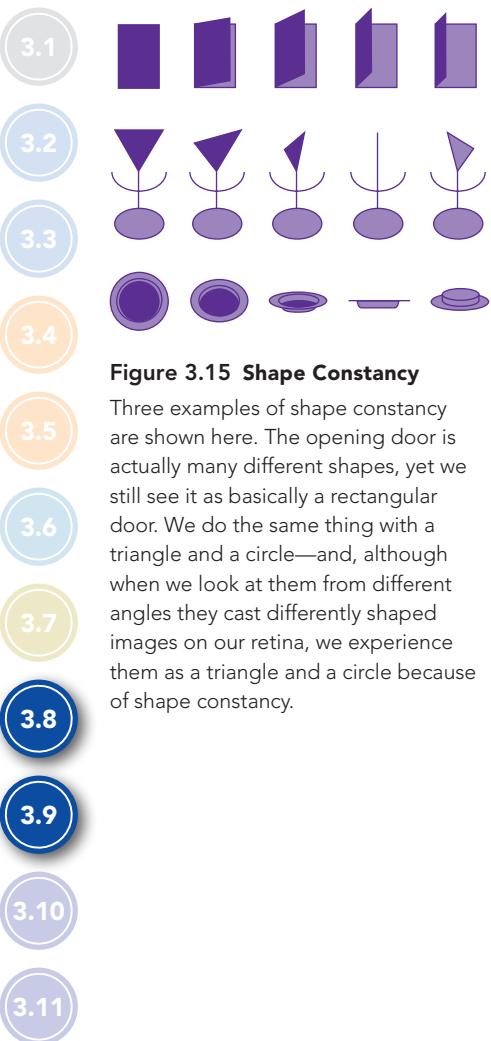
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**Figure 3.15 Shape Constancy**

Three examples of shape constancy are shown here. The opening door is actually many different shapes, yet we still see it as basically a rectangular door. We do the same thing with a triangle and a circle—and, although when we look at them from different angles they cast differently shaped images on our retina, we experience them as a triangle and a circle because of shape constancy.

The ABCs of Perception

What are perception and perceptual constancies?

Perception is the method by which the brain takes all the sensations a person experiences at any given moment and allows them to be interpreted in some meaningful fashion. Perception has some individuality to it. For example, two people might be looking at a cloud and while one thinks it's shaped like a horse, the other thinks it's more like a cow. They both *see* the same cloud, but they *perceive* that cloud differently. As individual as perception might be, some similarities exist in how people perceive the world around them, as the following section will discuss.  Watch the Video, Special Topics: Recognizing Faces, at [MyPsychLab](#)

THE CONSTANCES: SIZE, SHAPE, AND BRIGHTNESS

One form of perceptual constancy* is **size constancy**, the tendency to interpret an object as always being the same size, regardless of its distance from the viewer (or the size of the image it casts on the retina). So if an object that is normally perceived to be about 6 feet tall appears very small on the retina, it will be interpreted as being very far away.

Another perceptual constancy is the tendency to interpret the shape of an object as constant, even when it changes on the retina. This **shape constancy** is why a person still perceives a coin as a circle even if it is held at an angle that makes it appear to be an oval on the retina. Dinner plates on a table are also seen as round, even though from the angle of viewing they are oval. (See Figure 3.15.)

A third form of perceptual constancy is **brightness constancy**, the tendency to perceive the apparent brightness of an object as the same even when the light conditions change. If a person is wearing black pants and a white shirt, for example, in broad daylight the shirt will appear to be much brighter than the pants. But if the sun is covered by thick clouds, even though the pants and shirt have less light to reflect than previously, the shirt will still appear to be just as much brighter than the pants as before—because the different amount of light reflected from each piece of clothing is still the same difference as before (Zeki, 2001).

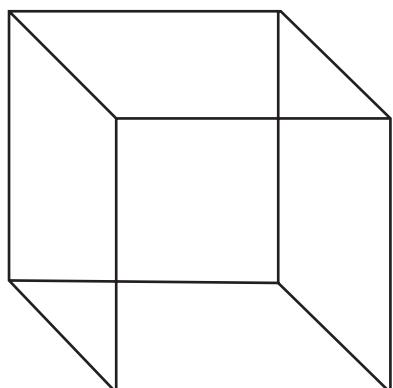
THE GESTALT PRINCIPLES

What are the Gestalt principles of perception?

Remember the discussion of the Gestalt theorists in Chapter One? Their original focus on human perception can still be seen in certain basic principles today, including the Gestalt tendency to group objects and perceive whole shapes.

FIGURE-GROUND RELATIONSHIPS Take a look at the drawing of the cube in Figure 3.16. Which face of the cube is in the front? Look again—do the planes and corners of the cube seem to shift as you look at it?

This is called the “Necker cube.” It has been around officially since 1832, when Louis Albert Necker, a Swiss scientist who was studying the structure of crystals, first drew it in his published papers. The problem with this cube is that there are conflicting sets of depth cues, so the viewer is never really sure which plane or edge is in the back and which is in the front—the visual presentation of the cube seems to keep reversing its planes and edges.

**Figure 3.16 The Necker Cube**

This is an example of a reversible figure. It can also be described as an ambiguous figure, since it is not clear which pattern should predominate.

*constancy: something that remains the same, the property of remaining stable and unchanging.

A similar illusion can be seen in Figure 3.17. In this picture, the viewer can switch perception back and forth from two faces looking at each other to the outline of a goblet in the middle. Which is the figure in front and which is the background?

Figure-ground relationships refer to the tendency to perceive objects or figures as existing on a background. People seem to have a preference for picking out figures from backgrounds even as early as birth. The illusions in Figures 3.16 and 3.17 are **reversible figures**, in which the figure and the ground seem to switch back and forth.

PROXIMITY Another very simple rule of perception is the tendency to perceive objects that are close to one another as part of the same grouping, a principle called **proximity**, or “nearness.” (See Figure 3.18.)

SIMILARITY **Similarity** refers to the tendency to perceive things that look similar as being part of the same group. When members of a sports team wear uniforms that are all the same color, it allows people viewing the game to perceive them as one group even when they are scattered around the field or court.

CLOSURE **Closure** is the tendency to complete figures that are incomplete. A talented artist can give the impression of an entire face with just a few cleverly placed strokes of the pen or brush—the viewers fill in the details.

CONTINUITY The principle of **continuity** is easier to see than it is to explain in words. It refers to the tendency to perceive things as simply as possible with a continuous pattern rather than with a complex, broken-up pattern. Look at Figure 3.18 for an example of continuity. Isn’t it much easier to see the figure on the left as two wavy lines crossing each other than as the little sections in the diagrams to the right?

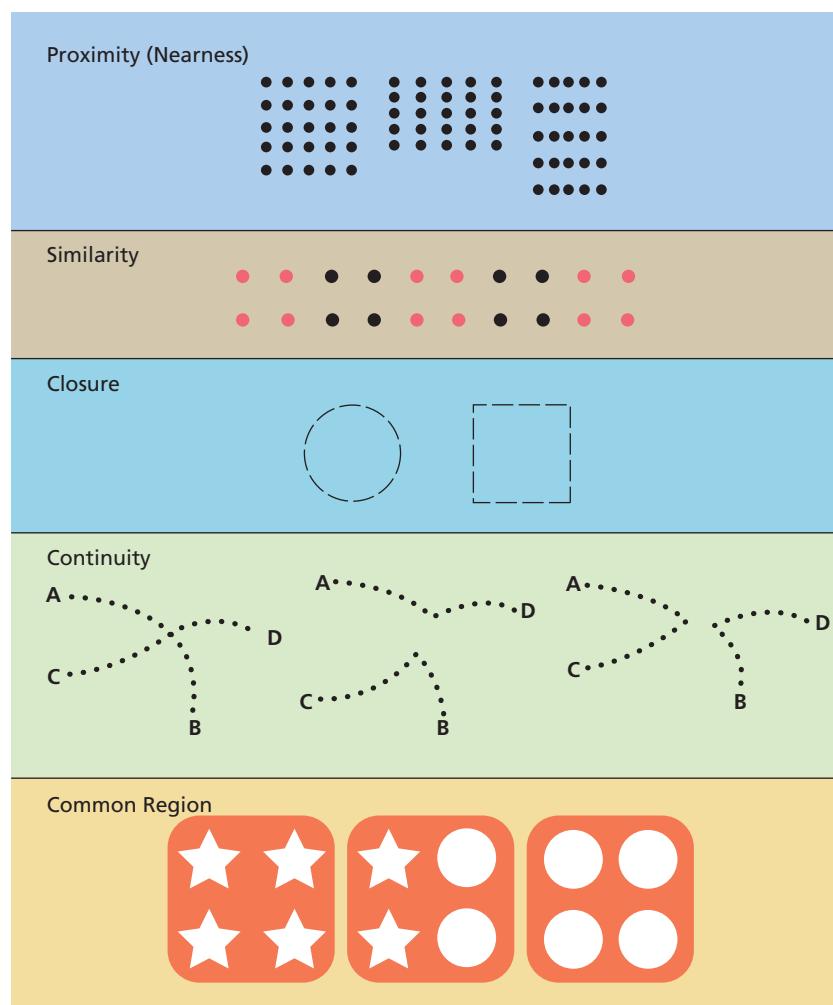


Figure 3.17 Figure-Ground Illusion

What do you see when you look at this picture? Is it a wine goblet? Or two faces looking at each other? This is an example in which the figure and the ground seem to “switch” each time you look at the picture.

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Figure 3.18 Gestalt Principles of Grouping

The Gestalt principles of grouping are shown here. These are the human tendency to organize isolated stimuli into groups on the basis of five characteristics: proximity, similarity, closure, continuity, and common region.

Proximity: The dots on the left can be seen as horizontal or vertical rows—neither organization dominates. But just by changing the proximity of certain dots, as in the other two examples, we experience the dots as vertical columns (middle) or horizontal rows (right).

Similarity: The similarity of color here makes you perceive these dots as forming black squares and color squares rather than two rows of black and colored dots.

Closure: Even though the lines are broken, we still see these figures as a circle and a square—an example of how we tend to “close” or “fill in” missing parts from what we know of the whole.

Continuity: Because of continuity, we are much more likely to see the figure on the left as being made up of two lines, A to B and C to D, than we are to see it as a figure made up of lines A to D and C to B or A to C and B to D.

Common Region: Similarity would suggest that people see two groups, stars and circles. But the colored backgrounds define a visible common region, and the tendency is to perceive three different groups.

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CONTIGUITY Contiguity isn't shown in Figure 3.18 because it involves not just nearness in space but nearness in time also. Basically, contiguity is the tendency to perceive two things that happen close together in time as being related. Usually the first occurring event is seen as causing the second event. Ventriloquists* make vocalizations without appearing to move their own mouths but move their dummy's mouth instead. The tendency to believe that the dummy is doing the talking is due largely to contiguity.

There is one other principle of perceptual grouping that was not one of the original principles. It was added to the list (and can be seen at the bottom of Figure 3.18) by Stephen Palmer (Palmer, 1992). In *common region*, the tendency is to perceive objects that are in a common area or region as being in a group. In Figure 3.18, people could perceive the stars as one group and the circles as another on the basis of similarity. But the colored backgrounds so visibly define common regions that people instead perceive three groups—one of which has both stars and circles in it.

DEPTH PERCEPTION

What is depth perception and what kind of cues are important for it to occur?

The capability to see the world in three dimensions is called **depth perception**. It's a handy ability because without it you would have a hard time judging how far away objects are. How early in life do humans develop depth perception? It seems to develop very early in infancy, if it is not actually present at birth. People who have had sight restored have almost no ability to perceive depth if they were blind from birth. Depth perception, like the constancies, seems to be present in infants at a very young age.  [LINK](#) to Learning Objective 8.5.

Various cues exist for perceiving depth in the world. Some require the use of only one eye (**monocular cues**) and some are a result of the slightly different visual patterns that exist when the visual fields** of both eyes are used (**binocular cues**).

MONOCULAR CUES Monocular cues are often referred to as **pictorial depth cues** because artists can use these cues to give the illusion of depth to paintings and drawings. Examples of these cues are discussed next and can be seen in Figure 3.19.

1. **Linear perspective:** When looking down a long interstate highway, the two sides of the highway appear to merge together in the distance. This tendency for lines that are actually parallel to *seem* to converge*** on each other is called **linear perspective**. It works in pictures because people assume that in the picture, as in real life, the converging lines indicate that the “ends” of the lines are a great distance away from where the people are as they view them.
2. **Relative size:** The principle of size constancy is at work in **relative size**, when objects that people expect to be of a certain size appear to be small and are, therefore, assumed to be much farther away. Movie makers use this principle to make their small models seem gigantic but off in the distance.
3. **Overlap:** If one object seems to be blocking another object, people assume that the blocked object is behind the first one and, therefore, farther away. This cue is also known as **interposition**.

*ventriloquist: an entertainer who, through the use of misdirection and skill, makes other objects, such as a dummy, appear to talk.

**visual field: the entire area of space visible at a given instant without moving the eyes.

***converge: come together.



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Figure 3.19 Examples of Pictorial Depth Cues

(a) Both the lines of the trees and the sides of the road appear to come together or converge in the distance. This is an example of *linear perspective*. (b) Notice how the larger pebbles in the foreground seem to give way to smaller and smaller pebbles near the middle of the picture. *Texture gradient* causes the viewer to assume that as the texture of the pebbles gets finer, the pebbles are getting farther away. (c) In *aerial* or *atmospheric perspective*, the farther away something is the hazier it appears because of fine particles in the air between the viewer and the object. Notice that the road and farmhouse in the foreground are in sharp focus while the mountain ranges are hazy and indistinct. (d) The depth cue of *relative size* appears in this photograph. Notice that the flowers in the distance appear much smaller than those in the foreground. Relative size causes smaller objects to be perceived as farther away from the viewer.

4. **Aerial (atmospheric) perspective:** The farther away an object is, the hazier the object will appear to be due to tiny particles of dust, dirt, and other pollutants in the air, a perceptual cue called **aerial (atmospheric) perspective**. This is why distant mountains often look fuzzy, and buildings far in the distance are blurrier than those that are close.
5. **Texture gradient:** If there are any large expanses of pebbles, rocks, or patterned roads (such as a cobblestone street) nearby, go take a look at them one day. The pebbles or bricks that are close to you are very distinctly textured, but as you look farther off into the distance, their texture becomes smaller and finer. **Texture gradient** is another trick used by artists to give the illusion of depth in a painting.
6. **Motion parallax:** The next time you're in a car, notice how the objects outside the car window seem to zip by very fast when they are close to the car, and objects in the distance, such as mountains, seem to move more slowly. This discrepancy in motion of near and far objects is called **motion parallax**.

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7. **Accommodation:** A monocular cue that is not one of the pictorial cues, **accommodation** makes use of something that happens inside the eye. The lens of the human eye is flexible and held in place by a series of muscles. The discussion of the eye earlier in this chapter mentioned the process of visual accommodation as the tendency of the lens to change its shape, or thickness, in response to objects near or far away. The brain can use this information about accommodation as a cue for distance. Accommodation is also called a “muscular cue.”

BINOCULAR CUES

As the name suggests, these cues require the use of two eyes.

1. **Convergence:** Another muscular cue, **convergence**, refers to the rotation of the two eyes in their sockets to focus on a single object. If the object is close, the convergence is pretty great (almost as great as crossing the eyes). If the object is far, the convergence is much less. Hold your finger up in front of your nose, and then move it away and back again. That feeling you get in the muscles of your eyes is convergence. (See Figure 3.20, left.)
2. **Binocular disparity:** **Binocular disparity** is a scientific way of saying that because the eyes are a few inches apart, they don't see exactly the same image. The brain interprets the images on the retina to determine distance from the eyes. If the two images are very different, the object must be pretty close. If they are almost identical, the object is far enough away to make the retinal disparity very small. You can demonstrate this cue for yourself by holding an object in front of your nose. Close one eye, note where the object is, and then open that eye and close the other. There should be quite a difference in views. But if you do the same thing with an object that is across the room, the image doesn't seem to “jump” or move nearly as much, if at all. (See Figure 3.20, right.)

In spite of all the cues for perception that exist, even the most sophisticated perceiver can still fail to perceive the world as it actually is, as the next section demonstrates.

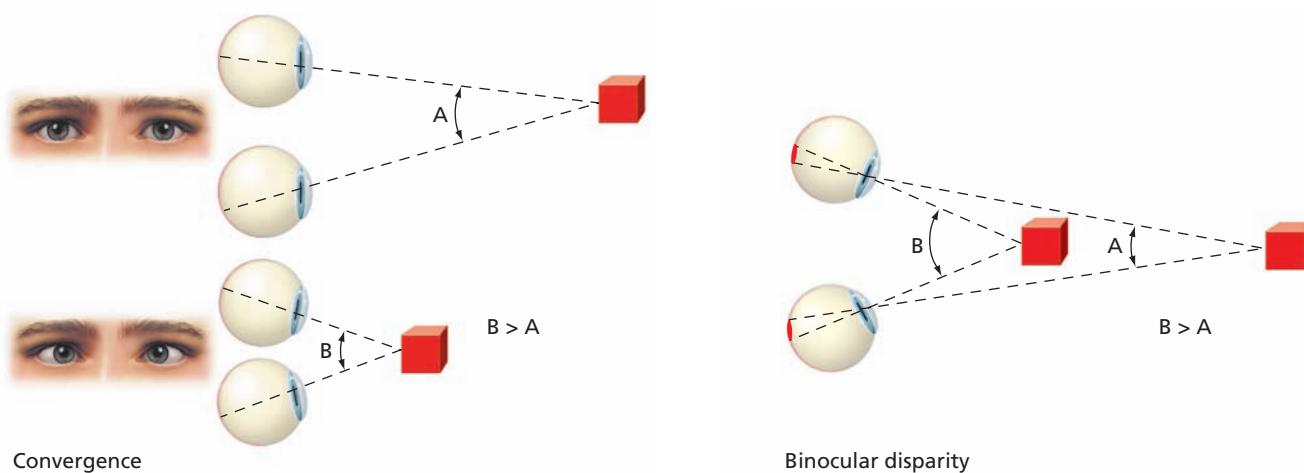


Figure 3.20 Binocular Cues to Depth Perception

(left) Convergence is a depth cue that involves the muscles of the eyes. When objects are far away, the eye muscles are more relaxed; when objects are close, the eye muscles move together, or converge. (right) Binocular disparity. Because your eyes are separated by several centimeters, each eye sees a slightly different image of the object in front of you. In A, the object is far enough away that the difference is small. In B, while the object is closer, there is a greater difference between what each eye sees. The brain interprets this difference as the distance of the object.

PERCEPTUAL ILLUSIONS

What are visual illusions and how can they and other factors influence and alter perception?

 You've mentioned the word illusion several times. Exactly what are illusions, and why is it so easy to be fooled by them?

An *illusion* is a perception that does not correspond to reality: People *think* they see something when the reality is quite different. Another way of thinking of illusions is as visual stimuli that "fool" the eye. (Illusions are not hallucinations: An illusion is a distorted perception of something that is really there, but a hallucination originates in the brain, not in reality.)

Research involving illusions can be very useful for both psychologists and neuroscientists. These studies often provide valuable information about how the sensory receptors and sense organs work and how humans interpret sensory input.

Sometimes illusions are based on early sensory processes, subsequent processing, or higher-level assumptions made by the brain's visual system (Eagleman, 2001; Macknik et al., 2008).

We've already discussed one visual illusion, color afterimages, which are due to opponent-processes in the retina or lateral geniculate nucleus (LGN) of the thalamus after light information has been detected by the rods and cones. Another postdetection, but still rather early, process has been offered for yet another illusion.

THE HERMANN GRID Look at the matrix of squares in Figure 3.21. Notice anything interesting as you look at different parts of the figure, particularly at the intersections of the white lines? You probably see gray blobs or diamonds that fade away or disappear completely when you try to look directly at them. This is the Hermann grid.

One explanation for this illusion is attributed to the responses of neurons in the primary visual cortex that respond best to bars of light of a specific orientation (Schiller & Carvey, 2005). Such neurons are called "simple cells" and were first discovered by David Hubel and Torsten Wiesel (Hubel & Wiesel, 1959). They also discovered other cells including "complex cells," which respond to orientation and movement, and "end-stopped cells," which respond best to corners, curvature, or sudden edges. Collectively these cells have been referred to as *feature detectors* because they respond to specific features of a stimulus. Hubel and Wiesel were later awarded the Nobel Prize for extensive work in the visual system. Other research into the Hermann grid illusion has documented that straight edges are necessary for this illusion to occur, as the illusion disappears when the edges of the grid lines are slightly curved, and further suggests that the illusion may be due to a unique function of how our visual system processes information (Geier et al., 2008).

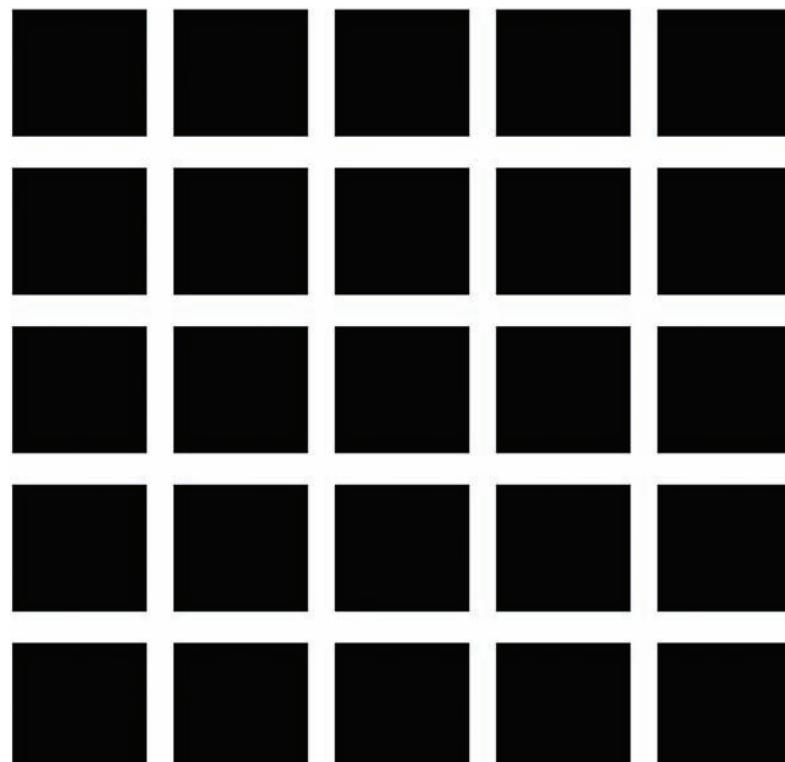


Figure 3.21 The Hermann Grid

Look at this matrix of squares. Do you notice anything interesting at the white intersections? What happens if you focus your vision directly on one of the intersections?

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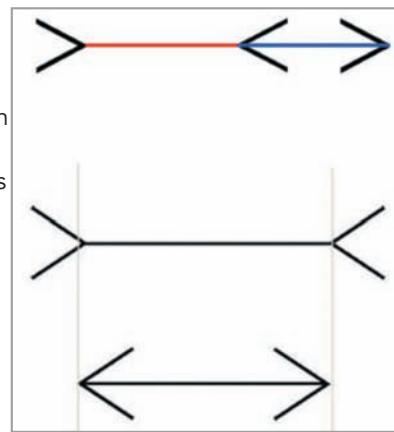
MÜLLER-LYER ILLUSION One of the most famous visual illusions, the **Müller-Lyer illusion**, is shown in Figure 3.22. The distortion happens when the viewer tries to determine if the two lines are exactly the same length. They are identical, but one line looks longer than the other. (It's always the line with the angles on the end facing outward.) You can try to determine the length of the lines yourself in the experiment, *Müller-Lyer Illusion*.

Simulation

Müller-Lyer Illusion

The Müller-Lyer optical illusion features a red line that appears to be longer than a blue line. In reality, both lines are equal in length. As can be seen in the bottom two lines, outward facing fins create a visual perception of greater length than do inward facing fins. In this experiment, we'll look at why this effect occurs, and determine if you are susceptible to the Müller-Lyer illusion.

[Go to the Experiment ►](#)



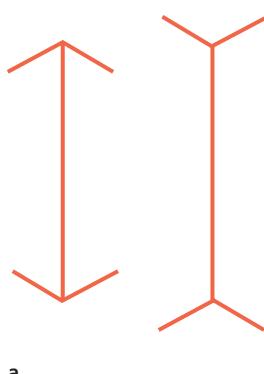
☞ Simulate the Experiment, Müller-Lyer Illusion, at [MyPsychLab](#)

Why is this illusion so powerful? The explanation is that most people live in a world with lots of buildings. Buildings have corners. When a person is outside a building, the corner of the building is close to that person, while the walls seem to be moving away (like the line with the angles facing inward). When the person is inside a building, the corner of the room seems to move away from the viewer while the walls are coming closer (like the line with the angles facing outward). In their minds, people “pull” the inward-facing angles toward them like the outside corners of a building, and they make the outward-facing angles “stretch” away from them like the inside corners of the room (Enns & Coren, 1995; Gregory, 1990).

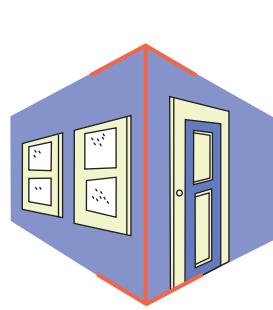
Marshall Segall and colleagues (Segall et al., 1966) found that people in Western cultures, having carpentered buildings with lots of straight lines and corners (Segall and colleagues refer to this as a “carpentered world”), are far more susceptible to this illusion

Figure 3.22 The Müller-Lyer Illusion

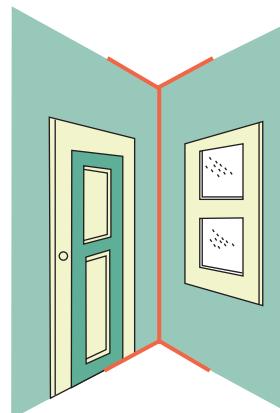
(a) Which line is longer? In industrialized Western countries, people generally see the lines in part (a) in situations similar to those in part (b). According to one theory, people have become accustomed to seeing right angles in their environment and assume that the short, slanted lines are forming a right angle to the vertical line. They make that assumption because they are accustomed to seeing corners, such as the ones depicted in the house interior shown on the right in part (b). Consequently, in part (a), they tend to perceive the line on the right as slightly longer than the line on the left.



a.



b.



than people from non-Western cultures (having round huts with few corners—an “uncarpentered world”). Richard Gregory (1990) found that Zulus, for example, rarely see this illusion. They live in round huts arranged in circles, use curved tools and toys, and experience few straight lines and corners in their world.

THE MOON ILLUSION Another common illusion is the *moon illusion*, in which the moon on the horizon* appears to be much larger than the moon in the sky (Plug & Ross, 1994). One explanation for this is that the moon high in the sky is all alone, with no cues for depth surrounding it. But on the horizon, the moon appears behind trees and houses, cues for depth that make the horizon seem very far away. The moon is seen as being behind these objects and, therefore, farther away from the viewer. Because people know that objects that are farther away from them yet still appear large are very large indeed, they “magnify” the moon in their minds—a misapplication of the principle of size constancy. This explanation of the moon illusion is called the *apparent distance hypothesis*. This explanation goes back to the second century A.D., first written about by the Greek–Egyptian astronomer Ptolemy and later further developed by an eleventh-century Arab astronomer, Al-Hazan (Ross & Ross, 1976).

ILLUSIONS OF MOTION Sometimes people perceive an object as moving when it is actually still. One example of this takes place as part of a famous experiment in conformity called the *autokinetic effect*. In this effect, a small, stationary light in a darkened room will appear to move or drift because there are no surrounding cues to indicate that the light is *not* moving. Another is the *stroboscopic motion* seen in motion pictures, in which a rapid series of still pictures will seem to be in motion. Many a student has discovered that drawing little figures on the edges of a notebook and then flipping the pages quickly will also produce this same illusion of movement.

Another movement illusion related to stroboscopic motion is the *phi phenomenon*, in which lights turned on in sequence appear to move. For example, if a light is turned on in a darkened room and then turned off, and then another light a short distance away is flashed on and off, it will appear to be one light moving across that distance. This principle is used to suggest motion in many theater marquee signs, flashing arrows indicating direction that have a series of lights going on and off in a sequence, and even in strings of decorative lighting, such as the “chasing” lights seen on houses at holiday times.

What about seeing motion in static images? There are several examples, both classic and modern, of illusory movement or apparent motion being perceived in a static image. The debate about the causes for such illusions, whether they begin in the eyes or the brain, has been going on for at least 200 years (Troncoso et al., 2008).

Look at Figure 3.23 on the next page. What do you see?

The “Rotating Snakes” illusion is one of many motion-illusion images designed by Dr. Akiyoshi Kitaoka. There have been a variety of explanations for this type of motion illusion, ranging from factors that depend on the image’s luminance and/or the color arrangement, or possibly slight differences in the time it takes the brain to process this



The moon illusion. When this moon is high in the night sky, it will still be the same size to the eye as it is now. Nevertheless, it is perceived to be much larger when on the horizon. In the sky, there are no objects for comparison, but on the horizon, objects such as this tree are seen as being in front of a very large moon.

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Figure 3.23 “Rotating Snakes”

Notice anything as you move your eyes over this image? The image is not moving; seeing the “snakes” rotate is due at least in part to movements of your eyes.

Created by and courtesy of Dr. Akiyoshi Kitaoka, Ritumeikan University.

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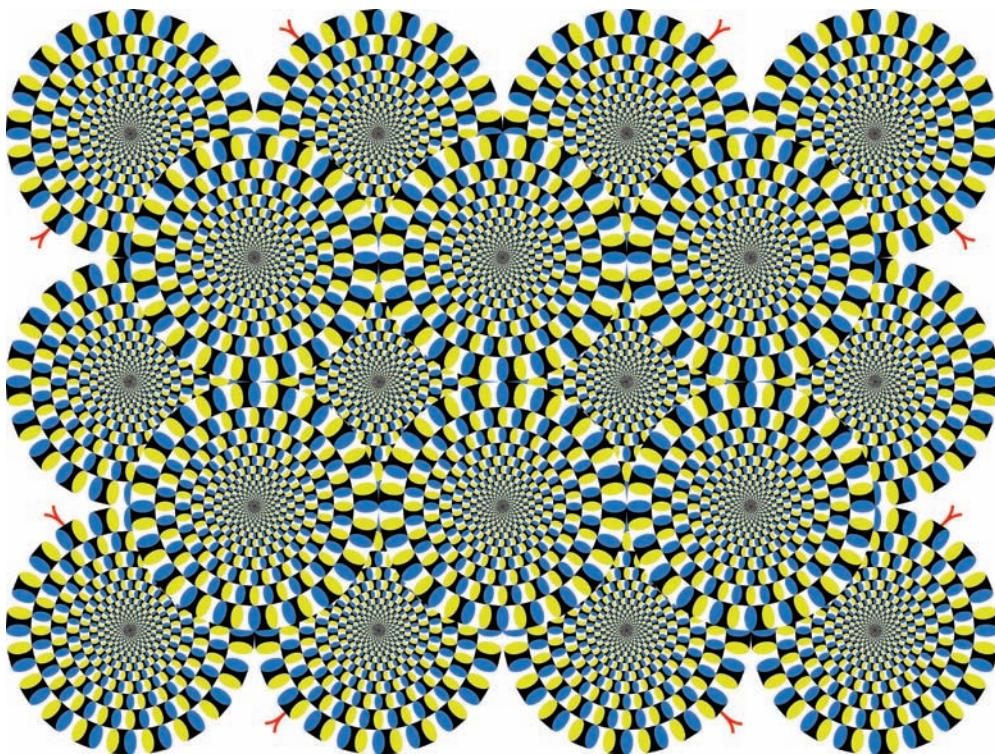
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information. When fMRI and equipment used to track eye movements were used to investigate participants’ perception of the illusion, researchers found that there was an increase in brain activity in a visual area sensitive to motion. However, this activity was greatest when accompanied by guided eye movements, suggesting eye movements play a significant role in the perception of the illusion (Kuriki et al., 2008).

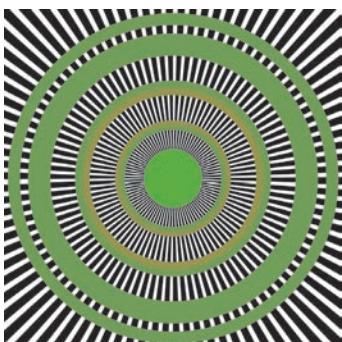
Eye movements have also been found to be a primary cause for the illusory motion seen in images based on a 1981 painting by Isia Levant, *The Enigma*. Look at the center of Figure 3.24; notice anything within the green rings? Many people will see the rings start to “sparkle” or the rings rotating. Why does this occur? By using special eye-tracking equipment that allowed them to record even the smallest of eye movement, researchers found that tiny eye movements called *microsaccades*, discussed earlier in the chapter, are directly linked to the perception of motion in *Enigma* and are at least one possible cause of the illusion (Troncoso et al., 2008).

These two studies highlight some of the advances researchers have made in examining questions related to visual perception. For more information about the study of visual illusions as used in magic, and the study of such illusions from a neuroscientific perspective, see the Applying Psychology section at the end of the chapter.

OTHER FACTORS THAT INFLUENCE PERCEPTION

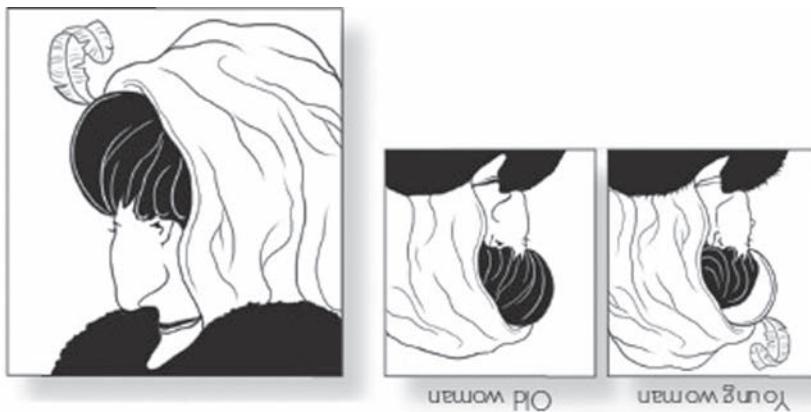
Human perception of the world is obviously influenced by things such as culture and misinterpretations of cues. Following are other factors that cause people to alter their perceptions.

People often misunderstand what is said to them because they were expecting to hear something else. People’s tendency to perceive things a certain way because their previous experiences or expectations influence them is called **perceptual set** or **perceptual expectancy**. Although expectancies can be useful in interpreting certain stimuli, they can also lead people down the wrong path. For example, look at the picture on the left in Figure 3.25. It is possible to see two different figures in this picture. Do you see a young girl? Or do you see an old woman? To see a more biased version of the two possibilities, turn the figure upside down and look at the two smaller pictures. What you see depends

**Figure 3.24 “Reinterpretation of Enigma”**

As in Figure 3.23, the motion you see in this static image is because of movements of your eyes, this time due more to tiny movements called *microsaccades*.

Created by and courtesy of Jorge Otero-Millan, Martinez-Conde Laboratory, Barrow Neurological Institute.

**Figure 3.25 Perceptual Set**

Look at the drawing on the left. What do you see? Now turn the figure upside down and look at the two smaller pictures. Would you have interpreted the original drawing differently if you had viewed these images first?

Source: Hill, "My Wife and My Mother-in-Law," Puck, p.11, 1915.

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upon what you expect to see. Participate in the experiment *Ambiguous Figures* to see how perceptual set influences how you identify various ambiguous figures.

Simulation

Ambiguous Figures

This experiment will present a series of trials in which you will be asked to identify what you see in ambiguous figures. Each trial will begin with the presentation of several pictures, followed by the test ambiguous figure. Once the ambiguous figure is presented, you will be asked to choose between several options to describe what you see.

[Go to the Experiment ▶](#)



The Ames Room illusion. This illusion is influenced by our past experiences and expectancies. The viewer perceives the room as a rectangle but in reality, it is actually a trapezoid with angled walls and floor.

☞ [Simulate the Experiment, Ambiguous Figures, at MyPsychLab](#)

The way in which people *interpret* what they perceive can also influence their perception. For example, people can try to understand what they perceive by using information they already have (as is the case of perceptual expectancy). But if there is no existing information that relates to the new information, they can look at each feature of what they perceive and try to put it all together into one whole.

Anyone who has ever worked on a jigsaw puzzle knows that it's a lot easier to put it together if there is a picture of the finished puzzle to refer to as a guide. It also helps to have worked the puzzle before—people who have done that already know what it's going to look like when it's finished. In the field of perception, this is known as **top-down processing**—the use of preexisting knowledge to organize individual features into a unified whole. This is also a form of perceptual expectancy.

If the puzzle is one the person has never worked before or if that person has lost the top of the box with the picture on it, he or she would have to start with a small section, put it together, and keep building up the sections until the recognizable picture appears. This analysis of smaller features and building up to a complete perception is called **bottom-up processing** (Cave & Kim, 1999). In this case, there is no expectancy to help organize the perception, making bottom-up processing more difficult in some

**Figure 3.26 The Devil's Trident**

At first glance, this seems to be an ordinary three-pronged figure. But a closer look reveals that the three prongs cannot be real as drawn. Follow the lines of the top prong to see what goes wrong.

respects. Fortunately, the two types of processing are often used together in perceiving the surrounding world.

Would people of different cultures perceive objects differently because of different expectancies? Some research suggests that this is true. For example, take a look at **Figure 3.26**. This figure is often called the “devil’s trident.” Europeans and North Americans insist on making this figure three dimensional, so they have trouble looking at it—the figure is impossible if it is perceived in three dimensions. But people in less technologically oriented cultures have little difficulty with seeing or even reproducing this figure, because they see it as a two-dimensional drawing, quite literally a collection of lines and circles rather than a solid object (Deregowski, 1969). By contrast, if you give Europeans and North Americans the task of reproducing a drawing of an upside-down face, their drawings tend to be more accurate because the upside-down face has become a “collection of lines and circles.” That is, they draw what they actually see in terms of light and shadow rather than what they “think” is there three dimensionally.

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Explore the Concept at [MyPsychLab](#)

The ABCs of Perception

perception

- method by which the sensations experienced at any given moment are interpreted and organized in some meaningful fashion
- may have unique features depending on sensory modality
- may not always be based on an accurate interpretation of the stimulus

perceptual illusions

CONCEPT MAP

has a subjective nature; no two people perceive the world in the exact same way

ability to perceive the world in three dimensions
made possible by differential information from the eyes

- an illusion is a perception that does not correspond to physical reality
- can be caused by default mode of sensory or brain processing and perceptual sets or expectancies

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. When opening a door, the actual image on your retina changes drastically but you still perceive the door as a rectangle. This is an example of
 - a. size constancy.
 - b. shape constancy.
 - c. color constancy.
 - d. brightness constancy.
2. Hunters who wear camouflage so that they can blend in with their surroundings are relying on which principle of perception?
 - a. shape constancy
 - b. expectancy
 - c. figure-ground relationships
 - d. depth perception
3. What monocular depth cue can best explain why railroad tracks appear to come together in the distance?
 - a. convergence
 - b. linear perspective
 - c. overlap
 - d. texture gradient
4. The Müller-Lyer illusion occurs more frequently in
 - a. children than adults.
 - b. men than women.
 - c. people living in a Western culture.
 - d. individuals living in poverty.
5. Jason’s uncle claimed to have seen a black panther in the trees beside the highway although no one else saw it. Knowing that his uncle has been looking for a black panther for years, Jason attributes his uncle’s “sighting” to
 - a. perceptual set.
 - b. perceptual defense.
 - c. bottom-up processing.
 - d. cognitive convergence.
6. The first time Megan had to install a ceiling fan in her new home, it took a long time. But later when she helped install a ceiling fan in her best friend’s home, she completed the job very quickly. Her improved speed and skill can partially be attributed to
 - a. bottom-up processing.
 - b. top-down processing.
 - c. perceptual expectancy.
 - d. perceptual set.

Applying Psychology to Everyday Life: Beyond "Smoke and Mirrors"—The Psychological Science and Neuroscience of Magic

Many people enjoy watching magic acts in person or on television. Perhaps you have been amazed by a Mindfreak® performed by Criss Angel or the performance and edgy antics of Penn & Teller. If you are one of those people, you likely witnessed a performance that included many various illusions. And like many of us, you probably wondered at some point in the performance, "How did they do that?" Did you think the tricks were due to some type of special device (such as a fake thumb tip for hiding a scarf), or perhaps they were accomplished with "smoke and mirrors," or maybe the magician distracted the audience with one movement while actually doing something else to pull off the illusion? Magicians use many techniques to take advantage of, or manipulate, our actual level of awareness of what is happening right in front of us or perhaps to manipulate our attention.  [Watch the Video](#), *What's In It For Me?: Perceptual Magic in Art: Interview with Sound Artist, at MyPsychLab*

Though magic is not a new topic of interest in psychology, there has been renewed interest in recent years, especially in the neuroscientific study of magic. This view suggests that researchers can work alongside magicians so we may be able to gain a better understanding of various cognitive and perceptual processes by not only examining the sensory or physical mechanics behind magic tricks, or even the psychological explanations, but to look further by examining what is happening in the brain (Macknik & Martinez-Conde, 2009).

Dr. Stephen L. Macknik and Dr. Susanna Martinez-Conde of the Barrow Neurological Institute are two neuroscientists who have teamed up with professional magicians to study their techniques and tricks in the effort to better understand the brain mechanisms underlying the illusions and how that information can be used by researchers in the laboratory. They have identified several types of illusions that can be used alone or in combination with others to serve as a basis for various magic tricks; two of these are visual illusions and cognitive illusions (Macknik et al., 2008).

As discussed earlier in the chapter, visual illusions occur when our individual perception does not match a physical stimulus. These illusions are caused by organizational or processing biases in the brain. Furthermore, our brain activity from the perception does not directly match the brain activity associated with the physical stimulus (Macknik et al., 2008). One example Dr. Macknik and Dr. Martinez-Conde point out is similar to a trick you may have performed yourself in grade school. Did you ever take a pencil or pen, grasp it in the middle, and then shake or wiggle it up and down? If you did it correctly, the pen or pencil would appear to bend or be made of rubber. Magicians use this illusion when they "bend" solid objects, such as spoons. So what is the brain explanation? We have special neurons in the visual cortex that are sensitive to both motion and edges called *end-stopped neurons*. These neurons respond differently if an object is bouncing or moving up and down quickly, causing us to perceive a solid spoon or pencil as if it is bending.

Another effect or trick that is based on the functioning of our visual system is when a magician makes an object disappear, such as a ball vanishing into the air or perhaps the outfit of an assistant changing suddenly. By showing the audience the target object, such as the ball or outfit, and then removing it very quickly from the visual field, the *persistence of vision* effect will make it appear that the object is still there. This is due to a response in vision neurons called the after-discharge, which will create an afterimage that lasts for up to 100 milliseconds after a stimulus is removed (Macknik et al., 2008). Again, you may have performed a similar trick if you have ever taken a lit sparkler or flashlight and twirled it around quickly to make a trail of light in the dark.



Penn & Teller have performed together for over 30 years and have joined neuroscientists in the effort to gain insights into the brain mechanisms behind magical illusions.

Questions for Further Discussion

1. The examples highlighted in this discussion are based on visual illusions; can you think of a magic trick or performance that may have been based on an illusion in a different sensory modality?
2. Of the neuroimaging methods covered in Chapter Two, which methods might be best for examining the brain activity of someone who is watching a magic performance? Why?

Writing Prompt

▼ The Gestalt psychologists maintained that when people perceive sensory elements their tendency is to see things in terms of the entire form or pattern rather than as individual parts. Identify and describe these basic principles of perceptual organization from the Gestalt perspective: figure-ground, similarity, proximity, and closure.

Words: 0

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chapter summary

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The ABCs of Sensation

3.1 How does sensation travel through the central nervous system, and why are some sensations ignored?

- Sensation is the activation of receptors located in the eyes, ears, skin, nasal cavities, and tongue.
- Sensory receptors are specialized forms of neurons that are activated by different stimuli such as light and sound.
- A just noticeable difference is the point at which a stimulus is detectable half the time it is present.
- Weber's law of just noticeable differences states that the just noticeable difference between two stimuli is always a constant.
- Absolute thresholds are the smallest amount of energy needed for conscious detection of a stimulus at least half the time it is present.
- Subliminal stimuli are stimuli presented just below the level of conscious awareness, and subliminal perception has been demonstrated in the laboratory. It has not been shown to be effective in advertising.
- Habituation occurs when the brain ignores a constant stimulus.
- Sensory adaptation occurs when the sensory receptors stop responding to a constant stimulus.

The Science of Seeing

3.2 What is light, and how does it travel through the various parts of the eye?

- Brightness corresponds to the amplitude of light waves, whereas color corresponds to the length of the light waves.

- Saturation is the psychological interpretation of wavelengths that are all the same (highly saturated) or varying (less saturated).
- Light enters the eye and is focused through the cornea, passes through the aqueous humor, and then through the hole in the iris muscle called the pupil.
- The lens also focuses the light on the retina, where it passes through ganglion and bipolar cells to stimulate the rods and cones.

3.3 How do the eyes see, and how do the eyes see different colors?

- Rods detect changes in brightness but do not see color and function best in low levels of light. They are found everywhere in the retina except the center, or fovea.
- Cones are sensitive to colors and work best in bright light. They are responsible for the sharpness of visual information and are found in the fovea.
- Trichromatic theory of color perception assumes three types of cones: red, green, and blue. All colors would be perceived as various combinations of these three.
- Opponent-process theory of color perception assumes four primary colors of red, green, blue, and yellow. Colors are arranged in pairs, and when one member of a pair is activated, the other is not.
- Color blindness is a total lack of color perception, whereas color-deficient vision refers to color perception that is limited primarily to yellows and blues or reds and greens only.

The Hearing Sense: Can You Hear Me Now?

3.4 What is sound, and how does it travel through the various parts of the ear?

- Sound has three aspects: pitch (frequency), loudness, and timbre (purity).
- Sound enters the ear through the visible outer structure, or pinna, and travels to the eardrum and then to the small bones of the middle ear.
- The bone called the stirrup rests on the oval window, causing the cochlea and basilar membrane to vibrate with sound.
- The organ of Corti on the basilar membrane contains the auditory receptors, which send signals to the brain about sound qualities as they vibrate.
- Place theory states that the location of the hair cells on the organ of Corti correspond to different pitches of sound. This can explain pitch above 1000 Hz.
- Frequency theory states that the speed with which the basilar membrane vibrates corresponds to different pitches of sound. This can explain pitch below 1000 Hz.
- The volley principle states that neurons take turns firing for sounds above 400 Hz and below 4000 Hz.

3.5 Why are some people unable to hear, and how can their hearing be improved?

- Conduction hearing impairment is caused by damage to the outer or middle ear structures, whereas nerve hearing impairment is caused by damage to the inner ear or auditory pathways in the brain.
- Hearing aids may be used for those with conductive hearing impairment, while cochlear implants may restore some hearing to those with nerve hearing impairment.

Chemical Senses: It Tastes Good and Smells Even Better

3.6 How do the senses of taste and smell work, and how are they alike?

- Gustation is the sense of taste. Taste buds in the tongue receive molecules of substances, which fit into receptor sites.
- The five basic types of taste are sweet, sour, salty, bitter, and umami (brothy).
- Olfaction is the sense of smell. The olfactory receptors in the upper part of the nasal passages receive molecules of substances and create neural signals that then go to the olfactory bulbs under the frontal lobes.
- Both gustation and olfaction are chemical senses. Gustation involves detection of chemicals dissolved in saliva whereas olfaction involves detection of chemicals suspended in the air.

Somesthetic Senses: What the Body Knows

3.7 What allows people to experience the sense of touch, pain, motion, and balance?

- The somesthetic senses include the skin senses and the vestibular senses.
- Pacinian corpuscles respond to pressure, certain nerve endings around hair follicles respond to pain and pressure, and free nerve endings respond to pain, pressure, and temperature.

- The gate-control theory of pain states that when receptors sensitive to pain are stimulated, a neurotransmitter called substance P is released into the spinal cord, activating other pain receptors by opening “gates” in the spinal column and sending the message to the brain.
- The kinesthetic senses allow the brain to know the position and movement of the body through the activity of special receptors responsive to movement of the joints and limbs.
- The vestibular sense also contributes to the body’s sense of spatial orientation and movement through the activity of the otolith organs (up-and-down movement) and the semicircular canals (movement through arcs).
- Motion sickness is explained by sensory conflict theory, in which information from the eyes conflicts with information from the vestibular sense, causing nausea.

The ABCs of Perception

3.8 What are perception and perceptual constancies?

- Perception is the interpretation and organization of sensations.
- Size constancy is the tendency to perceive objects as always being the same size, no matter how close or far away they are.
- Shape constancy is the tendency to perceive objects as remaining the same shape even when the shape of the object changes on the retina of the eye.
- Brightness constancy is the tendency to perceive objects as a certain level of brightness, even when the light changes.

3.9 What are the Gestalt principles of perception?

- The Gestalt psychologists developed several principles of perception that involve interpreting patterns in visual stimuli. The principles are figure-ground relationships, closure, similarity, continuity, contiguity, and common region.

3.10 What is depth perception, and what kind of cues are important for it to occur?

- Depth perception is the ability to see in three dimensions.
- Monocular cues for depth perception include linear perspective, relative size, overlap, aerial (atmospheric) perspective, texture gradient, motion parallax, and accommodation.
- Binocular cues for depth perception include convergence and binocular overlap.

3.11 What are visual illusions and how can they and other factors influence and alter perception?

- Illusions are perceptions that do not correspond to reality or are distortions of visual stimuli.
- Perceptual set or expectancy refers to the tendency to perceive objects and situations in a particular way because of prior experiences.
- Top-down processing involves the use of preexisting knowledge to organize individual features into a unified whole.
- Bottom-up processing involves the analysis of smaller features, building up to a complete perception.

test YOURSELF

ANSWERS AVAILABLE IN ANSWER KEY.

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Pick the best answer.

1. In making a large pot of chili for a family reunion, you find that you have to add 1 onion to your pot of chili that already has 5 onions mixed in it to notice a difference. According to Weber's Law, how many onions would you have to add to notice a difference if you are making twice as much chili with 10 onions?
 - a. 1
 - b. 2
 - c. 4
 - d. 5
2. A study purportedly conducted by James Vicary teaches us what about the power of subliminal perception and its effect on advertising?
 - a. Subliminal advertising can profoundly affect a consumer's decision-making process.
 - b. Subliminal advertising affects a consumer's decision-making process but only when it involves comfort foods such as popcorn and soda.
 - c. Subliminal advertising is effective on those who believe in the power of the unconscious.
 - d. Subliminal advertising was never supported, since Vicary ultimately admitted that he never truly conducted such a study.
3. You detect the strong smell of cedar when you enter a furniture store. However, after a short while in the store, you no longer can detect the smell. This process is known as
 - a. sensory adaptation.
 - b. habituation.
 - c. perceptual constancy.
 - d. accommodation.
4. Which of the following terms refers to the amplitude of a light wave such as how high or low the wave is?
 - a. color
 - b. brightness
 - c. pitch
 - d. hue
5. When an ophthalmologist surgically corrects a patient's vision through LASIK or PRK, the doctor is making adjustments to the patient's
 - a. cornea.
 - b. lens.
 - c. retina.
 - d. iris.
6. What part of the eye hardens as we age thus causing many to suffer from presbyopia?
 - a. rods
 - b. cones
 - c. lens
 - d. vitreous humor
7. A deer's inability to quickly respond to the headlights of an approaching car is due to what sensory phenomenon?
 - a. dark adaptation
 - b. light adaptation
 - c. afterimage
 - d. opponent-process theory
8. The hammer, the anvil, and the stirrup are part of the
 - a. outer ear.
 - b. middle ear.
 - c. inner ear.
 - d. cochlea.
9. John has played his music loudly for years. Now, in his 20s, he finds he has a continuous ringing in both of his ears. What would John probably be diagnosed with?
 - a. Tinnitus, which is a nerve-based disorder that has no permanent cure.
 - b. Conduction-based hearing impairment; however, hearing aids may be able to help.
 - c. Damage to the pinna, which can be corrected with surgery.
 - d. Regardless of the disorder, John will ultimately require a cochlear implant.
10. Studies show that taste preference can typically begin
 - a. before a baby is born.
 - b. in the first 3–6 months after birth.
 - c. by age 1.
 - d. during preschool.
11. Jude is suffering from a severe cold. His nose has been stopped up for several days. What effect, if any, might his cold have on his sense of taste?
 - a. His sense of taste will be increased since he isn't receiving additional sensory input from his smell.
 - b. His sense of taste will be dulled since taste and smell often work together.
 - c. His sense of taste will get better but not until 48 hours after he loses his sense of smell.
 - d. His sense of taste will be no better or worse since the senses of taste and smell are completely separate.
12. If a child suffers from congenital analgesia, why must he or she be careful when outside playing?
 - a. The child often cannot hear sounds unless he or she is within 3 feet of the source.
 - b. The child cannot feel pain and can suffer injuries without even knowing it.
 - c. The child lacks the ability to react to a dangerous situation.
 - d. The child's sense of smell does not work properly.
13. If Tabitha closes her eyes when she rides in her parent's car, she can still tell that the car is moving. This is due to the movement of tiny crystals in the
 - a. outer ear.
 - b. cochlea.
 - c. otolith organs.
 - d. middle ear.
14. A child may sometimes play by quickly turning around in a circle. When the child stops, he or she often feels like his or her head is still spinning. What is responsible for this sensation?
 - a. fluid still rotating in the semicircular canals
 - b. proprioceptors
 - c. compression of the otolith organs
 - d. disruption of the otolith crystals

15. Little Karla is with her mother at the docks waiting for her daddy to return from his naval deployment. While the boat is still a ways out, her mother says, "There is daddy's boat." Karla is confused. She cannot understand how her dad can be on a boat that is so small that she can hold up her thumb and boat disappears. It's safe to assume that Karla does not yet understand
- a. size constancy.
 - b. shape constancy.
 - c. brightness constancy.
 - d. color constancy.
16. XX XX XX XXXXXX
XX XX XX XXXXXX
XX XX XX XXXXXX
- In viewing the items above, seeing three columns of Xs on the left versus three rows of Xs on the right can be explained by the Gestalt principle of _____.
- a. closure
 - b. similarity
 - c. proximity
 - d. contiguity
17. From past experience, you know that commercial jets typically fly around 500 miles per hour at a height of 30,000 feet. However, as you watch one fly high overhead, it seems to slowly pass by. What monocular depth cue best explains this?
- a. motion parallax
 - b. linear perspective
 - c. overlap
 - d. texture gradient
18. The Müller-Lyer illusion is influenced greatly by one's
- a. age.
 - b. gender.
 - c. level of intellect.
 - d. culture.
19. Allison opened her new jigsaw puzzle but soon realized that she had the same puzzle when she was a child. With her past experience to rely upon, Allison will probably use _____ to help her reassemble the puzzle.
- a. bottom-up processing
 - b. top-down processing
 - c. perceptual expectancy
 - d. perceptual set
20. Kip enjoys playing with sparklers on the 4th of July. He always loves watching a friend run with a sparkler and the momentary trail of light that seems to be left behind. Which aspect of our visual system best explains this trail of light?
- a. lateral inhibition
 - b. microsaccades of the eyes
 - c. persistence of vision
 - d. achromatopsia

4

consciousness

California police departments are cracking down on texting and talking on cell phones while driving, using a video game-like simulator to teach college students just how dangerous trying to do two such demanding mental processes at once can be. AT&T has a safety campaign in which public service announcements recount the disastrous, and often fatal, consequences of texting while driving—both sending texts and receiving them. A majority of states now ban all cell phone use by new drivers and text messaging for all drivers. Why? Because contrary to common belief, we cannot truly multitask, and both driving and talking or texting on a phone are thought processes that make heavy demands on our conscious awareness.

What are some ways in which you multitask throughout the day? How does multitasking impact your awareness or affect the quality of your work, if at all?



A woman with dark hair, wearing a white t-shirt and a black jacket, stands in front of a white background. Floating around her are various icons: a crescent moon and a small cloud to the left, a large blue circle to the right, a red and white capsule, and a blue capsule above it. At the bottom of the frame is a dark grey video player bar with a play button, volume control, and other video controls. Below the video player is a button labeled "Watch the Video at MyPsychLab.com".

Why study consciousness?

In a very real sense, to understand consciousness is to understand what it means to be who we are. Waking, sleeping, dreaming, daydreaming, and other forms of conscious awareness make up the better part of the human experience. Lack of sleep may increase the likelihood of diabetes, interfere with the onset of puberty changes, decrease memory for learning, and increase weight gain. Drug use can affect consciousness as well, and not always to our benefit. Clearly, an understanding of the workings of the conscious mind is important to both our mental and our physical well-being.

Learning objectives

- 4.1** What does it mean to be conscious, and are there different levels of consciousness?
- 4.2** Why do people need to sleep, and how does sleep work?
- 4.3** What are the different stages of sleep, including the stage of dreaming and its importance?
- 4.4** How do sleep disorders interfere with normal sleep?
- 4.5** Why do people dream, and what do they dream about?
- 4.6** How does hypnosis affect consciousness?
- 4.7** What is the difference between a physical dependence and a psychological dependence on a drug?
- 4.8** How do stimulants and depressants affect consciousness and what are the dangers associated with taking them, particularly alcohol?
- 4.9** What are some of the effects and dangers of using hallucinogens, including marijuana?
- 4.10** How can the workings of our consciousness explain “supernatural” visitations?



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What Is Consciousness?

What does it mean to be conscious, and are there different levels of consciousness?

 What exactly is meant by the term consciousness? I've heard it a lot, but I'm not sure that I know everything it means.

Consciousness is one of those terms that most people think they understand until someone asks them to define it. Various sorts of scientists, psychologists, neuroscientists, philosophers, and even computer scientists (who have been trying to develop an artificial intelligence for some time now), have tried to define consciousness, and so there are several definitions—one for nearly every field in which consciousness is studied. Philosopher Daniel Dennett, in his 1991 book *Consciousness Explained*, asserts that (contrary to the opinion of William James in his 1894 text) there is no single stream of consciousness but rather multiple “channels,” each of which is handling its own tasks (Dennett, 1991). All of these channels operate in parallel, a kind of chaos of consciousness. People must somehow organize all this conscious experience, and that organization is influenced by their particular social groups and culture.

Do animals experience consciousness in the same way as people? That is a question too complex to answer fully here, but many researchers into animal behavior, language, and cognition have some reason to propose that there is a kind of consciousness in at least some animals, although its organization would naturally not be the same as human consciousness (Block, 2005; Browne, 2004; Hurley & Nudds, 2006; Koch & Mormann, 2010). In their chapter on neurobiology and consciousness, Dr. Christof Koch and Dr. Florian Mormann (Koch & Mormann, 2010, p. 1225) state that “there is little reason to doubt that other mammals share conscious feelings ... with humans.” Chapter Seven in this text includes a discussion of animal language that touches on some of these issues.

 to Learning Objective 7.10.

DEFINITION OF CONSCIOUSNESS



 So where does that leave us in the search for a working definition of consciousness?

For our purposes, a more useful definition of consciousness might be the following: **Consciousness** is your awareness of everything that is going on around you and inside your own head at any given moment, which you use to organize your behavior (Farthing, 1992), including your thoughts, sensations, and feelings. In a cognitive neuroscience view, consciousness is generated by a set of action potentials in the communication among neurons just sufficient to produce a specific perception, memory, or experience in our awareness (Crick & Koch, 1990, 2003; Koch & Mormann, 2010). In other words, your eyes see a dog, the neurons along the optic pathway to the occipital lobe’s visual cortex are activated, and the visual association cortex is activated to identify the external stimulus as a “dog.” Bam!—consciousness!  to Learning Objective 2.9.  Watch the **Video**, *The Big Picture: States of Consciousness*, at **MyPsychLab**.

Much of people’s time awake is spent in a state called **waking consciousness** in which their thoughts, feelings, and sensations are clear and organized, and they feel alert. But there are many times in daily activities and in life when people experience states of consciousness that differ from this organized waking state. These variations are called “altered states of consciousness.”

ALTERED STATES OF CONSCIOUSNESS

An **altered state of consciousness** occurs when there is a shift in the quality or pattern of your mental activity. Thoughts may become fuzzy and disorganized and you may feel less alert, or your thoughts may take bizarre turns, as they so often do in dreams. Sometimes being in an altered state may mean being in a state of *increased* alertness, as when under the influence of a stimulant. You may also divide your conscious awareness, as when you drive to work or school and then wonder how you got there—one level of conscious awareness was driving, while the other was thinking about the day ahead, perhaps. This altered state of divided consciousness can be a dangerous thing, as many people who try to drive and talk on a cell phone at the same time have discovered. Studies have shown that driving while talking on a cell phone, even a hands-free phone, puts a person at the same degree of risk as driving under the influence of alcohol (Alm & Nilsson, 1995; Briem & Hedman, 1995; Strayer & Drews, 2007; Strayer & Johnston, 2001; Strayer et al., 2006). Texting while driving is more than risky—it can be murderous (Eastern Virginia Medical School, 2009; Wang et al., 2012).  [Learning Objective PIA.2](#). Participate in the experiment *What Altered States Have You Experienced?* to discover more about your own encounters with various states of consciousness.



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Simulation

What Altered States Have You Experienced?

In altered states of consciousness there is a shift in the way we perceive and judge the world. Altered states can occur naturally, such as sleep, or we may make them happen, such as getting hypnotized. This survey asks you about your experiences with various types of altered states of consciousness.

[Go to the Experiment ▶](#)

Have you EVER intentionally tried to put yourself into an altered state of consciousness other than sleep (by meditating, taking drugs, hypnosis, etc)?

- Yes
- No
- Not Sure
- Prefer Not to State

 [Simulate the Experiment, What Altered States Have You Experienced? on MyPsychLab](#)

There are many forms of altered states of consciousness. For example, daydreaming, being hypnotized, or achieving a meditative state are usually considered to be altered states.  [Learning Objective 11.7](#). Being under the influence of certain drugs such as caffeine, tobacco, or alcohol are definitely examples of altered states. Over several decades, there has been a definite rise in the use of stimulants that would ordinarily be prescribed for children and adolescents with attention-deficit/hyperactivity disorder, but are also used by college students and older adults who feel that the drugs give them an “edge” (Szalavitz, 2009; Zkasekis & Vitlielo, 2012). But the most common altered state people experience is the one they spend about a third of their lives in on a nightly basis—sleep.  [Watch the Video, What's In It For Me?: Altered States of Consciousness, at MyPsychLab](#)

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Sleep, according to Webb (1992), is the “gentle tyrant.” As this picture shows, when the urge to sleep comes upon a person, it can be very difficult to resist—no matter where that person is at the time. Can you think of a time or place when you fell asleep without meaning to do so? Why do you think it happened?

Sleep

Have you ever wondered why people have to sleep? They could get so much more work done if they didn’t have to sleep, and they would have more time to play and do creative things.

THE BIOLOGY OF SLEEP

Why do people need to sleep, and how does sleep work?

Sleep was once referred to as “the gentle tyrant” (Webb, 1992). People can try to stay awake, and sometimes they may go for a while without sleep, but eventually they *must* sleep. One reason for this fact is that sleep is one of the human body’s *biological rhythms*, natural cycles of activity that the body must go through. Some biological rhythms are monthly, like the cycle of a woman’s menstruation, whereas others are far shorter—the beat of the heart is a biological rhythm. But many biological rhythms take place on a daily basis, like the rise and fall of blood pressure and body temperature or the production of certain body chemicals (Moore-Ede et al., 1982). The most obvious of these is the sleep–wake cycle (Baehr et al., 2000).

THE RHYTHMS OF LIFE: CIRCADIAN RHYTHMS The sleep–wake cycle is a **circadian rhythm**. The term actually comes from two Latin words, *circa* (“about”) and *diem* (“day”). So a circadian rhythm is a cycle that takes “about a day” to complete.

For most people, this means that they will experience several hours of sleep at least once during every 24-hour period. The sleep–wake cycle is ultimately controlled by the brain, specifically by an area within the *hypothalamus*, the tiny section of the brain that influences the glandular system. [LINK](#) to Learning Objective 2.8. [Watch the Video](#), *The Basics: Rhythms of Consciousness: Sleep Cycles*, at [MyPsychLab](#)



There was a big fuss over something called melatonin a few years ago—isn’t melatonin supposed to make people sleep?

THE ROLE OF THE HYPOTHALAMUS: THE MIGHTY MITE A lot of people were buying supplements of *melatonin* (a hormone normally secreted by the pineal gland) several years ago, hoping to sleep better and perhaps even slow the effects of aging (Folkard et al., 1993; Herxheimer & Petrie, 2001; Young, 1996). The release of melatonin is influenced by a structure deep within the tiny hypothalamus in an area called the *suprachiasmatic* (SOO-prah-ki-AS-ma-tik) *nucleus*, the internal clock that tells people when to wake up and when to fall asleep (Quintero et al., 2003; Yamaguchi et al., 2003; Zisapel, 2001). The suprachiasmatic nucleus, or SCN, is sensitive to changes in light. As daylight fades, the SCN tells the pineal gland (located in the base of the brain) to secrete melatonin (Bondarenko, 2004; Delagrange & Guardiola-Lemaitre, 1997). As melatonin accumulates, a person will feel sleepy. As the light coming into the eyes increases (as it does in the morning), the SCN tells the pineal gland to stop secreting melatonin, allowing the body to awaken. That’s a lot of control for such a small part of the brain.

Melatonin supplements are often used to treat a condition called *jet lag*, in which the body’s circadian rhythm has been disrupted by traveling to another time zone. There is some evidence that melatonin may be linked to a healthier metabolism (Cardinali et al., 2013). It may help people who suffer from sleep problems due to shift work. Shift-work sleep problems, often attributed to the custom of having workers change shifts against their natural circadian rhythms (e.g., from a day shift to a night shift, and then back again to an evening shift), have been linked to increased accident rates, increased absence from work due to illness, and lowered productivity rates (Folkard et al., 1993; Folkard & Tucker, 2003; Folkard et al., 2005). In addition to melatonin supplements, it has been found that gradually changing the shifts that workers take according to the natural cycle of the day (e.g., from day shift to evening shift to night shift, rather than from day shift directly to night shift) has significantly reduced the problems (Czeisler et al., 1982; Folkard et al., 2006).

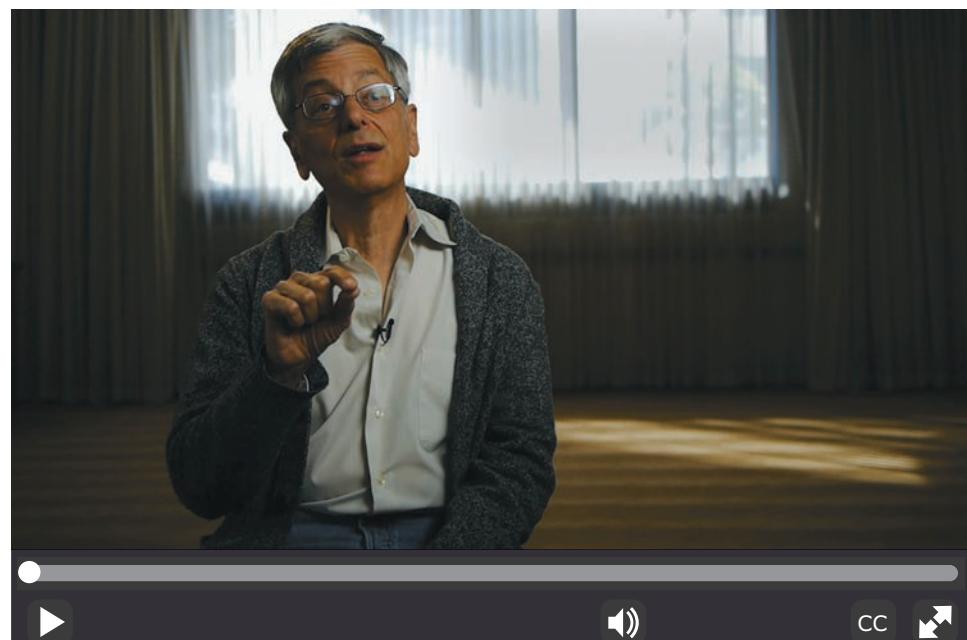
Melatonin is not the whole story, of course. Several neurotransmitters are associated with arousal and sleep regulation, including serotonin. It was once theorized that serotonin promoted sleepiness. However, it is not that simple. Serotonin-producing neurons are most active during wakefulness, less active during SWS, and relatively inactive during REM (Elmenhorst et al., 2012; Hornung, 2012; Siegel, 2011). Furthermore, effects differ based on which serotonergic cells are firing and which brain structures are receiving those messages. Lastly, some serotonin receptors are excitatory and others are inhibitory. For example, some receptors facilitate some stages of sleep while others inhibit other stages (Siegel, 2011).

Body temperature plays a part in inducing sleep, too. The suprachiasmatic nucleus, as part of the hypothalamus, controls body temperature. The higher the body temperature, the more alert people are; the lower the temperature, the sleepier they are. When people are asleep at night, their body temperature is at its lowest level. Be careful: The research on the effects of serotonin and body temperature on sleep is correlational, we cannot assume causation and there are many different factors involved in sleep. [LINK](#) to Learning Objective 1.9.

In studies in which volunteers spend several days without access to information about day or night, their sleep-wake cycles lengthened (Czeisler, 1995; Czeisler et al., 1980). The daily activities of their bodies—such as sleeping, waking, waste production, blood pressure rise and fall, and so on—took place over a period of 25 hours rather than 24 hours. Based on this research, it appears that the suprachiasmatic nucleus may be responsible for resetting the body's biological "clock" to a 24-hour cycle every day.

In the same studies, body temperature dropped consistently even in the absence of light (Czeisler et al., 1980). As body temperature dropped, sleep began, giving further support to the importance of body temperature in the regulation of sleep.

THE IMPORTANCE OF SLEEP AND THE PRICE OF NOT SLEEPING How much sleep is enough sleep? The answer varies from person to person because of each person's age and possibly inherited sleep needs (Feroah et al., 2004), but most young adults need about 7 to 9 hours of sleep each 24-hour period in order to function well. (See **Figure 4.1** on the next page.). Some people are short sleepers, needing only 4 or 5 hours, whereas others are long sleepers and require more than 9 hours of sleep (McCann & Stewin, 1988). As we age, we seem to sleep less during each night until the average length of sleep approaches only 6 hours. As sleep researcher Dr. Jerry Siegel describes in the video *The Basics: Rhythms of Consciousness: How Much Sleep Do We Need?*, the amount of sleep that we get can have an impact on our health.



[Watch the Video](#), *The Basics: Rhythms of Consciousness: How Much Sleep Do We Need?*, at [MyPsychLab](#)

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Figure 4.1 Sleep Patterns of Infants and Adults

Infants need far more sleep than older children and adults. Both REM sleep and NREM sleep decrease dramatically in the first 10 years of life, with the greatest decrease in REM sleep. Nearly 50 percent of an infant's sleep is REM, compared to only about 20 percent for a normal, healthy adult (Roffwarg, 1966).

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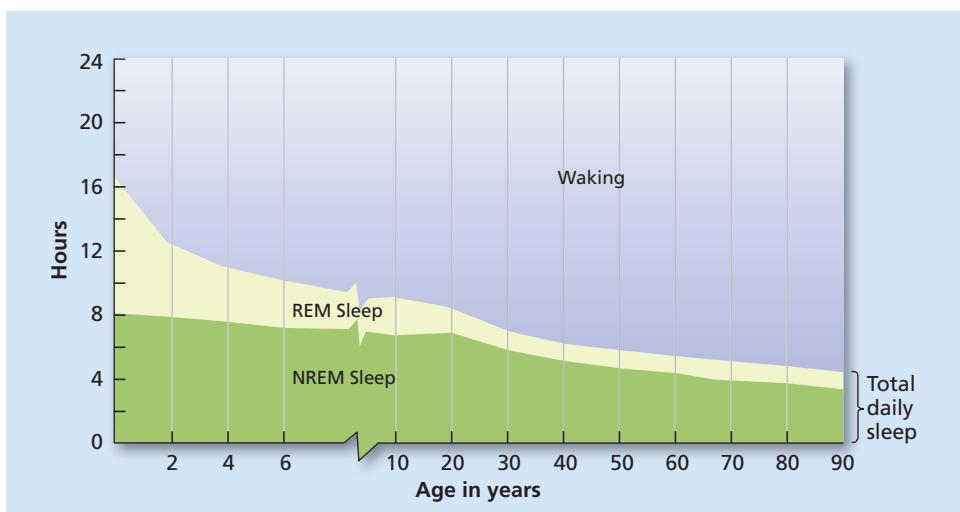
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Contrary to popular belief, sleep deprivation often affects younger people more than it does older people, who need less sleep. Does this young man look well rested and able to successfully complete the task of brushing his teeth?

Although people can do without sleep for a while, they cannot do without it altogether. In one experiment, rats were placed on moving treadmills over water. They couldn't sleep normally because they would then fall into the water and be awakened, but they did drift repeatedly into **microsleeps**, or brief sidesteps into sleep lasting only seconds (Goleman, 1982; Konowal et al., 1999). People can have microsleeps, too, and if this happens while they are driving a car or a truck, it's obviously bad news (Dinges, 1995; Lyznicki et al., 1998; Thomas et al., 1998). Microsleep periods are no doubt responsible for a lot of car accidents that occur when drivers have had very little sleep.

What will losing out on one night's sleep do to a person? For most people, a missed night of sleep will result in concentration problems and the inability to do simple tasks that normally would take no thought at all, such as loading a DVD into a player. More complex tasks, such as math problems, suffer less than these simple tasks because people *know* they must concentrate on a complex task (Chee & Choo, 2004; Lim et al., 2007).



In one study, researchers found that air-traffic controllers, such as the man pictured here, were significantly more impaired in performance after working an 8-hour midnight shift as compared to a day or evening shift of equal length (Heslegrave & Rhodes, 1997).

Even so, **sleep deprivation**, or loss of sleep, is a serious problem, which many people have without realizing it. Students, for example, may stay up all night to study for an important test the next day. In doing so, they will lose more information than they gain, as a good night's sleep is important for memory and the ability to think well (Gillen-O'Neal et al., 2012).  to Learning Objective PIA.5. Even a few nights of poor sleep have serious

consequences for mental and physical functioning (Van Dongen et al., 2003; Jackson et al., 2013). Some typical symptoms of sleep deprivation include trembling hands, inattention, staring off into space, droopy eyelids, and general discomfort (Naitoh et al., 1989), as well as emotional symptoms such as irritability and even depression. [LINK](#) to [Learning Objective 14.5](#). Add to that list an increased risk of insulin resistance, which can lead to diabetes (Matthews et al., 2012), and even possible delays in the onset of puberty (Saw et al., 2012).

Sleep is also important for forming memories. Studies have shown that the physical changes in the brain that occur when we form memories are strengthened during sleep, and particularly so for children (Racsmany et al., 2010; Wilhem et al., 2013). [LINK](#) to [Learning Objective 6.13](#). This memory effect is no doubt due, at least in part, to the finding that sleep enhances the synaptic connections among neurons, thus increasing the plasticity of the brain—the brain's ability to adapt to experiences (Aton et al., 2009; Bushey et al., 2011; Cirelli et al., 2012; Frank & Benington, 2006). [LINK](#) to [Learning Objective 2.3](#).  Watch the [Video](#), *In the Real World: Sleep, Memory, and Learning*, at [MyPsychLab](#)

 Okay, so we obviously need to sleep. But what does it do for us? Why do we have to sleep at all?

THEORIES OF SLEEP While it's clear that sleep is essential to life, theories about *why*—the purpose of sleep—differ.

The Adaptive Theory of Sleep Sleep is a product of evolution (Webb, 1992) according to the **adaptive theory** of sleep. It proposes that animals and humans evolved different sleep patterns to avoid being present during their predators' normal hunting times, which typically would be at night. For example, if a human or a prey animal (one a predator will eat) is out and about at night, they are more at risk of being eaten. However, if during active hunting hours the prey is in a safe place sleeping and conserving energy, it is more likely to remain unharmed. If this theory is true, then one would expect prey animals to sleep mostly at night and for shorter periods of time than predator animals; you would also expect that predators could sleep in the daytime—virtually as much as they want. This seems to be the case for predators like lions that have very few natural predators themselves. Lions will sleep nearly 15 hours a day, whereas animals such as gazelles that are lions' prey sleep a mere 4 hours a day, usually in short naps. Nocturnal animals such as the opossum can afford to sleep during the day and be active at night (when their food sources are available), because they are protected from predators by sleeping high up in trees.

The Restorative Theory of Sleep The other major theory of why organisms sleep is called **restorative theory**, which states that sleep is necessary to the physical health of the body. During sleep, chemicals that were used up during the day's activities are replenished and cellular damage is repaired (Adam, 1980; Moldofsky, 1995). As discussed earlier, brain plasticity is enhanced by sleep, and there is evidence that most bodily growth and repair occur during the deepest stages of sleep, when enzymes responsible for these functions are secreted in higher amounts (Saper et al., 2001).

Which of these theories is correct? The answer is that both are probably needed to understand why sleep occurs the way it does. Adaptive theory explains why people sleep *when* they do, and restorative theory explains why people *need* to sleep.



These lionesses are predators and have no need to sleep at night to protect themselves. They sleep and hunt on and off during the day in perfect safety, while the animals that the lionesses prey upon sleep at night in the safety of trees, dens, or other shelter—often in very short naps.

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 Explore the Concept at MyPsychLab

CONCEPT MAP

What Is Consciousness?

people's awareness of everything that is going on around them at any given moment (thoughts, sensations, and feelings); much of the day is spent in waking consciousness where these are clear and organized

altered states of consciousness occur when there is a shift in the quality or pattern of mental activity as compared to waking consciousness; alertness, thought content, and focus can vary greatly

hypothalamus contains the suprachiasmatic nucleus (SCN)

- SCN is sensitive to light— influences pineal gland's secretion of melatonin (\uparrow melatonin = \uparrow sleepiness)
- light through eyes relayed to SCN; SCN signals pineal gland to stop producing melatonin (\downarrow melatonin = \uparrow alertness / \downarrow sleepiness)
- SCN also influences body temperature (\downarrow temperature = \uparrow sleepiness)

Sleep

(sleep is one of the body's daily [circadian] biological rhythms; sleep–wake cycle controlled by the brain including the hypothalamus and the neurotransmitter serotonin)

people can live without sleep for a while, can't live without it altogether

- **sleep deprivation** can lead to serious changes in body and mental functioning
- **amount of sleep needed** ranges from 4–10 hours; most people need 7–9 hours every 24 hours
- **adaptive theory of sleep** suggests sleep is a product of evolution; sleep has evolved to avoid the active time of predators
- **restorative theory of sleep** suggests sleep is vital to the physical health of the body; body growth and repair occur during the deepest stages of sleep

PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. A change in the quality or pattern of mental activity, such as increased alertness or divided consciousness, is called a(n)
 - a. waking consciousness.
 - b. altered state of consciousness.
 - c. transient state of consciousness.
 - d. hallucination.
2. The sleep–wake cycle typically follows a 24-hour cycle and is regulated by the _____.
 - a. cerebellum
 - b. frontal lobe
 - c. pituitary gland
 - d. suprachiasmatic nucleus
3. The pineal gland receives instructions from the _____ to release _____.
 - a. thalamus; dopamine
 - b. occipital lobe; serotonin
 - c. suprachiasmatic nucleus; melatonin
 - d. spinal cord; acetylcholine
4. Which of the following is involved in determining when we sleep?

a. body position	c. digestion
b. body temperature	d. GABA
5. Which theory states that sleep is a product of evolution?

a. restorative theory	c. reactive theory
b. adaptive theory	d. REM theory

THE STAGES OF SLEEP

What are the different stages of sleep, including the stage of dreaming and its importance?



 So are there different kinds of sleep? Do you go from being awake to being asleep and dreaming—is it instant?

There are actually two kinds of sleep: **REM (rapid eye movement) sleep** and **non-REM (NREM) sleep**. REM sleep is a relatively psychologically active type of sleep when most of a person's dreaming takes place, whereas non-REM sleep spans from lighter stages to a much deeper, more restful kind of sleep. In REM sleep, the voluntary muscles

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are inhibited, meaning that the person in REM sleep moves very little, whereas in non-REM sleep the person's body is free to move around (including kicking one's bed partner!). There are also several different stages of sleep that people go through each night in which REM sleep and non-REM sleep occur. A machine called an electroencephalograph allows scientists to record the brain-wave activity as a person passes through the various stages of sleep and to determine what type of sleep the person has entered (Aserinsky & Kleitman, 1953). See **Figure 4.2** for a look at what happens in each stage of sleep.

A person who is wide awake and mentally active will show a brain-wave pattern on the electroencephalogram (EEG) called **beta waves**. Beta waves are very small and very fast. As the person relaxes and gets drowsy, slightly larger and slower **alpha waves** appear. The alpha waves are eventually replaced by even slower and larger **theta waves**.

Much of existing sleep research is based on terminology describing sleep stages that dates back to the 1960s (Carskadon & Dement, 2011; Rechtschaffen & Kales, 1968). This terminology describes four stages (NREM) in addition to REM and wakefulness. The American Academy of Sleep Medicine (AASM) has published updated guidelines for the recording and scoring of sleep activity, which includes changes in some of the terminology. The new guidelines use R in place of REM, N instead of NREM, and W instead of wakefulness. The AASM guidelines also combine NREM Stages 3 and 4 into

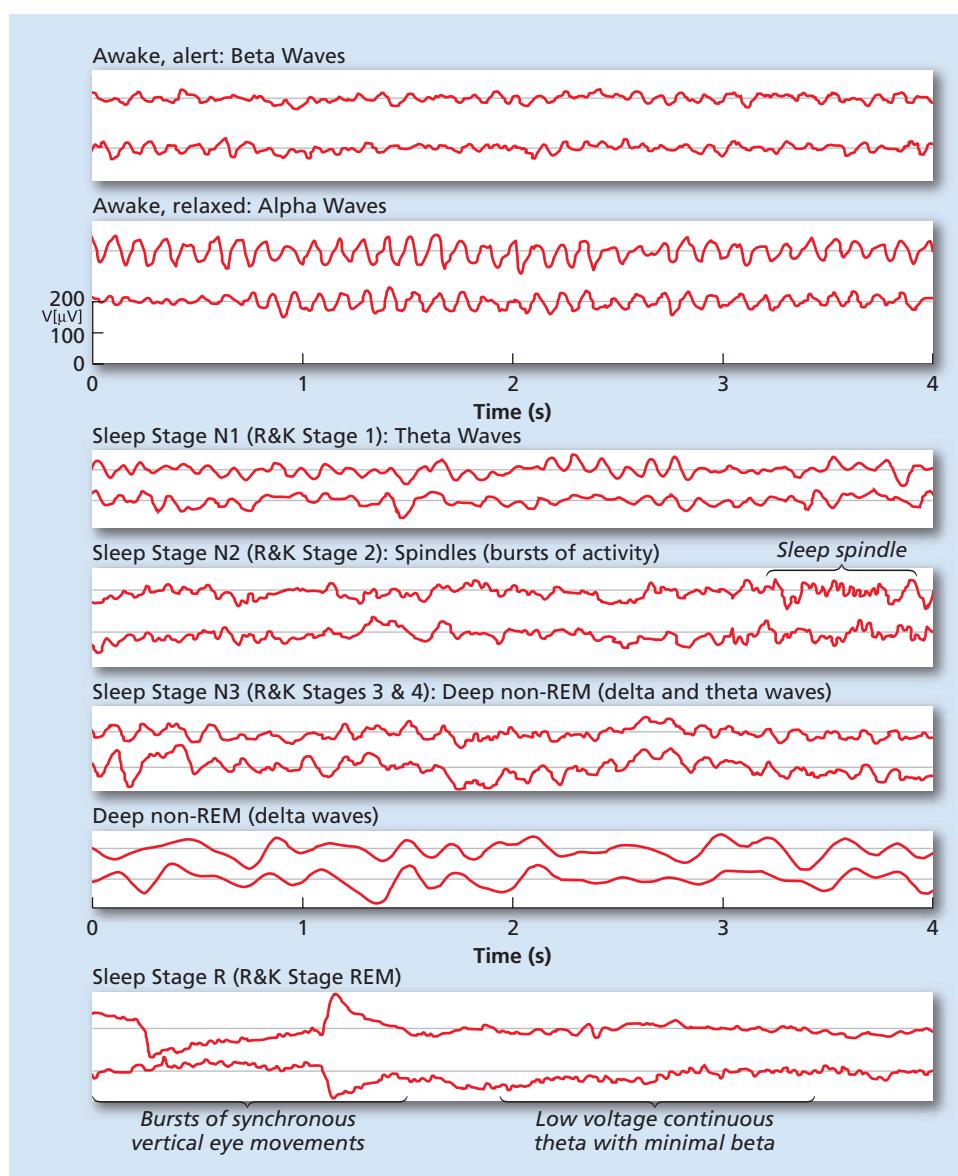


Figure 4.2 Brain Activity During Sleep

The EEG reflects brain activity during both waking and sleep. This activity varies according to level of alertness while awake (top two segments) and the stage of sleep. Stage N3 of sleep is characterized by the presence of delta activity, which is much slower and accounts for the larger, slower waves on these graphs. REM has activity that resembles alert wakefulness but has relatively no muscle activity except rapid eye movement. EEG data and images in this figure are courtesy of Dr. Leslie Sherlin.

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a single stage, now indicated by N3 (Iber et al., 2007). In looking at past research, you might encounter the sleep stages labeled as wakefulness, REM, and NREM Stages 1–4 (or simply Stages 1–4), whereas more recent studies may use W, R, N1, N2, and N3. As the area of sleep research is still in a period of transition, in the descriptions that follow, we will use the new AASM terminology as primary and the older Rechtschaffen and Kales (1968) sleep manual terminology noted in parentheses as “R&K.”  **Watch** the [Video, The Basics: Rhythms of Consciousness: Stages of Sleep, at MyPsychLab](#)

N1 (R&K STAGE 1): LIGHT SLEEP As theta wave activity increases and alpha wave activity fades away, people are said to be entering N1 sleep, or light sleep. Several rather interesting things can happen in this non-REM stage of sleep. If people are awakened at this point, they will probably not believe that they were actually asleep. They may also experience vivid visual events called *hypnagogic images* or *hallucinations* (Mavromatis, 1987; Mavromatis & Richardson, 1984). (The Greek word *hypnos* means “sleep.”) Many researchers now believe that peoples’ experiences of ghostly visits, alien abductions, and near-death experiences may be most easily explained by these hallucinations (Moody & Perry, 1993). For more about hypnagogic experiences and the role they may play in “hauntings,” see the Applying Psychology section at the end of this chapter.

A much more common occurrence is called the *hypnic jerk* (Mahowald & Schenck, 1996; Oswald, 1959). Have you ever been drifting off to sleep when your knees, legs, or sometimes your whole body gives a big “jerk”? Although experts have no solid proof of why this occurs, many believe that it has something to do with the possibility that our ancestors slept in trees: The relaxation of the muscles as one drifts into sleep causes a “falling” sensation, at which point the body jerks awake to prevent the “fall” from the hypothetical tree (Coolidge, 2006; Sagan, 1977).

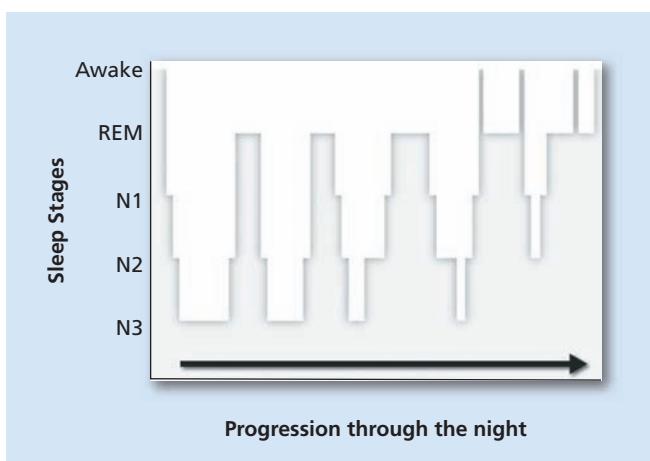
N2 (R&K STAGE 2): SLEEP SPINDLES As people drift further into sleep, the body temperature continues to drop. Heart rate slows, breathing becomes more shallow and irregular, and the EEG will show the first signs of *sleep spindles*, brief bursts of activity lasting only a second or two. Theta waves still predominate in this stage, but if people are awakened during this stage, they will be aware of having been asleep.

N3 (R&K STAGES 3 AND 4): DELTA WAVES ROLL IN In the third stage of sleep, the slowest and largest waves make their appearance. These waves are called **delta waves**. These waves increase during this stage from about 20 percent to more than 50 percent of total brain activity. Now the person is in the deepest stage of sleep, often referred to as slow-wave sleep (SWS) or simply, deep sleep (Carskadon & Dement, 2011).

It is during this stage that growth hormones (often abbreviated as GH) are released from the pituitary gland and reach their peak. The body is at its lowest level of functioning. Eventually, the delta waves become the dominant brain activity for this stage of sleep. See **Figure 4.3**, which shows progression through the sleep stages throughout one night.

Figure 4.3 A Typical Night’s Sleep

The graph shows the typical progression through the night of Stages N1–N3 and REM sleep. The REM periods occur about every 90 minutes throughout the night (based on Dement, 1974).



People in deep sleep are very hard to awaken. If something does wake them, they may be very confused and disoriented at first. It is not unusual for people to wake up in this kind of disoriented state only to hear the crack of thunder and realize that a storm has come up. Children are even harder to wake up when in this state than are adults. Deep sleep is the time when body growth occurs. This may explain why children in periods of rapid growth need to sleep more and also helps to explain why children who are experiencing disrupted sleep (as is the case in situations of domestic violence) suffer delays in growth (Gilmore & Skuse, 1999; Saper et al., 2001; Swanson, 1994).

The fact that children do sleep so deeply may explain why certain sleep disorders are more common in childhood. Indeed, many sleep disorders are more common in boys than in girls because boys sleep more deeply than do girls due to high levels of the male hormone testosterone (Miyatake et al., 1980; Thiedke, 2001).

R (R&K REM) After spending some time in N3, the sleeping person will go back up through N2 and then into a stage in which body temperature increases to near-waking levels, the eyes move rapidly under the eyelids, the heart beats much faster, and brain waves resemble beta waves—the kind of brain activity that usually signals wakefulness. The person is still asleep but in the stage known as rapid eye movement sleep (REM) and sometimes referred to as paradoxical sleep.

REM Sleep: Perchance to Dream? When a person in REM sleep is awakened, he or she almost always reports being in a dream state (Shafton, 1995). REM sleep is, therefore, associated with dreaming, and 90 percent of dreams actually take place in REM sleep. People do have dreams in the other non-REM stages, but REM dreams tend to be more vivid, more detailed, longer, and more bizarre than the dreams of NREM sleep. NREM dreams tend to be more like thoughts about daily occurrences and far shorter than REM dreams (Foulkes & Schmidt, 1983; Takeuchi et al., 2003). Fortunately, the body is unable to act upon these dreams under normal conditions because the voluntary muscles are paralyzed during REM sleep, a condition known as **sleep paralysis**. (This is why you sometimes have a dream in which you are trying to run or move, and can't—you are partially aware of sleep paralysis.)

What Is the Purpose of REM Sleep? Why two kinds of sleep? And why would REM sleep ever be considered restful when the body is almost awake and the brain is so active? REM sleep seems to serve a different purpose than does NREM, or deep sleep. After a very physically demanding day, people tend to spend more time in NREM deep sleep than is usual. But an emotionally stressful day leads to increased time in REM sleep (Horne & Staff, 1983). Perhaps the dreams people have in REM sleep are a way of dealing with the stresses and tensions of the day, whereas physical activity would demand more time for recovery of the body in NREM sleep. Also, if deprived of REM sleep (as would occur with the use of sleeping pills or other depressant drugs), a person will experience greatly increased amounts of REM sleep the next night, a phenomenon called **REM rebound** (Vogel, 1975, 1993).

An early study of REM sleep deprivation (Dement, 1960) seemed to suggest that people deprived of REM sleep would become paranoid, seemingly mentally ill from lack of this one stage of sleep. This is called the *REM myth* because later studies failed to reliably produce the same results (Dement et al., 1969).

Other early research attempted to link REM sleep with the physical changes that occur during storing a memory for what one has recently learned, but the evidence today suggests that no one particular stage of sleep is the "one" in which this memory process occurs; rather, the evidence is mounting for sleep in general as necessary to the formation of memory (Ellenbogen et al., 2006; Maquet et al., 2003; Siegel, 2001; Stickgold et al., 2001; Walker, 2005).

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While this infant is sleeping, her REM sleep (occurring about half of the time she is asleep) allows her brain to make new neural connections.



Nightmares of being chased by a monster or a similar frightening creature are common, especially in childhood.

REM sleep in early infancy differs from adult REM sleep in several ways: Babies spend nearly 50 percent of their sleep in REM as compared to adults' 20 percent, the brain-wave patterns on EEG recordings are not exactly the same in infant REM when compared to adult REM recordings, and infants can and do move around quite a bit during REM sleep (Carskadon & Dement, 2005; Davis et al., 2004; Sheldon, 2002; Tucker et al., 2006). These differences can be explained: When infants are engaged in REM sleep, they are not dreaming but rather forming new connections between neurons (Carskadon & Dement, 2005; Davis et al., 2004; Sheldon, 2002). The infant brain is highly plastic, and much of brain growth and development takes place during REM sleep. [LINK](#) to Learning Objective 2.3. As the infant's brain nears its adult size by age 5 or 6, the proportion of REM sleep has also decreased to a more adultlike ratio of REM to non-REM. For infants, to sleep is perchance to grow synapses.

SLEEP DISORDERS

How do sleep disorders interfere with normal sleep?

What happens when sleep goes wrong? Nightmares, sleepwalking, and being unable to sleep well are all examples of sleep disorders. [Watch the Video, Special Topics: Sleep Disorders, at MyPsychLab](#)

 What would happen if we could act out our dreams? Would it be like sleepwalking?

NIGHTMARES AND REM BEHAVIOR DISORDER Being able to act out one's dreams, especially nightmares, is a far more dangerous proposition than sleepwalking. **Nightmares** are bad dreams, and some nightmares can be utterly terrifying. Children tend to have more nightmares than adults do because they spend more of their sleep in the REM state, as discussed earlier. As they age, they have fewer nightmares because they have less opportunity to have them. But some people still suffer from nightmares as adults.

Some people have a rare disorder in which the brain mechanisms that normally inhibit the voluntary muscles fail, allowing the person to thrash around and even get up and act out nightmares. This disorder is called **REM behavior disorder**, which is a fairly serious condition (Shafton, 1995). Usually seen in men over age 60, it can happen in younger men and in women. For more about this disorder, read the Psychology in the News section.

NIGHT TERRORS A rare disorder, **night terrors** are more likely in children and also likely to disappear as the child grows older (Garland & Smith, 1991). A night terror is essentially a state of panic experienced while sound asleep. People may sit up, scream, run around the room, or flail at some unseen attacker. It is also not uncommon for people to feel unable to breathe while they are in this state. Considering that people suffering a night-terror episode are in a deep stage of sleep and breathing shallowly, one can understand why breathing would seem difficult when they are suddenly active. Most people do not remember what happened during a night-terror episode, although a few people can remember vividly the images and terror they experienced.



 But that sounds like the description of a nightmare—what's the difference?

Some very real differences exist between night terrors and nightmares. Nightmares are usually vividly remembered immediately upon waking. A person who has had a nightmare, unlike a person experiencing a night terror, will actually be able to awaken

and immediately talk about the bad dream. Perhaps the most telling difference is that nightmares occur during REM sleep rather than deep non-REM sleep, which is the domain of night terrors, which means that people don't move around in a nightmare as they do in a night-terror experience.

psychology in the news



Murder While Sleepwalking



According to a compilation of information by Dr. Lawrence Martin, associate professor at Case Western Reserve University and specialist in pulmonary* and sleep medicine, at least 20 cases of "murder while *sleepwalking*" have been recorded.

The term *sleepwalking* as used in these cases most likely refers to the very real condition called REM behavior disorder rather than ordinary sleepwalking. Use of this disorder as a defense in a murder trial has sometimes been successful. Here are short descriptions of three cases and their outcomes.

Case One: In 1987, Kenneth Parks, a 23-year-old man from Toronto, Canada, got up early in the morning, got in his car, and drove 23 kilometers (about 14 miles) to the home of his wife's parents. He stabbed his mother-in-law to death, attacked his father-in-law, and then drove to the police. Once there, he told them that he thought he had killed some people. Parks had no motive and had been suffering from severe insomnia. He did have a history of sleepwalking and his defense team, which included sleep experts and psychiatrists, concluded that he was indeed unaware of his actions at the time of the crime. He was acquitted (Denno, 2002; Martin, 2004).

Case Two: Scott Falater, 43 years old, was accused of murdering his wife in 1997. A neighbor, looking over a fence, witnessed Scott holding his wife's head under water in the swimming pool. He called the police, who found a bloody pool and the body of Yamila Falater with 44 stab wounds.

Falater had performed a series of very deliberate and time-consuming actions in cleaning up after the murder. But Falater claimed to be sleepwalking during all of these actions. Although sleep experts for the defense stated that Falater's story was possible, the prosecution pointed to marital troubles as motive. Most damaging to his case was the witness who stated that 3 weeks before the murder, Falater had been discussing the case of Kenneth Parks and Parks's acquittal for murder based on a sleepwalking defense. The jury found Falater guilty of murder in the first degree and he was given a life sentence (Martin, 2004; Tresniowski, 1999).

Case Three: In July of 2008, Brian Thomas of South Wales in Great Britain, a devoted husband and father of two children, killed his wife while dreaming of intruders breaking into their camper. Thomas had a history of sleepwalking and normally slept apart from his wife. Experts found that he suffered from night terrors, and he was acquitted of her murder by reason of temporary insanity (Morris, 2009).

Questions for Further Discussion

1. Should sleepwalking be a valid defense for a crime as serious as murder? What about other kinds of crimes?
2. What kind of evidence should be required to convince a jury that a crime was committed while sleepwalking?

SLEEPWALKING Real *sleepwalking*, or **somnambulism**, occurs in about 20 percent of the population and is at least partially due to heredity (Abe et al., 1984; Kales et al., 1980).

*pulmonary: having to do with the lungs.

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Scott Falater testifies at his trial for the murder of his wife, which he claims he committed while he was sleepwalking.

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"Wait! Don't! It can be dangerous to wake them."

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Tossing and turning can be a sign of someone who has trouble getting to sleep, staying asleep, or getting enough sleep—all signs of insomnia. If this woman does suffer from insomnia, how might she feel when she wakes up in the morning?

It is much more common in childhood and also occurs more frequently in boys than in girls. A person who is sleepwalking may do nothing more than sit up in bed. But other episodes may involve walking around the house, looking in the refrigerator or even eating, and getting into the car. Most people typically do not remember the episode the next day. One student said that her brother walked in his sleep, and one morning his family found him sound asleep behind the wheel of the family car in the garage. Fortunately, he had not been able to find the keys in his sleep.

Many people with this disorder grow out of their sleepwalking by the time they become adolescents. Many parents have found that preventing sleep loss makes sleepwalking a rare occurrence. This is most likely due to the deeper N3 sleep becoming even deeper during sleep loss, which would make fully waking even more difficult (Pilon et al., 2008; Zadra et al., 2008, 2013). The only real precaution that the families of people who sleepwalk should take is to clear their floors of obstacles and to put not-easy-to-reach locks on the doors. And although it is typically not dangerous to wake sleepwalkers, they may strike out before awakening.

INSOMNIA Most people think that **insomnia** is the inability to sleep. Although that is the literal meaning of the term, in reality insomnia is the inability to get to sleep, stay asleep, or get a good quality of sleep (Kryger et al., 1999). There are many causes of insomnia, both psychological and physiological. Some of the psychological causes are worrying, trying too hard to sleep, or having anxiety. Some of the physiological causes are too much caffeine, indigestion, or aches and pain.

There are several steps people can take to help them sleep. Obvious ones are consuming no caffeinated drinks or foods that cause indigestion before bedtime, taking medication for pain, and dealing with anxieties in the daytime rather than facing them at night. That last bit of advice is easy to say but not always easy to do. Here are some other helpful hints (Kupfer & Reynolds, 1997; National Sleep Foundation, 2009):

1. Go to bed only when you are sleepy. If you lie in bed for 20 minutes and are still awake, get up and do something like reading or other light activity (avoid watching TV or being in front of a computer screen) until you feel sleepy, and then go back to bed.
2. Don't do anything in your bed but sleep. Your bed should be a cue for sleeping, not for studying or watching television. Using the bed as a cue for sleeping is a kind of learning called *classical conditioning*, or the pairing of cues and automatic responses. to Learning Objective 5.2.
3. Don't try too hard to get to sleep, and especially do not look at the clock and calculate how much sleep you aren't getting. That just increases the tension and makes it harder to sleep.
4. Keep to a regular schedule. Go to bed at the same time and get up at the same time, even on days that you don't have to go to work or class.
5. Don't take sleeping pills or drink alcohol or other types of drugs that slow down the nervous system (see the category Depressants later in this chapter). These drugs force you into deep sleep and do not allow you to get any REM or lighter stages of sleep. When you try to sleep without these drugs the next night, you will experience REM rebound, which will cause you to feel tired and sleepy the next day. REM rebound is one way to experience the form of insomnia in which a person sleeps but sleeps poorly.

If none of these things seems to be working, there are sleep clinics and sleep experts who can help people with insomnia. The American Academy of Sleep Medicine has an excellent Web site at www.aasmnet.org that provides links to locate sleep clinics in any area. One treatment that seems to have more success than any kind of sleep medication is the use of cognitive-behavior therapy, a type of therapy in which both rational thinking and controlled behavior are stressed (Bastien et al., 2004; Irwin et al., 2006; Morin et al., 2006). to Learning Objective 15.5.

SLEEP APNEA Gerald was a snorer. Actually, that's an understatement. Gerald could give a jet engine some serious competition. Snoring is fairly common, occurring when the breathing passages (nose and throat) get blocked. Most people snore only when they have a cold or some other occasional problem, but some people snore every night and quite loudly, like Gerald. It is this type of snoring that is often associated with a condition called **sleep apnea**, in which the person stops breathing for 10 seconds or more. When breathing stops, there will be a sudden silence, followed shortly by a gasping sound as the person struggles to get air into the lungs. Many people do not wake up while this is happening, but they do not get a good, restful night's sleep because of the apnea.

Apnea is a serious problem. According to the National Institutes of Health (2011), from 5 to 25 percent of adults in the United States suffer from apnea (it is difficult to be precise, as many people are unaware that they have apnea). Apnea can cause heart problems as well as poor sleep quality (Flemons, 2002). If a person suspects the presence of apnea, a visit to a physician is the first step in identifying the disorder and deciding on a treatment. While some people can benefit from wearing a nasal opening device, losing weight (obesity is often a primary cause of apnea), or using a nasal spray to shrink the nasal tissues, others must sleep with a device that delivers a continuous stream of air under mild pressure, called a *continuous positive airway pressure (CPAP) device*. Still others undergo a simple surgery in which the *uvula* (the little flap that hangs down at the back of the throat) and some of the soft tissues surrounding it are removed.

Some very young infants also experience a kind of apnea due to immaturity of the brain stem. These infants are typically placed on monitors that sound an alarm when breathing stops, allowing caregivers to help the infant begin breathing again. Although sleep apnea in infants is often associated with sudden infant death syndrome, or SIDS, it is not necessarily caused by it: Many infants who die of SIDS were never diagnosed with sleep apnea (Blackmon et al., 2003).

NARCOLEPSY A disorder affecting 1 in every 2,000 persons, **narcolepsy** is a kind of "sleep seizure." In narcolepsy, the person may slip suddenly into REM sleep during the day (especially when the person experiences strong emotions). Another symptom is excessive daytime sleepiness that results in the person falling asleep throughout the day at inappropriate times and in inappropriate places (Overeem et al., 2001). These sleep attacks may occur many times and without warning, making the operation of a car or other machinery very dangerous for the person with narcolepsy. The sudden REM attacks are especially dangerous because of the symptom of *cataplexy*, or a sudden loss of muscle tone. This sleep paralysis may cause injuries if the person is standing when the attack occurs. The same hypnagogic images that may accompany N1 (NREM Stage 1) sleep may also occur in the person with narcolepsy. **Table 4.1** has a more detailed list of known sleep disorders.

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"On your application it says you have narcolepsy. What is that?"

Table 4.1

Sleep Disorders

NAME OF DISORDER	PRIMARY SYMPTOMS
Somnambulism	Sitting, walking, or performing complex behavior while asleep
Night terrors	Extreme fear, agitation, screaming while asleep
Restless leg syndrome	Uncomfortable sensations in legs causing movement and loss of sleep
Nocturnal leg cramps	Painful cramps in calf or foot muscles
Hypersomnia	Excessive daytime sleepiness
Circadian rhythm disorders	Disturbances of the sleep–wake cycle such as jet lag and shift work
Enuresis	Urinating while asleep in bed

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 Explore the Concept at [MyPsychLab](#)

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Sleep

consist of both REM (rapid eye movement) and non-REM stages; REM is relatively active whereas non-REM is much deeper and restful; stages defined by level of brain activity as measured by the EEG (beta, alpha, theta, delta waves); sleep cycle is made up of various stages repeated 4–5 times a night

- **N1 (R&K Stage 1):** while awake, primarily beta activity, more alpha as one relaxes, onset of sleep in N1 is associated with alpha being replaced by theta
- **N2 (R&K Stage 2):** EEG sleep spindles appear; theta activity is predominant; body temperature continues to drop, heart rate and breathing slow
- **N3 (R&K Stages 3 and 4):** deepest stage of sleep; delta activity makes up 20% to more than 50% of EEG activity; body is at lowest level of functioning and people are hard to awaken; sleep disorders such as sleepwalking and night terrors occur in this stage
- **R (R&K REM):** dreaming occurs, including nightmares; eyes move rapidly under the eyelids and EEG indicates presence of beta, but body is typically still, due to sleep paralysis; REM behavior disorder occurs when body is not still or acts out dreams, usually seen in men over age 60

sleep disorders include a variety of problems that can interfere with sleep

- **insomnia** is the inability to get to sleep, stay asleep, or get good quality sleep
- **sleep apnea** consists of loud snoring and stopped breathing
- **narcolepsy** consists of sudden onset of REM sleep during otherwise waking hours

PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. In which stage(s) of sleep do people typically experience hypnagogic images?
 - a. N1 (NREM Stage 1)
 - b. N2 (NREM Stage 2)
 - c. N3 (NREM Stage 3)
 - d. REM
2. Which of the following is a characteristic of N3 (NREM Stage 3) sleep?
 - a. paralysis of voluntary muscles
 - b. increased heart rate
 - c. deepest stage of sleep
 - d. increased body temperature
3. A person who relies heavily on sleeping pills or alcohol to sleep might experience _____ the following night.
 - a. sleep apnea
 - b. night terrors
 - c. REM rebound
 - d. REM behavior disorder
4. Sleepwalking occurs in _____ sleep, whereas nightmares occur in _____ sleep.
 - a. N1 (NREM Stage 1); N2 (NREM Stage 2)
 - b. REM; N3 (NREM Stage 3)
 - c. N2 (NREM Stage 2); N1 (NREM Stage 1)
 - d. N3 (NREM Stage 3); REM
5. If you find yourself lying in bed unable to sleep for more than 20 minutes, what should you do?
 - a. Start watching television or read so as to help you fall off to sleep.
 - b. Brew some tea to help relax you.
 - c. Get out of bed and find some light activity to do (e.g., reading a book).
 - d. Lie in bed until you fall asleep, even if it takes several hours.
6. In which disorder do people tend to snore in a very loud manner?
 - a. sleep apnea
 - b. night terrors
 - c. sleepwalking
 - d. narcolepsy

THINKING CRITICALLY:

Do you think that sleepwalking is an adequate defense for someone who has harmed or killed another person? Should a person who has done harm while sleepwalking be forced by the courts to take preventive actions, such as installing special locks on bedroom doors? How might this affect the person's safety, such as in a fire?

Dreams

Why do people dream, and what do they dream about?

Dreams have long been a source of curiosity. People of ancient times tried to find meaning in dreams. Some viewed dreams as prophecy, some as messages from the spirits. But the real inquiry into the process of dreaming began with the publication of Freud's *The Interpretation of Dreams* (1900).

FREUD'S INTERPRETATION: DREAMS AS WISH FULFILLMENT

Sigmund Freud (1856–1939) believed that the problems of his patients stemmed from conflicts and events that had been buried in their unconscious minds since childhood. These early traumas were seen as the cause of behavior problems in adulthood, in which his patients suffered from symptoms such as a type of paralysis that had no physical basis or repetitive, ritualistic* hand washing. One of the ways Freud devised to get at these early memories was to examine the dreams of his patients, believing that conflicts, events, and desires of the past would be represented in symbolic** form in the dreams. Freud believed dreams to be a kind of wish fulfillment for his patients.  to Learning Objective 13.2.

MANIFEST CONTENT The *manifest content* of a dream is the actual dream itself. For example, if Chad has a dream in which he is trying to climb out of a bathtub, the manifest content of the dream is exactly that—he's trying to climb out of a bathtub.

LATENT CONTENT But, of course, Freud would no doubt find more meaning in Chad's dream than is at first evident. He believed that the true meaning of a dream was hidden, or *latent*, and only expressed in symbols. In the dream, the water in the tub might symbolize the waters of birth, and the tub itself might be his mother's womb. Using a Freudian interpretation, Chad may be dreaming about being born.

  Seems like quite a stretch. Wouldn't there be lots of other possible interpretations?

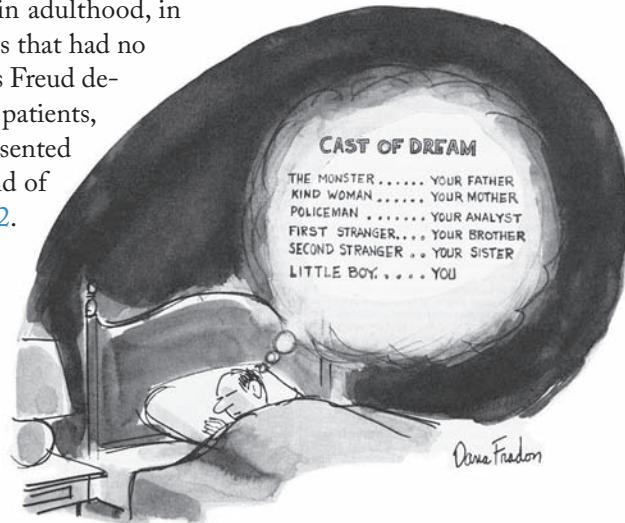
Yes, and today many professionals are no longer as fond of Freud's dream analysis as they once were. But there are still some people who insist that dreams have symbolic meaning. For example, dreaming about being naked in a public place is very common, and most dream analyzers interpret that to mean feeling open and exposed, an expression of childhood innocence, or even a desire for sex. Exactly how the dream is interpreted depends on the other features of the dream and what is happening in the person's waking life.

The development of techniques for looking at the structure and activity of the brain (see  to Learning Objective 2.6) has led to an explanation of why people dream that is more concrete than that of Freud.

THE ACTIVATION-SYNTHESES HYPOTHESIS

Using brain-imaging techniques such as a PET scan (see Chapter Two), researchers have found evidence that dreams are products of activity in the pons (Hobson, 1988; Hobson & McCarley, 1977; Hobson et al., 2000). This lower area inhibits the neurotransmitters that would allow movement of the voluntary muscles while sending random signals to the areas of the cortex that interpret vision, hearing, and so on (see **Figure 4.4** on the next page).

When signals from the pons bombard*** the cortex during waking consciousness, the association areas of the cortex interpret those signals as seeing, hearing, and so on. Because those signals come from the real world, this process results in an experience of reality. But when people are asleep, the signals from the brain stem are random and



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Dreams are often filled with unrealistic and imaginative events and images. A common dream is that of flying. What do you think flying might represent in a dream?

*ritualistic: referring to an action done in a particular manner each time it is repeated, according to some specific pattern.

**symbolic: having the quality of representing something other than itself.

***bombard: to attack or press.

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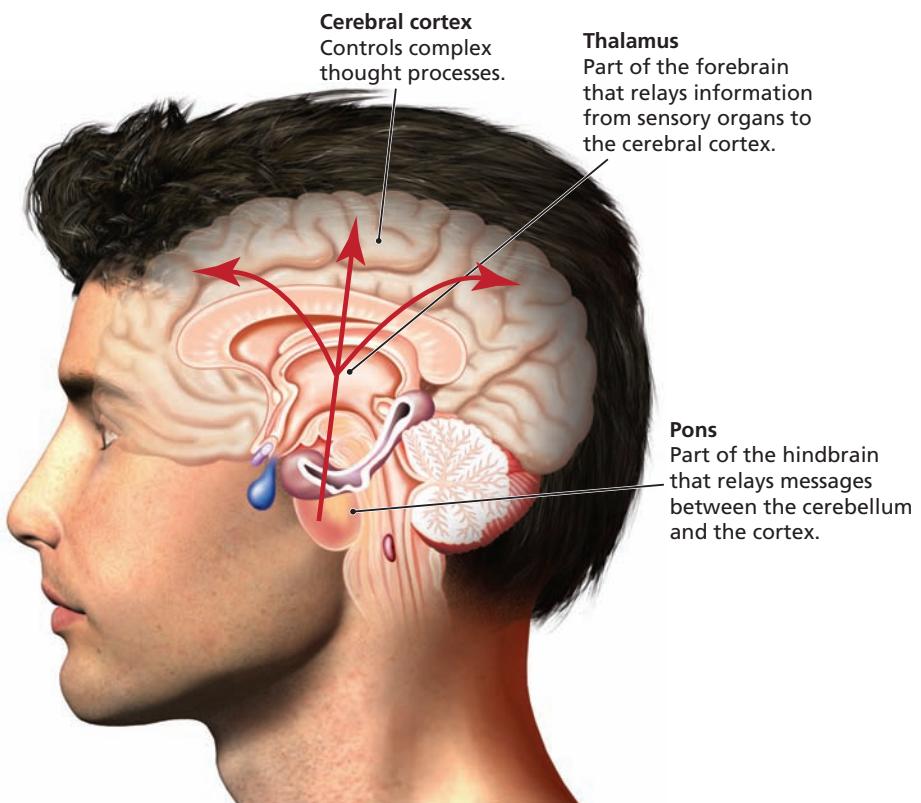
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4.1 **Figure 4.4 The Brain and Activation-Synthesis Theory**

According to the activation-synthesis theory of dreaming, the pons in the brainstem sends random signals to the upper part of the brain during REM sleep. These random signals pass through the thalamus, which sends the signals to the proper sensory areas of the cortex. Once in the cortex, the association areas of the cortex respond to the random activation of these cortical cells by synthesizing (making up) a story, or dream, using bits and pieces of life experiences and memories.

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not necessarily attached to actual external stimuli, yet the brain must somehow interpret these random signals. It *synthesizes* (puts together) an explanation of the cortex's activation from memories and other stored information.

In this theory, called the **activation-synthesis hypothesis**, a dream is merely another kind of thinking that occurs when people sleep. It is less realistic because it comes not from the outside world of reality but from within people's memories and experiences of the past. The frontal lobes, which people normally use in daytime thinking, are more or less shut down during dreaming, which may also account for the unrealistic and often bizarre nature of dreams (Macquet & Franck, 1996).

 My dreams can be really weird, but sometimes they seem pretty ordinary or even seem to mean something. Can dreams be more meaningful?

There are dream experts who suggest that dreams may have more meaning than Hobson and McCarley originally theorized. A survey questioning subjects about their dream content, for example, concluded that much of the content of dreams is meaningful, consistent over time, and fits in with past or present emotional concerns rather than being bizarre, meaningless, and random (Domhoff, 1996, 2005).

Hobson and colleagues have reworked the activation-synthesis hypothesis to reflect concerns about dream meaning, calling it the **activation-information-mode model**, or **AIM** (Hobson et al., 2000). In this newer version, information that is accessed during waking hours can have an influence on the synthesis of dreams. In other words, when the brain is "making up" a dream to explain its own activation, it uses meaningful bits and pieces of the person's experiences from the previous day or the last few days rather than just random items from memory.

WHAT DO PEOPLE DREAM ABOUT?

Calvin Hall collected over 10,000 dreams and concluded that most dreams reflect the events that occur in everyday life (Hall, 1966). Although most people dream in color, people who grew up in the era of black-and-white television sometimes have dreams in black and white. There are gender differences, although whether those differences are caused by hormonal/genetic influences, sociocultural influences, or a combination of influences remains to be seen. In his book *Finding Meaning in Dreams*, Dr. William Domhoff (1996) concluded that across many cultures, men more often dream of other males whereas women tend to dream about males and females equally. Men across various cultures also tend to have more physical aggression in their dreams than do women, and women are more often the victims of such aggression in their own dreams. Domhoff also concluded that where there are differences in the content of dreams across cultures, the differences make sense in light of the culture's "personality." For example, American culture is considered fairly aggressive when compared to the culture of the Netherlands, and the aggressive content of the dreams in both cultures reflects this difference: There were lower levels of aggression in the dreams of those from the Netherlands when compared to the Americans' dream content.

Girls and women tend to dream about people they know, personal appearance concerns, and issues related to family and home. Boys and men tend to have more male characters in their dreams, which are also typically in outdoor or unfamiliar settings and may involve weapons, tools, cars, and roads. Men also report more sexual dreams, usually with unknown and attractive partners (Domhoff, 1996; Domhoff & Schneider, 2008; Foulkes, 1982; Van de Castle, 1994).

In dreams people run, jump, talk, and do all of the actions that they do in normal daily life. Nearly 50 percent of the dreams recorded by Hall (1966) had sexual content, although later research has found lower percentages (Van de Castle, 1994). Then there are dreams of flying, falling, and of trying to do something and failing—all of which are very common dreams, even in other cultures (Domhoff, 1996). So is that often recounted dream of being naked in public! Take the survey experiment *Are Dreams Meaningful?* to discover more about your own experiences and attitudes toward dreams.

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Simulation

Are Dreams Meaningful?

Many psychological theorists believe that dreams are meaningful experiences. Other theorists believe dreams are a random by-product of the processing our brains go through when we sleep. What do you think? Are dreams meaningful? This survey explores your experiences with and attitudes towards dreams.

[Go to the Experiment ►](#)

Some common themes people dream about include relationships (with boyfriend/girlfriend, parents, friends, spouses, children, etc.) and success/failure (in school, job, project, etc.). Thinking about the dreams you've had, which theme do you tend to dream about more often?

- I dream about relationships more often
- I dream about success/failure more often
- I dream about relationships and success/failure about the same
- Not sure
- Prefer Not to State

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 Explore the Concept at [MyPsychLab](#)

 Why do we dream?

- Freud's interpretation: wish fulfillment—conflicts, events, and desires represented in symbolic form in dreams
- activation-synthesis hypothesis

- manifest content: actual dream itself
- latent content: hidden or symbolic meaning of dream

Dreams

 What do people dream about?

- typically about events that occur in everyday life; most in color; content influenced by gender and culture

- dreams are product of random signals (activation), with brain forming explanation of signals based on memories and other information (synthesis)
- activation-information-mode model (AIM) suggests that information access during waking hours can influence the synthesis of dreams

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. In Freud's theory, the actual content of a dream is called
 - a. manifest content.
 - b. latent content.
 - c. symbolic content.
 - d. hidden content.
2. Michael finds that most of his dreams are little more than random images that seemingly have been put into a strange storyline. Which theory of dreams best explains this?
 - a. Freudian dream theory
 - b. dreams for survival theory
 - c. activation-synthesis hypothesis
 - d. Hall's dreams as reflections of everyday life
3. According to Calvin Hall, what are most dreams centered around?
 - a. everyday life
 - b. unfulfilled fantasies
 - c. frightening events
 - d. past childhood
4. Freud says that dreams are a means of
 - a. addressing anxieties.
 - b. becoming aware of insecurities.
 - c. resolving conflicts.
 - d. wish fulfillment.

5. Studies show that most people tend to
 - a. dream in black and white.
 - b. dream in color.
 - c. only have nightmares.
 - d. not dream at all.

THINKING CRITICALLY

Keep a notepad near your bed for the next few nights. When you wake up, immediately write down any dream that you experienced. After you've recorded a few dreams, think about how the events in the dream relate to your life. Are things included that were happening the day before the dream occurred? Were there memories? Were some of the elements of the dream repetitions from past dreams? Which dream theory seems to fit your dreams best?

The Effects of Hypnosis

How does hypnosis affect consciousness?

Hypnosis is a state of consciousness in which a person is especially susceptible to suggestion. Although a lot of misunderstandings exist about hypnosis, it can be a useful tool when properly managed.  [Watch the Video](#), Thinking Like a Psychologist: The Uses and Limitations of Hypnosis: Is Hypnosis a Unique State of Consciousness?, at [MyPsychLab](#)

STEPS IN HYPNOTIC INDUCTION

There are four key steps in inducing hypnosis (Druckman & Bjork, 1994):

1. The hypnotist tells the person to focus on what is being said.
2. The person is told to relax and feel tired.
3. The hypnotist tells the person to "let go" and accept suggestions easily.
4. The person is told to use vivid imagination.

The real key to hypnosis seems to be a heightened state of suggestibility.* People can be hypnotized when active and alert, but only if they are willing to be hypnotized. Only 80 percent of all people can be hypnotized, and only 40 percent are good hypnotic subjects.

*suggestibility: being readily influenced.

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Table 4.2**Examples of Items That Would Appear on a Hypnotic Susceptibility Scale**

- | | |
|---|---|
| 1. Movement of the body back and forth | 5. Responding to posthypnotic suggestion |
| 2. Closing eyes and unable to open them | 6. Loss of memory for events during the session |
| 3. Fingers locked together | 7. Unable to state one's own name |
| 4. One arm locked into position | 8. Seeing or hearing nonexistent stimuli |

Source: Based on Hilgard, E, Hypnotic Susceptibility, 1965.

The ability to be hypnotized may lie in the way the brain functions. Using brain-scanning techniques, researchers found that two areas in the brains of highly hypnotizable people, areas associated with decision-making and attention, seem to be more active and connected when compared to people who cannot be hypnotized (Hoeft et al., 2012).

A test of *hypnotic susceptibility*, or the degree to which a person is a good hypnotic subject, often makes use of a series of ordered suggestions. The more suggestions in the ordered list the person responds to, the more susceptible* that person is. (See **Table 4.2** for examples of the types of items on a typical hypnotic susceptibility scale.)

FACT OR MYTH: WHAT CAN HYPNOSIS REALLY DO?

- Is it true that people can be hypnotized into doing things that they would never do under normal conditions?

Although the popular view is that the hypnotized person is acting involuntarily, the fact is that the hypnotist may only be a guide into a more relaxed state, while the subject actually hypnotizes himself or herself (Kirsch & Lynn, 1995). People cannot be hypnotized against their will. The tendency to act as though their behavior is automatic and out of their control is called the *basic suggestion effect* (Kihlstrom, 1985); it gives people an excuse to do things they might not otherwise do because the burden of responsibility for their actions falls on the hypnotist.

As the video *Thinking Like a Psychologist: The Uses and Limitations of Hypnosis: Therapy and Recovered Memories*, explains, hypnosis is also a controversial tool when used in



Watch the Video, *Thinking Like a Psychologist: The Uses and Limitations of Hypnosis: Therapy and Recovered Memories*, at **MyPsychLab**

*susceptible: easily affected emotionally.

Table 4.3**Facts About Hypnosis**

HYPNOSIS CAN:	HYPNOSIS CANNOT:
Create amnesia for whatever happens during the hypnotic session, at least for a brief time (Bowers & Woody, 1996).	Give people superhuman strength. (People may use their full strength under hypnosis, but it is no more than they had before hypnosis.)
Relieve pain by allowing a person to remove conscious attention from the pain (Holroyd, 1996).	Reliably enhance memory. (There's an increased risk of false-memory retrieval because of the suggestible state hypnosis creates.)
Alter sensory perceptions. (Smell, hearing, vision, time sense, and the ability to see visual illusions can all be affected by hypnosis.)	Regress people back to childhood. (Although people may act like children, they do and say things children would not.)
Help people relax in situations that normally would cause them stress, such as flying on an airplane (Muhlberger et al., 2001).	Regress people to some "past life." There is no scientific evidence for past-life regression (Lilienfeld et al., 2004).

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therapy to help people "recover" what are thought to be repressed memories.  to [Learning Objective 6.9](#).

In general, hypnosis is a handy way to help people relax and/or to control pain. These subjective experiences are very much under people's mental influence. Actual physical behavior is harder to change, and that is why hypnosis is not as effective at changing eating habits or helping people to stop smoking (Druckman & Bjork, 1994). Hypnosis is sometimes used in psychological therapy to help people cope with anxiety or deal with cravings for food or drugs. For a concise look at what hypnosis can and cannot do, see **Table 4.3**.

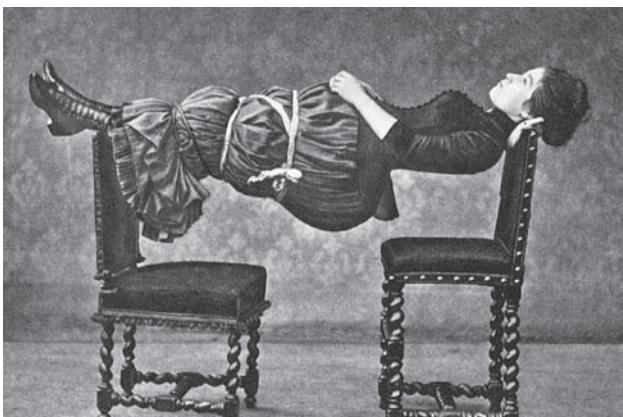
THEORIES OF HYPNOSIS

There are two views of why hypnosis works. One emphasizes the role of **dissociation**, or a splitting of conscious awareness, whereas the other involves a kind of social role-playing.

HYPNOSIS AS DISSOCIATION: THE HIDDEN OBSERVER Ernest Hilgard (1991; Hilgard & Hilgard, 1994) believed that hypnosis worked only on the immediate conscious mind of a person, while a part of that person's mind (a "hidden observer") remained aware of all that was going on. It's the same kind of dissociation that takes place when people drive somewhere familiar and then wonder how they got there. One part of the mind, the conscious part, is thinking about dinner or a date or something else, while the other part is doing the actual driving. When people arrive at their destination, they don't really remember the actual trip. In the same way, Hilgard believes that there is a hidden part of the mind that is very much

aware of the hypnotic subject's activities and sensations, even though the "hypnotized" part of the mind is blissfully unaware of these same things.

In one study (Miller & Bowers, 1993), subjects were hypnotized and told to put their arms in ice water, although they were instructed to feel no pain. There had to be pain—most people can't even get an ice cube out of the freezer without *some* pain—but subjects reported no pain at all. The subjects who were successful at denying the pain



Stage hypnotists often make use of people's willingness to believe that something ordinary is extraordinary. This woman was hypnotized and suspended between two chairs after the person supporting her middle stepped away. The hypnotist led the audience to believe that she could not do this unless hypnotized, but in reality anyone can do this while fully conscious.

also reported that they imagined being at the beach or in some other place that allowed them to dissociate* from the pain.

HYPNOSIS AS SOCIAL ROLE-PLAYING: THE SOCIAL-COGNITIVE EXPLANATION The other theory of why hypnosis works began with an experiment in which participants who were *not* hypnotized were instructed to behave as if they were (Sarbin & Coe, 1972). These participants had no trouble copying many actions previously thought to require a hypnotic state, such as being rigidly suspended between two chairs. The researchers also found that participants who were not familiar with hypnosis, and had no idea what the “role” of a hypnotic subject was supposed to be, could not be hypnotized.

Add to those findings the later findings that expectancies of the hypnotized person play a big part in how the person responds and what the person does under hypnosis (Kirsch, 2000). The **social-cognitive theory of hypnosis** assumes that people who are hypnotized are not in an altered state but are merely playing the role expected of them in the situation. They might believe that they are hypnotized, but in fact it is all a very good performance, so good that even the “participants” are unaware that they are role-playing. Social roles are very powerful influences on behavior, as anyone who has ever worn a uniform can understand—the uniform stands for a particular role that becomes very easy to play (Zimbardo, 1970; Zimbardo et al., 2000).  to Learning Objective 12.11.

*dissociate: break a connection with something.

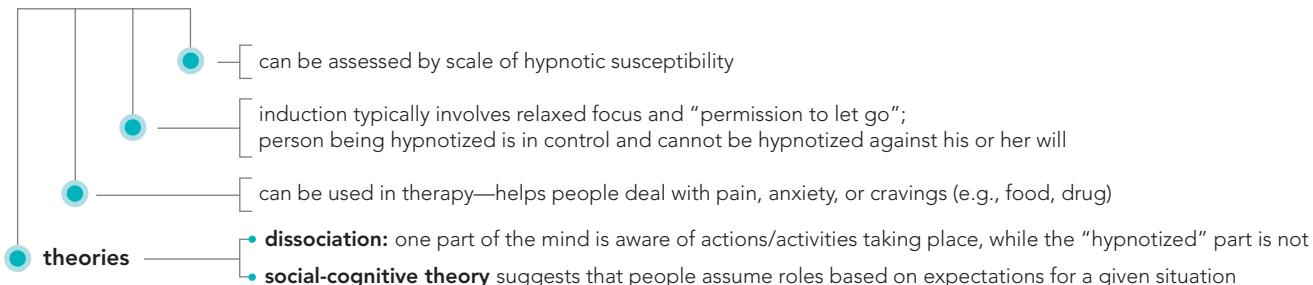
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 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP

The Effects of Hypnosis

(state of consciousness during which person is more susceptible to suggestion)



PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. The primary key to hypnosis is finding someone who
 - a. accepts suggestions easily.
 - c. is already very tired.
 - b. has a vivid imagination.
 - d. is easily distracted.
2. “Hey, I couldn’t help it. I was hypnotized.” What best explains this rationale for one’s behavior while hypnotized?
 - a. dissociative theory
 - c. basic suggestion effect
 - b. expectancy theory
 - d. biological theory
3. Your friend tells you she is seeing a therapist who wishes to use hypnosis as part of her therapy. However, your friend is concerned that she might be hypnotized without knowing it. What might you tell her?
 - a. Be careful. Hypnotists are in control of you while hypnotized.
 - b. Not to worry. Hypnotists can only control their patient’s behavior about 40 percent of the time.
 - c. That you actually hypnotize yourself and you cannot be hypnotized against your will.
 - d. Don’t worry. Hypnosis is just an illusion and doesn’t really work.

4. Which theory of hypnosis includes the idea of a “hidden observer”?
 - a. social cognitive
 - b. biological
 - c. expectancy
 - d. dissociative

THINKING CRITICALLY:

Based on your knowledge of hypnosis, develop a theory to explain why some people can make themselves believe that they have been abducted by aliens.

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The Influence of Psychoactive Drugs

Whereas some people seek altered states of consciousness in sleep, daydreaming, meditation, or even hypnosis, others try to take a shortcut. They use **psychoactive drugs**, chemical substances that alter thinking, perception, memory, or some combination of those abilities. Many of the drugs discussed in the following sections are very useful and were originally developed to help people. Some put people to sleep so that surgeries and procedures that would otherwise be impossible can be performed, whereas others help people deal with the pain of injuries or disease. Still others may be used in helping to control various conditions such as sleep disorders or attention deficits in children and adults.

DEPENDENCE

What is the difference between a physical dependence and a psychological dependence on a drug?

The usefulness of these drugs must not blind us to the dangers of misusing or abusing them. When taken for pleasure, to get “high” or to dull psychological pain, or when taken without the supervision of a qualified medical professional, these drugs can pose serious risks to one’s health and may even cause death. One danger of such drugs is their potential to create either a physical or psychological dependence, both of which can lead to a lifelong pattern of abuse as well as the risk of taking increasingly larger doses, leading to one of the clearest dangers of dependence: a drug overdose. Drug overdoses do not happen only with illegal drugs; even certain additives in so-called natural supplements can have a deadly effect. For example, in January 2003, Steve Bechler, a prospective pitcher for the Baltimore Orioles, died after taking three Ephedra pills on an empty stomach (Shekelle et al., 2003). Ephedra is a substance derived from a shrub found in desert areas and has been used in supplements that claim to promote weight loss.

PHYSICAL DEPENDENCE Drugs that people can become physically dependent on cause the user’s body to crave the drug (Abadinsky, 1989; Fleming & Barry, 1992; Pratt, 1991). After using the drug for some period of time, the body becomes unable to function normally without the drug and the person is said to be dependent or addicted, a condition commonly called **physical dependence**.

One sign of physical dependence is the development of a **drug tolerance** (Pratt, 1991). As the person continues to use the drug, larger and larger doses of the drug are needed to achieve the same initial effects of the drug.

Another sign of a physical dependence is that the user experiences symptoms of **withdrawal** when deprived of the drug. Depending on the drug, these symptoms can range from headaches, nausea, and irritability to severe pain, cramping, shaking, and dangerously elevated blood pressure. These physical sensations occur because the body is trying to adjust to the absence of the drug. Many users will take more of the drug to alleviate the symptoms of withdrawal, which makes the entire situation worse. This is actually an example of *negative reinforcement*, the tendency to continue a behavior that leads to the removal of or escape from unpleasant circumstances or sensations. Negative reinforcement is a very powerful motivating factor, and scores of drug-dependent users exist as living proof of that power.  to Learning Objective 5.5.

The “high” of drug use, whether it comes from an opiate derivative, a stimulant, or a depressant such as alcohol, often takes place in certain surroundings, with certain other people, and perhaps even using certain objects, such as the tiny spoons used by cocaine addicts. These people, settings, and objects can become cues that are associated with the

drug high. When the cues are present, it may be even harder to resist using the drug because the body and mind have become conditioned, or trained, to associate drug use with the cues. This is a form of *classical conditioning*. [LINK](#) to Learning Objective 5.2. This learned behavioral effect has led to nondrug treatments that make use of behavioral therapies such as *contingency-management therapy* (an operant conditioning strategy), in which patients earn vouchers for negative drug tests (Tusel et al., 1994). The vouchers can be exchanged for healthier, more desirable items like food. These behavioral therapies can include residential and outpatient approaches. [LINK](#) to Learning Objective 15.4. *Cognitive-behavioral interventions* work to change the way people think about the stresses in their lives and react to those stressors, working toward more effective coping without resorting to drugs.

The mechanisms of dependence are not just a product of learning—the brain itself plays an important part. Drugs that can lead to dependence cause the release of dopamine in a part of the brain called the mesolimbic pathway, a neural track that begins in the midbrain area (just above the pons) and connects to limbic system structures, including the amygdala and the hippocampus, and continues to the middle of the prefrontal cortex (Hnasko et al., 2010; Schmitt & Reith, 2010). [LINK](#) to Learning Objective 2.8. When a drug enters the body, it goes quickly to this area, known as the brain's "reward pathway," causing a release of dopamine and intense pleasure. The brain tries to adapt to this large amount of dopamine by decreasing the number of synaptic receptors for dopamine. The next time the user takes the drug, he or she needs more of it to get the same pleasure response because of the reduced number of receptors—drug tolerance has developed (Koob & Le Moal, 2005; Laviolette et al., 2008; Salamone & Correa, 2012).

But not all drugs produce physical dependence, right? For example, some people say that you can't get physically dependent on marijuana. If that's true, why is it so hard for some people to quit smoking pot?

PSYCHOLOGICAL DEPENDENCE Not all drugs cause physical dependence; some cause **psychological dependence**, or the belief that the drug is needed to continue a feeling of emotional or psychological well-being, which is a very powerful factor in continued drug use. The body may not need or crave the drug, and people may not experience the symptoms of physical withdrawal or tolerance, but they will continue to use the drug because they *think* they need it. In this case, it is the rewarding properties of using the drug that cause a dependency to develop. This is an example of *positive reinforcement*, or the tendency of a behavior to strengthen when followed by pleasurable consequences. [LINK](#) to Learning Objective 5.5. Negative reinforcement is also at work here, as taking the drug will lower levels of anxiety.

Although not all drugs produce physical dependence, *any* drug can become a focus of psychological dependence. Indeed, because there is no withdrawal to go through or to recover from, psychological dependencies can last forever. Some people who gave up smoking marijuana decades ago still say that the craving returns every now and then (Roffman et al., 1988).

The effect of a particular drug depends on the category to which it belongs and the particular neurotransmitter the drug affects. [LINK](#) to Learning Objective 2.2. In this current chapter we will describe several of the major drug categories, including **stimulants** (drugs that increase the functioning of the nervous system), **depressants** (drugs that decrease the functioning of the nervous system), and **hallucinogenics** (drugs that alter perceptions and may cause hallucinations).

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One of the dangers of psychoactive drugs is that they may lead to physical or psychological dependence.

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STIMULANTS: UP, UP, AND AWAY

How do stimulants and depressants affect consciousness and what are the dangers associated with taking them, particularly alcohol?

Stimulants are a class of drugs that cause either the sympathetic division or the central nervous system (or both) to increase levels of functioning, at least temporarily. In simple terms, stimulants “speed up” the nervous system—the heart may beat faster or the brain may work faster, for example. Many of these drugs are called “uppers” for this reason.

AMPHETAMINES **Amphetamines** are stimulants that are synthesized (made) in laboratories rather than being found in nature. Among the amphetamines are drugs like Benzedrine, Methedrine, and Dexedrine. A related compound, *methamphetamine*, is sometimes used to treat attention-deficit/hyperactivity disorder or narcolepsy. “Crystal meth” is a crystalline form that can be smoked and is used by “recreational” drug users, people who do not need drugs but instead use them to gain some form of pleasure.

Like other stimulants, amphetamines cause the sympathetic nervous system to go into overdrive.  [Learning Objective 2.4](#). Some truck drivers use amphetamines to stay awake while driving long hours. Stimulants won’t give people any extra energy, but they will cause people to burn up whatever energy reserves they do have. They also depress the appetite, which is another function of the sympathetic division. Many doctors used to prescribe these drugs as diet pills. Today they are only used on a short-term basis and under strict medical supervision. Diet pills sold over the counter usually contain another relatively mild stimulant, caffeine.

When the energy reserves are exhausted, or the drug wears off, a “crash” is inevitable and the tendency is to take more pills to get back “up.” The person taking these pills finds that it takes more and more pills to get the same stimulant effect (drug tolerance). Nausea, vomiting, high blood pressure, and strokes are possible, as is a state called “amphetamine psychosis.” This condition causes addicts to become delusional (losing contact with what is real) and paranoid. They think people are out to “get” them. Violence is a likely outcome, both against the self and others (Kratochvil et al., 1996; Paparelli et al., 2011).



Far from being illegal, cocaine was once used in many health drinks and medications, such as this toothache medicine used in the late 1800s.

COCAINE Unlike amphetamines, **cocaine** is a natural drug found in coca plant leaves. It produces feelings of euphoria (a feeling of great happiness), energy, power, and pleasure. It also deadens pain and suppresses the appetite. It was used rather liberally by both doctors and dentists (who used it in numbing the mouth prior to extracting a tooth, for example) near the end of the nineteenth century and the beginning of the twentieth century, until the deadly effects of its addictive qualities became known. Many patent medicines contained minute traces of cocaine, including the now famous Coca-Cola™ (this popular soft drink was originally marketed as a nerve tonic). The good news is that even in 1902, there wasn’t enough cocaine in a bottle of cola to affect even a fly, and by 1929, all traces of cocaine were removed (Allen, 1994).

Cocaine is a highly dangerous drug, not just for its addictive properties. Some people have convulsions and may even die when using cocaine for the first time (Lacayo, 1995). It can have devastating effects on the children born to mothers who use cocaine and has been associated with increased risk of learning disabilities, delayed language development, and an inability to cope adequately with stress, among other symptoms (Cone-Wesson, 2005; Eiden et al., 2009; Kable et al., 2008; Morrow et al., 2006). Laboratory animals have been known to press a lever to give themselves cocaine rather than eating or drinking, even to the point of starvation and death (Iwamoto & Martin, 1988; Ward et al., 1996).

Although cocaine users do not go through the same kind of physical withdrawal symptoms that users of heroin, alcohol, and other physically addictive drugs go through, users will experience a severe mood swing into depression (the “crash”), followed by extreme tiredness, nervousness, an inability to feel pleasure, and paranoia. The brain is the part of the body that develops the craving for cocaine because of chemical changes caused by the drug (Hurley, 1989; Schmitt & Reith, 2010). [LINK](#) to Learning Objective 2.2.

As addictive as cocaine is, there is one other stimulant that is usually described as even more addictive. Most experts in addiction seem to agree that although crack cocaine (a less pure, cheaper version found on the streets) produces addiction in nearly three fourths of the people who use it, nicotine produces addiction in 99 percent of the people who use it (Benowitz, 1988; Centers for Disease Control and Prevention [CDC], 1992; Franklin, 1990; Henningfield et al., 1991; Hilts, 1998; Perrine, 1997).



Hasn't nicotine just been the victim of a lot of bad press? After all, it's legal, unlike cocaine and heroin.

NICOTINE Every year, nearly 430,000 people in the United States die from illnesses related to smoking. That's more people than those who die from accidents in motor vehicles, alcohol, cocaine, heroin and other drug abuse, AIDS, suicide, and homicide *combined* (CDC, 2008). Remember, cocaine, heroin, morphine, and many other currently controlled substances or illegal drugs once used to be legal. One has to wonder what would have been the fate of these drugs if as many people had been making money off of them at that time as do those who farm, manufacture, and distribute tobacco products today.

Nicotine is a relatively mild but nevertheless toxic stimulant, producing a slight “rush” or sense of arousal as it raises blood pressure and accelerates the heart, as well as providing a rush of sugar into the bloodstream by stimulating the release of adrenalin in addition to raising dopamine levels in the brain's reward pathway (Kovacs et al., 2010; Rezvani & Levin, 2001). As is the case with many stimulants, it also has a relaxing effect on most people and seems to reduce stress (Pormerleau & Pormerleau, 1994).

Although fewer Americans are smoking (down to about 25 percent from over 40 percent in the 1960s), women and teenagers are actually smoking more than before (CDC, 2008). This is alarming news when one considers the toxic nature of nicotine: In the 1920s and 1930s it was used as an insecticide and is considered to be highly toxic and fast acting (Gosselin et al., 1984). Although the amount of nicotine in a cigarette is low, first-time smokers often experience nausea as a result of the toxic effects after just a few puffs.

Why is it so difficult to quit using tobacco products? Aside from the powerfully addictive nature of nicotine, the physical withdrawal symptoms can be as bad as those resulting from alcohol, cocaine, or heroin abuse (Epping-Jordan et al., 1998). People don't think about nicotine as being as bad as cocaine or heroin because nicotine is legal and easily obtainable, but in terms of its addictive power, it is *more powerful* than heroin or alcohol (CDC, 2010; Henningfield et al., 1990).

CAFFEINE Although many people will never use amphetamines or take cocaine, and others will never smoke or will quit successfully, there is one stimulant that almost everyone uses, with many using it every day. This, of course, is **caffeine**, the stimulant found in coffee, tea, most sodas, chocolate, and even many over-the-counter drugs.

Caffeine is another natural substance, like cocaine and nicotine, and is found in coffee beans, tea leaves, cocoa nuts, and at least 60 other types of plants (Braun, 1996). It is a mild stimulant, helps maintain alertness, and can increase the effectiveness of some

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Nicotine is highly addictive, and many smokers will go to great lengths to be able to smoke—including smoking right next to the “No Smoking” sign.

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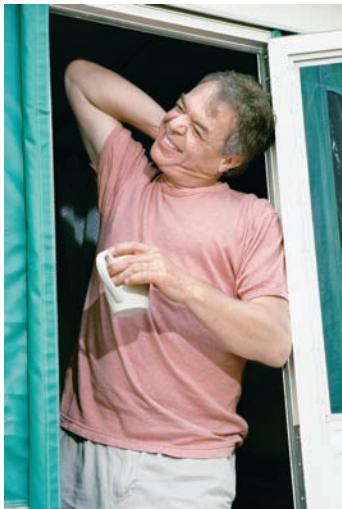
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Sleep deprivation causes this man to struggle to wake up. Caffeine can help with alertness but may worsen his sleep deprivation when he tries to get a decent night's sleep tonight.



Actor Heath Ledger died on January 22, 2008, from an accidental drug interaction. Six different types of depressant drugs were found in his system. He was 28.

pain relievers such as aspirin. Caffeine is often added to pain relievers for that reason and is the key ingredient in medications meant to keep people awake.

Contrary to popular belief, coffee does not help induce sobriety. All one would get is a wide-awake drunk. Coffee is fairly acidic, too, and acids are not what the stomach of a person with a hangover needs. (And since the subject has come up, drinking more alcohol or “hair of the dog that bit you” just increases the problem later on—the best cure for a hangover is lots of water to put back all the fluids that alcohol takes out of the body, and sleep.)

DOWN IN THE VALLEY: DEPRESSANTS

Another class of psychoactive drugs is *depressants*, drugs that slow the central nervous system.

MAJOR AND MINOR TRANQUILIZERS Commonly known as the *major tranquilizers* (drugs that have a strong depressant effect) or sleeping pills, **barbiturates** are drugs that have a sedative (sleep-inducing) effect. Overdoses can lead to death as breathing and heart action are stopped.

The *minor tranquilizers* (drugs having a relatively mild depressant effect) include the **benzodiazepines**. These drugs are used to lower anxiety and reduce stress. Some of the most common are Valium, Xanax, Halcion, Ativan, and Librium.

Both major and minor tranquilizers can be addictive, and large doses can be dangerous, as can an interaction with alcohol or other drugs (Olin, 1993).

Rohypnol is a benzodiazepine tranquilizer that has become famous as the “date rape” drug. Unsuspecting victims drink something that has been doctored with this drug, which causes them to be unaware of their actions, although still able to respond to directions or commands. Rape or some other form of sexual assault can then be carried out without fear that the victim will remember it or be able to report it (Armstrong, 1997; Gable, 2004).

ALCOHOL The most commonly used and abused depressant is **alcohol**, the chemical resulting from fermentation or distillation of various kinds of vegetable matter. Anywhere from 10 to 20 million people in the United States suffer from alcoholism. Aside from the obvious health risks to the liver, brain, and heart, alcohol is associated with loss of work time, loss of a job, and loss of economic stability.

Many people are alcoholics but deny the fact. They believe that getting drunk, especially in college, is a ritual of adulthood. Many college students and even older adults engage in binge drinking (drinking four or five drinks within a limited amount of time, such as at “happy hour”). Binge drinking quickly leads to being drunk, and drunkenness is a major sign of alcoholism. Some other danger signs are feeling guilty about drinking, drinking in the morning, drinking to recover from drinking, drinking alone, being sensitive about how much one drinks when others mention it, drinking so much that one does and says things one later regrets, drinking enough to have blackouts or memory loss, drinking too fast, lying about drinking, and drinking enough to pass out.

The dangers of abusing alcohol cannot be stressed enough. According to the Centers for Disease Control and Prevention (CDC, 2011), the number of alcohol-induced deaths in 2010 was 25,692. This figure does *not* include deaths due to accidents and homicides that may be related to abuse of alcohol—only those deaths that are caused by the body’s inability to handle the alcohol. Of these deaths, 15,990 were attributed to liver disease caused by alcoholism. The National Institute on Alcoholism and Alcohol Abuse (National Institute on Alcoholism and Alcohol Abuse [NIAAA], 2007) has statistics from 2001 to 2002 showing that the rate of psychiatric disorders, including alcohol and other drug abuse as well as depression and anxiety disorders, increases from about 2.5 percent for a light drinker to 13.2 percent for a moderate drinker and around

17.1 percent for a heavy drinker. Alcohol was involved in nearly 22.5 percent of the fatal traffic crashes for drivers under 21 years old and 24.8 percent of the fatal crashes for those over 21 (NIAAA, 2007).

Pregnant women should not drink at all, as alcohol can damage the growing embryo, causing a condition of mental retardation and physical deformity known as fetal alcohol syndrome. [LINK](#) to [Learning Objective 8.4](#). Increased risk of loss of bone density (known as osteoporosis) and heart disease has also been linked to alcoholism (Abbott et al., 1994). These are just a few of the many health problems that alcohol can cause.

If you are concerned about your own drinking or are worried about a friend or loved one, there is a free and very simple online assessment at this site on the Internet: www.alcoholscreening.org.



Although many young adults see drinking as a rite of passage into adulthood, few may understand the dangers of “binge” drinking, or drinking four to five drinks within a limited amount of time. Inhibitions are lowered and poor decisions may be made, such as driving while intoxicated. Binge drinking, a popular activity on some college campuses, can also lead to alcoholism.



I have friends who insist that alcohol is a stimulant because they feel more uninhibited when they drink, so why is it considered a depressant?

Alcohol is often confused with stimulants. Many people think this is because alcohol makes a person feel “up” and euphoric (happy). Actually, alcohol is a depressant that gives the illusion of stimulation, because the very first thing alcohol depresses is a person’s natural inhibitions, or the “don’ts” of behavior. Inhibitions are all the social rules people have learned that allow them to get along with others and function in society. Inhibitions also keep people from taking off all their clothes and dancing on the table at a crowded bar—inhinations are a good thing.

Many people are unaware of exactly what constitutes a “drink.” **Table 4.4** on the next page explains this and shows the effects of various numbers of drinks on behavior. Alcohol indirectly stimulates the release of a neurotransmitter called GABA, the brain’s major depressant (Brick, 2003; Santhakumar et al., 2007). GABA slows down or stops neural activity. As more GABA is released, the brain’s functioning actually becomes more and more inhibited, depressed, or slowed down. The areas of the brain that are first affected by alcohol are unfortunately the areas that control social inhibitions, so alcohol (due to its simulation of GABA) has the effect of depressing the inhibitions. As the effects continue, motor skills, reaction time, and speech are all affected.

Some people might be surprised that only one drink can have a fairly strong effect. People who are not usually drinkers will feel the effects of alcohol much more quickly than those who have built up a tolerance. Women also feel the effects sooner, as their bodies process alcohol differently than men’s bodies do. (Women are typically smaller, too, so alcohol has a quicker impact on women.)

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Table 4.4**Blood Alcohol Level and Behavior Associated With Amounts of Alcohol**

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A drink is a drink. Each contains half an ounce of alcohol.

So a drink is...

- 1 can of beer (12 oz 4–5% alcohol)
- 1 glass of wine (4 oz 12% alcohol)
- 1 shot of most liquors (1 oz 40–50% alcohol)

At times “a drink” is really the equivalent of more than just one drink, like when you order a drink with more than one shot of alcohol in it, or you do a shot followed by a beer.

AVERAGE NUMBER OF DRINKS	BLOOD ALCOHOL LEVEL	BEHAVIOR
1–2 drinks	0.05%	Feeling of well-being Release of inhibitions Judgment impaired Coordination and level of alertness lowered Increased risk of collision while driving
3–5 drinks	0.10%	Reaction time significantly slowed Muscle control and speech impaired Limited night and side vision Loss of self-control Crash risk greatly increased
6–7 drinks	0.15%	Consistent and major increases in reaction time
8–10 drinks	0.20%	Loss of equilibrium and technical skills Sensory and motor capabilities depressed Double vision and legal blindness (20/200) Unfit to drive for up to 10 hours
10–14 drinks	0.20% and 0.25%	Staggering and severe motor disturbances
10–14 drinks	0.30%	Not aware of surroundings
10–14 drinks	0.35%	Surgical anesthesia Lethal dosage for a small percentage of people
14–20 drinks	0.40%	Lethal dosage for about 50% of people Severe circulatory/respiratory depression Alcohol poisoning/overdose

Source: Adapted from the *Moderate Drinking Skills Study Guide*. (2004). Eau-Claire, WI: University of Wisconsin.

NARCOTICS: I FEEL YOUR PAIN Narcotics are a type of depressant that suppress the sensation of pain by binding to and stimulating the nervous system’s natural receptor sites for endorphins, the neurotransmitters that naturally deaden pain sensations (Olin, 1993). Because they also slow down the action of the nervous system, drug interactions with alcohol and other depressants are possible—and deadly. All narcotics are a derivative of a particular plant-based substance—opium.

Opium Opium, made from the opium poppy, has pain-relieving and euphoria-inducing properties that have been known for at least 2,000 years. Highly addictive, it mimics the effects of endorphins, the nervous system’s natural painkillers. The nervous system slows or stops its production of endorphins. When the drug wears off, there is no protection against any kind of pain, causing the severe symptoms of withdrawal associated with these drugs. It was not until 1803 that opium was developed for use as a

medication by a German physician. The new form—morphine—was hailed as “God’s own medicine” (Hodgson, 2001).

Morphine Morphine was created by dissolving opium in an acid and then neutralizing the acid with ammonia. Morphine was thought to be a wonder drug, although its addictive qualities soon became a major concern to physicians and their patients. Morphine is still used today to control severe pain, but in carefully controlled doses and for very short periods of time.

Heroin Ironically, **heroin** was first hailed as the new wonder drug—a derivative of morphine that did not have many of the disagreeable side effects of morphine. The theory was that heroin was a purer form of the drug, and that the impurities in morphine were the substances creating the harmful side effects. It did not take long, however, for doctors and others to realize that heroin was even more powerfully addictive than morphine or opium. Although usage as a medicine ceased, it is still used by many people.

Drugs such as *methadone*, *buprenorphine*, and *naltrexone* may be used to control withdrawal symptoms and help treat opiate addictions (Kahan & Sutton, 1998; Kakko et al., 2003; Ward et al., 1999). Eventually, as the addicted person is weaned from these drugs, the natural endorphin system starts to function more normally.

HALLUCINOGENS: HIGHER AND HIGHER

What are some of the effects and dangers of using hallucinogens, including marijuana?

Hallucinogens actually cause the brain to alter its interpretation of sensations (Olin, 1993) and can produce sensory distortions very similar to *synesthesia* (LINK to Chapter Three: Sensation and Perception), in which sensations cross over each other—colors have sound, sounds have smells, and so on. False sensory perceptions, called *hallucinations*, are often experienced, especially with the more powerful hallucinogens. There are two basic types of hallucinogens—those that are created in a laboratory and those that are from natural sources. Before we begin our discussion of hallucinogens, take the survey experiment *What Drugs Have You Used?* to discover more about your experiences and attitudes toward these drugs.

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Simulation

What Drugs Have You Used?

This survey asks you about your use of and attitudes towards hallucinogenic drugs.

Which of the following hallucinogenic drugs have you used at least once for recreational purposes, that is, just for fun? (Select all that apply.)

Please check all that apply

- LSD
- PCP
- Ecstasy/MDMA
- Marijuana (pot)
- Psilocybin (mushrooms)
- Mescaline
- N/A - I have never used a hallucinogenic drug.

Go to the Experiment ►

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MANUFACTURED HIGHS There are several drugs that were developed in the laboratory instead of being found in nature. Perhaps because these drugs are manufactured, they are often more potent than drugs found in the natural world.

LSD LSD, or **lysergic acid diethylamide**, is synthesized from a grain fungus called *ergot*. Ergot fungus commonly grows on rye grain but can be found on other grains as well. First manufactured in 1938, LSD is one of the most potent, or powerful, hallucinogens (Johnston et al., 2007; Lee & Shlain, 1986). It takes only a very tiny drop of LSD to achieve a “high.”

People who take LSD usually do so to get that high feeling. Some people feel that LSD helps them expand their consciousness or awareness of the world around them. Colors seem more intense, sounds more beautiful, and so on. But the experience is not always a pleasant one, just as dreams are not always filled with positive emotions. “Bad trips” are quite common, and there is no way to control what kind of “trip” the brain is going to decide to take.

One of the greater dangers in using LSD is the effect it has on a person’s ability to perceive reality. Real dangers and hazards in the world may go unnoticed by a person “lost” in an LSD fantasy, and people under the influence of this drug may make poor decisions, such as trying to drive while high.

PCP Another synthesized drug was found to be so dangerous that it remains useful only in veterinary medicine as a tranquilizer. The drug is **PCP** (which stands for *p*-phenyl cyclohexyl *p*iperidine, a name which is often contracted as *phencyclidine*) and can have many different effects. Depending on the dosage, it can be a hallucinogen, stimulant, depressant, or an analgesic (painkilling) drug. As with LSD, users of PCP can experience hallucinations, distorted sensations, and very unpleasant effects. PCP can also lead to acts of violence against others or suicide (Brecher 1988; Cami et al., 2000; Johnston et al., 2007). Users may even physically injure themselves unintentionally because PCP causes them to feel no warning signal of pain.

MDMA (Ecstasy) The last synthetic drug we will address here is technically an amphetamine but it is capable of producing hallucinations as well. In fact, both **MDMA** (a “designer drug” known on the streets as **Ecstasy** or simply X) and PCP are now classified as **stimulatory hallucinogenics**, drugs that produce a mixture of psychomotor stimulant and hallucinogenic effects (National Institute on Drug Abuse, 2006; Shuglin, 1986). Although many users of MDMA believe that it is relatively harmless, the fact is that it—like many other substances—can be deadly when misused. MDMA causes the release of large amounts of serotonin and also blocks the reuptake of this neurotransmitter (Hall & Henry, 2006; Liechti & Vollenweider, 2001; Montgomery & Fisk, 2008). The user feels euphoria, energized, and may feel increased emotional warmth toward others. But there is some evidence that MDMA may damage the serotonin receptors, which could lead to depression. Other negative effects include severe dehydration and raised body temperature, which can lead to excessive intake of liquids—with possible fatal results (Lecce et al., 2000).

NONMANUFACTURED HIGH: MARIJUANA One of the best known and most commonly abused of the hallucinogenic drugs, **marijuana** (also called “pot” or “weed”) comes from the leaves and flowers of the hemp plant called *Cannabis sativa*. (*Hashish* is the concentrated substance made by scraping the resin from these leaves, and both marijuana and hashish contain *cannabinoids*.) The most psychoactive cannabinoid, and the active ingredient in marijuana, is **tetrahydrocannabinol (THC)**. Marijuana is best known for its ability to produce a feeling of well-being, mild intoxication, and mild sensory distortions or hallucinations.

The effects of marijuana are relatively mild compared to the other hallucinogens. In fact, an inexperienced user who doesn’t know what to expect upon smoking that first



Many of these young people enjoying themselves at a rave may be using MDMA, or Ecstasy. The dehydrating effect of the drug, together with the intense dancing and physical activity at raves like this one, can have a deadly effect on the user.

marijuana cigarette may feel nothing at all. Most people do report a feeling of mild euphoria and relaxation, along with an altered time sense and mild visual distortions. Higher doses can lead to hallucinations, delusions, and the all-too-common paranoia. Most studies of marijuana's effects have concluded that while marijuana can create a powerful psychological dependency, it does not produce physical dependency or physical withdrawal symptoms. However, after alcohol and nicotine, cannabis dependence is the most common form of drug dependence in the United States, Canada, and Australia (Hall & Degenhardt, 2009).

Even at mild doses, it is not safe to operate heavy machinery or drive a car while under the influence of marijuana because it negatively affects reaction time and perception of surroundings; the drug reduces a person's ability to make the split-second decisions that driving a car or other equipment requires. Information processing in general, attention, and memory are all likely to be impaired in a person who has used marijuana.

Marijuana is most commonly smoked like tobacco, but some people have been known to eat it baked into brownies or other foods. This is a kind of double duty for the doctored food, as marijuana stimulates the appetite.

Although no one has ever been known to die from an overdose of marijuana, smoking it is not a healthy habit. Research linking marijuana smoking and lung cancer is not definitive due to the fact that many studies have not been able to control for confounding variables, such as cigarette smoking, alcohol use, or other risk factors (Hall & Degenhardt, 2009). [LINK](#) to Learning Objective 1.10. Aside from those previously mentioned, probable adverse effects from chronic nonmedical marijuana use also include increased risk of motor vehicle crashes, chronic bronchitis or other lung problems, and cardiovascular disease. In adolescents who are regular users, psychosocial development, educational attainment, and mental health can be negatively impacted (Hall & Degenhardt, 2009). With regard to the possible mental health problems, there especially appears to be an increased risk for psychotic symptoms and disorders later in life for adolescents who are regular and heavier users (Hall & Degenhardt, 2009; Moore et al., 2007).

Table 4.5 summarizes the various types of drugs, their common names, and their effects on human behavior.

Table 4.5

How Drugs Affect Consciousness

DRUG CLASSIFICATION	COMMON NAME	MAIN EFFECT	ADVERSE EFFECTS
Stimulants		Stimulation, excitement	
Amphetamines	Methamphetamine, speed, Ritalin, Dexedrine		Risk of addiction, stroke, fatal heart problems, psychosis
Cocaine	Cocaine, crack		Risk of addiction, stroke, fatal heart problems, psychosis
Nicotine	Tobacco		Addiction, cancer
Caffeine	Coffee, tea		Addiction, high blood pressure
Depressants		Relaxation	
Barbiturates (major tranquilizers)	Nembutal, Seconal		Addiction, brain damage, death
Benzodiazepines (minor tranquilizers)	Valium, Xanax, Halcion, Ativan, Rohypnol		Lower risk of overdose and addiction when taken alone
Alcohol	Beer, wine, spirits		Alcoholism, health problems, depression, increased risk of accidents, death
Narcotics	Opium, Morphine, heroin	Euphoria	Addiction, death
Hallucinogens		Distorted consciousness, altered perception	Possible permanent memory problems, bad "trips," suicide, overdose, and death



This woman is preparing a cannabis (marijuana) cigarette. Cannabis is reported to relieve pain in cases of multiple sclerosis and chronic pain from nerve damage. Such use is controversial as cannabis is classified as an illegal drug in some countries.

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 Explore the Concept at [MyPsychLab](#)
CONCEPT MAP

Why do some people continue to use or become addicted to psychoactive drugs?

- physical dependence: user's body needs a drug to function; drug tolerance and withdrawal are warning signs/symptoms
- psychological dependence: user believes drug is needed to function

The Influence of Psychoactive Drugs

(drugs that alter thinking, perception, or memory)

types

stimulants

increase functioning of nervous system

- amphetamines
- cocaine
- nicotine
- caffeine

depressants

have sedative effect

- barbiturates major tranquilizers
- benzodiazepines minor tranquilizers—Valium, Xanax, Halcion, Ativan, Librium, Rohypnol
- alcohol
- narcotics euphoria-producing and pain-relieving drugs derived from opium
 - morphine
 - heroin
 - methadone does not produce euphoria; used to treat heroin addiction

hallucinogens

alter brain's interpretation of sensations

- manufactured
 - LSD
 - PCP
 - MDMA (Ecstasy)
- nonmanufactured
 - marijuana

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. As consequences to stopping drug use, headaches, nausea, shaking, and elevated blood pressure are all signs of
 - a. withdrawal.
 - b. overdose.
 - c. psychological dependency.
 - d. amphetamine toxicity.
2. What drug's physical withdrawal symptoms include severe mood swings (crash), paranoia, extreme fatigue, and an inability to feel pleasure?

<ol style="list-style-type: none"> a. heroin b. caffeine 	<ol style="list-style-type: none"> c. alcohol d. cocaine
--	--
3. Which of the following statements about nicotine is true?
 - a. In terms of addictive power, nicotine is more powerful than heroin or alcohol.
 - b. Nicotine can slow the heart and therefore create a sense of relaxation.
 - c. Overall, the number of Americans smoking is on the increase.
 - d. Overall, the number of women and teenagers smoking is on the decrease.
4. _____ is a tranquilizer that is also known as the "date rape" drug.
 - a. Halcion
 - b. Librium
 - c. Rohypnol
 - d. Xanax
5. Typically, narcotics have the ability to
 - a. cause intense hallucinations.
 - b. suppress the sensation of pain.
 - c. stimulate the user.
 - d. cause deep levels of depression.
6. Most studies of marijuana's effects have found that
 - a. it creates a powerful psychological dependency.
 - b. it creates a strong physical dependency.
 - c. it produces intense withdrawal symptoms.
 - d. it is easy to overdose on the substance.

THINKING CRITICALLY:

What might happen if the use of nicotine products became illegal?

Applying Psychology to Everyday Life: Thinking Critically About Ghosts, Aliens, and Other Things That Go Bump in the Night

4.10 How can the workings of our consciousness explain “supernatural” visitations?

Down through the ages, people have been visited by ghosts, spirits, and other sorts of mystical or mysterious visitors—or so they have believed. In more modern times, ghostly visitations have often given way to aliens, who may perform some sort of medical examination or who may abduct the person, only to return them to their beds. And it is to their beds that they are usually returned, and such visitations typically are experienced when the person is in bed. Is there a simpler explanation for these experiences?

As mentioned earlier in this chapter, a type of hallucination can occur just as a person is entering N1 (NREM Stage 1) sleep, called a *hypnogogic hallucination* (Ohayon et al., 1996; Siegel & West, 1975). If you remember that people in N1, when awakened, will deny having been asleep, a simple explanation for so-called supernatural visitations does present itself. Hypnagogic hallucinations are not dreamlike in nature. Instead, they feel very real to the person experiencing them (who does not think he or she is asleep, remember). Most common are the auditory hallucinations, in which a person might hear a voice calling out the person’s name, not all that unusual and probably not remembered most of the time.

Imagine for a moment, though, that your hypnagogic hallucination is that of some person whom you know to be dead or ill, or a strange and frightening image, perhaps with equally strange and frightening sound effects. That you will remember, especially since you are likely to wake up right after *and be completely convinced that you were awake at the time of the hallucination*. Combine this experience with the natural tendency many people have to want to believe that there is life after death or that there are other sentient life forms visiting our planet, and *voilà!*—a ghost/spirit/alien has appeared.

Sometimes people have a similar experience in the middle of the night. They awaken to find that they are paralyzed and that something—ghost, demon, alien—is standing over them and perhaps doing strange things to their helpless bodies. When a hallucination happens just as a person is in the between-state of being in REM sleep (in which the voluntary muscles are paralyzed) and not yet fully awake, it is called a *hypnopompic hallucination* and is once again a much simpler explanation of visits by aliens or spirits during the night than any supernatural explanation. Such visitations are not as rare as you might think, but once again, it is only the spectacular, frightening, or unusual ones that will be remembered (Cheyne, 2003; Greeley, 1987; Ohayon et al., 1996).

Questions for Further Discussion

1. Have you ever had one of these experiences? Can you now understand how that experience might have been one that you would remember?
2. Talk to friends or family about their similar experiences, looking for the simpler explanation.



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Writing Prompt

▼ Your roommate has been coming back to the dorm at all hours of the night, disrupting your sleep. Describe a typical night's sleep cycle and then describe how your sleep deprivation impacts your ability to learn and your health.

Words: 0

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 Write the Response on **MyPsychLab**

chapter summary

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What Is Consciousness?

4.1 What does it mean to be conscious, and are there different levels of consciousness?

- Consciousness is a person's awareness of everything that is going on at any given moment. Most waking hours are spent in waking consciousness.
- Altered states of consciousness are shifts in the quality or pattern of mental activity.

Sleep

4.2 Why do people need to sleep, and how does sleep work?

- Sleep is a circadian rhythm, lasting 24 hours, and is a product of the activity of the hypothalamus, the hormone melatonin, the neurotransmitter serotonin, and body temperature.
- Adaptive theory states that sleep evolved as a way to conserve energy and keep animals safe from predators that hunt at night.
- Restorative theory states that sleep provides the body with an opportunity to restore chemicals that have been depleted during the day as well as the growth and repair of cell tissue.
- The average amount of sleep needed by most adults is about 7 to 9 hours within each 24-hour period.

4.3 What are the different stages of sleep, including the stage of dreaming and its importance?

- N1 (NREM Stage 1) sleep is light sleep.
- N2 (NREM Stage 2) sleep is indicated by the presence of sleep spindles, bursts of activity on the EEG.
- N3 (NREM Stages 3 and 4) is highlighted by the first appearance of delta waves, the slowest and largest waves, and the body is at its lowest level of functioning.
- REM sleep occurs four or five times a night, replacing N1 after a full cycle through N1–N3 and then ascending back to lighter

stages of sleep. It is accompanied by paralysis of the voluntary muscles but rapid movement of the eyes.

4.4 How do sleep disorders interfere with normal sleep?

- Sleepwalking and sleepalking occur in N3 sleep.
- Voluntary muscles are paralyzed during REM sleep.
- Night terrors are attacks of extreme fear that the victim has while sound asleep.
- Nightmares are bad or unpleasant dreams that occur during REM sleep.
- REM behavior disorder is a rare condition in which sleep paralysis fails and the person moves violently while dreaming, often acting out the elements of the dream.
- Insomnia is an inability to get to sleep, stay asleep, or get enough sleep.
- Sleep apnea occurs when a person stops breathing for 10 seconds or more.
- Narcolepsy is a genetic disorder in which the person suddenly and without warning collapses into REM sleep.

Dreams

4.5 Why do people dream, and what do they dream about?

- Manifest content of a dream is the actual dream and its events. Latent content of a dream is the symbolic content, according to Freud.
- Without outside sensory information to explain the activation of the brain cells in the cortex by the pons area, the association areas of the cortex synthesize a story, or dream, to explain that activation in the activation-synthesis hypothesis.
- A revision of activation-synthesis theory, the activation-information-mode model (AIM), states that information experienced during waking hours can influence the synthesis of dreams.

The Effects of Hypnosis

4.6 How does hypnosis affect consciousness?

- Hypnosis is a state of consciousness in which a person is especially susceptible to suggestion.
- The hypnotist will tell the person to relax and feel tired, to focus on what is being said, to let go of inhibitions and accept suggestions, and to use vivid imagination.
- Hypnosis cannot give increased strength, reliably enhance memory, or regress people to an earlier age or an earlier life, but it can produce amnesia, reduce pain, and alter sensory impressions.
- Hilgard believed that a person under hypnosis is in a state of dissociation, in which one part of consciousness is hypnotized and susceptible to suggestion, while another part is aware of everything that occurs.
- Other theorists believe that the hypnotized subject is merely playing a social role—that of the hypnotized person. This is called the social-cognitive theory of hypnosis.

The Influence of Psychoactive Drugs

4.7 What is the difference between a physical dependence and a psychological dependence on a drug?

- Drugs that are physically addictive cause the user's body to crave the drug. When deprived of the drug, the user will go through physical withdrawal.
- Drug tolerance occurs as the user's body becomes conditioned to the level of the drug. After a time, the user must take more and more of the drug to get the same effect.
- In psychological dependence, the user believes that he or she needs the drug to function well and maintain a sense of well-being. Any drug can produce psychological dependence.

4.8 How do stimulants and depressants affect consciousness and what are the dangers associated with taking them, particularly alcohol?

- Stimulants are drugs that increase the activity of the nervous system, particularly the sympathetic division and the central nervous system.
- Amphetamines are synthetic drugs such as Benzedrine or Dexedrine. They help people stay awake and reduce appetite but are highly physically addictive.
- Cocaine is highly addictive and can cause convulsions and death in some first-time users.
- Nicotine is a mild stimulant and is very physically addictive.

- Caffeine is the most commonly used stimulant, found in coffee, tea, chocolate, and many sodas.
- Barbiturates, also known as major tranquilizers, have a sedative effect and are used as sleeping pills.
- The minor tranquilizers are benzodiazepines such as Valium or Xanax.
- Alcohol is the most commonly used and abused depressant.
- Alcohol can interact with other depressants.
- Excessive use of alcohol can lead to alcoholism, health problems, loss of control, and death.
- Narcotics are pain-relieving drugs of the depressant class that are derived from the opium poppy.
- Opium is the earliest form of this drug and is highly addictive because it directly stimulates receptor sites for endorphins. This causes natural production of endorphins to decrease.
- Morphine is a more refined version of opium but is highly addictive.
- Heroin was believed to be a purer form of morphine and, therefore, less addictive but in fact is even more powerfully addictive.
- Methadone has the ability to control the symptoms of heroin or morphine withdrawal without the euphoria, or "high," of heroin or morphine.

4.9 What are some of the effects and dangers of using hallucinogens, including marijuana?

- Hallucinogens are stimulants that alter the brain's interpretation of sensations, creating hallucinations. Three synthetically created hallucinogens are LSD, PCP, and MDMA.
- Marijuana is a mild hallucinogen, producing a mild euphoria and feelings of relaxation in its users. Larger doses can lead to hallucinations and paranoia. It contains substances that may be carcinogenic and impairs learning and memory.

Applying Psychology to Everyday Life: Thinking Critically About Ghosts, Aliens, and Other Things That Go Bump in the Night

4.10 How can the workings of our consciousness explain "supernatural" visitations?

- Vivid, realistic hallucinations that occur in N1 (NREM Stage 1) sleep are called hypnagogic hallucinations and are often misinterpreted as ghosts or other supernatural visitations.
- Similar hallucinations that occur when awakening from REM sleep are called hypnopompic hallucinations.

test YOURSELF

ANSWERS AVAILABLE IN ANSWER KEY.

 **Study** and **Review** with more quizzes and a customized study plan at **MyPsychLab**

Pick the best answer.

1. Jane is aware that she is sitting in her psychology class and it is almost lunchtime. She is also aware of how tired she is since staying up late to watch a movie. Thus, if Jane is aware of what is going on around her and what is going on within her, then it is safe to say that she is in a(n)
 - a. state of waking consciousness.
 - b. altered state of consciousness.
 - c. unconscious state.
 - d. preconscious state.
2. What part of the brain is influential in determining when to sleep?
 - a. hippocampus
 - b. hypothalamus
 - c. thalamus
 - d. frontal lobe
3. As the sun begins to set, Winston finds himself becoming more and more sleepy. What structure is sensitive to light and influences when to go to sleep and when to awaken?
 - a. corpus callosum
 - b. occipital lobe
 - c. thalamus
 - d. suprachiasmatic nucleus
4. Carlos is pulling an all-nighter in preparation for his big psychology test tomorrow. According to the research, what is the result on Carlos's memory when he deprives himself of sleep the night prior to his exam?
 - a. Carlos will retain information from staying up all night, but only if his test is early in the morning.
 - b. The ability to retain information can be influenced by the presence of sunlight. Thus, if the sun is shining, Carlos will remember more than if it is a cloudy day.
 - c. Carlos will actually remember less if he deprives himself of sleep the night before.
 - d. Carlos's memory will not be affected in any way assuming he only stays awake for one all-night study session.
5. Your uncle Karl, who recently retired, has mentioned how he doesn't sleep as well as he did when he was younger. For many years, he regularly slept about 7–8 hours, but now that he is in his 60s he tends to get only 5–6 hours of sleep per night. What would you tell him?
 - a. Getting less sleep seems to be a common consequence of aging.
 - b. Getting less sleep as we age is not normal, since studies show we need more sleep as we age.
 - c. Getting less sleep is dangerous as we age. People should seek medical intervention to help them sleep.
 - d. Getting less sleep is associated with mental health problems in our later years. Uncle Karl should consider seeing a psychologist.
6. You find yourself driving very late at night. As you are driving, you realize that you actually were falling off to sleep for a couple of seconds. Such a phenomenon is known as
 - a. microsleep.
 - b. daydreaming.
 - c. circadian rhythms.
 - d. hypnic jerk.
7. Studies have found that certain chemicals that help repair damaged cells only function while we sleep. What theory best explains this?
 - a. circadian rhythm of sleep
 - b. adaptive theory of sleep
 - c. restorative theory of sleep
 - d. sleep deprivation theory
8. In which stage of sleep do sleep spindles occur?
 - a. N1 (NREM Stage 1)
 - b. N2 (NREM Stage 2)
 - c. N3 (NREM Stage 3)
 - d. REM
9. Josef has had a very demanding day. Though his work is not physically challenging, it tends to mentally drain him. What type of sleep will Josef probably require more of?
 - a. N1 (NREM Stage 1)
 - b. N2 (NREM Stage 2)
 - c. N3 (NREM Stage 3)
 - d. REM sleep
10. Your doctor has told you that your youngest son suffers from somnambulism. What is another name for somnambulism?
 - a. insomnia
 - b. sleepwalking
 - c. sleep apnea
 - d. narcolepsy
11. Gerald has difficulty falling off to sleep. Harley can fall off to sleep easily but often wakes up early. Dale typically sleeps for 10 hours. All three are tired and not rested upon rising. Who seems to be experiencing insomnia?
 - a. Gerald
 - b. Harley
 - c. Dale
 - d. All three suffer from insomnia.
12. Very young infants who suffer from sleep apnea may be more at risk for SIDS, or sudden infant death syndrome. Why might these infants have difficulty breathing?
 - a. Many of these infants are obese and therefore their airways are obstructed.
 - b. The brain stem is not yet fully mature.
 - c. The tissue lining in the nasal passageway may be obstructing their airflow.
 - d. No medical explanation has been determined.

13. Bill suddenly and without warning slips into REM sleep during the day. He often falls to the ground and is difficult to awaken. Bill may have a condition called
- sleep apnea.
 - insomnia.
 - narcolepsy.
 - epilepsy.
14. Calvin had a dream about his dog Snoopy in which he constantly looked for him but couldn't find him. In reality, Calvin's dog had died after being hit by a car. According to Sigmund Freud, his dream in which he was searching for his dog is an example of _____, while the inner meaning that he misses his dog terribly is an example of _____.
a. wish fulfillment; manifest content
b. latent content; wish fulfillment
c. latent content; manifest content
d. manifest content; latent content
15. When Tawny is asked to write down her dreams as a class assignment, she is bothered by the fact that her dreams often seem to jump randomly from scene to scene with little meaning. What theory best explains her dreams?
a. activation-synthesis
b. dreams-for-survival
c. sociocultural theory
d. Freudian
16. Anthony's therapist is using hypnosis to help him recall the night he was supposedly abducted by aliens. Danny's therapist is using hypnosis to help him prepare for the pain of dental surgery since Danny is allergic to the dentist's painkillers. Patrick's therapist is using hypnosis to help him quit drinking and smoking. Which client has the highest chance for success?
a. Anthony
b. Danny
c. Patrick
d. All three can benefit from hypnosis since each technique is proven effective.
17. Bobby agreed to be hypnotized during a comedy routine. While hypnotized, he stood on his chair and crowed like a rooster. Later, when his friends asked why he did this, Bobby replied that he didn't know, it must have been because he was hypnotized. What theory best explains his behavior?
a. the hidden observer theory of hypnosis
b. the social-cognitive explanation of hypnosis
c. the biological theory of hypnosis
d. the behavioral theory of hypnosis
18. Jackie has found that when she tries to quit drinking, she gets headaches, has night sweats, and shakes uncontrollably. Such a reaction is an example of
a. psychological dependence.
b. overdose.
c. withdrawal.
d. learned behavior.
19. What is the most commonly used and abused depressant?
a. alcohol
b. Prozac
c. tranquilizers
d. caffeine
20. Which drug, depending on the dosage, can be a hallucinogen, stimulant, depressant, or painkiller?
a. marijuana
b. opium
c. PCP
d. caffeine

5

learning

Yoshiko's first-grade teacher started a reading contest. For every book read, a child would get a gold star on the reading chart, and at the end of one month the child with the most stars would get a prize. Yoshiko went to the library and checked out several books each week. At the end of the month, Yoshiko had the most gold stars and got to stand in front of her classmates to receive her prize. Would it be candy? A toy? She was so excited! Imagine her surprise and mild disappointment when the big prize turned out to be another book! Disappointing prize aside, Yoshiko's teacher had made use of a key technique of learning called *reinforcement*. Reinforcement is anything that when following a response, increases the likelihood that the response will occur again. The reinforcers of gold stars and a prize caused Yoshiko's reading to increase.

How have you used reinforcement to modify your own behavior or the behavior of others?

A video player interface featuring a smiling Black man in a dark t-shirt with a blue and white graphic. He is surrounded by floating blue circles and stars, with a large 'A+' grade bubble to his right. The video player includes a play bar with a progress slider, volume icon, CC button, and share icon. Below the video is a call-to-action button: 'Watch the Video at MyPsychLab.com'.

Why study learning?

If we had not been able to learn, we would have died out as a species long ago. Learning is the process that allows us to adapt to the changing conditions of the world around us. We can alter our actions until we find the behavior that leads us to survival and rewards, and we can eliminate actions that have been unsuccessful in the past. Without learning, there would be no buildings, no agriculture, no lifesaving medicines, and no human civilization.

Learning objectives

5.1

What does the term *learning* really mean?

5.2

How was classical conditioning first studied, and what are the important elements and characteristics of classical conditioning?

5.3

What is a conditioned emotional response, and how do cognitive psychologists explain classical conditioning?

5.4

How does operant conditioning occur, and what were the contributions of Thorndike and Skinner?

5.5

What are the important concepts in operant conditioning?

5.6

What are the schedules of reinforcement?

5.7

What is punishment and how does it differ from reinforcement?

5.8

What are some of the problems with using punishment?

5.9

How do operant stimuli control behavior, and what are some other concepts that can enhance or limit operant conditioning?

5.10

What is behavior modification, and how can behavioral techniques be used to modify involuntary biological responses?

5.11

How do latent learning, insight, and learned helplessness relate to cognitive learning theory?

5.12

What is observational learning, and what are the four elements of modeling?

5.13

What is a real-world example of the use of conditioning?



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Definition of Learning

What does the term *learning* really mean?

The term *learning* is one of those concepts whose meaning is crystal clear until one has to put it in actual words. “Learning is when you learn something.” “Learning is learning how to do something.” A more useful definition is as follows: **Learning** is any relatively permanent change in behavior brought about by experience or practice.

What does “relatively permanent” mean? And how does experience change what we do?

The “relatively permanent” part of the definition refers to the fact that when people learn anything, some part of their brain is physically changed to record what they’ve learned (Farmer et al., 2013; Loftus & Loftus, 1980). This is actually a process of memory, for without the ability to remember what happens, people cannot learn anything. Although there is no conclusive proof as yet, research suggests that once people learn something, it may be present somewhere in memory in physical form (Barsalou, 1992; Smolen et al., 2008). They may be unable to “get” to it, but it’s there. [LINK](#) to Learning Objective 6.4.

As for the inclusion of experience or practice in the definition of learning, think about the last time you did something that caused you a lot of pain. Did you do it again? Probably not. You didn’t want to experience that pain again, so you changed your behavior to avoid the painful consequence.* This is how children learn not to touch hot stoves. In contrast, if a person does something resulting in a very pleasurable experience, that person is more likely to do that same thing again. This is another change in behavior and is explained by the law of effect, a topic we will discuss later in the chapter.

Not all change is accomplished through learning. Changes like an increase in height or the size of the brain are another kind of change, controlled by a genetic blueprint. This kind of change is called *maturity*, and is due to biology, not experience. For example, practice alone will not allow a child to walk. Children learn to walk because their nervous systems, muscle strength, and sense of balance have reached the point where walking is physically possible for them—all factors controlled by maturation. Once that maturational readiness has been reached, then practice and experience play their important part.

the neighborhood Jerry Van Amerongen



An instantaneous learning experience.

It Makes Your Mouth Water: Classical Conditioning

How was classical conditioning first studied, and what are the important elements and characteristics of classical conditioning?

*consequence: an end result of some action.

In the early 1900s, research scientists were unhappy with psychology's focus on mental activity. [LINK](#) to Learning Objective 1.3. Many were looking for a way to bring some kind of objectivity and scientific research to the field. It was a Russian *physiologist* (a person who studies the workings of the body) named Ivan Pavlov (1849–1936) who pioneered the empirical study of the basic principles of a particular kind of learning (Pavlov, 1906, 1926).

Studying the digestive system in his dogs, Pavlov had built a device that would accurately measure the amount of saliva produced by the dogs when they were fed a measured amount of food. Normally, when food is placed in the mouth of any animal, the salivary glands automatically start releasing saliva to help with chewing and digestion. This is a normal **reflex**—an unlearned, involuntary response that is not under personal control or choice—one of many that occur in both animals and humans. The food causes a particular reaction, the salivation. A *stimulus* can be defined as any object, event, or experience that causes a *response*, the reaction of an organism. In the case of Pavlov's dogs, the food is the stimulus and salivation is the response.

PAVLOV AND THE SALIVATING DOGS

Pavlov soon discovered that his dogs began salivating when they weren't supposed to be salivating. Some dogs would start salivating when they saw the lab assistant bringing their food, others when they heard the clatter of the food bowl from the kitchen, and still others when it was the time of day they were usually fed. Switching his focus, Pavlov spent the rest of his career studying what eventually he termed **classical conditioning**, learning to elicit* an involuntary, reflex-like, response to a stimulus other than the original, natural stimulus that normally produces the response.

ELEMENTS OF CLASSICAL CONDITIONING

Pavlov eventually identified several key elements that must be present and experienced in a particular way for conditioning to take place.

UNCONDITIONED STIMULUS The original, naturally occurring stimulus is called the **unconditioned stimulus (UCS)**. The term *unconditioned* means “unlearned.” This is the stimulus that ordinarily leads to the involuntary response. In the case of Pavlov's dogs, the food is the unconditioned stimulus.

UNCONDITIONED RESPONSE The automatic and involuntary response to the unconditioned stimulus is called the **unconditioned response (UCR)** for much the same reason. It is unlearned and occurs because of genetic “wiring” in the nervous system. For example, in Pavlov's experiment, the salivation to the food is the UCR (unconditioned response).

CONDITIONED STIMULUS Pavlov determined that almost any kind of stimulus could become associated with the unconditioned stimulus (UCS) if it is paired with the UCS often enough. In his original study, the sight of the food dish itself became a stimulus for salivation *before* the food was given to the dogs. Every time they got food (to which they automatically salivated), they saw the dish. At this point, the dish was a **neutral stimulus (NS)** because it had no effect on salivation. After being paired with the food so many times, the dish came to produce a salivation response, although a somewhat weaker one, as did the food itself. When a previously neutral stimulus, through repeated pairing with the unconditioned stimulus, begins to cause the same kind of involuntary response, learning has occurred. The previously neutral stimulus can now be called a **conditioned stimulus (CS)**. (*Conditioned* means “learned,” and, as mentioned earlier, *unconditioned* means “unlearned.”)



Dr. Ivan Pavlov and students working in his laboratory. Pavlov, a Russian physiologist, was the first to study and write about the basic principles of classical conditioning.

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*elicit: to draw forth.

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Classical conditioning in the real world. These children are, no doubt, salivating to the sound of the ice cream truck's bell, much as Pavlov's dogs were conditioned to respond to a metronome. What other kinds of stimuli might make a person salivate?

CONDITIONED RESPONSE The response that is given to the CS (conditioned stimulus) is not usually quite as strong as the original unconditioned response (UCR), but it is essentially the same response. However, because it comes as a learned response to the conditioned stimulus (CS), it is called the **conditioned response (CR)**.

PUTTING IT ALL TOGETHER: PAVLOV'S CANINE CLASSIC, OR TICK TOCK TICK TOCK

Pavlov did a classic experiment in which he paired the ticking sound of a metronome (a simple device that produces a rhythmic ticking sound) with the presentation of food to see if the dogs would eventually salivate at the sound of the metronome (Pavlov, 1927). Since the metronome's ticking did not normally produce salivation, it was a neutral stimulus (NS) before any conditioning took place. The repeated pairing of a NS and the UCS (unconditioned stimulus) is usually called *acquisition*, because the organism is in the process of acquiring learning. **Figure 5.1** explains how each element of the conditioning relationship worked in Pavlov's experiment.

Watch the [Video, The Basics I: Classical Conditioning: An Involuntary Response : Pavlov's Experiment](#), at [MyPsychLab](#)

Notice that the responses, CR (conditioned response) and UCR (unconditioned response), are very similar—salivation. However, they differ not only in strength but also in the stimulus to which they are the response. An *unconditioned stimulus* (UCS) is always followed by an *unconditioned response* (UCR), and a *conditioned stimulus* (CS) is always followed by a *conditioned response* (CR).

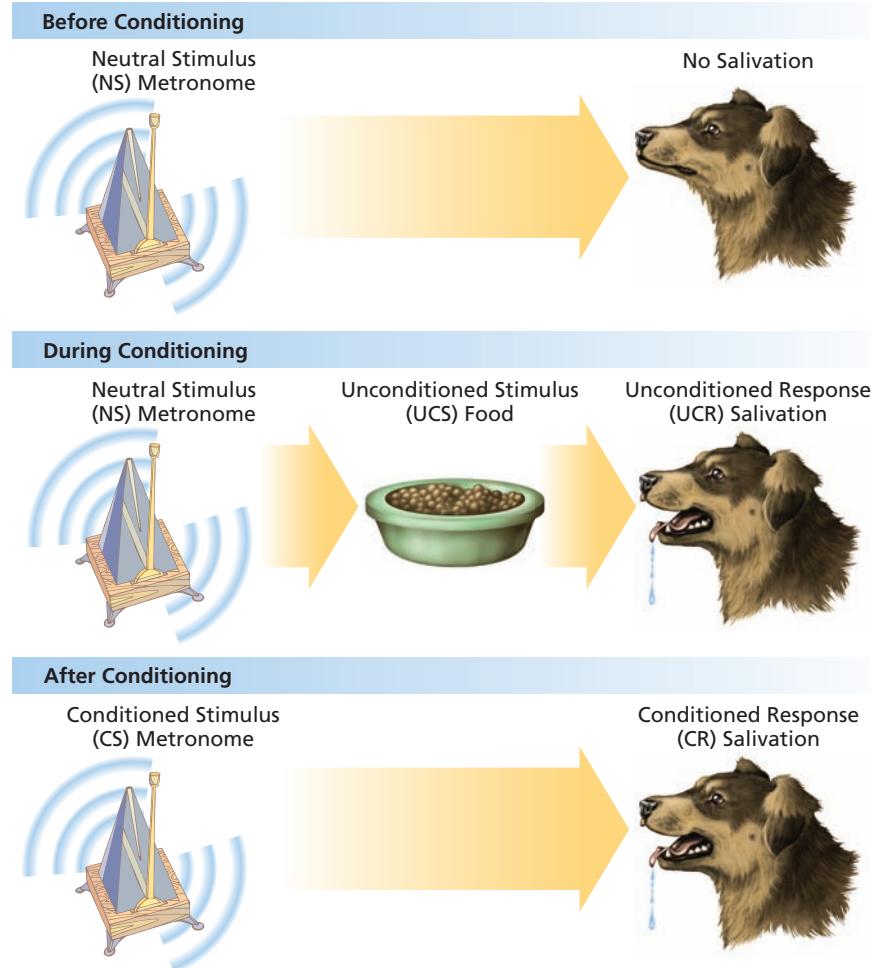


Figure 5.1 Classical Conditioning

Before conditioning takes place, the sound of the metronome does not cause salivation and is a neutral stimulus, or NS. During conditioning, the sound of the metronome occurs just before the presentation of the food, the UCS. The food causes salivation, the UCR. When conditioning has occurred after several pairings of the metronome with the food, the metronome will begin to elicit a salivation response from the dog without any food. This is learning, and the sound of the metronome is now a CS and the salivation to the metronome is the CR.

Is this rocket science? No, not really. Classical conditioning is actually one of the simplest forms of learning. It's so simple that it happens to people all the time without them even being aware of it. Does your mouth water when you merely *see* an advertisement for your favorite food on television? Do you feel anxious every time you hear the high-pitched whine of the dentist's drill? These are both examples of classical conditioning. Over the course of many visits to the dentist, for example, the body comes to associate that sound (CS) with the anxiety or fear (UCR) the person has felt while receiving a painful dental treatment (UCS), and so the sound produces a feeling of anxiety (CR) whether that person is in the chair or just in the outer waiting area.

Pavlov and his fellow researchers did many experiments with the dogs. In addition to the metronome, whistles, tuning forks, various visual stimuli, and bells were used (Thomas, 1994). Although classical conditioning happens quite easily, Pavlov and his other researchers formulated a few basic principles about the process (although we will see that there are a few exceptions to some of these principles):

1. The CS must come *before* the UCS. If Pavlov sounded the metronome just after he gave the dogs the food, they did not become conditioned (Rescorla, 1988).
2. The CS and UCS must come very close together in time—ideally, no more than 5 seconds apart. When Pavlov tried to stretch the time between the potential CS and the UCS to several minutes, no association or link between the two was made. Too much could happen in the longer interval of time to interfere with conditioning (Pavlov, 1926; Wasserman & Miller, 1997). Recent studies have found that the interstimulus interval (ISI, or the time between the CS and UCS) can vary depending on the nature of the conditioning task and even the organism being conditioned. In these studies, shorter ISIs (less than 500 milliseconds) have been found to be ideal for conditioning (Polewan et al., 2006).
3. The neutral stimulus must be paired with the UCS several times, often many times, before conditioning can take place (Pavlov, 1926).
4. The CS is usually some stimulus that is distinctive* or stands out from other competing stimuli. The metronome, for example, was a sound that was not normally present in the laboratory and, therefore, distinct (Pavlov, 1927; Rescorla, 1988).



That seems simple enough. But I wonder—would Pavlov's dogs salivate to other ticking sounds?

STIMULUS GENERALIZATION AND DISCRIMINATION Pavlov did find that similar sounds would produce a similar conditioned response from his dogs. He and other researchers found that the strength of the response to similar sounds was not as strong as it was to the original one, but the more similar the other sound was to the original sound (be it a metronome or any other kind of sound), the more similar the strength of the response was (Siegel, 1969). (See **Figure 5.2**.) The tendency to respond to a stimulus that is similar to the original conditioned stimulus is called **stimulus generalization**. For example, a person who reacts with anxiety to the sound of a dentist's drill might react with some slight anxiety to a similar-sounding machine, such as an electric coffee grinder.

*distinctive: separate, having a different quality from something else.



Could this be you? The anxiety that many people feel while in the dentist's office is a conditioned response, with the dentist's chair and the smells of the office acting as conditioned stimuli.

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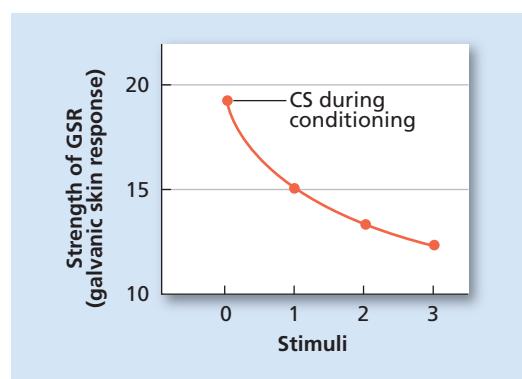
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Figure 5.2 Strength of the Generalized Response

An example of stimulus generalization. The UCS was an electric shock and the UCR was the galvanic skin response (GSR), a measure associated with anxiety. The subjects had been conditioned originally to a CS tone (0) of a given frequency. When tested with the original tone, and with tones 1, 2, and 3 of differing frequencies, a clear generalization effect appeared. The closer the frequency of the test tone to the frequency of tone 0, the greater was the magnitude of the galvanic skin response to the tone (Hovland, 1937).



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Of course, Pavlov did not give the dogs any food after the similar ticking sound. They only got food following the correct CS. It didn't take long for the dogs to stop responding (generalizing) to the "fake" ticking sounds altogether. Because only the real CS was followed with food, they learned to tell the difference, or to *discriminate*, between the fake ticking and the CS ticking, a process called **stimulus discrimination**. Stimulus discrimination occurs when an organism learns to respond to different stimuli in different ways. For example, although the sound of the coffee grinder might produce a little anxiety in the dental-drill-hating person, after a few uses that sound will no longer produce anxiety because it isn't associated with dental pain.

EXTINCTION AND SPONTANEOUS RECOVERY What would have happened if Pavlov had stopped giving the dogs food after the real CS? Pavlov did try just that, and the dogs gradually stopped salivating to the sound of the ticking. When the metronome's ticking (CS or conditioned stimulus) was repeatedly presented in the absence of the UCS (unconditioned stimulus or food, in this case), the salivation (CR or conditioned response) "died out" in a process called **extinction**.

Why does the removal of an unconditioned stimulus lead to extinction of the conditioned response? One theory is that the presentation of the CS alone leads to new learning. During extinction, the CS–UCS association that was learned is weakened, as the CS no longer predicts the UCS. In the case of Pavlov's dogs, through extinction they learned to not salivate to the metronome's ticking, as it no longer predicted that food was on its way.

Look back at Figure 5.1. Once conditioning is acquired, the conditioned stimulus (CS) and conditioned response (CR) will always come *before* the original unconditioned stimulus (UCS). The UCS, which comes after the CS and CR link, now serves as a strengthener, or reinforcer of the CS–CR association. Remove that reinforcer, and the CR it strengthens will weaken and disappear—at least for a while.

The term *extinction* is a little unfortunate in that it seems to mean that the original conditioned response is totally gone, dead, never coming back, just like the dinosaurs. Remember the definition of learning is any relatively *permanent* change in behavior. The fact is that once people learn something, it's almost impossible to "unlearn" it. People can learn new things that replace it or lose their way to it in memory, but it's still there. In the case of classical conditioning, this is easily demonstrated.

After extinguishing the conditioned salivation response in his dogs, Pavlov waited a few weeks, putting the conditioned stimulus (i.e., the metronome) away. There were no more training sessions and the dogs were not exposed to the metronome's ticking in that time at all. But when Pavlov took the metronome back out and set it ticking, the dogs all began to salivate, although it was a fairly weak response and didn't last very long. This brief recovery of the conditioned response proves that the CR is "still in there" somewhere (remember, learning is *relatively permanent*). It is just suppressed or inhibited by the lack of an association with the unconditioned stimulus of food (which is no longer reinforcing or strengthening the CR). As time passes, this inhibition weakens, especially if the original conditioned stimulus has not been present for a while. In **spontaneous recovery** the conditioned response can briefly reappear when the original CS returns, although the response is usually weak and short-lived. See **Figure 5.3** for a graph showing both extinction and spontaneous recovery.

HIGHER-ORDER CONDITIONING Another concept in classical conditioning is **higher-order conditioning** (see **Figure 5.4**). This occurs when a strong conditioned stimulus is paired with a neutral stimulus. The strong CS can actually play the part of a UCS, and the previously neutral stimulus becomes a *second* conditioned stimulus.

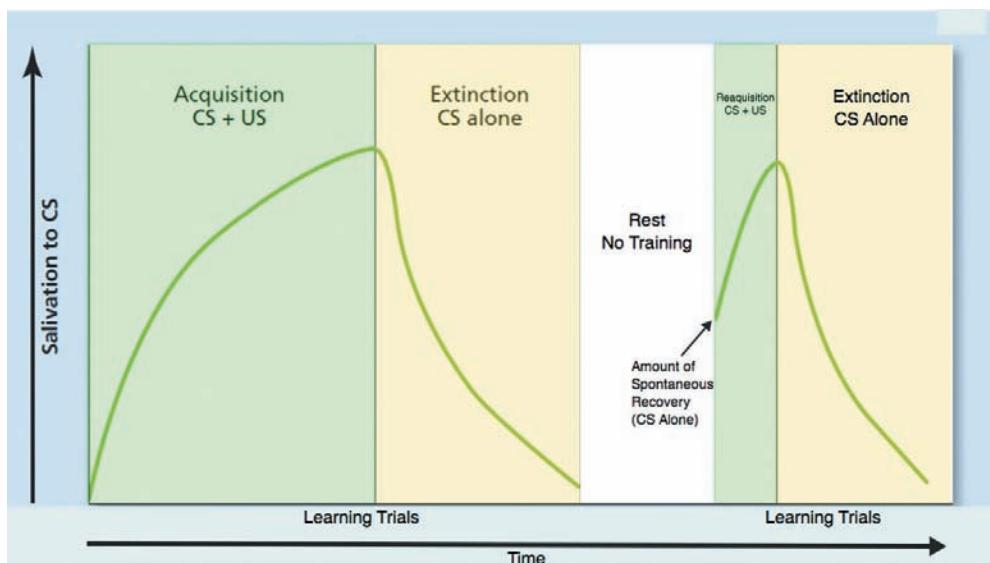


Figure 5.3 Extinction and Spontaneous Recovery

This graph shows the acquisition, extinction, spontaneous recovery, and reacquisition of a conditioned salivary response. Typically, the measure of conditioning is the number of drops of saliva elicited by the CS on each trial. Note that on the day following extinction, the first presentation of the CS elicits quite a large response. This response is due to spontaneous recovery.

For example, let's revisit the point when Pavlov has conditioned his dogs to salivate at the sound of the metronome. What would happen if just before Pavlov turned on the metronome, he snapped his fingers? The sequence would now be "snap-ticking-salivation," or "NS-CS-CR" ("neutral stimulus/conditioned stimulus/conditioned response"). If this happens enough times, the finger snap will eventually also produce a salivation response. The finger snap becomes associated with the ticking through the same process that the ticking became associated with the food originally and is now another conditioned stimulus. Of course, the food (UCS) would have to be presented every now and then to maintain the original conditioned response to the metronome's ticking. Without the UCS, the higher-order conditioning would be difficult to maintain and would gradually fade away.

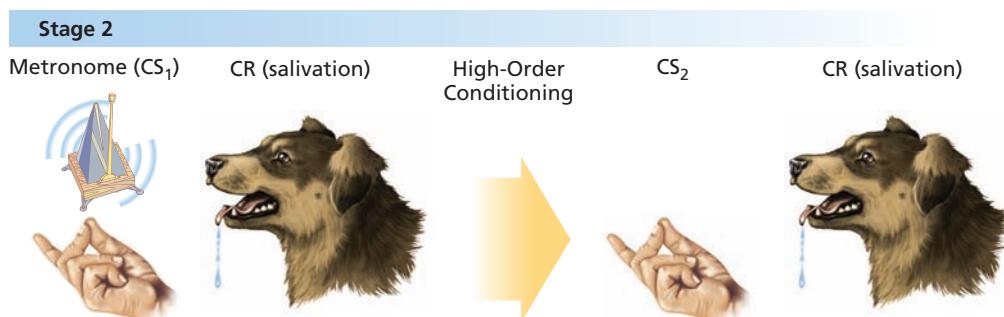
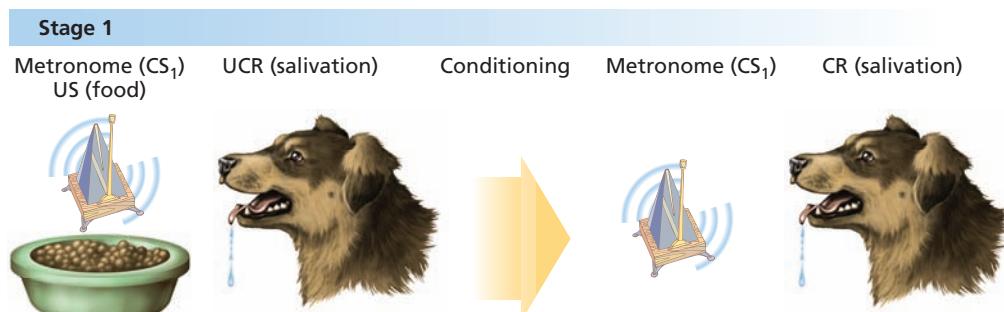


Figure 5.4 Higher-Order Conditioning

In Stage 1, a strong salivation response is conditioned to occur to the sound of the metronome (CS₁). In Stage 2, finger snapping (CS₂) is repeatedly paired with the ticking of the metronome (CS₁) until the dog begins to salivate to the finger snapping alone. This is called "higher-order conditioning," because one CS is used to create another, "higher" CS.

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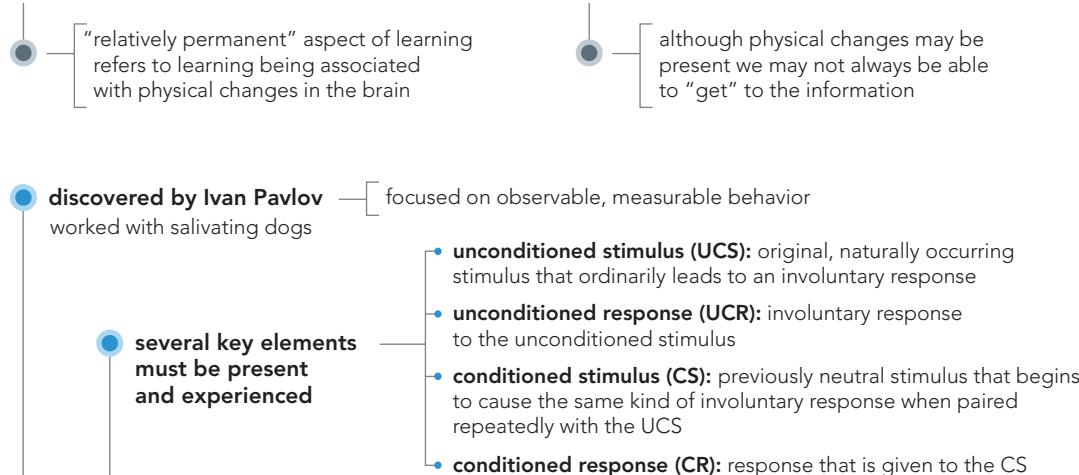
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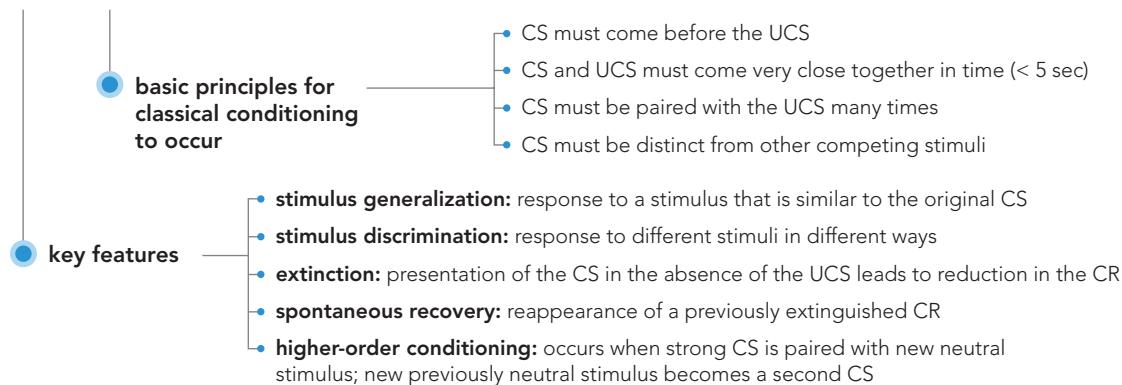
CONCEPT MAP

Definition of Learning

(any relatively permanent change in behavior brought about by experience or practice)

**Classical Conditioning**

(learning to make an involuntary response to a stimulus other than the original, natural stimulus that normally produces it)

**PRACTICE quiz How Much Do You Remember?**

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Learning can best be described as
 - a. a relatively permanent change in behavior.
 - b. a permanent change in behavior.
 - c. due primarily to unconscious motives.
 - d. momentary changes that require biological changes from within.
2. Michael noticed that whenever he moved his dog's food dish, his dog would come into the kitchen and act hungry and excited. He reasoned that because he feeds the dog using that dish, the sound of the dish had become a(n)
 - a. unconditioned stimulus.
 - b. conditioned stimulus.
 - c. unconditioned response.
 - d. conditioned response.
3. Which of the following statements is essential to classical conditioning?
 - a. The CS and UCS must come close together in time.
 - b. The CS must come immediately after the CR.
 - c. The neutral stimulus and UCR must be paired several times before conditioning takes place.
 - d. The CS should be something highly unusual.
4. Ever since she was scared by a dog as a young child, Angelica has been afraid of all dogs. The fact that she is not only afraid of the original dog but all types of dogs is an example of
 - a. extinction.
 - b. spontaneous recovery.
 - c. stimulus discrimination.
 - d. stimulus generalization.

5. Helen has overcome her fear of toy snakes. However, on one occasion her fear returned when she found a toy snake in the cushions of her couch. Such a reaction is called
- a. spontaneous recovery.
b. higher-order conditioning.
c. extinction.
d. stimulus generalization.

CONDITIONED EMOTIONAL RESPONSES: RATS!

What is a conditioned emotional response, and how do cognitive psychologists explain classical conditioning?

Later scientists took Pavlov's concepts and expanded them to explain not only animal behavior but also human behavior. One of the earliest of these studies showed that even an emotional response could be conditioned.

In the first chapter of this text, John B. Watson's classic experiment with "Little Albert" and the white rat was discussed. This study was a demonstration of the classical conditioning of a phobia—an irrational fear response (Watson & Rayner, 1920).

Watson paired the presentation of the white rat to the baby with a loud, scary noise. Although the baby was not initially afraid of the rat, he was naturally afraid of the loud noise and started to cry. After only seven pairings of the noise with the rat, every time the baby saw the rat, he started to cry. In conditioning terms, the loud noise was the UCS, the fear of the noise the UCR, the white rat became the CS, and the fear of the rat (the phobia) was the CR. (See **Figure 5.5**.) (It should be pointed out that Watson didn't really "torture" the baby—Albert's fright was temporary. Still, no ethics committee today would approve an experiment in which an infant experiences psychological distress like this.)

The learning of phobias is a very good example of a certain type of classical conditioning, the **conditioned emotional response (CER)**. Conditioned emotional responses are some of the easiest forms of classical conditioning to accomplish and our lives are full of them. It's easy to think of fears people might have that are conditioned or learned: a child's fear of the doctor's office, a puppy's fear of a rolled-up newspaper, or the fear of dogs that is often shown by a person who has been attacked by a dog in the past. But other emotions can be conditioned, too.  [Watch the Video](#), Special Topics: Learning to Overcome Phobias: Social Phobia, at [MyPsychLab](#)

The next time you watch television, watch the commercials closely. Advertisers often use certain objects or certain types of people in their ads to generate a specific emotional response in viewers, hoping that the emotional response will become associated with their product. Sexy models, cute little babies, and adorable puppies are some of the examples of stimuli the advertising world uses to tug at our heartstrings, so to speak.

It is even possible to become classically conditioned by simply watching someone else respond to a stimulus in a process called **vicarious conditioning** (Bandura & Rosenthal, 1966; Hygge & Öhman, 1976; Jones & Menzies, 1995). Many years ago, children received vaccination shots in school. The nurse lined up the children, and one by one they had to go forward to get a needle in the arm. When some children received their shots, they cried quite a bit. By the time the nurse got near the end of the line of children, they were all crying—many of them before she ever touched needle to skin. They had learned their fear response from watching the reactions of the other children. The good news is that the same learning principles that can contribute to phobias and anxiety disorders can also be used to treat them as we'll see in the video *The Basics 1: Classical Conditioning: An Involuntary Response : Treating Disorders*.



Figure 5.5 Conditioning of "Little Albert"

After "Little Albert" had been conditioned to fear a white rat, he also demonstrated fear to a rabbit, a dog, and a sealskin coat (although it remains uncertain if stimulus generalization actually occurred as this fear was to a single rabbit, a single dog, etc.). Can you think of any emotional reactions you experience that might be classically conditioned emotional responses?



What kind of conditioning could be happening to the children who are waiting to get their vaccination?

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[Watch the Video](#), *The Basics I: Classical Conditioning: An Involuntary Response: Treating Disorders*, at [MyPsychLab](#)

BIOLOGICAL INFLUENCES ON CONDITIONING

Some kinds of associations in classical conditioning seem to be easier to make than others. For example, are there any foods that you just can't eat anymore because of a bad experience with them? Believe it or not, your reaction to that food is a kind of classical conditioning.

CONDITIONED TASTE AVERSIONS Many experiments have shown that laboratory rats will develop a **conditioned taste aversion** for any liquid or food they swallow up to 6 hours before becoming nauseated. Researchers (Garcia et al., 1989; Garcia & Koelling, 1966) found that rats that were given a sweetened liquid and then injected with a drug or exposed to radiation* that caused nausea would not touch the liquid again. In a similar manner, alcoholics who are given a drug to make them violently nauseated when they drink alcohol may learn to avoid drinking any alcoholic beverage. The chemotherapy drugs that cancer patients receive also can create severe nausea, which causes those people to develop a taste aversion for any food they have eaten before going in for the chemotherapy treatment (Berteretche et al., 2004).

But I thought that it took several pairings of these stimuli to bring about conditioning. How can classical conditioning happen so fast?

It's interesting to note that birds, which find their food by sight, will avoid any object or insect that simply *looks* like the one that made them sick. There is a certain species of moth with coloring that mimics the monarch butterfly. That particular butterfly is poisonous to birds, but the moth isn't. The moth's mimicry causes birds to avoid eating it, even though it is quite edible. Whereas mammals are biologically prepared to associate taste with illness, birds are biologically prepared to associate visual characteristics with illness (Shapiro et al., 1980).

As for phobias, fear is a natural emotional response that has ties to survival—we need to remember what the fear-inducing stimuli are so we can safely avoid them in future. Nausea and fear are both examples of involuntary reactions that help organisms survive to reproduce and pass on their genetic material, so the innate tendency to make quick and strong associations between stimuli and these reactions has evolutionary importance.

*radiation: beams of electromagnetic energy.

Biological preparedness for fear of objects that are dangerous makes sense for survival, but when objects are not typically dangerous, it turns out to be very difficult to condition a fear of those objects. In one study, monkeys easily learned to be afraid of a toy snake or crocodile by watching videos of other monkeys reacting fearfully to these stimuli (a good example of vicarious conditioning). But the monkeys never learned to fear flowers or a toy rabbit by the same means (Cook & Mineka, 1989). Snakes and crocodiles are predators; flowers and rabbits are not.

WHY DOES CLASSICAL CONDITIONING WORK?

Pavlov believed that the conditioned stimulus, through its association close in time with the unconditioned stimulus, came to activate the same place in the animal's brain that was originally activated by the unconditioned stimulus. He called this process *stimulus substitution*. But if a mere association in time is all that is needed, why would conditioning *fail to happen* when the CS is presented immediately *after* the UCS?

Robert Rescorla (1988) found that the CS has to provide some kind of information about the coming of the UCS in order to achieve conditioning. In other words, the CS must predict that the UCS is coming. In one study, Rescorla exposed one group of rats to a tone, and just after the tone's onset and while the tone was still able to be heard, an electric shock was administered for some of the tone presentations. Soon the rats became agitated* and reacted in fear by shivering and squealing at the onset of the tone, a kind of conditioned emotional response. But with a second group of rats, Rescorla again sounded a tone but administered the electric shock only *after* the tone *stopped*, not while the tone was being heard. That group of rats responded with fear to the *stopping* of the tone (Rescorla, 1968).

The tone for the second group of rats provided a different kind of information than the tone in the first instance. For the first group, the tone means the shock is coming, whereas for the second group, the tone means there is no shock while the tone is on. It was the particular *expectancy* created by pairing the tone or absence of tone with the shock that determined the particular response of the rats. Because this explanation involves the mental activity of consciously expecting something to occur, it is an example of an explanation for classical conditioning called the **cognitive perspective**.

*agitated: excited, upset.



Conditioned taste aversions in nature. This moth is not poisonous to birds, but the monarch butterfly whose coloring the moth imitates is quite poisonous. Birds find their food by vision and will not eat anything that resembles the monarch.

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other features

- **conditioned emotional responses:** emotional responses that have become classically conditioned to occur in response to learned stimuli; based on work of John B. Watson; helps explain development of phobias
- **conditioned taste aversion** is one situation where classical conditioning can occur quickly without repeated pairings
- **vicarious conditioning** can occur by simply watching someone else respond to a stimulus

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CONCEPT MAP

some associations are relatively quick and easy to learn due to survival value for organism (biological preparedness)

Classical Conditioning (continued)

(learning to make an involuntary response to a stimulus other than the original, natural stimulus that normally produces it)

Why does it work?

- **Pavlov**—stimulus substitution occurs where the CS comes to activate the same part of the brain that was originally activated by the UCS
- **cognitive perspective**—organism consciously expects something to occur; CS provides information about the coming of the UCS (based on work of Rescorla)

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PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. In Watson's experiment with "Little Albert," the conditioned stimulus was
 - a. the white rat.
 - b. the loud noise.
 - c. the fear of the rat.
 - d. the fear of the noise.

2. Which of the following would be an example of vicarious classical conditioning?
 - a. As a young child, Tony frequently observed his older sisters jump around and scream whenever any of them saw a spider, as they were very afraid of them. Subsequently, Tony experiences feelings of fear when he sees a spider.
 - b. Tommy is told about a new product from a close friend and decides to buy it for himself.
 - c. A cat responds to the sound of a bell because it sounds similar to a bell it hears on the television.
 - d. Tonja watches her grandfather check the air pressure in her bike tire and then uses a hand pump to add air to the tire. She is later able to check the air pressure and pump up the tire herself.

3. Cindy had cheesy tacos at a local Mexican restaurant. Later she became terribly ill and suffered bouts of nausea and vomiting. What might we predict based on conditioned taste aversion research?
 - a. Cindy will probably develop a strong liking for cheesy tacos.
 - b. Cindy will probably be able to eat cheesy tacos with no nausea at all.
 - c. Cindy will probably get nauseated the next time she tries to eat cheesy tacos.
 - d. Cindy will probably continue to eat cheesy tacos except when she feels nauseous.

4. Rescorla found that the CS must _____ the UCS for conditioning to take place.
 - a. replace
 - b. come after
 - c. come at the same time as
 - d. predict



So far, all learning seems to involve involuntary behavior, but I know that I am more than just automatic responses. People do things on purpose, so is that kind of behavior also learned?

What's in It for Me? Operant Conditioning

How does operant conditioning occur, and what were the contributions of Thorndike and Skinner?

There are two kinds of behavior that all organisms are capable of doing: involuntary and voluntary. If Inez blinks her eyes because a gnat flies close to them, that's a reflex and totally involuntary. But if she then swats at the gnat to frighten it, that's a voluntary choice. She *had to* blink, but she *chose* to swat.

Classical conditioning is the kind of learning that occurs with automatic, involuntary behavior. The kind of learning that applies to voluntary behavior is called **operant conditioning**, which is both different from and similar to classical conditioning.

FRUSTRATING CATS: THORNDIKE'S PUZZLE BOX AND THE LAW OF EFFECT

Edward L. Thorndike (1874–1949) was one of the first researchers to explore and attempt to outline the laws of learning voluntary responses, although the field was not yet called operant conditioning. Thorndike placed a hungry cat inside a "puzzle box" from which the only escape was to press a lever located on the floor of the box. Thorndike placed a dish of food *outside* the box, so the hungry cat is highly motivated to get out. Thorndike observed that the cat would move around the box, pushing and rubbing up against the walls in an effort to escape. Eventually, the cat would accidentally push the lever, opening the door. Upon escaping, the cat was fed from a dish placed just outside the box. The lever is the stimulus, the pushing of the lever is the response, and the consequence is both escape (good) and food (even better).

The cat did not learn to push the lever and escape right away. After a number of trials (and many errors) in a box like this one, the cat took less and less time to push the lever that would open the door (see **Figure 5.6**). It's important not to assume that the cat had "figured out" the connection between the lever and freedom—Thorndike kept moving the lever to a different position, and the cat had to learn the whole process over again. The cat would simply continue to rub and push in the same general area that led to food and freedom the last time, each time getting out and fed a little more quickly.

Based on this research, Thorndike developed the **law of effect**: If an action is followed by a pleasurable consequence, it will tend to be repeated. If an action is followed by an unpleasant consequence, it will tend not to be repeated (Thorndike, 1911). This is the basic principle behind learning voluntary behavior. In the case of the cat in the box, pushing the lever was followed by a pleasurable consequence (getting out and getting fed), so pushing the lever became a repeated response.

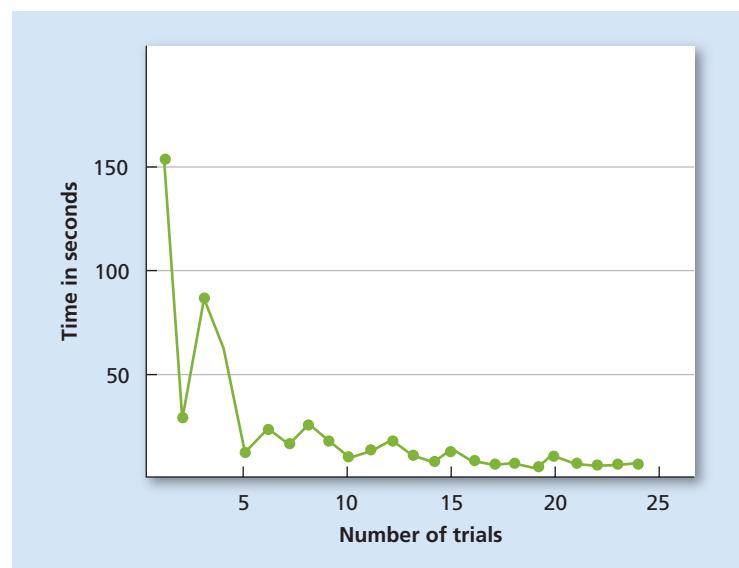


Figure 5.6 Graph of the Time to Learn in Thorndike's Experiment

This is one of the earliest "learning curves" in the history of the experimental study of conditioning. The time required by one of Thorndike's cats to escape from the puzzle box gradually decreased with trials but with obvious reversals.

B. F. SKINNER: THE BEHAVIORIST'S BEHAVIORIST

B. F. Skinner (1904–1990) was the behaviorist who assumed leadership of the field after John Watson. He was even more determined than Watson that psychologists should study only measurable, observable behavior. In addition to his knowledge of Pavlovian classical conditioning, Skinner found in the work of Thorndike a way to explain all behavior as the product of learning. He even gave the learning of voluntary behavior a special name: *operant conditioning* (Skinner, 1938). Voluntary behavior is what people and animals do to *operate* in the world. When people perform a voluntary action, it is to get something they want or to avoid something they don't want, right? So voluntary behavior, for Skinner, is **operant** behavior, and the learning of such behavior is operant conditioning.

The heart of operant conditioning is the effect of consequences on behavior. Thinking back to the section on classical conditioning, learning an involuntary behavior really depends on what comes *before* the response—the unconditioned stimulus and what will become the conditioned stimulus. These two stimuli are the *antecedent* stimuli (antecedent means something that comes before another thing). But in operant conditioning, learning depends on what happens *after* the response—the consequence. In a way, operant conditioning could be summed up as this: "If I do this, what's in it for me?"

THE CONCEPT OF REINFORCEMENT

What are the important concepts in operant conditioning?

"What's in it for me?" represents the concept of **reinforcement**, one of Skinner's major contributions to behaviorism. The word itself means "to strengthen," and Skinner defined reinforcement as anything that, when following a response, causes that response to be more likely to happen again. Typically, this means that reinforcement is a consequence that is in some way pleasurable to the organism, which relates back to Thorndike's law of effect. The "pleasurable consequence" is what's "in it" for the organism. (Keep in mind that a pleasurable consequence might be something like getting food when hungry or a paycheck when

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Figure 5.7 A Typical Skinner Box

This rat is learning to press the bar in the wall of the cage in order to get food (delivered a few pellets at a time in the food trough on lower left). In some cases, the light on the top left might be turned on to indicate that pressing the bar will lead to food or to warn of an impending shock delivered by the grate on the floor of the cage.

you need money, but it might also mean *avoiding* a tiresome chore, like doing the dishes or taking out the garbage. I'll do almost anything to get out of doing the dishes, myself!)

Going back to Thorndike's puzzle-box research, what was in it for the cat? We can see that the escape from the box and the food that the cat received after getting out are both *reinforcement* of the lever-pushing response. Every time the cat got out of the box, it got reinforced for doing so. In Skinner's view, this reinforcement is the reason that the cat learned anything at all. In operant conditioning, reinforcement is the key to learning.

Skinner had his own research device called a "Skinner box" or "operant conditioning chamber" (see **Figure 5.7**). His early research often involved placing a rat into one of these chambers and training it to push down on a bar to get food.

PRIMARY AND SECONDARY REINFORCERS The events or items that can be used to reinforce behavior are not all alike. Let's say that a friend of yours asks you to help her move some books from the trunk of her car to her apartment on the second floor. She offers you a choice of \$25 or a candy bar. Unless you've suffered recent brain damage, you'll most likely choose the money, right? With \$25, you could buy more than one candy bar. (At today's prices, you might even be able to afford three.)

Now pretend that your friend offers the same deal to a 3-year-old child who lives downstairs for carrying up some of the paperback books: \$25 or a candy bar. Which reward will the child more likely choose? Most children at that age have no real idea of the value of money, so the child will probably choose the candy bar. The money and the candy bar represent two basic kinds of **reinforcers**, items or events that when following a response will strengthen it. The reinforcing properties of money must be learned, but candy gives immediate reward in the form of taste and satisfying hunger.

A reinforcer such as a candy bar that fulfills a basic need like hunger is called a **primary reinforcer**. Examples would be any kind of food (hunger drive), liquid (thirst drive), or touch (pleasure drive). Infants, toddlers, preschool-age children, and animals can be easily reinforced by using primary reinforcers. (It's not a good idea, however, to start thinking of reinforcers as rewards—freedom from pain is also a basic need, so pain itself can be a primary reinforcer when it is *removed*. Removal of a painful stimulus fills a basic need just as eating food when hungry fills the hunger need.)

A **secondary reinforcer** such as money, however, gets its reinforcing properties from being associated with primary reinforcers in the past. A child who is given money to spend soon realizes that the ugly green paper can be traded for candy and treats—primary reinforcers—and so money becomes reinforcing in and of itself. If a person praises a puppy while petting him (touch, a primary reinforcer), the praise alone will eventually make the puppy squirm with delight.



That sounds very familiar. Isn't this related to classical conditioning?

Secondary reinforcers do indeed get their reinforcing power from the process of classical conditioning. After all, the pleasure people feel when they eat, drink, or get a back rub is an automatic response, and any automatic response can be classically conditioned to occur to a new stimulus. In the case of money, the candy is a UCS for pleasure (the UCR) and the money is present just before the candy is obtained. The money becomes a CS for pleasure, and people certainly do feel pleasure when they have a lot of that green stuff, don't they?

In the case of the puppy, the petting is the UCS, the pleasure at being touched and petted is the UCR. The praise, or more specifically the tone of voice, becomes the CS for pleasure. Although classical and operant conditioning often "work together," as in the creation of secondary reinforcers, they are two different processes. **Table 5.1** presents a brief look at how the two types of conditioning differ from each other.

Table 5.1**Comparing Two Kinds of Conditioning**

OPERANT CONDITIONING	CLASSICAL CONDITIONING
End result is an increase in the rate of an already occurring response.	End result is the creation of a new response to a stimulus that did not normally produce that response.
Responses are voluntary, emitted by the organism.	Responses are involuntary and automatic, elicited by a stimulus.
Consequences are important in forming an association.	Antecedent stimuli are important in forming an association.
Reinforcement should be immediate.	CS must occur immediately before the UCS.
An expectancy develops for reinforcement to follow a correct response.	An expectancy develops for UCS to follow CS.

POSITIVE AND NEGATIVE REINFORCEMENT Reinforcers can also differ in the way they are used. Most people have no trouble at all understanding that following a response with some kind of pleasurable consequence (like a reward) will lead to an increase in the likelihood of that response being repeated. This is called **positive reinforcement**, the reinforcement of a response by the *addition* or experience of a pleasurable consequence, such as a reward or a pat on the back. But many people have trouble understanding that the opposite is also true: Following a response with *the removal or escape* from something *unpleasant* will also increase the likelihood of that response being repeated—a process called **negative reinforcement**. Remember the idea that pain can be a reinforcer if it is removed? If a person's behavior gets pain to stop, the person is much more likely to do that same thing again—which is part of the reason people can get addicted to painkilling medication. (We'll discuss the concepts of positive and negative reinforcement in more detail later on.)

We've discussed what reinforcement is and how it affects the behavior that follows the reinforcement. In the next section we'll discuss the different ways in which reinforcement can be administered as well as the difference between reinforcement and punishment. We'll also look at the role of the stimuli that come *before* the behavior that is to be reinforced and a few other operant conditioning concepts.

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 Explore the Concept at [MyPsychLab](#)
CONCEPT MAP

 **Thorndike**
was among the first
to study learning of
voluntary responses

focused on observable, measurable behavior
developed law of effect—action followed
by pleasurable consequence will tend to be
repeated; action followed by unpleasant
consequence will tend not to be repeated

 **Skinner**
led field of
behaviorism
after Watson
coined term **operant conditioning**—
voluntary behavior that people
and animals do to operate in the world

Operant Conditioning

(learning to make voluntary responses through the effects of positive or negative consequences)

 **reinforcement**
any event or stimulus, that when
following a response increases
the probability that the response
will occur again

- **primary reinforcers:** satisfy basic biological needs (e.g., hunger, thirst, touch)
- **secondary reinforcers:** gain reinforcing properties through previous association with primary reinforcers
- **positive reinforcement:** addition, or experiencing of, a pleasurable stimulus
- **negative reinforcement:** removal, escape, or avoidance of unpleasant stimulus

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PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Which of the following is an example of Thorndike's law of effect?
 - a. John, a teenager, gets compliments from Carla for wearing a nice shirt. Subsequently, John wears the shirt whenever he thinks he will be seeing Carla.
 - b. James always cleans his room or he knows he will be punished.
 - c. Josh tries to complete his homework even though he hates having to do it.
 - d. Jeremy often sits around inside hoping that someone will call him to go do something.

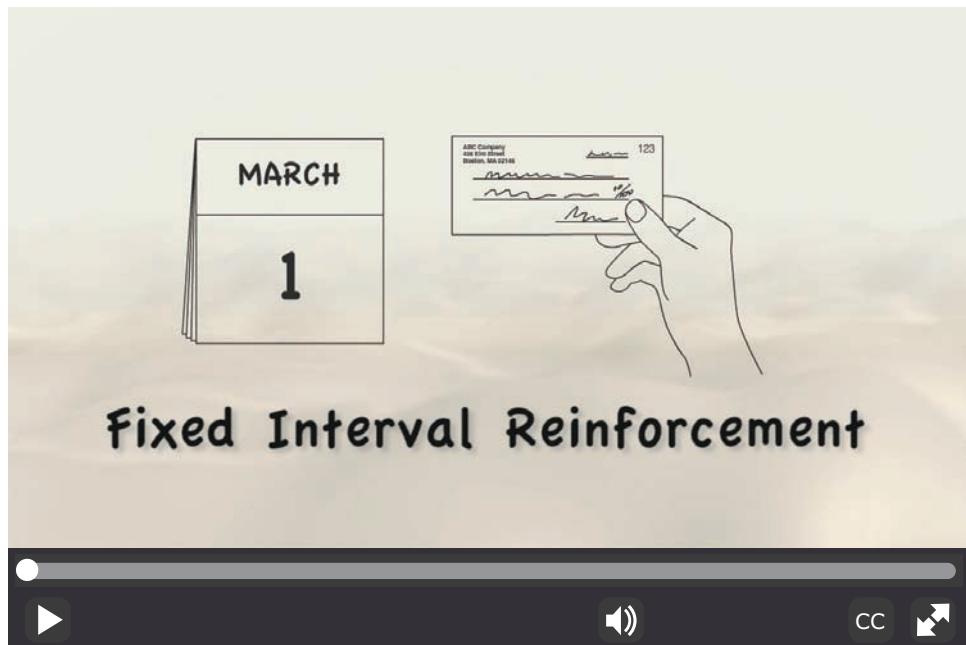
2. To a dog, _____ is an example of a primary reinforcer, whereas _____ is an example of a secondary reinforcer.
 - a. a paycheck; money
 - b. dog food; a Frisbee
 - c. dog food; dog treats
 - d. a gold star; candy

3. Edgar cannot sleep because he is terribly worried about his research paper. So Edgar decides to get out of bed and continue working on the paper. Although he stays up to nearly 3 A.M., he is relieved that it is done and easily falls off to sleep. In the future, Edgar will be more likely to finish his work before going to bed so that he can avoid the worry and sleeplessness. Such behavior is an example of
 - a. positive reinforcement.
 - b. negative reinforcement.
 - c. punishment.
 - d. classical conditioning.

4. With operant conditioning, _____ are important in forming an association, whereas with classical conditioning, _____ are important in forming an association.
 - a. consequences; antecedent stimuli
 - b. reflexes; rewards
 - c. conditioned stimuli; reflexive stimuli
 - d. positive reinforcement; negative reinforcement

SCHEDULES OF REINFORCEMENT: WHY THE ONE-ARMED BANDIT IS SO SEDUCTIVE**What are the schedules of reinforcement?**

The timing of reinforcement can make a tremendous difference in the speed at which learning occurs and the strength of the learned response. However, Skinner (1956) found that reinforcing every response was not necessarily the best schedule of reinforcement for long-lasting learning as we'll see in the video, *The Basics: Operant Conditioning: Learning from Consequences: Schedules of Reinforcement*.



[Watch the Video](#), *The Basics: Operant Conditioning: Learning from Consequences: Schedules of Reinforcement*, at [MyPsychLab](#)

THE PARTIAL REINFORCEMENT EFFECT Consider the following scenario: Alicia's mother agrees to give her a quarter every night she remembers to put her dirty clothes in the clothes hamper. Bianca's mother agrees to give her a dollar at the end of the week, but only if she has put her clothes in the hamper every night. Alicia learns to put her clothes in the hamper more quickly than does Bianca because responses that are reinforced each time they occur are more easily and quickly learned. After a time, the mothers stop giving the girls the money. Which child is more likely to stop putting her clothes in the hamper?

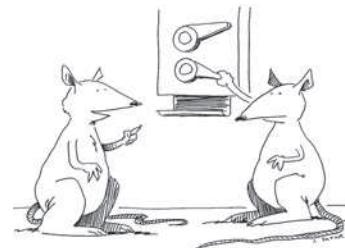
The answer might surprise you. It is more likely that Alicia, who has expected to get a reinforcer (the quarter) after *every single response*, will stop putting her clothes in the hamper. As soon as the reinforcers stop for her, the behavior is no longer reinforced and is likely to extinguish. In contrast, Bianca has expected to get a reinforcer only after *seven correct responses*. When the reinforcers stop for her, she might continue to put the clothes in the hamper for several more days or even another whole week, hoping that the reinforcer will eventually come anyway. Bianca may have learned more slowly than Alicia, but once she learned the connection between putting her clothes in the hamper and getting that dollar, she is less likely to stop doing it—even when her mother fails to give the dollar as expected.

Bianca's behavior illustrates the **partial reinforcement effect** (Skinner, 1956): A response that is reinforced after some, but not all, correct responses will be more resistant to extinction than a response that receives **continuous reinforcement** (a reinforcer for each and every correct response). Although it may be easier to teach a new behavior using continuous reinforcement, partially reinforced behavior is not only more difficult to suppress but also more like real life. Imagine being paid for every hamburger you make or every report you turn in. In the real world, people tend to receive partial reinforcement rather than continuous reinforcement for their work.

Partial reinforcement can be accomplished according to different patterns or schedules. For example, it might be a certain interval of time that's important, such as an office safe that can only be opened at a certain time of day. It wouldn't matter how many times one tried to open the safe if the effort didn't come at the right *time*. On the other hand, it might be the number of responses that is important, as it would be if one had to sell a certain number of raffle tickets in order to get a prize. When the timing of the response is more important, it is called an *interval schedule*. When it is the number of responses that is important, the schedule is called a *ratio schedule* because a certain number of responses is required for each reinforcer (e.g., 50 raffle tickets for each prize). The other way in which schedules of reinforcement can differ is in whether the number of responses or interval of time is *fixed* (the same in each case) or *variable* (a different number or interval is required in each case). So it is possible to have a fixed interval schedule, a variable interval schedule, a fixed ratio schedule, and a variable ratio schedule (Skinner, 1961).

FIXED INTERVAL SCHEDULE OF REINFORCEMENT If you receive a paycheck once a week, you are familiar with what is called a **fixed interval schedule of reinforcement**, in which a reinforcer is received *after* a certain, fixed interval of time has passed. If Professor Conner were teaching a rat to press a lever to get food pellets, she might require it to push the lever *at least once* within a 2-minute time span to get a pellet. It wouldn't matter how many times the rat pushed the bar; the rat would only get a pellet at the end of the 2-minute interval if it had pressed the bar at least once. It is the *first* correct response that gets reinforced at the end of the interval.

As shown in **Figure 5.8a** on the next page, a fixed interval schedule of reinforcement does not produce a fast rate of responding (notice that the line doesn't go "up" as fast as the fixed ratio line in the graph on the bottom left). Since it only matters that at least *one* response is made *during* the specific interval of time, speed is not that important. Eventually, the rat will start pushing the lever only as the interval of time nears its end, causing the *scalloping effect* you see in the graph. The response rate goes up just before the reinforcer and then drops off immediately after, until it is almost time for the next



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Figure 5.8 Schedules of Reinforcement

These four graphs show the typical pattern of responding for both fixed and variable interval and ratio schedules of reinforcement. The responses are cumulative, which means new responses are added to those that come before, and all graphs begin after the learned pattern is well established. Slash marks mean that a reinforcement has been given. In both the fixed interval and fixed ratio graphs, there is a pause after each reinforcement as the learner briefly "rests." The "scalloped" shape of the fixed interval curve is a typical indicator of this pause, as is the stair-step shape of the fixed ratio curve. In the variable interval and ratio schedules, no such pause occurs, because the reinforcements are unpredictable. Notice that both fixed and variable interval schedules are slower (less steep) than the two ratio schedules because of the need to respond as quickly as possible in the ratio schedules.

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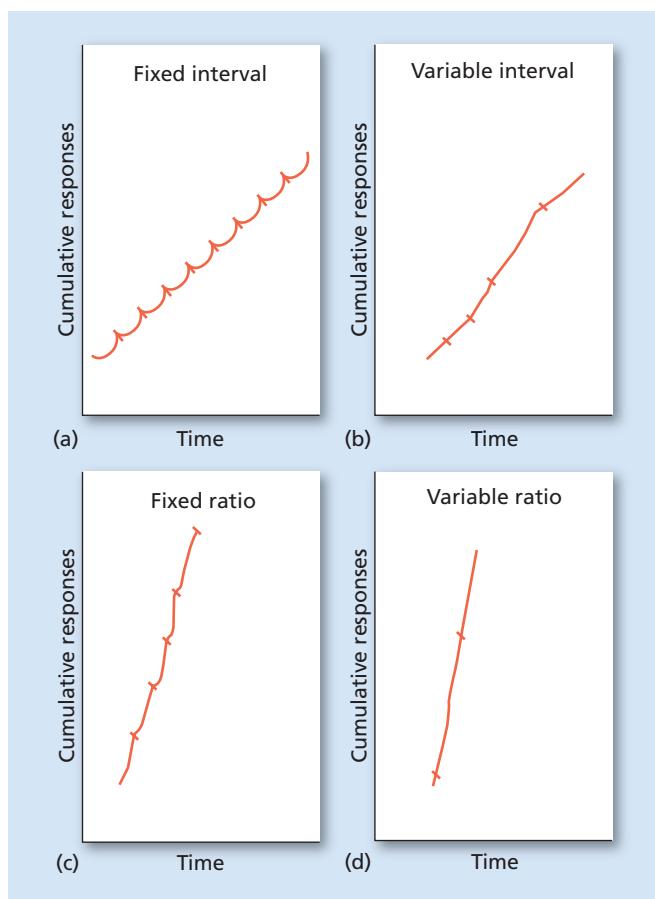
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food pellet. This is similar to the way in which factory workers speed up production just before payday and slow down just after payday (Critchfield et al., 2003).

Paychecks aren't the only kind of fixed schedule that people experience. When do you study the hardest? Isn't it right before a test? If you know when the test is to be given, that's like having a fixed interval of time that is predictable, and you can save your greatest studying efforts until closer to the exam. (Some students save *all* of their studying for the night before the exam, which is not the best strategy.) Another example of a fixed interval schedule would be the way that many people floss and brush their teeth most rigorously* for a few days before their next dental exam—especially those who have not been flossing until just before their appointment! In this case, they are probably hoping for negative reinforcement. The cleaner they get their teeth before the appointment, the less time they might have to spend in that chair.



So if a scheduled test is a fixed interval, then would a pop quiz be a variable interval schedule?

VARIABLE INTERVAL SCHEDULE OF REINFORCEMENT Pop quizzes are unpredictable. Students don't know exactly what day they might be given a pop quiz, so the best strategy is to study a little every night just in case there is a quiz the next day. Pop quizzes are good examples of a **variable interval schedule of reinforcement**, where the interval of time after which the individual must respond in order to receive a reinforcer (in this case, a good grade on the quiz) changes from one time to the next. In a more basic example, a rat might receive a food pellet when it pushes a lever, every 5 minutes on average. Sometimes the interval might be 2 minutes, sometimes 10, but the rat must push the lever at least once *after*

*rigorously: strictly, consistently.

that interval to get the pellet. Because the rat can't predict how long the interval is going to be, it pushes the bar more or less continuously, producing the smooth graph **Figure 5.8b**. Once again, speed is not important, so the rate of responding is slow but steady.

Another example of a variable interval schedule might be the kind of fishing in which people put the pole in the water and wait—and wait—and—wait, until a fish takes the bait, if they are lucky. They only have to put the pole in once, but they might refrain from taking it out for fear that just when they do, the biggest fish in the world would swim by. Dialing a busy phone number is also this kind of schedule, as people don't know *when* the call will go through, so they keep dialing and dialing.

FIXED RATIO SCHEDULE OF REINFORCEMENT In ratio schedules, it is the number of responses that counts. In a **fixed ratio schedule of reinforcement**, the number of responses required to receive each reinforcer will always be the same number.

Notice two things about **Figure 5.8c**. The rate of responding is very fast, especially when compared to the fixed interval schedule above it, and there are little "breaks" in the response pattern immediately after a reinforcer is given. The rapid response rate occurs because the rat wants to get to the next reinforcer just as fast as possible, and the number of lever pushes counts. The pauses or breaks come right after a reinforcer, because the rat knows "about how many" lever pushes will be needed to get to the next reinforcer because it's always the same. Fixed schedules—both ratio and interval—are predictable, which allows rest breaks.

In human terms, anyone who does piecework, in which a certain number of items have to be completed before payment is given, is reinforced on a fixed ratio schedule. Some sandwich shops use a fixed ratio schedule of reinforcement with their customers by giving out punch cards that get punched one time for each sandwich purchased. When the card has 10 punches, for example, the customer might get a free sandwich.

 The graph on the lower right (Figure 5.8d) is also very fast, but it's so much smoother, like the variable interval graph above it. Why are they similar?

VARIABLE RATIO SCHEDULE OF REINFORCEMENT A **variable ratio schedule of reinforcement** is one in which the number of responses changes from one trial to the next. In the rat example, the rat might be expected to push the bar an *average* of 20 times to get reinforcement. That means that sometimes the rat would push the lever only 10 times before a reinforcer comes, but at other times it might take 30 lever pushes or more.

Figure 5.8d shows a line that is just as rapid a response rate as the fixed ratio schedule because the *number* of responses still matters. But the graph is much smoother because the rat is taking no rest breaks. It can't afford to do so because it *doesn't know* how many times it may have to push that lever to get the next food pellet. It pushes as fast as it can and eats while pushing. It is the *unpredictability* of the variable schedule that makes the responses more or less continuous—just as in a variable interval schedule.

In human terms, people who shove money into the one-armed bandit, or slot machine, are being reinforced on a variable ratio schedule of reinforcement (they hope). They put their coins in (response), but they don't know how many times they will have to do this before reinforcement (the jackpot) comes. People who do this tend to sit there until they either win or run out of money. They don't dare stop because the "next one" might hit that jackpot. Buying lottery tickets is much the same thing, as is any kind of gambling. People don't know how many tickets they will have to buy, and they're afraid that if they don't buy the next one, that will be the ticket that would have won, so they keep buying and buying.

Regardless of the schedule of reinforcement one uses, two additional factors contribute to making reinforcement of a behavior as effective as possible. The first factor is *timing*: In general, a reinforcer should be given as immediately as possible *after* the



When people go fishing, they never know how long they may have to dangle the bait in the water before snagging a fish. This is an example of a variable interval schedule of reinforcement and explains why some people, such as this father and son, are reluctant to pack up and go home.

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Slot machines provide reinforcement in the form of money on a variable ratio schedule, making the use of these machines very addictive for many people. People don't want to stop for fear the next pull of the lever will be that "magic" one that produces a jackpot.

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desired behavior. Delaying reinforcement tends not to work well, especially when dealing with animals and small children. (For older children and adults who can think about future reinforcements, such as saving up one's money to buy a highly desired item, some delayed reinforcement can work—for them, just saving the money is reinforcing as they think about their future purchase.) The second factor in effective reinforcement is to reinforce *only* the desired behavior. This should be obvious, but we all slip up at times; for example, many parents make the mistake of giving a child who has not done some chore the promised treat anyway, which completely undermines the child's learning of that chore or task. And who hasn't given a treat to a pet that has not really done the trick?

So I think I get reinforcement now, but what about punishment?
How does punishment fit into the big picture?

THE ROLE OF PUNISHMENT IN OPERANT CONDITIONING

What is punishment and how does it differ from reinforcement?

Let's go back to the discussion of positive and negative reinforcement. These strategies are important for *increasing* the likelihood that the targeted behavior will occur again. But what about behavior that we do not want to reoccur?

DEFINING PUNISHMENT **Punishment** is actually the opposite of reinforcement. It is any event or stimulus that, when following a response, causes that response to be less likely to happen again. Punishment *weakens* responses, whereas reinforcement (no matter whether it is positive or negative) *strengthens* responses. Let's look at these two concepts in more detail.

People experience two kinds of things as consequences in the world: things they like (food, money, candy, sex, praise, and so on) and things they don't like (spankings, being yelled at, and experiencing any kind of pain, to name a few). In addition, people experience these two kinds of consequences in one of two ways: Either people experience them directly (such as getting money for working or getting yelled at for misbehaving) or they don't experience them, such as losing an allowance for misbehaving or avoiding a scolding by lying about misbehavior. These four consequences are named and described in **Table 5.2**.

First, take a look at the left column of Table 5.2, the one labeled "Reinforcement." Getting money for working is an example of *positive reinforcement*, the reinforcement of a response by the *addition* or experience of a *pleasurable* consequence, as mentioned earlier. That one everyone understands. But what about avoiding a penalty by turning one's income tax return in on time? That is an example of *negative reinforcement*, the reinforcement of a response by the *removal or escape* from an *unpleasant* consequence. Because the behavior (submitting the return before the deadline) results in *avoiding* an unpleasant stimulus (a penalty), the likelihood that the person will behave that way again (turn it in on time in the future) is *increased*—just as positive reinforcement will increase a behavior's likelihood. Examples are the best way to figure out the difference between these two types of reinforcement, so try to figure out which of the following examples would be positive reinforcement and which would be negative reinforcement:

1. Arnie's father nags him to wash his car. Arnie hates being nagged, so he washes the car so his father will stop nagging.
2. Trey learns that talking in a funny voice gets him lots of attention from his classmates, so now he talks that way often.
3. Allen is a server at a restaurant and always tries to smile and be pleasant because that seems to lead to bigger tips.
4. An Li turns her report in to her teacher on the day it is due because papers get marked down a letter grade for every day they are late.

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Table 5.2**Four Ways to Modify Behavior**

	REINFORCEMENT	PUNISHMENT
Positive (Adding)	Something valued or desirable	Something unpleasant
	<i>Positive Reinforcement</i> Example: getting a gold star for good behavior in school	<i>Punishment by Application</i> Example: getting a spanking for disobeying
Negative (Removing/ Avoiding)	Something unpleasant	Something valued or desirable
	<i>Negative Reinforcement</i> Example: fastening a seat belt to stop the alarm from sounding	<i>Punishment by Removal</i> Example: losing a privilege such as going out with friends

Here are the answers:

1. Arnie is being negatively reinforced for washing his car because the nagging (unpleasant stimulus) stops when he does so.
2. Trey is getting positive reinforcement in the form of his classmates' attention.
3. Allen's smiling and pleasantness are positively reinforced by the customers' tips.
4. An Li is avoiding an unpleasant stimulus (the marked-down grade) by turning in her paper on time, which is an example of negative reinforcement.

 I'm confused—I thought taking something away was a kind of punishment?

TWO KINDS OF PUNISHMENT People get confused because “negative” sounds like it ought to be something bad, like a kind of punishment. But negative reinforcement *strengthens* a response, while punishment *weakens* a response. But just as there are two ways in which reinforcement can happen, there are also two ways in which punishment can happen.

Now take a look at the right column of Table 5.2, labeled “Punishment.” **Punishment by application** occurs when something unpleasant (such as a spanking, scolding, or other unpleasant stimulus) is added to the situation or *applied*. This is the kind of punishment that most people think of when they hear the word *punishment*. This is also the kind of punishment that many child development specialists strongly recommend parents avoid using with their children because it can easily escalate into abuse (Dubowitz & Bennett, 2007; Durrant & Ensom, 2012; Straus, 2000; Trocmé et al., 2001). A spanking might be *physically* harmless if it is only two or three swats with a hand, but if done in anger or with a belt or other instrument, it becomes abuse, both physical and emotional.

Punishment by removal, on the other hand, is the kind of punishment most often confused with negative reinforcement. In this type of punishment, behavior is punished by the removal of something pleasurable or desired after the behavior occurs. “Grounding” a teenager is removing the freedom to do what the teenager wants to do and is an example of this kind of punishment. Other examples would be placing a child in time-out (removing the attention of the others in the room), fining someone for disobeying the law (removing money), and punishing aggressive behavior by taking away television privileges. This type of punishment is typically far more acceptable to child development specialists because it involves no physical aggression and avoids many of the problems caused by more aggressive punishments.

The confusion over the difference between negative reinforcement and punishment by removal makes it worth examining the difference just a bit more. Negative reinforcement occurs when a response is followed by the *removal* of an *unpleasant* stimulus. If something



This young girl's father is applying punishment by removal by forcing her to cut up her credit card.

Table 5.3**Negative Reinforcement Versus Punishment by Removal**

EXAMPLE OF NEGATIVE REINFORCEMENT	EXAMPLE OF PUNISHMENT BY REMOVAL
Stopping at a red light to avoid getting in an accident.	Losing the privilege of driving because you got into too many accidents.
Mailing an income tax return by April 15 to avoid paying a penalty.	Having to lose some of your money to pay the penalty for late tax filing.
Obeying a parent before the parent reaches the count of "three" to avoid getting a scolding.	Being "grounded" (losing your freedom) because of disobedience.

unpleasant has just gone away as a consequence of that response, wouldn't that response tend to happen again and again? If the response increases, the consequence has to be a kind of *reinforcement*. The problem is that the name sounds like it should be some kind of punishment because of the word *negative*, and that's exactly the problem that many people experience when they are trying to understand negative reinforcement. Many people get negative reinforcement mixed up with punishment by removal, in which a *pleasant* thing is removed (like having your driver's license taken away because you caused a bad accident). Because something is removed (taken away) in both cases, it's easy to think that they will both have the effect of punishment, or weakening a response. The difference between them lies in *what* is taken away: In the case of negative reinforcement, it is an *unpleasant* thing; in the case of punishment by removal, it is a *pleasant* or desirable thing. For a head-to-head comparison of negative reinforcement and this particular type of punishment by removal, see **Table 5.3**.

PROBLEMS WITH PUNISHMENT**What are some of the problems with using punishment?**

Although punishment can be effective in reducing or weakening a behavior, it has several drawbacks as explained in the video *Thinking Like a Psychologist: Physical Punishment—You Decide! : Problems with Punishment*.



Watch the Video, *Thinking Like a Psychologist: Physical Punishment—You Decide! : Problems with Punishment*, at **MyPsychLab**

The job of punishment is much harder than that of reinforcement. In using reinforcement, all one has to do is strengthen a response that is already there. But punishment is used

to weaken a response, and getting rid of a response that is already well established is not that easy. (Ask any parent or pet owner.) Many times punishment only serves to temporarily suppress or inhibit a behavior until enough time has passed. For example, punishing a child's bad behavior doesn't always eliminate the behavior completely. As time goes on, the punishment is forgotten, and the "bad" behavior may occur again in a kind of spontaneous recovery of the old (and probably pleasurable for the child) behavior.

Look back at Table 5.2 under the "Punishment" column. Punishment by application can be quite severe, and severe punishment does do one thing well: It stops the behavior immediately (Bucher & Lovaas, 1967; Carr & Lovaas, 1983). It may not stop it permanently, but it does stop it. In a situation in which a child might be doing something dangerous or self-injurious, this kind of punishment is sometimes more acceptable (Duker & Seys, 1995). For example, if a child starts to run into a busy street, the parent might scream at the child to stop and then administer several rather severe swats to the child's rear. If this is NOT typical behavior on the part of the parent, the child will most likely never run into the street again.

Other than situations of immediately stopping dangerous behavior, severe punishment has too many drawbacks to be really useful. It should also be discouraged because of its potential for leading to abuse (Dubowitz & Bennett, 2007; Gershoff, 2000; Millan et al., 1999; Trocmé et al., 2001):

- Severe punishment may cause the child (or animal) to avoid the punisher instead of the behavior being punished, so the child (or animal) learns the wrong response.
- Severe punishment may encourage lying to avoid the punishment (a kind of negative reinforcement)—again, not the response that is desired.
- Severe punishment creates fear and anxiety, emotional responses that do not promote learning (Baumrind, 1997; Gershoff, 2000, 2002). If the point is to teach something, this kind of consequence isn't going to help.
- Hitting provides a successful model for aggression (Gershoff, 2000; Milner, 1992).

That last point is worth a bit more discussion. In using an aggressive type of punishment, such as spanking, the adult is actually modeling (presenting a behavior to be imitated by the child). After all, the adult is using aggression to get what the adult wants from the child. Children sometimes become more likely to use aggression to get what they want when they receive this kind of punishment (Bryan & Freed, 1982; Larzelere, 1986), and the adult has lost an opportunity to model a more appropriate way to deal with parent-child disagreements. Since aggressive punishment does tend to stop the undesirable behavior, at least for a while, the parent who is punishing actually experiences a kind of negative reinforcement: "When I spank, the unpleasant behavior goes away." This may increase the tendency to use aggressive punishment over other forms of discipline and could even lead to child abuse (Dubowitz & Bennett, 2007). There is some evidence that physical punishment that would not be considered abusive (i.e., pushing, shoving, grabbing, hitting) is associated with an increased risk of mental illness for the child in later life (Afifi et al., 2012; Ma et al., 2012). Finally, some children are so desperate for attention from their parents that they will actually misbehave on purpose. The punishment is a form of attention, and these children will take whatever attention they can get, even negative attention.

Punishment by removal is less objectionable to many parents and educators and is the only kind of punishment that is permitted in many public schools. But this kind of punishment also has its drawbacks—it teaches the child what *not* to do but not what the child should do. Both punishment by removal and punishment by application are usually only temporary in their effect on behavior. After some time has passed, the behavior will most likely return as the memory of the punishment gets weaker, allowing spontaneous recovery.

 If punishment doesn't work very well, what can a parent do to keep a child from behaving badly?

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HOW TO MAKE PUNISHMENT MORE EFFECTIVE The way to make punishment more effective involves remembering a few simple rules:  [Watch the Video](#), Thinking Like a Psychologist: Physical Punishment—You Decide! Best Practices, at [MyPsychLab](#)

- Punishment should immediately follow the behavior it is meant to punish.** If the punishment comes long after the behavior, it will not be associated with that behavior. (This is also true of reinforcement.)
- Punishment should be consistent.** This actually means two things. First, if the parent says that a certain punishment will follow a certain behavior, then the parent must make sure to follow through and do what he or she promised to do. Second, punishment for a particular behavior should stay at the same intensity or increase slightly but never decrease. For example, if a child is scolded for jumping on the bed the first time, the second time this behavior happens the child should also be punished by scolding or by a stronger penalty, such as removal of a favorite toy. But if the first misbehavior is punished by spanking and the second by only a scolding, the child learns to “gamble” with the possible punishment.
- Punishment of the wrong behavior should be paired, whenever possible, with reinforcement of the right behavior.** Instead of yelling at a 2-year-old for eating with her fingers, the parent should pull her hand gently out of her plate while saying something such as, “No, we do not eat with our fingers. We eat with our fork,” and then placing the fork in the child’s hand and praising her for using it. “See, you are doing such a good job with your fork. I’m so proud of you.” Pairing punishment (the mild correction of pulling her hand away while saying “No, we do not eat with our fingers”) with reinforcement allows parents (and others) to use a much milder punishment and still be effective. It also teaches the desired behavior rather than just suppressing the undesired one.

The following section discusses research on the problems that can be generated by a particular form of punishment by application: spanking.

issues in psychology



The Link Between Spanking and Aggression in Young Children



To spank or not to spank has been a controversial issue for many years now. Child development experts have typically advised parents to use other methods of disciplining their children, citing the possibility of encouraging child abuse as well as the role spanking plays in the modeling of aggression. The results of a recent study suggest that there is a significantly increased risk of higher levels of aggression at age 5 when spanking is used at age 3 (C. Taylor et al., 2010).

While older studies have found similar results, the study by Dr. Catherine Taylor and her colleagues, Drs. Jennifer Manganello, Shawna Lee, and Janet Rice, differs from those earlier studies in that possible maternal risk factors such as neglect, the mother’s use of drugs, and maternal psychological problems were measured and controlled.

In this study, 2,461 mothers participated in reporting their use of spanking at age 3 as well as their children’s aggressive behavior at age 3 and then 2 years later at age 5. Factors such as child maltreatment by the mothers, psychological maltreatment, neglect, aggression from the mother’s intimate partner, victimization, stress, depression, substance abuse, and the mother’s consideration of abortion were also assessed. The Taylor study found that when mothers stated that they spanked their 3-year-olds more than twice in the previous month, those same children at 5 years of age were much more likely to be more aggressive (bullying, for example) when compared to children of mothers who spanked less than twice or not at all.

when their children were 3. This result held even when the individual differences between the natural aggression levels of the 3-year-olds and the other possible confounding factors were taken into account.

The conclusion seems to be that sparing the rod may spare the child (and those around the child) from an unpleasant personality trait.

Questions for Further Discussion

1. How did your own parents discipline you, and do you think that it affected you in a positive or negative way?
2. Why might spanking at age 3 lead to higher aggression in that same child at age 5?

STIMULUS CONTROL: SLOW DOWN, IT'S THE COPS

How do operant stimuli control behavior, and what are some other concepts that can enhance or limit operant conditioning?

You see a police car in your rearview mirror and automatically slow down, even if you weren't speeding. The traffic light turns red, so you stop. When you want to get into a store, you head for the door and push or pull on the handle. All of these things—slowing down, stopping, using the door handle—are learned. But how do you know what learned response to make, and when? The police car, the stoplight, and the door handle are all cues, or stimuli, which tell you what behavior will get you what you want.

A **discriminative stimulus** is any stimulus that provides an organism with a cue for making a certain response in order to obtain reinforcement—specific cues would lead to specific responses, and discriminating between the cues leads to success. For example, a police car is a discriminative stimulus for slowing down and a red stoplight is a cue for stopping because both of these actions are usually followed by negative reinforcement—people don't get a ticket or don't get hit by another vehicle. A doorknob is a cue for where to grab the door in order to successfully open it. In fact, if a door has a knob, people always turn it, but if it has a handle, people usually pull it, right? The two kinds of opening devices each bring forth a different response from people, and their reward is opening the door.



How do the circus trainers get their animals to do all those complicated tricks?

SHAPING AND OTHER CONCEPTS IN OPERANT CONDITIONING

Operant conditioning is more than just the reinforcement of simple responses. For example, have you ever tried to teach a pet to do a trick? Yes, it was really hard.

SHAPING When you see an animal in a circus or in a show at a zoo perform tricks, you are seeing the result of applying the rules of conditioning—both classical and operant—to animals. But the more complex tricks are a process in operant conditioning called **shaping**, in which small steps toward some ultimate goal are reinforced until the goal itself is reached.

For example, if Jody wanted to train his dog to jump through a hoop, he would have to start with some behavior that the dog is already capable of doing on its own. Then he would gradually “mold” that starting behavior into the jump—something the dog is capable of doing but not likely to do on its own. Jody would have to start with the hoop on the ground in front of Rover's face and then call the dog through the hoop, using the treat as bait. After Rover steps through the hoop (as the shortest way to the treat), Jody should give Rover the treat (positive reinforcement). Then he could raise the hoop just a little, reward



This dog has been trained to help its physically challenged owner. Operant conditioning principles can be used to train animals to do many useful tasks, including opening the refrigerator.

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him for walking through it again, raise the hoop, reward him . . . until Rover is jumping through the hoop to get the treat. The goal is achieved by reinforcing each *successive approximation* (small steps one after the other that get closer and closer to the goal). This process is shaping (Skinner, 1974). Through pairing of a sound such as a whistle or clicker with the primary reinforcer of food, animal trainers can use the sound as a secondary reinforcer and avoid having an overfed learner.  [Watch the Video, The Basics: Operant Conditioning: Learning from Consequences: Shaping, at MyPsychLab](#)

EXTINCTION, GENERALIZATION, AND SPONTANEOUS RECOVERY IN OPERANT CONDITIONING

Extinction in classical conditioning involves the removal of the UCS, the unconditioned stimulus that eventually acts as a reinforcer of the CS–CR bond. It should come as no surprise, then, that extinction in operant conditioning involves the removal of the reinforcement. Have you ever seen a child throw a temper tantrum in the checkout line because the little one wanted some candy or toy? Many exasperated* parents will cave in and give the child the treat, positively reinforcing the tantrum. The parent is also being negatively reinforced for giving in, because the obnoxious** behavior stops. The only way to get the tantrum behavior to stop is to remove the reinforcement, which means no candy, no treat, and if possible, no attention from the parent. (Not only is this hard enough to do while enduring the tantrum but also the tantrum behavior may actually get worse before it extinguishes!)

Just as in classical conditioning, operantly conditioned responses also can be generalized to stimuli that are only *similar* to the original stimulus. For example, what parent has not experienced that wonderful moment when Baby, who is just learning to label objects and people, says “Dada” in response to the presence of her father and is reinforced by his delight and attention to her. But in the beginning, Baby may cause Dad to cringe when she generalizes her “Dada” response to any man. As other men fail to reinforce her for this response, she’ll learn to discriminate among them and her father and only call her father “Dada.” In this way, the man who is actually her father becomes a discriminative stimulus just like the stoplight or the doorknob mentioned earlier.

Spontaneous recovery (in classical conditioning, the recurrence of a conditioned response after extinction) will also happen with operant responses. Remember the hoop-jumping dog? Anyone who has ever trained animals to do several different tricks will say that when first learning a new trick, most animals will try to get reinforcers by performing their *old* tricks. Rover might very well have tried to roll over, speak, and shake paws to get that treat before finally walking through the hoop.

While animals can learn many types of behavior through the use of operant conditioning, it seems that not every animal can be taught *anything*—see the following section on biological constraints for more on this topic.



One way to deal with a child's temper tantrum is to ignore it. The lack of reinforcement for the tantrum behavior will eventually result in extinction.

classic studies in psychology



Biological Constraints on Operant Conditioning

Raccoons are fairly intelligent animals and are sometimes used in learning experiments. In a typical experiment, a behaviorist would use shaping and reinforcement to teach a raccoon a trick. The goal might be to get the raccoon to pick up several coins and drop them into a metal container, for which the raccoon would be rewarded with food. The behaviorist starts by reinforcing the raccoon for picking up a single coin. Then the metal container is introduced

*exasperated: irritated or annoyed.

**obnoxious: highly offensive or undesirable.

and the raccoon is now required to drop the coin into the slot on the container in order to get reinforcement.

It is at this point that operant conditioning seems to fail. Instead of dropping the coin in the slot, the raccoon puts the coin in and out of the slot and rubs it against the inside of the container, then holds it firmly for a few seconds before finally letting it go. When the requirement is upped to two coins, the raccoon spends several minutes rubbing them against each other and dipping them into the container, without actually dropping them in. In spite of the fact that this dipping and rubbing behavior is not reinforced, it gets worse and worse until conditioning becomes impossible.

Keller and Marian Breland, in their attempt to train a raccoon, found that this problem was not limited to the raccoon (Breland & Breland, 1961). They ran into a similar difficulty with a pig that was being trained to pick up a total of five large wooden coins and put them into a "piggy bank." Although at first successful, the pig became slower and slower at the task over a period of weeks, dropping the coin, rooting (pushing) it around with its nose, picking it up, dropping it again, and rooting some more. This behavior became so persistent that the pig actually did not get enough to eat for the day.

The Brelands concluded that the raccoon and the pig were reverting* to behavior that was instinctual for them. Instinctual behavior is genetically determined and not under the influence of learning. Apparently, even though the animals were at first able to learn the tricks, as the coins became more and more associated with food, the animals began to drift back into the instinctual patterns of behavior that they used with real food. Raccoons rub their food between their paws and dip it in and out of water. Pigs root and throw their food around before eating it. The Brelands called this tendency to revert to genetically controlled patterns **instinctive drift**.

In their 1961 paper describing these and other examples of instinctive drift, the Brelands (both trained by Skinner himself) determined that, contrary to Skinner's original ideas:

1. The animal does NOT come to the laboratory a *tabula rasa*, or "blank slate," and cannot be taught just *any* behavior.
2. Differences between species of animals matter in determining what behavior can or cannot be conditioned.
3. Not all responses are equally able to be conditioned to any stimulus.

As became quickly obvious in their studies with these animals, each animal comes into the world (and the laboratory) with certain genetically determined instinctive patterns of behavior already in place. These instincts differ from species to species, with the result that there are some responses that simply cannot be trained into an animal regardless of conditioning.

Questions for Further Discussion

1. What other kinds of limitations do animals have in learning?
2. What kinds of behavior might people do that would be resistant to conditioning?
3. How can these research findings about animal behavior be generalized to human behavior?

USING OPERANT CONDITIONING: BEHAVIOR MODIFICATION

What is behavior modification, and how can behavioral techniques be used to modify involuntary biological responses?

Operant conditioning principles such as reinforcement and the process of shaping have been used for many years to change undesirable behavior and create desirable responses



Raccoons commonly dunk their food in and out of water before eating. This "washing" behavior is controlled by instinct and difficult to change even using operant techniques.

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*reverting: to go back in action, thought, speech, and so on.

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in animals and humans—particularly in schoolchildren. The term **behavior modification** refers to the application of operant conditioning (and sometimes classical conditioning) to bring about such changes. The video *What's In It For Me?: How to Make Healthier Choices* describes a sample behavior modification plan for someone who wants to watch less television and exercise more.



[Watch the Video](#), *What's In It For Me?: How to Make Healthier Choices*, at [MyPsychLab](#)

As another example, if a teacher wants to use behavior modification to help a child learn to be more attentive during the teacher's lectures, the teacher may do the following:

1. Select a target behavior, such as making eye contact with the teacher.
2. Choose a reinforcer. This may be a gold star applied to the child's chart on the wall, for example.
3. Put the plan in action. Every time the child makes eye contact, the teacher gives the child a gold star. Inappropriate behavior (such as looking out of the window) is not reinforced with gold stars.
4. At the end of the day, the teacher gives the child a special treat or reward for having a certain number of gold stars. This special reward is decided on ahead of time and discussed with the child.

The gold stars in this example can be considered *tokens*, secondary reinforcers that can be traded in for other kinds of reinforcers. The use of tokens to modify behavior is called a **token economy**. [LINK](#) to [Learning Objective 15.4](#). In the example, the child is collecting gold stars to "buy" the special treat at the end of the day. When one thinks about it, the system of money is very much a token economy. People are rewarded for working for money, which they then trade for food, shelter, and so on. Credit card companies encourage the use of their card by offering reward points that can be exchanged for desirable goods and services, and airlines offer frequent flyer miles. Many fast-food restaurants offer punch cards or stamps that are exchanged for free food when filled up. The points, miles, and punches on the cards are all forms of tokens.

Another tool that behaviorists can use to modify behavior is the process of *time-out*. Time-out is a form of mild punishment by removal in which a misbehaving animal, child, or adult is placed in a special area away from the attention of others. Essentially, the organism is being "removed" from any possibility of positive reinforcement in the form of

attention. When used with children, a time-out should be limited to 1 minute for each year of age, with a maximum time-out of 10 minutes (longer than that and the child can forget why the time-out occurred).

Applied behavior analysis (ABA), is the modern term for a form of behavior modification that uses both analysis of current behavior and behavioral techniques to address a socially relevant issue. In ABA, skills are broken down to their simplest steps and then taught to the child through a system of reinforcement. Prompts (such as moving a child's face back to look at the teacher or the task) are given as needed when the child is learning a skill or refuses to cooperate. As the child begins to master a skill and receives reinforcement in the form of treats or praise, the prompts are gradually withdrawn until the child can do the skill independently. Applied behavior analysis is a growing field with many colleges and universities offering degrees at both the undergraduate and graduate levels. A person graduating from one of these programs may act as a consultant* to schools or other institutions, or may set up a private practice. Typical uses for ABA are treating children with disorders, training animals, and developing effective teaching methods for children and adults of all levels of mental abilities (Baer et al., 1968).

An example of how ABA can be used is found in the use of shaping to mold desirable, socially acceptable behavior in individuals with *autism*. Autism is a disorder in which the person has great difficulty in communicating with others, often refusing to look at another person. People who have autism may also fail to learn to speak at all, and they normally do not like to be touched.  to [Learning Objective 8.6](#). This specific application of ABA can be said to have begun with the work of Dr. O. Ivar Lovaas (1964) and his associates, although the basic general techniques are those first outlined by Skinner. Lovaas used small pieces of candy as reinforcers to teach social skills and language to children with autism. Other techniques for modifying responses have been developed so that even biological responses that are normally considered involuntary such as blood pressure, muscle tension, and hyperactivity can be brought under conscious control. For nearly 60 years, scientists have known how to use feedback from person's biological information (such as heart rate) to create a state of relaxation (Margolin & Kubic, 1944). **Biofeedback** is the traditional term used to describe this kind of biological feedback of information, and through its use many problems can be relieved or controlled.

A relatively newer biofeedback technique called **neurofeedback** involves trying to change brain activity.  to [Learning Objective 2.6](#). Although this technique uses the latest in technology, the basic principles behind it are much older. Traditionally, this technique was based on recording the electrical activity of the brain, or EEG. To record the EEG, a person would have to be connected to a stand-alone *electroencephalograph*, a machine that amplifies and records the brain's electrical activity. Modern biofeedback and neurofeedback amplifiers are often connected to a computer that records and analyzes the physiological activity of the brain. Neurofeedback can be integrated with video-game-like programs that individuals can use to learn how to produce brain waves or specific types of brain activity associated with specific cognitive or behavioral states (e.g., increased attention, staying focused, relaxed awareness). Individuals learn to make these changes through the principles of operant conditioning (Sherlin et al., 2011). Neurofeedback using the EEG continues to be investigated in specific disorders such as attention-deficit/hyperactivity disorder (ADHD) and in new areas such as the control of chronic pain (Arns et al., 2009; Jensen et al., 2013). Other recent neurofeedback studies have incorporated MRI or fMRI to examine the effects of EEG-based neurofeedback on the brain (Ghaziri et al., 2013; Ros et al., 2013). And in some studies, fMRI is being used as a neurofeedback method in and of itself (Ruiz et al., 2013; Scharnowski et al., 2012; Sulzer et al., 2013).

*consultant: someone who offers expert advice or services.

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 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP



PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

- Joe owned a small repair shop. Each day, he would check the mail to see if any of his customers mailed in a payment for the work he had done for them. Some days, he would receive a check or two. At other times, he would have to wait days before getting another payment. What schedule of reinforcement is evident here?
 - fixed interval
 - fixed ratio
 - variable interval
 - variable ratio
- Little Jimmie's mother was upset to find that Jimmie had not picked up his building blocks after repeated requests to do so. The next morning, Jimmie found all his blocks had been picked up and put into a bag on the top of the refrigerator. Jimmie's mother told him that he couldn't play with his blocks for the next two days. Which type of discipline did she use?
 - negative reinforcement
 - punishment by application
 - punishment by removal
 - positive reinforcement
- The study by Keller and Marian Breland found that instinctive drift in animal behavior is
 - caused by confusion between punishment types.
 - caused by overuse of positive reinforcement.
 - the result of conscious decisions on the part of animals not to take part in further testing.
 - genetically determined and not under the influence of learning.
- Tabitha signed up for a new credit card that offers reward miles for every purchase. Tabitha plans to make as many purchases as she can so that she can accumulate enough miles to go on a trip over spring break. Such an approach is an example of
 - token economy.
 - shaping.
 - a schedule of reinforcement.
 - a form of negative reinforcement.

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5. Which of the following is the best example of applied behavior analysis?
- Tiffany works with children by asking them what they want to accomplish and then helping them attain that goal through different forms of classical conditioning.
 - Bethany has children watch her repeatedly so as to understand how a task is to be done. Once they have finished the observation, then they are asked to imitate the behavior.
 - Agatha observes a child to see what purpose a disruptive classroom behavior serves, and identifies a new replacement behavior. She then implements a training program for the new behavior, reinforcing often at the simplest levels and gradually removing reinforcers as the child demonstrates the behavior independently.
 - Camille wants children to learn a new behavior and uses punishment as the basis for the behavior change.

6. Neurofeedback is a form of _____ and works to change a person's _____ through a series of reinforcements.
- classical conditioning; thoughts
 - operant conditioning; anxieties
 - observation learning; behaviors
 - biofeedback; brain activity

THINKING CRITICALLY:

Imagine that you adopted a 4-year-old child who was abused in his original home before ultimately ending up in your care. Which child rearing approach do you think would be best for such a child? How would you discipline your child? What type of reinforcement or punishment would you use most often?

Cognitive Learning Theory

How do latent learning, insight, and learned helplessness relate to cognitive learning theory?

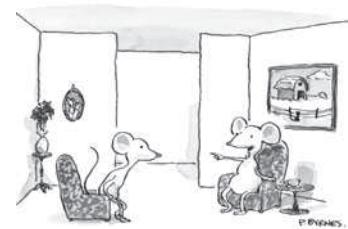
In the early days of behaviorism, the focus of Watson, Skinner, and many of their followers was on observable, measurable behavior. Anything that might be occurring inside a person's or animal's head during learning was considered to be of no interest to the behaviorist because it could not be seen or directly measured. Other psychologists, however, were still interested in the mind's influence over behavior. Gestalt psychologists, for instance, were studying the way that the human mind tried to force a pattern on stimuli in the world around the person.  to Learning Objective 1.3. This continued interest in the mind was followed, in the 1950s and 1960s, by the comparison of the human mind to the workings of those fascinating "thinking machines," computers. Soon after, interest in *cognition*, the mental events that take place inside a person's mind while behaving, began to dominate experimental psychology. Many behavioral psychologists could no longer ignore the thoughts, feelings, and expectations that clearly existed in the mind and that seemed to influence observable behavior, and eventually began to develop a cognitive learning theory to supplement the more traditional theories of learning (Kandler, 1985). Three important figures often cited as key theorists in the early days of the development of cognitive learning theory were the Gestalt psychologists Edward Tolman and Wolfgang Köhler, and modern psychologist Martin Seligman.

TOLMAN'S MAZE-RUNNING RATS: LATENT LEARNING

One of Gestalt psychologist Edward Tolman's best-known experiments in learning involved teaching three groups of rats the same maze, one at a time (Tolman & Honzik, 1930). In the first group, each rat was placed in the maze and reinforced with food for making its way out the other side. The rat was then placed back in the maze, reinforced upon completing the maze again, and so on until the rat could successfully solve the maze with no errors (see Figure 5.9 on the next page).

The second group of rats was treated exactly like the first, except that they never received any reinforcement upon exiting the maze. They were simply put back in again and again, until the 10th day of the experiment. On that day, the rats in the second group began to receive reinforcement for getting out of the maze. The third group of rats, serving as a control group, was also not reinforced and was not given reinforcement for the entire duration of the experiment.

A strict Skinnerian behaviorist would predict that only the first group of rats would learn the maze successfully because learning depends on reinforcing consequences. At first, this seemed to be the case. The first group of rats did indeed solve the maze after a



"Bathroom? Sure, it's just down that hall to the left, jog right, left, another left, straight past two more lefts, then right, and it's at the end of the third corridor on your right."

©The New Yorker Collection 2000 Pat Byrnes from cartoonbank.com. All Rights Reserved.

Figure 5.9 A Typical Maze

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This is an example of a maze such as the one used in Tolman's experiments in latent learning. A rat is placed in the start box. The trial is over when the rat gets to the end box.

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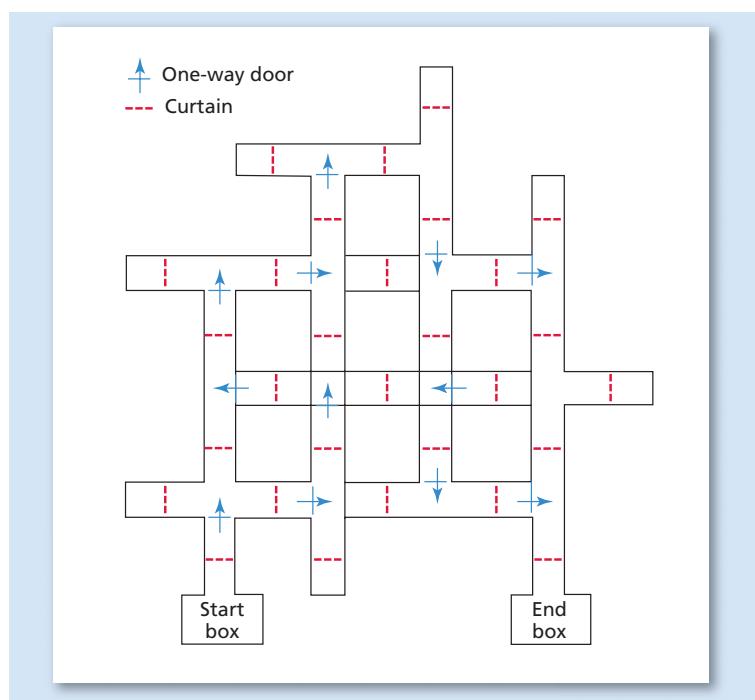
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certain number of trials, whereas the second and third groups seemed to wander aimlessly around the maze until accidentally finding their way out.

On the 10th day, however, something happened that would be difficult to explain using only Skinner's basic principles. The second group of rats, upon receiving the reinforcement for the first time, *should* have then taken as long as the first group to solve the maze. Instead, they began to solve the maze almost immediately (see **Figure 5.10**).

Tolman concluded that the rats in the second group, while wandering around in the first 9 days of the experiment, had indeed learned where all the blind alleys, wrong turns, and correct paths were and stored this knowledge away as a kind of "mental map," or *cognitive map* of the physical layout of the maze. The rats in the second group had learned and stored that learning away mentally but had not *demonstrated* this learning because there was no reason to do so. The cognitive map had remained hidden, or latent, until the rats had a reason to demonstrate their knowledge by getting to the food. Tolman called this **latent learning**. The idea that learning could happen without reinforcement, and then later affect behavior, was not something traditional operant conditioning could explain. To see a real-life example of latent learning, participate in the experiment *Learning*.

Simulation

Learning

In this experiment, you will be asked to memorize a series of words presented to you one at a time. Twenty words will be flashed on the screen for a very short time and will be separated briefly by a blank screen. After the last word is flashed on the screen, you will be asked some questions to test your recall.



[Go to the Experiment ▶](#)

KÖHLER'S SMART CHIMP: INSIGHT LEARNING

Another exploration of the cognitive elements of learning came about almost by accident. Wolfgang Köhler (1887–1967) was a Gestalt psychologist who became marooned* on an island in the Canaries (a series of islands off the coast of North Africa) when World War I broke out. Stuck at the primate research lab that had first drawn him to the island, he turned to studies of animal learning.

In one of his more famous studies (Köhler, 1925), he set up a problem for one of the chimpanzees. Sultan the chimp was faced with the problem of how to get to a banana that was placed just out of his reach outside his cage. Sultan solved this problem relatively easily, first trying to reach through the bars with his arm, then using a stick that was lying in the cage to rake the banana into the cage. As chimpanzees are natural tool users, this behavior is not surprising and is still nothing more than simple trial-and-error learning.

But then the problem was made more difficult. The banana was placed just out of reach of Sultan's extended arm with the stick in his hand. At this point there were two sticks lying around in the cage, which could be fitted together to make a single pole that would be long enough to reach the banana. Sultan first tried one stick, then the other (simple trial and error). After about an hour of trying, Sultan seemed to have a sudden flash of inspiration. He pushed one stick out of the cage as far as it would go toward the banana and then pushed the other stick behind the first one. Of course, when he tried to draw the sticks back, only the one in his hand came. He jumped up and down and was very excited, and when Köhler gave him the second stick, he sat on the floor of the cage and looked at them carefully. He then fitted one stick into the other and retrieved his banana. Köhler called Sultan's rapid "perception of relationships" **insight** and determined that insight could not be gained through trial-and-error learning alone (Köhler, 1925). Although Thorndike and other early learning theorists believed that animals could not demonstrate insight, Köhler's work seems to demonstrate that insight requires a sudden "coming together" of all the elements of a problem in a kind of "aha" moment that is not predicted by traditional animal learning studies.  to Learning Objective 7.2. More recent research has also found support for the concept of animal insight (Heinrich, 2000; Heyes, 1998; Zentall, 2000), but there is still controversy over how to interpret the results of those studies (Wynne, 1999).

SELIGMAN'S DEPRESSED DOGS: LEARNED HELPLESSNESS

Martin Seligman is now famous for founding the field of *positive psychology*, a new way of looking at the entire concept of mental health and therapy that focuses on the adaptive, creative, and psychologically more fulfilling aspects of human experience rather than on mental disorders. But in the mid- to late 1960s, learning theorist Seligman (1975) and his colleagues were doing classical conditioning experiments on dogs. They accidentally discovered an unexpected phenomenon, which Seligman called **learned helplessness**, the tendency to fail to act to escape from a situation because of a history of repeated failures in the past. Their original intention was to study escape and avoidance learning. Seligman and

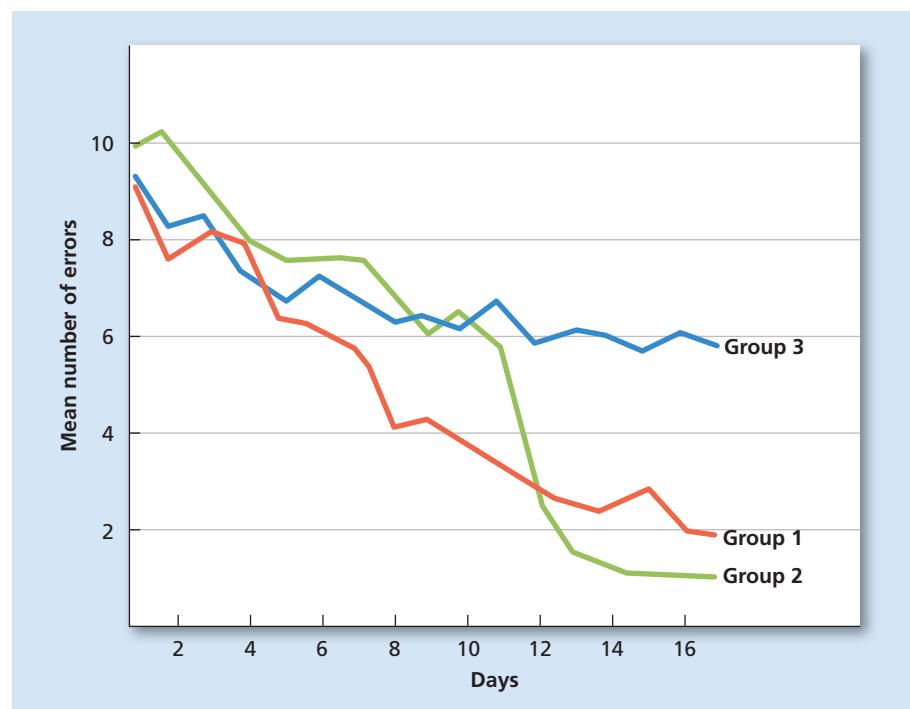


Figure 5.10 Learning Curves for Three Groups of Rats

In the results of the classic study of latent learning, Group 1 was rewarded on each day, while Group 2 was rewarded for the first time on Day 10. Group 3 was never rewarded. Note the immediate change in the behavior of Group 2 on Day 12 (Tolman & Honzik, 1930).



Another of Köhler's chimpanzees, Grande, has just solved the problem of how to get to the banana by stacking boxes. Does this meet the criteria for insight, or was it simple trial-and-error learning?

*marooned: in this sense, being placed on an island from which escape is impossible.

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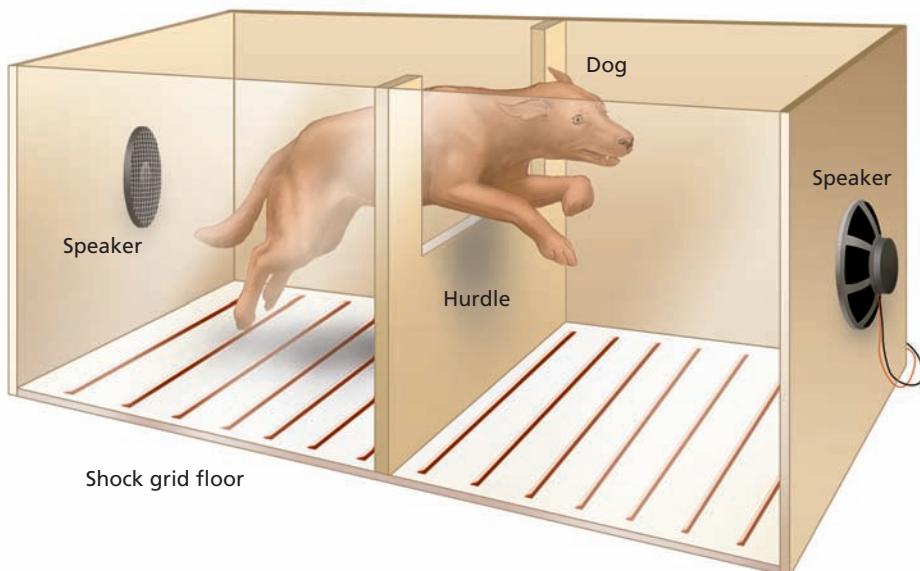
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**Figure 5.11** Seligman's Apparatus

In Seligman's studies of learned helplessness, dogs were placed in a two-sided box. Dogs that had no prior experience with being unable to escape a shock would quickly jump over the hurdle in the center of the box to land on the "safe" side. Dogs that had previously learned that escape was impossible would stay on the side of the box in which the shock occurred, not even trying to go over the hurdle.

colleagues presented a tone followed by a harmless but painful electric shock to one group of dogs (Overmier & Seligman, 1967; Seligman & Maier, 1967). The dogs in this group were harnessed so that they could not escape the shock. The researchers assumed that the dogs would learn to fear the sound of the tone and later try to escape from the tone before being shocked.

These dogs, along with another group of dogs that had not been conditioned to fear the tone, were placed into a special box consisting of a low fence that divided the box into two compartments. The dogs, which were now unharnessed, could easily see over the fence and jump over if they wished—

which is precisely what the dogs that had not been conditioned did as soon as the shock occurred (see **Figure 5.11**). Imagine the researchers' surprise when, instead of jumping over the fence when the tone sounded, the previously conditioned dogs just sat there. In fact, these dogs showed distress but didn't try to jump over the fence *even when the shock itself began*.

Why would the conditioned dogs refuse to move when shocked? The dogs that had been harnessed while being conditioned had apparently learned in the original tone/shock situation that there was nothing they could do to escape the shock. So when placed in a situation in which escape was possible, the dogs still did nothing because they had learned to be "helpless." They believed they could not escape, so they did not try.

More recently, Seligman's colleague and co-researcher in those early studies, Steven F. Maier, has revisited the phenomenon of learned helplessness from a neuroscientific approach, and this work has provided some new insights. Maier and others have investigated the brain mechanisms underlying this phenomenon, focusing on an area of the brain stem that releases serotonin and can play a role in activating the amygdala (which plays an important role in fear and anxiety) but also participates in decreasing activity in brain areas responsible for the "fight-or-flight" response. This combination of increased fear/anxiety with non-escape or freezing is the very behavior associated with learned helplessness. This part of the brain stem (the dorsal raphe nucleus) is a much older part of the brain and not able to determine what type of stressors are controllable. Their research suggests that a higher-level area, a part of the frontal lobe called the *ventromedial prefrontal cortex* (vmPFC), is able to help determine what is controllable. In turn, the vmPFC inhibits the brain stem area and calms the amygdala's response, allowing an animal to effectively respond to a stressor and exhibit control (Amat et al., 2005; Maier et al., 2006; Maier & Watkins, 2005). In other words, it is possible that the dogs in the early studies, rather than learning to be helpless were *not* learning how to relax and take control of the situation. Maier and colleagues suggest that both training and input from the vmPFC are necessary for animals to learn how to take control (Maier et al., 2006).

I know some people who seem to act just like those dogs—they live in a horrible situation but won't leave. Is this the same thing?

Seligman extended the concept of learned helplessness to explain some behaviors characteristic of *depression*. Depressed people seem to lack normal emotions and become somewhat apathetic, often staying in unpleasant work environments or bad marriages or relationships rather than trying to escape or better their situation. Seligman proposed that this depressive behavior is a form of learned helplessness. Depressed people may have learned in the past that they seem to have no control over what happens to them (Alloy & Clements, 1998). A sense of

powerlessness and hopelessness is common to depressed people, and certainly this would seem to apply to Seligman's dogs as well. Maier's recent work also has implications here, especially the focus on the components necessary for learning how to relax and exhibit control: input from the vmPFC, and training (repeated exposures to stressors). This combination provides a mechanism for not only understanding resilience,* but also for possibly helping people foster resilience and avoid anxiety or mood disorders such as posttraumatic stress disorder (PTSD) or depression (Maier et al., 2006).  to Learning Objectives 14.4 and 14.5. Maier and colleagues are continuing to study the brain foundations of learned helplessness and examining how factors related to control and controllability not only impact immediate events, but future stressful events as well (Amat et al., 2010; Rozeske et al., 2011; Varela et al., 2012).

Think about how learned helplessness might apply to other situations. Perceived control or learned helplessness can play an important role in coping with chronic or acute health conditions, either for the person with the disorder or for the family member making medical decisions for a loved one (Camacho et al., 2013; Sullivan et al., 2012). What about college? There are many students who feel that they are bad at math because they have had problems with it in the past. Is it possible that this belief could make them not try as hard or study as much as they should? Is this kind of thinking also an example of learned helplessness, or is it possible that these students have simply not had enough experiences of success or control?

Cognitive learning is also an important part of a fairly well-known form of learning, often simplified as "monkey see, monkey do." Let's take a look at learning through watching the actions of others.

Observational Learning

What is observational learning, and what are the four elements of modeling?

Observational learning is the learning of new behavior through watching the actions of a model (someone else who is doing that behavior). Sometimes that behavior is desirable, and sometimes it is not, as the next section describes.

BANDURA AND THE BOBO DOLL

Albert Bandura's classic study in observational learning involved having a preschool child in a room in which the experimenter and a model interacted with toys in the room in front of the child (Bandura et al., 1961). In one condition, the model interacted with the toys in a nonaggressive manner, completely ignoring the presence of a "Bobo" doll (a punch-bag doll in the shape of a clown). In another condition, the model became very aggressive with the doll, kicking it and yelling at it, throwing it in the air and hitting it with a hammer.

When each child was left alone in the room and had the opportunity to play with the toys, a camera filming through a one-way mirror caught the children who were exposed to the aggressive model beating up on the Bobo doll, in exact imitation of the model. (See **Figure 5.12** on the next page.) The children who saw the model ignore the doll did not act aggressively toward the toy. Obviously, the aggressive children had learned their aggressive actions from merely watching the model—with no reinforcement necessary. The fact that learning can take place without actual performance (a kind of latent learning) is called **learning/performance distinction**.

 Ah, but would that child have imitated the model if the model had been punished? Wouldn't the consequences of the model's behavior make a difference?

In later studies, Bandura showed a film of a model beating up the Bobo doll. In one condition, the children saw the model rewarded afterward. In another, the model

*resilience: the ability to recover quickly from change and/or stress.

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5.1 **Figure 5.12 Bandura's Bobo Doll Experiment**

In Albert Bandura's famous Bobo doll experiment, the doll was used to demonstrate the impact of observing an adult model performing aggressive behavior on the later aggressive behavior of children. The children in these photos are imitating the adult model's behavior even though they believe they are alone and are not being watched.



was punished. When placed in the room with toys, the children in the first group beat up the doll, but the children in the second group did not. But, when Bandura told the children in the second group that he would give them a reward if they could show him what the model in the film did, each child duplicated the model's actions. Both groups had learned from watching the model, but only the children watching the successful (rewarded) model imitated the aggression with no prompting (Bandura, 1965). Apparently, consequences do matter in motivating a child (or an adult) to imitate a particular model. The tendency for some movies and television programs to make "heroes" out of violent, aggressive "bad guys" is particularly disturbing in light of these findings. In fact, Bandura began this research to investigate possible links between children's exposure to violence on television and aggressive behavior toward others.

In one nationwide study of youth in the United States, it was found that young people ages 8 to 18 spend on average almost 7.5 hours per day involved in media consumption (television, computers, video games, music, cell phones, print, and movies), 7 days a week. Furthermore, given the prevalence of media multitasking (using more than one media device at a time), they are packing in approximately 10 hours and 45 minutes of media during those 7.5 hours! (Rideout et al., 2010). While not all media consumption is of violent media, it is quite easy to imagine that some of that media is of a violent nature.

Correlational research stretching over nearly 2 decades suggests that a link exists between viewing violent television and an increased level of aggression in children (Bushman & Huesmann, 2001; Huesmann & Eron, 1986). [LINK](#) to Learning Objective 1.9. While correlations do not prove that viewing violence on TV is the *cause* of increased violence, one cannot help but be curious as to the effects, especially given the continuing rise of media consumption in young people, coupled with the multiple ways young people interact with media. As such there has been an ongoing debate as to the validity of the links between aggression and exposure to media violence (primarily focusing on television, movies, video games, and music). Although still a topic of debate for some, there appears to be a strong body of evidence that exposure to media violence does have immediate and long-term effects, increasing the likelihood of aggressive verbal and physical behavior and aggressive thoughts and emotions—and the effects appear to impact children, adolescents, and adults (Anderson et al., 2003). [Watch the Video](#), *In the Real World: Learning Aggression*, at [MyPsychLab](#)

THE FOUR ELEMENTS OF OBSERVATIONAL LEARNING

Bandura (1986) concluded, from his studies and others, that observational learning required the presence of four elements.

ATTENTION To learn anything through observation, the learner must first pay *attention* to the model. For example, a person at a fancy dinner party who wants to know which utensil to use has to watch the person who seems to know what is correct. Certain characteristics

of models can make attention more likely. For example, people pay more attention to those they perceive as similar to them, and to those they perceive as attractive.

MEMORY The learner must also be able to retain the *memory* of what was done, such as remembering the steps in preparing a dish that was first seen on a cooking show.

IMITATION The learner must be capable of reproducing, or *imitating*, the actions of the model. A 2-year-old might be able to watch someone tie shoelaces and might even remember most of the steps, but the 2-year-old's chubby little fingers will not have the dexterity* necessary for actually tying the laces. A person with extremely weak ankles might be able to watch and remember how some ballet move was accomplished but will not be able to reproduce it. The mirror neurons discussed in Chapter Two may be willing, but the flesh is weak.  to Learning Objective 2.9.

DESIRE Finally, the learner must have the desire or *motivation* to perform the action. That person at the fancy dinner, for example, might not care which fork or which knife is the “proper” one to use. Also, if a person expects a reward because one has been given in the past, or has been promised a future reward (like the children in the second group of Bandura’s study), or has witnessed a model getting a reward (like the children in the first group), that person will be much more likely to imitate the observed behavior. Successful models are powerful figures for imitation, but rarely would we be motivated to imitate someone who fails or is punished.

(An easy way to remember the four elements of modeling is to remember the letters AMID, which stand for the first letters of each of the four elements. This is a good example of using a strategy to improve memory.  to Learning Objective PIA.7.)

*dexterity: skill and ease in using the hands.

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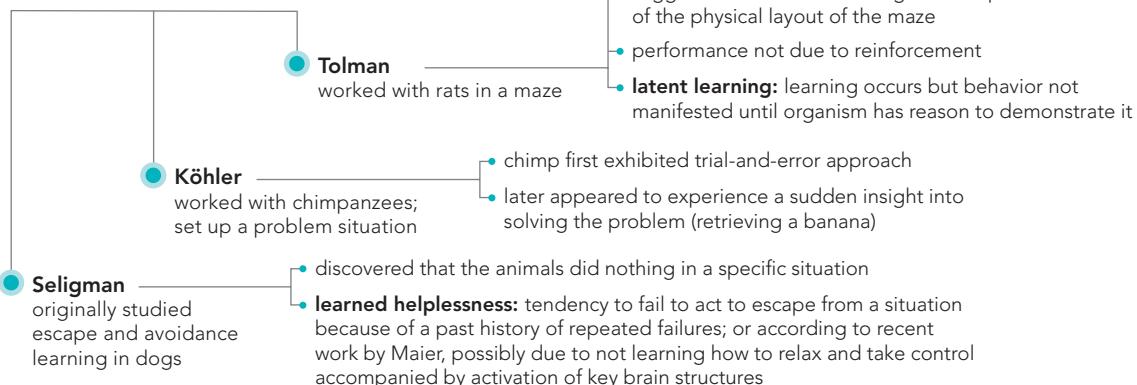
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 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP

Cognitive Learning Theory

(focuses on role of cognition, or thought processes, on learning)



Observational Learning

(the learning of a new behavior through the observation of a model; typically associated with classic work of Bandura and “Bobo doll” study)

 **children observing**
an adult model's aggressive or nonaggressive behaviors tended to later act in the same manner they saw modeled; no reinforcement was necessary

later research suggested that potential consequences can influence motivation to imitate a particular model

key elements for learner

- pay attention to the model
- able to remember what was done
- capable of reproducing, or imitating, the actions of the model
- have the desire or motivation to perform the action

(continued)

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PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. In Tolman's maze study, the fact that the group of rats receiving reinforcement only after day 10 of the study solved the maze far more quickly than did the rats who had been reinforced from the first day can be interpreted to mean that these particular rats
 - a. were much smarter than the other rats.
 - b. had already learned the maze in the first 9 days.
 - c. had the opportunity to cheat by watching the other rats.
 - d. were very hungry and, therefore, learned much more quickly.
 2. Lisa's parents have decided to take a 3-week trip to Europe. Consequently, Lisa's mother will not be able to make her famous pies for the upcoming bake sale. When her mother encourages Lisa to bake the pies herself, Lisa panics at first but then she finds that she knows how to put the recipe together. Her ability to prepare the recipe is an example of
 - a. latent learning. c. insight learning.
 - b. learned helplessness. d. discovery learning.
 3. Which theory is commonly referred to as the "aha!" phenomenon?
 - a. Tolman's latent learning theory
 - b. Köhler's insight theory
 - c. Seligman's learned helplessness theory
 - d. Bandura's observational learning
- 4.** Research by Steven Maier suggests that learned helplessness may be due to a higher-level region of the brain known as the _____, which helps subjects determine what is controllable.
- a. amygdala
 - b. hippocampus
 - c. dorsal raphe nucleus
 - d. ventromedial prefrontal cortex (vmPFC)
- 5.** Bandura's studies found that learning can take place without actual performance. What is this referred to as?
- a. learning/performance distinction
 - b. insight-based learning
 - c. ARID
 - d. cognitive learning
- 6.** What is the correct sequence of the four elements of observational learning?
- a. Attention, Imitation, Desire, Memory
 - b. Attention, Memory, Imitation, Desire
 - c. Desire, Attention, Memory, Imitation
 - d. Memory, Attention, Desire, Imitation

Applying Psychology to Everyday Life: Can You Really Toilet Train Your Cat?

What is a real-world example of the use of conditioning?

(This article has been excerpted with permission of the author and cat-trainer extraordinaire, Karawynn Long. Karawynn Long is a published writer and Web designer who lives in Seattle with her family. Sadly, since this article was written, her cat, Misha, has passed away. Ms. Long can be reached at her Web site, www.karawynn.name/mishacat/toilet.html. The italicized words in brackets are the author's "editorial" comments.)

There have been more books and articles about toilet-training cats than you'd think. In the summer of 1989, when Misha was a small kitten with big ears and enough meow for five cats, I searched out and read a half-dozen of them. And then tried it myself, and discovered there were a couple of things they all failed to mention . . . here's what worked for me and Misha.

The central idea is that the transition from litter box to toilet should be accomplished in a series of stages. [*This is shaping.*] You make a small change and then give your cat time to adjust before you make another small change. If at any time Felix gives the whole thing up and goes on the rug instead, you're pushing him too far too fast; back up a stage or two and try again, more slowly.

The very most important thing to remember is: Lid Up, Seat Down. Post a note on the back of the door or the lid of the toilet if you think you (or your housemates or guests) might forget. And if you are accustomed to closing the bathroom door when it's empty, you'll have to break that habit too. [*In operant conditioning, this is part of "preparing the training arena."*]

Begin by moving the cat's current litter box from wherever it is to one side of the toilet. Make sure he knows where it is and uses it. Rest (this means doing nothing for a period of between a day and a week, depending on how flappable your cat is). Next put something—a stack of newspapers, a phone book, a cardboard box—under the litter box to raise it, say, about an inch. (Magazines are too slick; you don't want the litter box sliding around and making your cat feel insecure. Tape the litter box down if you need to.) Rest. Get another box or phone book and raise it a little higher. Rest. Continue this process until the bottom of the litter box is level with the top of the toilet seat. (For Misha I raised it about two inches per day.) [Notice that this is the step-by-step process typically used in shaping.]

At the beginning of this process, your cat could just step into the litter box; later he began jumping up into it, until at some point he probably started jumping up onto the toilet seat first and stepping into the box from there. Lift the seat on your toilet and measure the inside diameter of the top of the bowl at its widest point. Venture forth and buy a metal mixing bowl of that diameter. Do not (I discovered this the hard way) substitute a plastic bowl. A plastic bowl will not support the cat's weight and will bend, dropping into the toilet bowl and spilling litter everywhere, not to mention startling the cat.

Now you move the litter box over so that it's sitting directly over the toilet seat. (If your cat has shown reluctance over previous changes, you might want to split this into two stages, moving it halfway onto the seat and then fully over.) Take away the stack of phone books or whatever you used. Rest. [Again, notice that everything has to be done in small steps. This is the heart of the shaping process—requiring too large a step will stop the process.]

Here's the cool part. Take away the litter box entirely. (Ta da!) Nestle the metal mixing bowl inside the toilet bowl and lower the seat. Fill the bowl with about two inches of litter (all of this is much easier if you have the tiny granules of litter that can be scooped out and flushed).

Naturally, any humans using the toilet at this point will want to remove the metal bowl prior to their own use and replace it afterward. The next week or two the whole process is likely to be something of an annoyance; if you begin to think it's not worth it, just remember that you will never have to clean a litter box again.

Watch your cat using the bathroom in the metal bowl. Count the number of feet he gets up on the toilet seat (as opposed to down in the bowl of litter). The higher the number, the luckier you are and the easier your job is going to be . . .

. . . because next you have to teach him proper squatting posture. Catch him beginning to use the toilet as much of the time as possible and show him where his feet are supposed to go. Just lift them right out of the bowl and place them on the seat (front legs in the middle, hind legs on the outside). If he starts out with three or, heaven forbid, all four feet in the bowl, just get the front two feet out first. Praise him all over the place every time he completes the activity in this position. [The praise is the positive reinforcement, and should be done with each successful step.]

(Misha is very doglike in that he craves approval and praise. If your cat is indifferent to this sort of thing, you can also reward him with small food treats and wean him from them later when the toilet behavior has "set." Just keep the treats as small and infrequent as possible—half a Pounce™ or similar treat per occasion should be plenty.) [If treats are too frequent, it will make it difficult to phase out the reinforcer after the behavior is well learned.]

When he is regularly using the toilet with his front feet out (and some cats naturally start from this position), begin lifting a hind foot out and placing it on the seat outside the front paws. Your cat will probably find this awkward at first and try to replace the foot in the litter. Be persistent. Move that foot four times in a row if you have to, until it stays there. Praise and/or treat.



This cat is being trained to use the toilet employing the learning techniques discussed in this section.

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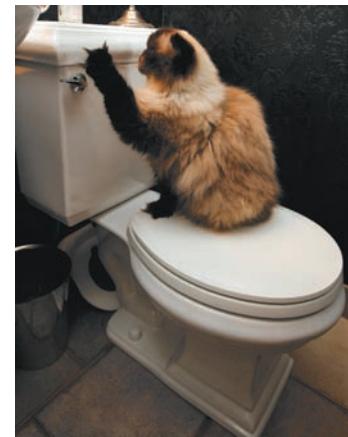
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Part of the training may include learning to press the flush handle.

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Repeat with the other hind foot, until your cat learns to balance in that squat. Once he's getting all four feet regularly on the seat, it's all easy from here.

Which is fortunate, because the last bit is also the most unpleasant. I suggest that you postpone this stage until you have at least a weekend, and preferably several days, when you (or another responsible party) will be at home most of the time. I skipped through this part in about two days; I only hope that your cat allows you to move along that fast.

Begin reducing the litter in the bowl. Go as fast as he'll feel comfortable with, because as the litter decreases, the odor increases. You'll want to be home at this point so that you can praise him and dump out the contents of the bowl immediately after he's finished, to minimize both the smell and the possibility that your cat, in a confused attempt to minimize the smell on his own, tries to cover it up with litter that no longer exists and ends up tracking unpleasantness into the rest of the house.

By the time you're down to a token teaspoonful of litter in the bottom of the bowl, your next-door neighbors will probably be aware of the precise instant your cat has used the toilet. This is as bad as it gets. The next time you rinse out the metal bowl, put a little bit of water in the bottom. Increase the water level each time, just as you decreased the litter level. Remember—if at any point Felix looks nervous enough about the change to give the whole thing up and take his business to the corner behind the door, back up a step or two and try the thing again more slowly. [*Shaping takes a lot of patience, depending on the behavior being shaped and the learning ability of the animal—or person.*]

Once the water in the mixing bowl is a couple of inches deep and your cat is comfortable with the whole thing, you get to perform the last bit of magic. Take the mixing bowl away, leaving the bare toilet. (Lid Up, Seat Down.)

Questions for Further Discussion

1. Why would this technique probably not work with a dog?
2. Are there any safety concerns with teaching a cat in this way?
3. Are there any other difficulties that might arise when doing this training?

Writing Prompt

- ▼ Imagine you are asked by a roommate to help him devise a weight loss program to increase his chances of making the football team. Create a one month behavior modification program based on the principles of operant conditioning which will get him started towards his goal. Be sure to describe how you will measure your roommate's progress and what schedules of reinforcement will be included in your program.

Words: 0

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chapter summary

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Definition of Learning

5.1 What does the term *learning* really mean?

- Learning is any relatively permanent change in behavior brought about by experience or practice and is different from maturation, which is genetically controlled.

It Makes Your Mouth Water: Classical Conditioning

5.2 How was classical conditioning first studied, and what are the important elements and characteristics of classical conditioning?

- Pavlov accidentally discovered the phenomenon in which one stimulus can, through pairing with another stimulus, come to produce a similar response. He called this “classical conditioning.”
- The unconditioned stimulus (UCS) is the stimulus that is naturally occurring and produces the innate, or involuntary unconditioned response (UCR). Both are called “unconditioned” because they are not learned.
- The conditioned stimulus (CS) begins as a neutral stimulus, but when paired with the unconditioned stimulus eventually begins to elicit an involuntary, and automatic behavior on its own. The response to the conditioned stimulus is called the “conditioned response” (CR), and both stimulus and response are learned.
- Pavlov paired a sound with the presentation of food to dogs and discovered several principles for classical conditioning: The neutral stimulus (NS) and UCS must be paired several times, and the CS must precede the UCS by only a few seconds.
- Other important aspects of classical conditioning include stimulus generalization, stimulus discrimination, extinction, spontaneous recovery, and higher-order conditioning.

5.3 What is a conditioned emotional response, and how do cognitive psychologists explain classical conditioning?

- Watson was able to demonstrate that an emotional disorder called a phobia could be learned through classical conditioning by exposing a baby to a white rat and a loud noise, producing conditioned fear of the rat in the baby.
- Conditioned taste aversions occur when an organism becomes nauseated some time after eating a certain food, which then becomes aversive to the organism.
- Some kinds of conditioned responses are more easily learned than others because of biological preparedness.
- Pavlov believed that the NS became a substitute for the UCS through association in time.
- The cognitive perspective asserts that the CS has to provide some kind of information or expectancy about the coming of the UCS in order for conditioning to occur.

What's in It for Me? Operant Conditioning

5.4 How does operant conditioning occur, and what were the contributions of Thorndike and Skinner?

- Thorndike developed the law of effect: A response followed by a pleasurable consequence will be repeated, but a response followed by an unpleasant consequence will not be repeated.
- B. F. Skinner named the learning of voluntary responses “operant conditioning” because voluntary responses are what we use to operate in the world around us.

5.5 What are the important concepts in operant conditioning?

- Skinner developed the concept of reinforcement, the process of strengthening a response by following it with a pleasurable, rewarding consequence.
- A primary reinforcer is something such as food or water that satisfies a basic, natural drive, whereas a secondary reinforcer is something that becomes reinforcing only after being paired with a primary reinforcer.
- In positive reinforcement, a response is followed by the presentation of a pleasurable stimulus, whereas in negative reinforcement, a response is followed by the removal or avoidance of an unpleasant stimulus.
- Shaping is the reinforcement of successive approximations to some final goal, allowing behavior to be molded from simple behavior already present in the organism.
- Extinction, generalization and discrimination, and spontaneous recovery also occur in operant conditioning.

5.6 What are the schedules of reinforcement?

- Continuous reinforcement occurs when each and every correct response is followed by a reinforcer.
- Partial reinforcement, in which only some correct responses are followed by reinforcement, is much more resistant to extinction. This is called the partial reinforcement effect.
- In a fixed interval schedule of reinforcement, at least one correct response must be made within a set interval of time to obtain reinforcement.
- In a variable interval schedule of reinforcement, reinforcement follows the first correct response made after an interval of time that changes for each reinforcement opportunity.
- In a fixed ratio schedule of reinforcement, a certain number of responses is required before reinforcement is given.
- In a variable ratio schedule of reinforcement, a varying number of responses is required to obtain reinforcement.

5.7 What is punishment and how does it differ from reinforcement?

- Punishment is any event or stimulus that, when following a response, makes that response less likely to happen again.
- In punishment by application, a response is followed by the application or experiencing of an unpleasant stimulus, such as a spanking.
- In punishment by removal, a response is followed by the removal of some pleasurable stimulus, such as taking away a child’s toy for misbehavior.

5.8 What are some of the problems with using punishment?

- A person who uses aggressive punishment, such as spanking, can act as a model for aggressive behavior. This will increase aggressive behavior in the one being punished, which is an undesirable response.
- Punishment of both kinds normally has only a temporary effect on behavior.
- Punishment can be made more effective by making it immediate and consistent and by pairing punishment of the undesirable behavior with reinforcement of the desirable one.

5.9 How do operant stimuli control behavior, and what are some other concepts that can enhance or limit operant conditioning?

- Discriminative stimuli are cues, such as a flashing light on a police car or a sign on a door that says “Open,” which provide information about what response to make in order to obtain reinforcement.
- Shaping, extinction, generalization and discrimination, and spontaneous recovery are other concepts in operant conditioning.
- Instinctive drift is the tendency for an animal that is being trained by operant conditioning to revert to instinctive patterns of behavior rather than maintaining the trained behavior.

5.10 What is behavior modification, and how can behavioral techniques be used to modify involuntary biological responses?

- Operant conditioning can be used in many settings on both animals and people to change, or modify, behavior. This use is termed *behavior modification* and includes the use of reinforcement and shaping to alter behavior.
- Token economies are a type of behavior modification in which secondary reinforcers, or tokens, are used.
- Applied behavior analysis (ABA) is the modern version of behavior modification and makes use of functional analysis and behavioral techniques to change human behavior.
- Neurofeedback is a modified version of biofeedback in which a person learns to modify the activity of his or her brain.

Cognitive Learning Theory**5.11** How do latent learning, insight, and learned helplessness relate to cognitive learning theory?

- Cognitive learning theory states that learning requires cognition, or the influence of an organism’s thought processes.
- Tolman found that rats that were allowed to wander in a maze but were not reinforced still showed evidence of having learned the maze once reinforcement became possible. He termed this hidden learning *latent learning*, a form of cognitive learning.
- Seligman found that dogs that had been placed in an inescapable situation failed to try to escape when it became possible to do so, remaining in the painful situation as if helpless to leave. Seligman called this phenomenon “learned helplessness” and found parallels between learned helplessness and depression.
- Köhler found evidence of insight, the sudden perception of the relationships among elements of a problem, in chimpanzees.

Observational Learning**5.12** What is observational learning, and what are the four elements of modeling?

- Observational learning is acquired by watching others perform, or model, certain actions.
- Bandura’s famous Bobo doll experiment demonstrated that young children will imitate the aggressive actions of a model even when there is no reinforcement for doing so.
- Bandura determined that four elements needed to be present for observational learning to occur: attention, memory, imitation, and desire.

Applying Psychology to Everyday Life: Can You Really Toilet Train Your Cat?**5.13** What is a real-world example of the use of conditioning?

- Writer Karawynn Long used shaping, reinforcement, and classical conditioning to train her cat to use the toilet in her bathroom instead of a litter box.

test YOURSELF

ANSWERS AVAILABLE IN ANSWER KEY.

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Pick the best answer.

- Sheila almost got hit by a car at a street corner because she was too busy texting on her phone. From that day on, Sheila looks before she reaches the street corner. Her change in behavior is a result of
 - learning.
 - memory.
 - motivation.
 - both sensation and perception.
- At home, you rattle the chain on your dog’s leash every time you prepare to take him for a walk. After several episodes like this, you find that your dog comes running to the front door even when you pick up the leash to put it back in the closet. In this example, what is the conditioned stimulus?
 - going for a walk
 - the sound of the leash
 - the front door
 - the dog runs to the door

- A child has been classically conditioned to fear a white rat. If the child does not show fear when shown a black rat, this is called
 - stimulus generalization.
 - stimulus discrimination.
 - spontaneous recovery.
 - extinction.
- During the cold winter, you have stopped taking your dog for walks. What’s more, your dog has gotten used to the fact that when you accidentally rattle his leash, he isn’t going for a walk, and subsequently he doesn’t come running to the front door. What has occurred?
 - stimulus generalization
 - stimulus discrimination
 - spontaneous recovery
 - extinction
- Rhonda had tartar sauce with her fish one night. The next morning she was nauseated and sick for much of the day. The next time she was offered the chance to go out for fish, she felt
 - going for a walk
 - the sound of the leash
 - the front door
 - the dog runs to the door

6

memory

Most of us, at some point in our busy lives, have trouble remembering things, especially events from the distant past. What if you could remember nearly every day of your life? This rare ability is possessed by Brad Williams, who is known as the “Human Google.” Brad is one of a small group of individuals with a syndrome called *hyperthymesia* (hī-pər-thī-mē-sē-uh). A person with hyperthymesia not only has an astonishing and rare ability to recall specific events from his or her personal past but also spends an unusually large amount of time thinking about that personal past. Brad can recall almost any news event or personal event he himself has experienced, particularly specific dates—and even the weather on those dates.

How is your memory of events? Do you find that you remember events from your past differently than others who were also present at that time?

A woman with dark hair tied back, wearing a red and blue horizontally striped short-sleeved shirt, stands with her arms crossed. She is positioned in front of a whiteboard. On the whiteboard to her left is a yellow sticky note with a drawing of a human brain pinned to it with a red pushpin. To her right, the word "memories" is written next to a pencil. The whiteboard is surrounded by several large, semi-transparent blue circles of varying sizes. At the bottom of the image is a dark grey video player bar. From left to right, it contains a play button icon, a volume icon, a closed captioning (CC) icon, and a share icon. Below the video player bar is a white rectangular button with a blue eye icon and the text "Watch the Video on MyPsychLab.com".

Watch the Video on MyPsychLab.com

Why study memory?

Without memory, how would we be able to learn anything? The ability to learn is the key to our very survival, and we cannot learn unless we can remember what happened the last time a particular situation arose. Why study forgetting? If we can learn about the ways in which we forget information, we can apply that learning so that unintended forgetting occurs less frequently.

Learning objectives

- 6.1** What are the three processes of memory and the different models of how memory works?
- 6.2** How does sensory memory work?
- 6.3** What is short-term memory, and how does it differ from working memory?
- 6.4** How is long-term memory different from other types of memory?
- 6.5** What are the various types of long-term memory, and how is information stored in long-term memory organized?
- 6.6** What kinds of cues help people remember?
- 6.7** How do the retrieval processes of recall and recognition differ, and how reliable are our memories of events?
- 6.8** How are long-term memories formed, and how can this process lead to inaccuracies in memory?
- 6.9** What is false-memory syndrome?
- 6.10** Why do we forget?
- 6.11** How and where are memories formed in the brain?
- 6.12** How does amnesia occur?
- 6.13** How do sleep, exercise, and diet affect memory?



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What Is Memory?

What are the three processes of memory and the different models of how memory works?

Is memory a place or a process? The answer to that question is not simple. In reading through this chapter, it will become clear that memory is a process but that it also has a “place” in the brain as well. Perhaps the best definition of **memory** is an active system that receives information from the senses, puts that information into a usable form, organizes it as it stores it away, and then retrieves the information from storage (adapted from Baddeley, 1996, 2003).  Watch the **Video**, *The Basics: Do You Remember When?: Memory Steps and Systems*, at **MyPsychLab**

THREE PROCESSES OF MEMORY

Although there are several different models of how memory works, all of them involve the same three processes: getting the information into the memory system, storing it there, and getting it back out.

PUTTING IT IN: ENCODING The first process in the memory system is to get sensory information (sight, sound, etc.) into a form that the brain can use. This is called **encoding**. Encoding is the set of mental operations that people perform on sensory information to convert that information into a form that is usable in the brain’s storage systems. For example, when people hear a sound, their ears turn the vibrations in the air into neural messages from the auditory nerve (*transduction*), which make it possible for the brain to interpret that sound.  to [Learning Objective 3.1](#).



 It sounds like memory encoding works just like the senses—is there a difference?

Encoding is not limited to turning sensory information into signals for the brain. Encoding is accomplished differently in each of three different storage systems of memory. In one system, encoding may involve rehearsing information over and over to keep it in memory, whereas in another system, encoding involves elaborating on the meaning of the information—but let’s elaborate on that later.

KEEPING IT IN: STORAGE The next step in memory is to hold on to the information for some period of time in a process called **storage**. The period of time will actually be of different lengths, depending on the system of memory being used. For example, in one system of memory, people hold on to information just long enough to work with it, about 20 seconds or so. In another system of memory, people hold on to information more or less permanently.

GETTING IT OUT: RETRIEVAL The biggest problem many people have is **retrieval**, that is, getting the information they know they have out of storage. Have you ever handed in an essay test and *then* remembered several other things you could have said? Retrieval problems are discussed thoroughly in a later section of this chapter.

MODELS OF MEMORY

Exactly how does memory work? When the storage process occurs, where does that information go and why? Memory experts have proposed several different ways of looking at memory. The model that many researchers feel is the most comprehensive* and has perhaps been the most influential over the last several decades

*comprehensive: all-inclusive, covering everything.

is the **information-processing model**. This approach focuses on the way information is handled, or processed, through three different systems of memory. The processes of encoding, storage, and retrieval are seen as part of this model.

While it is common to refer to the three systems of the information-processing model as *stages* of memory, that term seems to imply a sequence of events. While many aspects of memory formation may follow a series of steps or stages, there are those who see memory as a simultaneous* process, with the creation and storage of memories taking place across a series of mental networks “stretched” across the brain (McClelland & Rumelhart, 1988; Plaut & McClelland, 2010; Rumelhart et al., 1986). This simultaneous processing allows people to retrieve many different aspects of a memory all at once, facilitating much faster reactions and decisions—something Brad Williams in our opening story seems to be very good at. This model of memory, derived from work in the development of artificial intelligence (AI), is called the **parallel distributed processing (PDP) model**. In the AI world, PDP is related to *connectionism*, the use of artificial neural networks to explain the mental abilities of humans (Bechtel & Abrahamsen, 2002; Clark, 1991; Marcus, 2001; Schapiro & McClelland, 2009).

The information-processing model assumes that the length of time that a memory will be remembered depends on the stage of memory in which it is stored. Other researchers have proposed that a memory’s duration depends on the depth (i.e., the effort made to understand the meaning) to which the information is processed or encoded (Cermak & Craik, 1979; Craik & Lockhart, 1972). If the word *BALL* is flashed on a screen, for example, and people are asked to report whether the word was in capital letters or lowercase, the word itself does not have to be processed very much at all—only its visual characteristics need enter into conscious attention. But if those people were to be asked to use that word in a sentence, they would have to think about what a ball is and how it can be used. They would have to process its meaning, which requires more mental effort than processing just its “looks.” This model of memory is called the **levels-of-processing model**. Numerous experiments have shown that thinking about the meaning of something is a deeper level of processing and results in longer retention of the word (Cermak & Craik, 1979; Craik & Tulving, 1975; Paul et al., 2005; Watson et al., 1999).



So which model is right?

“Which model is right?” is not the correct question. The correct question is, *Which model explains the findings of researchers about how memory works?* The answer to that question is that all of these models can be used to explain some, if not all, research findings. Each of these views of the workings of memory can be seen as speaking to different aspects of memory. For example, the information-processing model provides a “big picture” view of how the various memory systems relate to each other—how the “memory machine” works. The PDP model is less about the mechanics of memory and more about the connections and timing of memory processes. The depth to which information is processed can be seen to address the strength of those parallel connections within each of the three memory systems, with strength and duration of the memory increasing as the level of processing deepens. Although the information-processing model of memory may take center stage for now, as you read this chapter, it is important to remember the concepts of the levels at which information is processed and the way that those processes may take place.



Like Brad Williams, the man with the amazing memory described in the opening pages of this chapter, Aurelian Hayman has been diagnosed with hyperthymesia.

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*simultaneous: all at the same time.

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6.1
 Explore the Concept at [MyPsychLab](#)
CONCEPT MAP

an active system that receives, organizes, stores, and retrieves information

information-processing model

- focuses on the way information is processed through different stages of memory

levels-of-processing model

- focuses on the depth of processing associated with specific information
- deeper processing associated with longer retention

What is Memory?

- models of memory
- encoding
- storage
- retrieval

parallel distributed processing (PDP) model

- focuses on simultaneous processing of information across multiple neural networks

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

- Human memory consists of multiple systems that have the ability to store information for periods of time that range from _____ to _____.
 - seconds; hours.
 - seconds; our lifetime.
 - minutes; decades.
 - hours; our lifetime.
- Ruth has just finished her research paper and handed it in. As she walks out of the classroom, she realizes that there were a few more things she should have included in the paper. Ruth's problem is in the memory process of
 - encoding.
 - storage.
 - retrieval.
 - retention.
- Which model of memory suggests that memory processes occur throughout a neural network simultaneously?
 - levels-of-processing model
 - parallel distributed processing model
 - information-processing model
 - three-stage model
- Research has demonstrated you can enhance your memory for specific words if you think about its meaning, how it can be used, and by giving a personal example of its use. This is best accounted for by which model of memory?
 - levels-of-processing model
 - parallel distributed processing model
 - information-processing model
 - three-stage model

The Information-Processing Model: Three Memory Systems

The link between cognitive psychology and information-processing theory was discussed briefly in Chapter One. Information-processing theory, which looks at how memory and other thought processes work, bases its model for human thought on the way that a computer functions (Massaro & Cowan, 1993). Data are encoded in a manner that the computer can understand and use. The computer stores that information on a disc, hard drive, or—these days—a memory stick, and then the data are retrieved out of storage as needed. It was also information-processing theorists who first proposed that there are three stages or types of memory systems (see **Figure 6.1**): sensory memory, short-term memory, and long-term memory (Atkinson & Shiffrin, 1968).  Explore the Concept, *Information-Processing Model of Memory*, at [MyPsychLab](#)

SENSORY MEMORY: WHY DO PEOPLE DO DOUBLE TAKES?

How does sensory memory work?

Sensory memory is the first stage of memory, the point at which information enters the nervous system through the sensory systems—eyes, ears, and so on. Think of it as a door that is open for a brief time. Looking through the door, one can see many people

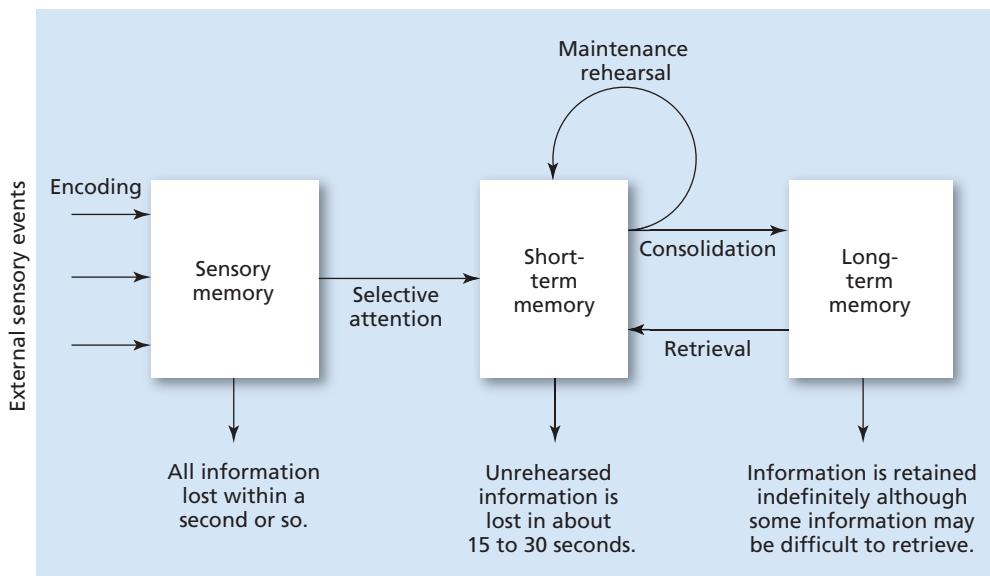


Figure 6.1 Three-Stage Process of Memory

Information enters through the sensory system, briefly registering in sensory memory. Selective attention filters the information into short-term memory, where it is held while attention (rehearsal) continues. If the information receives enough rehearsal (maintenance or elaborative), it will enter and be stored in long-term memory.

and objects, but only some of them will actually make it through the door itself. Sensory memory is a kind of door onto the world.

Information is encoded into sensory memory as neural messages in the nervous system. As long as those neural messages are traveling through the system, it can be said that people have a “memory” for that information that can be accessed if needed. For example, imagine that Elaina is driving down the street, looking at the people and cars on either side of her vehicle. All of a sudden she thinks, “What? Was that man wearing any pants?” and she looks back to check. How did she know to look back? Her eyes had already moved past the possibly pants-less person, but some part of her brain must have just processed what she saw (most likely it was the reticular formation, which notices new and important information). This is called a “double take” and can only be explained by the presence, however brief, of a memory for what she saw. [LINK](#) to Learning Objective 2.7.

There are two kinds of sensory memory that have been studied extensively. They are the iconic (visual) and echoic (auditory) sensory memories. These and other types of memories—as well as several of the experiments that have added a great deal of information to the understanding of memory—will be discussed in the sections that follow.

ICONIC SENSORY MEMORY The example of seeing the possibly pants-less person is an example of how visual sensory memory works. Visual sensory memory is often called **iconic memory**, and only lasts for a fraction of a second. *Icon* is the Greek word for “image.” Iconic memory was studied in several classic experiments by George Sperling (1960).

Capacity of Iconic Memory Sperling had found in his early studies that if he presented a grid of letters using a machine that allowed very fast presentation, his subjects could only remember about four or five of the letters, no matter how many had been presented.

Sperling became convinced that this method was an inaccurate measure of the capacity of iconic memory because the human tendency to read from top to bottom took long enough that the letters on the bottom of the grid may have faded from memory by the time the person had “read” the letters at the top. He developed a method called the *partial report method*, in which he showed a grid of letters similar to those in **Figure 6.2**, but immediately sounded a high, medium, or low tone just after the grid was shown. Subjects were told to report the top row of letters if they heard the high tone, the middle

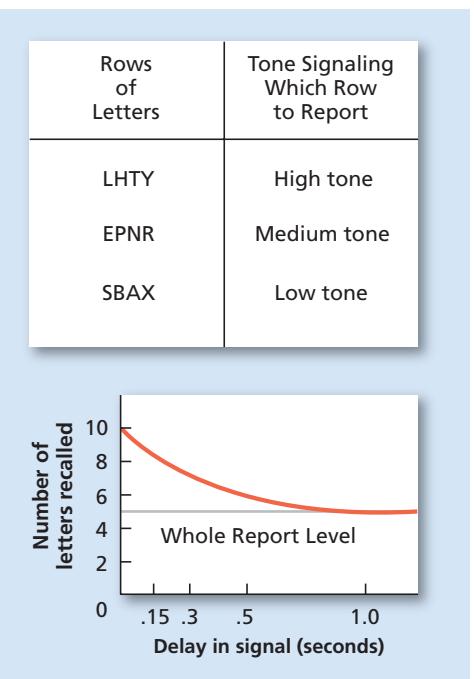


Figure 6.2 Iconic Memory Test

Sample grid of letters for Sperling’s test of iconic memory. To determine if the entire grid existed in iconic memory, Sperling sounded a tone associated with each row after the grid’s presentation. Participants were able to recall the letters in the row for which they heard the tone. The graph shows the decrease in the number of letters recalled as the delay in presenting the tone increased.

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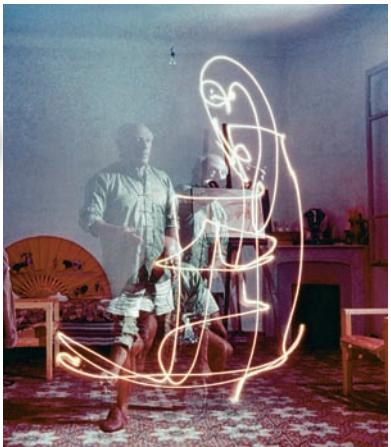
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Pablo Picasso was one of the most creative artists of his time. Here he is seen drawing an abstract of a woman in the air with a flashlight, using multiple exposures of the camera. What does his ability to "hold" the light image in his head long enough to complete the abstract tell us about his visual memory?

row for the medium tone, or the lowest row for the low tone. As they didn't hear the tone until after the grid went away, they couldn't look at just one row in advance.

Using this method, Sperling found that subjects could accurately report any of the three rows. This meant that the entire grid was in iconic memory and available to the subjects. The capacity of iconic memory is everything that can be seen at one time.

Duration* of Iconic Memory Sperling also found that if he delayed the tone for a brief period of time, after about a second, subjects could no longer recall letters from the grid any better than they had during the whole report procedure. The iconic information had completely faded out of sensory memory in that brief time.

In real life, information that has just entered iconic memory will be pushed out very quickly by new information, a process called *masking* (Cowan, 1988). Research suggests that after only a quarter of a second, old information is replaced by new information.

Although it is rare, some people do have what is properly called **eidetic imagery**, or the ability to access a visual sensory memory over a long period of time. Although the popular term *photographic memory* is often used to mean this rare ability, some people claiming to have photographic memory actually mean that they have an extremely good memory. Having a very good memory and having eidetic imagery ability are two very different things. People with eidetic imagery ability might be able to look quickly at a page in a book, then by focusing on a blank wall or piece of paper, "read" the words from the image that still lingers in their sensory memory. Although it might sound like a great ability to have while in college, it actually provides little advantage when taking tests, because it's just like having an open-book test. If a student can't *understand* what's written on the pages, having the book open is useless. It is unknown why some people have this ability, but it is more common in children and tends to diminish by adolescence or young adulthood (Haber, 1979; Leask et al., 1969; Stromeyer & Psotka, 1971).



If iconic memory lasts such a brief time, what use is it to us?

Function of Iconic Memory Iconic memory actually serves a very important function in the visual system. Chapter Three discussed the way the eyes make tiny little movements called *microsaccades* that keep vision from adapting to a constant visual stimulus, so that what is stared at steadily doesn't slowly disappear. Iconic memory helps the visual system to view surroundings as continuous and stable in spite of these saccadic movements. It also allows enough time for the brain stem to decide if the information is important enough to be brought into consciousness—like the possibly pants-less person.

ECHOIC SENSORY MEMORY Another type of sensory memory is **echoic memory**, or the brief memory of something a person has heard. A good example of echoic memory is the "What?" phenomenon. You might be reading or concentrating on the television, and your parent, roommate, or friend walks up and says something to you. You sit there for a second or two, and then say "What? Oh—yes, I'm ready to eat now," or whatever comment is appropriate. You didn't really process the statement from the other person as he or she said it. You heard it, but your brain didn't interpret it immediately. Instead, it took several seconds for you to realize that (1) something was said, (2) it may have been important, and (3) you'd better try to remember what it was. If you realize all this within about 4 seconds (the duration of echoic memory), you will more than likely be able to "hear" an echo of the statement in your head, a kind of "instant replay."

*duration: how long something lasts.

Echoic memory's capacity is limited to what can be heard at any one moment and is smaller than the capacity of iconic memory, although it lasts longer—about 2 to 4 seconds (Schweickert, 1993).

Echoic memory is very useful when a person wants to have meaningful conversations with others. It allows the person to remember what someone said just long enough to recognize the meaning of a phrase. As with iconic memory, it also allows people to hold on to incoming auditory information long enough for the lower brain centers to determine whether or not processing by higher brain centers is needed. It is echoic memory that allows a musician to tune a musical instrument, for example. The memory of the tuning fork's tone lingers in echoic memory long enough for the person doing the tuning to match that tone on the instrument.

What happens if the lower brain centers send the information on to the higher centers?

SHORT-TERM MEMORY

What is short-term memory, and how does it differ from working memory?

If an incoming sensory message is important enough to enter consciousness, that message will move from sensory memory to the next stage of memory, called **short-term memory (STM)**. Unlike sensory memory, short-term memories are held for up to 30 seconds or more.

SELECTIVE ATTENTION: HOW INFORMATION ENTERS Selective attention is the ability to focus on only one stimulus from among all sensory input (Broadbent, 1958). It is through selective attention that information enters our STM system. In Dr. Donald E. Broadbent's original filter theory, a kind of "bottleneck" occurs between sensory memory and short-term memory. Only a stimulus that is "important" enough (determined by a kind of "pre-analysis" accomplished by the attention centers in the brain stem) will be selected from all of the information in sensory memory to be consciously analyzed for meaning in STM. When a person is thinking actively about information, that information is said to be conscious and is also in STM.  to [Learning Objective 4.1](#).

It is somewhat difficult to use Broadbent's selective-attention filter to explain the "cocktail-party effect" that has been long established in studies of perception and attention (Bronkhorst & Adelbert, 2000; Cherry, 1953; Handel, 1989). If you've ever been at a party where there's a lot of noise and several conversations going on in the background but you are still able to notice when someone says your name, you have experienced this effect. In this kind of a situation, the areas of the brain that are involved in selective attention had to be working—even though you were not consciously aware of it. Then, when that important bit of information (your name) "appeared," those areas somehow filtered the information into your conscious awareness—in spite of the fact that you were not paying conscious attention to the other background noise (Hopfinger et al., 2000; Mesgarani & Chang, 2012; Stuss et al., 2002).

Dr. Anne M. Treisman (Treisman, 2006; Triesman & Gelade, 1980) proposed that selective attention operates in a two-stage filtering process: In the first stage, incoming stimuli in sensory memory are filtered on the basis of simple physical characteristics, similar to Broadbent's original idea. Instead of moving to STM or being lost, however, there



Once these piano strings have been attached to the tuning pins, the piano can be tuned. Tuning a piano requires the use of echoic sensory memory. What other occupations might find a good echoic memory to be an asset?



Each person at this gathering is involved in a conversation with others, with dozens of such conversations going on at the same time all around. Yet if a person in another conversation says the name of one of the people in the crowd, that person in the crowd will be able to selectively attend to his or her name. This is known as the "cocktail party effect."

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is only a lessening (*attenuation*) of the “signal strength” of unselected sensory stimuli in comparison to the selected stimuli. In the second stage, only the stimuli that meet a certain threshold of importance are processed. Since the attenuated stimuli are still present at this second stage, something as subjectively important as one’s own name may be able to be “plucked” out of the attenuated incoming stimuli. Even when deeply asleep, when the selective attention filter is not working at its peak level, it still functions: A sleeping mother will awake to her infant’s cries while sleeping through louder, less important sounds such as a passing train (LaBerge, 1980).

What happens when information does pass through the selective attention filter and into short-term memory? Short-term memory tends to be encoded primarily in auditory (sound) form. That simply means that people tend to “talk” inside their own heads. Although some images are certainly stored in STM in a kind of visual “sketchpad” (Baddeley, 1986), auditory storage accounts for much of short-term encoding. Even a dancer planning out moves in her head will not only visualize the moves but also be very likely to verbally describe the moves in her head as she plans. An artist planning a painting certainly has visual information in STM but may also keep up an internal dialogue that is primarily auditory. Research in which participants were asked to recall numbers and letters showed that errors were nearly always made with numbers or letters that *sounded like* the target but not with those that *looked like* the target word or number (Acheson et al., 2010; Conrad & Hull, 1964).

WORKING MEMORY Some memory theorists use the term *working memory* as another way of referring to short-term memory. We will use short-term memory to refer to simple storage and working memory as relating to storage and manipulation of information (Baddeley, 2012). Short-term memory has traditionally been thought of as a thing or a place into which information is put. **Working memory** is more correctly thought of as an active system that processes the information present in short-term memory. Working memory is thought to consist of three interrelated systems: a central executive (a kind of “CEO” or “Big Boss”) that controls and coordinates the other two systems, the visual “sketchpad” of sorts that was mentioned earlier, and a kind of auditory action “recorder” (Baddeley, 1986, 2012; Baddeley & Hitch, 1974; Baddeley & Larsen, 2007; Engle & Kane, 2004). The central executive acts as interpreter for both the visual and auditory information, and the visual and auditory information are themselves contained in short-term memory. For example, when a person is reading a book, the sketchpad will contain images of the people and events of the particular passage being read, while the recorder “plays” the dialogue in the person’s head. The central executive helps interpret the information from both systems and pulls it all together. In a sense, then, short-term memory can be seen as being a part of the working memory system (Acheson et al., 2010; Bayliss et al., 2005; Colom et al., 2006; Kail & Hall, 2001).

Another way to think about short-term memory is as a desk where you do your work. You might pull some files out of storage (permanent memory) or someone might hand you some files (sensory input). While the files are on your desk, you can see them, read them, and work with them (working memory). The “files” are now conscious material and will stay that way as long as they are on the desk. Less important files may get “thrown out” (forgotten as you fail to pay attention to them) while more important files might get stored away (permanent memory), where they are not conscious until they are once again retrieved—brought out of the desk.

CAPACITY: THE MAGICAL NUMBER SEVEN, OR FIVE, OR FOUR George Miller (1956) wanted to know how much information humans can hold in short-term memory at any one time (or how many “files” will fit on the “desk”). He reviewed several memory studies, including some using a memory test called the *digit-span test*, in which a series of numbers is read to subjects in the study who are then asked to recall the numbers in order.

Each series gets longer and longer, until the subjects cannot recall any of the numbers in order (see **Figure 6.3**).

What you will discover is that most everyone you test will get past the first two sequences of numbers, but some people will make errors on the six-digit span, about half of the people you test will slip up on the seven-digit span, and very few will be able to get past the nine-digit span without errors. This led Miller to conclude that the capacity of STM is about seven items or pieces of information, plus or minus two items, or from five to nine bits of information. Miller called this the magical number seven, plus or minus two. Since Miller's review of those early studies and subsequent conclusion about the capacity of STM being about seven items, research methods have improved, as has our knowledge and understanding of memory processes. Current research suggests younger adults can hold three to five items of information at a time if a strategy of some type is not being used. When the information is in the form of longer, similar-sounding, or unfamiliar words, however, that capacity reduces until it is only about four items (Cowan, 2001; Cowan et al., 2005; Palva et al., 2010).

There is a way to "fool" STM into holding more information than is usual. (Think of it as "stacking" related files on the desk.) If the bits of information are combined into meaningful units, or chunks, more information can be held in STM. If someone were to recode the last sequence of numbers as "654-789-3217," for example, instead of 10 separate bits of information, there would only be three "chunks" that read like a phone number. This process of recoding or reorganizing the information is called *chunking*. Chances are that anyone who can easily remember more than eight or nine digits in the digit-span test is probably recoding the numbers into chunks. To see how well you do at remembering numbers, participate in the *Digit Span* experiment.

Simulation

Digit Span

Digit span refers to the number of items (usually letters or digits) that a person can hold in working memory. In this experiment, you will have an opportunity to determine the approximate digit span of your working memory.

5	7	3									
9	0	7	6								
8	5	4	0	2							
0	9	1	3	5	6						
8	6	0	4	8	7	2					
1	7	5	4	2	4	1	9				
9	6	5	8	3	0	8	0	1			
5	7	3	5	1	2	0	2	8	5		
3	1	7	9	2	1	5	0	6	4	2	
2	1	0	1	6	7	4	1	9	8	3	5

[Go to the Experiment ►](#)

Simulate the Experiment, Digit Span, at [MyPsychLab](#)

WHY DO YOU THINK THEY CALL IT "SHORT TERM"? How long is the "short" of short-term memory? Research has shown that short-term memory lasts from about 12 to 30 seconds without rehearsal (Atkinson & Shiffrin, 1968; J. Brown, 1958; Peterson & Peterson, 1959). After that, the memory seems to rapidly "decay" or disappear. In fact, the findings of one study with mice suggest that in order to form new memories, old memories must be "erased" by the formation of newly formed neurons (Kitamura et al., 2009). The hippocampus only has so much storage room, and while many of the memories

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- 6.2 5 7 2 1 4
- 6.3 3 5 9 7 2 1
- 6.4 9 2 5 4 6 3 8
- 6.5 2 8 3 7 1 5 6 9
- 6.6 7 3 2 4 9 6 8 5 1
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Figure 6.3 Digit-Span Test

Instructions for the digit-span test:
Listen carefully as the instructor reads each string of numbers out loud. As soon as each string is ended (the instructor may say "go"), write down the numbers in the exact order in which they were given.

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This woman must hold the phone number she is reading in short-term memory long enough to dial it on her phone.



It is very important for this pharmacist to count out the number of pills in the prescription accurately. Short-term memory allows her to remember the last number she counted, but if she is interrupted, she will have to start all over again. Short-term memory is very susceptible to interference.

formed there will be transferred to more permanent storage in other areas of the brain, some memories, without rehearsal, will decay as new neurons (and newer memories) are added to the already existing neural circuits.

What do you mean by rehearsal? How long can short-term memories last if rehearsal is a factor?

Most people realize that saying something they want to remember over and over again in their heads can help them remember it longer. (Isn't that what most of us do when we want to remember a phone number—we keep repeating it just long enough to allow us to dial?) This is a process called **maintenance rehearsal**. With maintenance rehearsal, a person is simply continuing to pay attention to the information to be held in memory, and since attention is how that information got into STM in the first place, it works quite well (Atkinson & Shiffrin, 1968; Rundus, 1971). With this type of rehearsal, information will stay in short-term memory until rehearsal stops. When rehearsal stops, the memory rapidly decays and is forgotten. If anything interferes with maintenance rehearsal, memories are also likely to be lost. For example, if someone is trying to count items by reciting each number out loud while counting, and someone else asks that person the time and interferes with the counting process, the person who is counting will probably forget what the last number was and have to start all over again. Short-term memory helps people keep track of things like counting.

Interference in STM can also happen if the amount of information to be held in STM exceeds its capacity. Information already in STM may be “pushed out” to make room for newer information. This is why it might be possible to remember the first few names of people you meet at a party, but as more names are added, they displace the older names. A better way to remember a person's name is to associate the name with something about the person's appearance, a process that may help move the name from STM into more permanent storage. This more permanent storage is long-term memory, which is the topic of the next section.

Working memory is an important area of research and has implications for understanding not only intelligence but also learning and attention disorders such as attention-deficit/hyperactivity disorder, and various dementia-related memory problems (Alloway et al., 2009; Kensinger et al., 2003; Martinussen et al., 2005). Researchers have trained mice to improve their working memory and found that the mice become more intelligent with improved working memory (e.g., Light et al., 2010). Other researchers have found that working memory is helpful in solving mathematical problems, but may actually hurt the ability to solve creative problems (Wiley & Jarosz, 2012). Creative problem solving seems to benefit from a less focused approach than the focused attention taking place in working memory.

LONG-TERM MEMORY

How is long-term memory different from other types of memory?

The third stage of memory is **long-term memory (LTM)**, the system into which all the information is placed to be kept more or less permanently. In terms of capacity, LTM seems to be unlimited for all practical purposes (Bahrick, 1984; Barnyard & Grayson, 1996). Think about it: Would there ever really come a time when you could not fit one more piece of information into your head? When you could learn nothing more? If humans lived much longer lives, there might be a finite end to the capacity of LTM stores. But in practical terms, there is always room for more information (in spite of what some students may believe).

DURATION As for duration, the name *long term* says it all. There is a relatively permanent physical change in the brain itself when a memory is formed. That means that many of the memories people have stored away for a long, long time—even since childhood—may still be there. That does not mean that people can always retrieve those memories. The memories may be *available* but not *accessible*, meaning that they are still there, but for various reasons (discussed later under the topic of forgetting) people cannot “get to” them. It’s like knowing that there is a certain item on the back of the top shelf of the kitchen cabinet but having no ladder or step stool to reach it. The item is there (available), but you can’t get to it (not accessible).

“Long term” also does not mean that *all* memories are stored forever; our personal memories are too numerous to be permanently retained, for example. Nor do we store every single thing that has ever happened to us. We only store long-lasting memories of events and concepts that are meaningful and important to us.

 I once memorized a poem by repeating it over and over—that’s maintenance rehearsal, right? Since I still remember most of the poem, it must be in long-term memory. Is maintenance rehearsal a good way to get information into long-term memory?

Information that is rehearsed long enough may actually find its way into long-term memory. After all, it’s how most people learned their Social Security number and the letters of the alphabet (although people cheated a little on the latter by putting the alphabet to music, which makes it easier to retrieve). Most people tend to learn poems and the multiplication tables by maintenance rehearsal, otherwise known as rote learning. *Rote* is like “rotating” the information in one’s head, saying it over and over again. But maintenance rehearsal is not the most efficient way of putting information into long-term storage, because to get the information back out, one has to remember it almost exactly as it went in. Try this: What is the 15th letter of the alphabet? Did you have to recite or sing through the alphabet song to get to that letter?  [Watch the Video, What's in It for Me?: Making It Stick, at MyPsychLab](#)

Although many long-term memories are encoded as images (think of the *Mona Lisa*), sounds, smells, or tastes (Cowan, 1988), in general, LTM is encoded in meaningful form, a kind of mental storehouse of the meanings of words, concepts, and all the events that people want to keep in mind. Even the images, sounds, smells, and tastes involved in these events have some sort of meaning attached to them that gives them enough importance to be stored long term. If STM can be thought of as a working “surface” or desk, then LTM can be thought of as a huge series of filing cabinets behind the desk, in which files are stored in an organized fashion, according to meaning. Files have to be placed into the cabinets in a certain organized fashion to be useful—how could anyone ever remember any kind of information quickly if the files were not in some order? The best way to encode information into LTM in an organized fashion is to make it meaningful through *elaborative rehearsal*.

ELABORATIVE REHEARSAL **Elaborative rehearsal** is a way of transferring information from STM into LTM by making that information meaningful in some way (Postman, 1975). The easiest way to do this is to con-



These students are rehearsing for a concert. They will use maintenance rehearsal (repeating the musical passages over and over) until they can play their parts perfectly. The movements of their fingers upon their instruments will be stored in long-term memory. How is this kind of long-term memory different from something like the memorized lines of one’s part in a play?

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nect new information with something that is already well known (Craik & Lockhart, 1972; Postman, 1975). For example, the French word *maison* means “house.” A person could try to memorize that (using maintenance rehearsal) by saying over and over, “*Maison* means house, *maison* means house.” But it would be much easier and more efficient if that person simply thought, “*Maison* sounds like masons, and masons build houses.” That makes the meaning of the word tie in with something the person already knows (masons, who lay stone or bricks to build houses) and helps in remembering the French term.

As discussed in the beginning of this chapter, Craik and Lockhart (1972) theorized that information that is more “deeply processed,” or processed according to its meaning rather than just the sound or physical characteristics of the word or words, will be remembered more efficiently and for a longer period of time. As the levels-of-processing approach predicts, elaborative rehearsal is a deeper kind of processing than maintenance rehearsal and so leads to better long-term storage (Craik & Tulving, 1975).

 I can remember a lot of stuff from my childhood. Some of it is stuff I learned in school and some of it is more personal, like the first day of school. Are these two different kinds of long-term memories?

TYPES OF LONG-TERM INFORMATION

What are the various types of long-term memory, and how is information stored in long-term memory organized?

Long-term memories include general facts and knowledge, personal facts, and even skills that can be performed. Memory for skills is a type of *nondeclarative memory*, or *implicit memory*, because the skills have to be demonstrated and not reported. Memory for facts is called *declarative memory*, or *explicit memory*, because facts are things that are known and can be declared (stated outright). These two types of long-term memory are quite different, as the following sections will explain.

Nondeclarative (Implicit) LTM Memories for things that people know how to do, like tying shoes and riding a bicycle, are a kind of LTM called **nondeclarative (implicit) memory**. The fact that people have the knowledge of how to tie their shoes, for example, is *implied* by the fact that they can actually tie them. Nondeclarative memories are not only demonstrated in the performance of a task, such as *procedural memory* which includes skills and habits, or through *priming*, the improvement in identifying or processing concepts, words, or objects after having prior experience with them, but also in memory associations learned through classical or operant conditioning that may not be in conscious awareness (Schacter & Wagner, 2013; Squire & Kandel, 2009).  to Learning Objective 5.2, 5.3, 5.5. Referring back to Chapter Two, the amygdala is the most probable location for emotional associations, such as fear, and the cerebellum in the hind-brain is responsible for storage of memories of conditioned responses, skills, and habits (Debiec et al., 2010; Kandel & Siegelbaum, 2013; Squire et al., 1993).

Evidence that separate areas of the brain control nondeclarative memory comes from studies of people with damage to the hippocampal area of the brain. This damage causes them to have **anterograde amnesia**, in which new long-term declarative memories cannot be formed. (This disorder is fairly accurately represented by the character of Lenny in the 2000 motion picture *Memento*.) One of the more famous anterograde amnesia patients, H.M., is discussed in detail later in this chapter.



Procedural knowledge, such as tying one's shoes, often must be learned by doing, as it is difficult to put into words. Once this child learns how to tie shoes, the knowledge will always be there to retrieve.

In one study of procedural memory (Cohen et al., 1985), patients with this disorder were taught how to solve a particular puzzle called the Tower of Hanoi (see **Figure 6.4**). Although the patients were able to learn the sequence of moves necessary to solve the puzzle, when brought back into the testing room at a later time, they could not remember ever having seen the puzzle before—or, for that matter, the examiner. Yet they were able to solve the puzzle even while claiming that they had never seen it before. Their procedural memories for how to solve the puzzle were evidently formed and stored in a part of the brain separate from the part controlling the memories they could no longer form. Even people with Alzheimer's disease, who also suffer from anterograde amnesia, do not forget how to walk, talk, fasten clothing, or even tie shoes (although they do lose motor ability because the brain eventually fails to send the proper signals). These are all implicit, nondeclarative memories. In fact, it would be rare to find someone who has lost nondeclarative memory. Literally, these are the kind of memories people “never forget.”

Nondeclarative memories are not easily retrieved into conscious awareness. Have you ever tried to tell someone how to tie shoes without using your hands to show them? The subjects in the Tower of Hanoi study also provide a good example of implicit memory, as they could solve the puzzle but had no conscious knowledge of how to do so. Such knowledge is in people’s memories because they use this information, but they are often not consciously aware of this knowledge (Roediger, 1990). A memory from one’s early childhood of being frightened by a dog, for example, may not be a conscious memory in later childhood but may still be the cause of that older child’s fear of dogs. Conscious memories for events in childhood, on the other hand, are usually considered to be a different kind of long-term memory called declarative memory.

Declarative (Explicit) LTM Procedural memory is about the things that people can *do*, but **declarative (explicit) memory** is about all the things that people can *know*—the facts and information that make up knowledge. People know things such as the names of the planets in the solar system, that adding 2 and 2 makes 4, and that a noun is the name of a person, place, or thing. These are general facts, but people also know about the things that have happened to them personally. For example, I know what I ate for breakfast this morning and what I saw on the way to work, but I don’t know what you had for breakfast or what you might have seen. There are two types of declarative long-term memories, *semantic* and *episodic* (Nyberg & Tulving, 1996).

One type of declarative memory is general knowledge that anyone has the ability to know. Most of this information is what is learned in school or by reading. This kind of LTM is called **semantic memory**. The word *semantic* refers to meaning, so this kind of knowledge is the awareness of the meanings of words, concepts, and terms as well as names of objects, math skills, and so on. This is also the type of knowledge that is used on game shows such as *Jeopardy* and *Who Wants to Be a Millionaire?* Semantic memories, like procedural memories, are relatively permanent. But it is possible to “lose the way” to this kind of memory, as discussed later in the section on forgetting.

The other kind of factual memory is the personal knowledge that each person has of his or her daily life and personal history, a kind of autobiographical* memory (LePort et al., 2012). Memories of what has happened to people each day, certain birthdays, anniversaries that were particularly special, childhood events, and so on are called **episodic memory**, because they represent episodes from their lives. Unlike procedural and semantic long-term memories, episodic memories tend to be updated and revised more

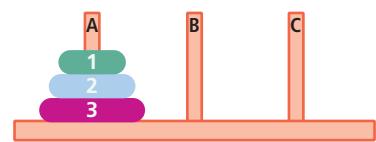


Figure 6.4 Tower of Hanoi

The Tower of Hanoi is a puzzle that is solved in a series of steps by moving one disk at a time. The goal is to move all of the disks from peg A to peg C; the rules are that a larger disk cannot be moved on top of a smaller one and a disk cannot be moved if there are other disks on top of it. Amnesic patients were able to learn the procedure for solving the puzzle but could not remember that they knew how to solve it.

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*autobiographical: the story of a person’s life as told by that person.

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or less constantly. You can probably remember what you had for breakfast today, but what you had for breakfast 2 years ago on this date is most likely a mystery. Episodic memories that are especially *meaningful*, such as the memory of the first day of school or your first date, are more likely to be kept in LTM (although these memories may not be as exact as people sometimes assume they are). The updating process is a kind of survival mechanism, because although semantic and procedural memories are useful and necessary on an ongoing basis, no one really needs to remember every little detail of every day. As becomes obvious later, the ability to forget some kinds of information is very necessary.

Episodic and semantic memories are explicit memories because they are easily made conscious and brought from long-term storage into short-term memory. The knowledge of semantic memories such as word meanings, science concepts, and so on can be brought out of the “filing cabinet” and placed on the “desk” where that knowledge becomes *explicit*, or obvious. The same is often true of personal, episodic memories.



But sometimes I can't remember all the names of the planets or what I had for breakfast yesterday. Doesn't that make these memories implicit instead of explicit?

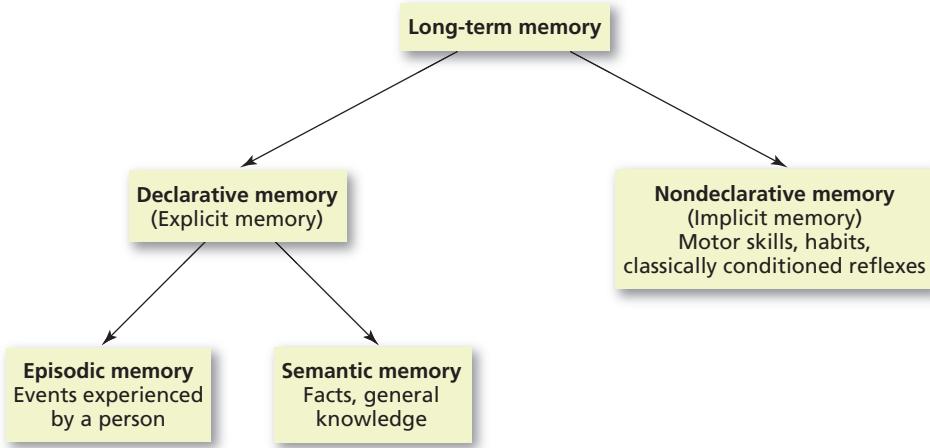
The difference between implicit memories, such as how to balance on a bicycle, and explicit memories, such as naming all the planets, is that it is impossible or extremely difficult to bring implicit memories into consciousness. Explicit memories can be forgotten but always have the potential to be made conscious. When someone reminds you of what you had for breakfast the day before, for example, you will remember that you had that knowledge all along—it was just temporarily “mislaid.” For a look at the connections among all these types of LTM, see **Figure 6.5**.

LONG-TERM MEMORY ORGANIZATION As stated before, LTM has to be fairly well organized for retrieval to be so quick. Can you remember the name of your first-grade teacher? If you can, how long did it take you to pull that name out of LTM and pull it into STM? It probably took hardly any time at all.

Research suggests that long-term memory is organized in terms of related meanings and concepts (Collins & Loftus, 1975; Collins & Quillian, 1969). In their original study, Allan Collins and M. Ross Quillian (1969) had subjects respond “true” or “false” as quickly as possible to sentences such as “a canary is a bird” and “a canary is an animal.” Looking at **Figure 6.6**, it is apparent that information exists in a kind of

Figure 6.5 Types of Long-Term Memories

Long-term memory can be divided into declarative memories, which are factual and typically conscious (explicit) memories, and nondeclarative memories, which are skills, habits, and conditioned responses that are typically unconscious (implicit). Declarative memories are further divided into episodic memories (personal experiences) and semantic memories (general knowledge).



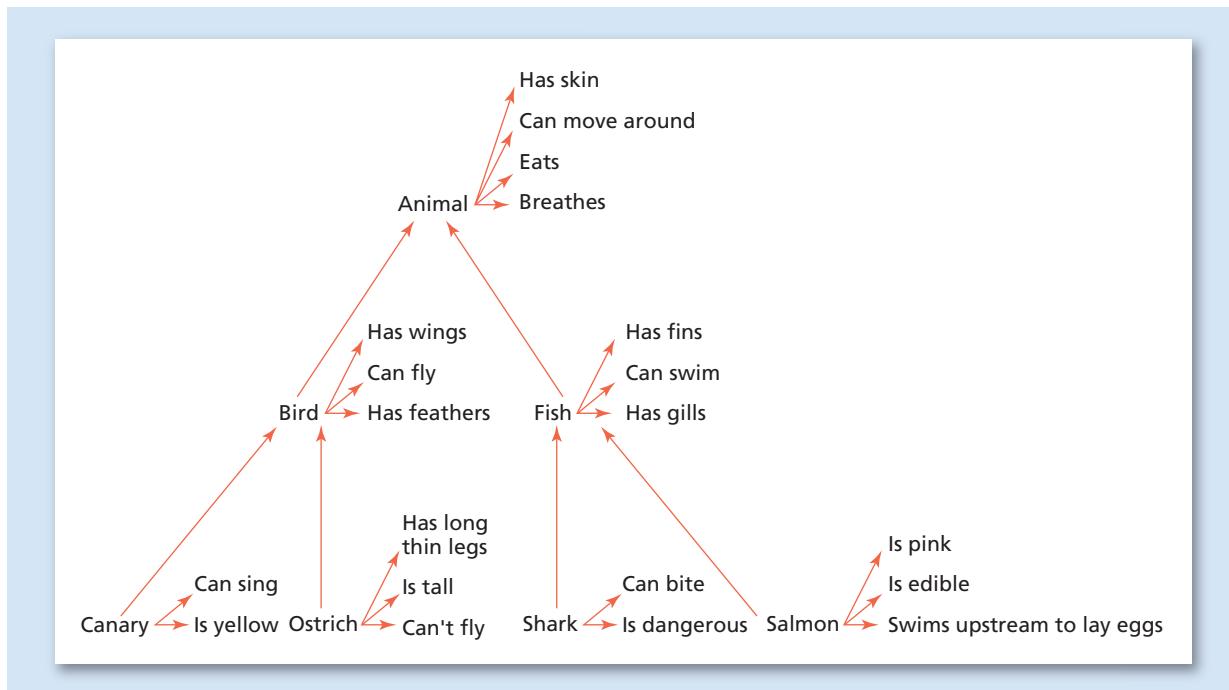


Figure 6.6 An Example of a Semantic Network

In the semantic network model of memory, concepts that are related in meaning are thought to be stored physically near each other in the brain. In this example, canary and ostrich are stored near the concept node for "bird," whereas shark and salmon are stored near "fish." But the fact that a canary is yellow is stored directly with that concept.

network, with nodes (focal points) of related information linked to each other in a kind of hierarchy.* To verify the statement "a canary is a bird" requires moving to only one node, but "a canary is an animal" would require moving through two nodes and should take longer. This was exactly the result of the 1969 study, leading the researchers to develop the **semantic network model**, which assumes that information is stored in the brain in a connected fashion with concepts that are related to each other stored physically closer to each other than concepts that are not highly related (Collins & Quillian, 1969).

The parallel distributed processing model (Rumelhart et al., 1986) discussed earlier in this chapter can be used to explain how rapidly the different points on the networks can be accessed. Although the access of nodes within a particular category (for example, *birds*) may take place in a serial fashion, explaining the different response times in the Collins and Quillian (1969) study, access across the entire network may take place in a parallel fashion, allowing several different concepts to be targeted at the same time (for example, one might be able to think about *birds*, *cats*, and *trees* simultaneously).

Perhaps the best way to think of how information is organized in LTM is to think about the Internet. A person might go to one Web site and from that site link to many other related sites. Each related site has its own specific information but is also linked to many other related sites, and a person can have more than one site open at the same time. This may be very similar to the way in which the mind organizes the information stored in LTM.

*hierarchy: a ranked and ordered list or series.

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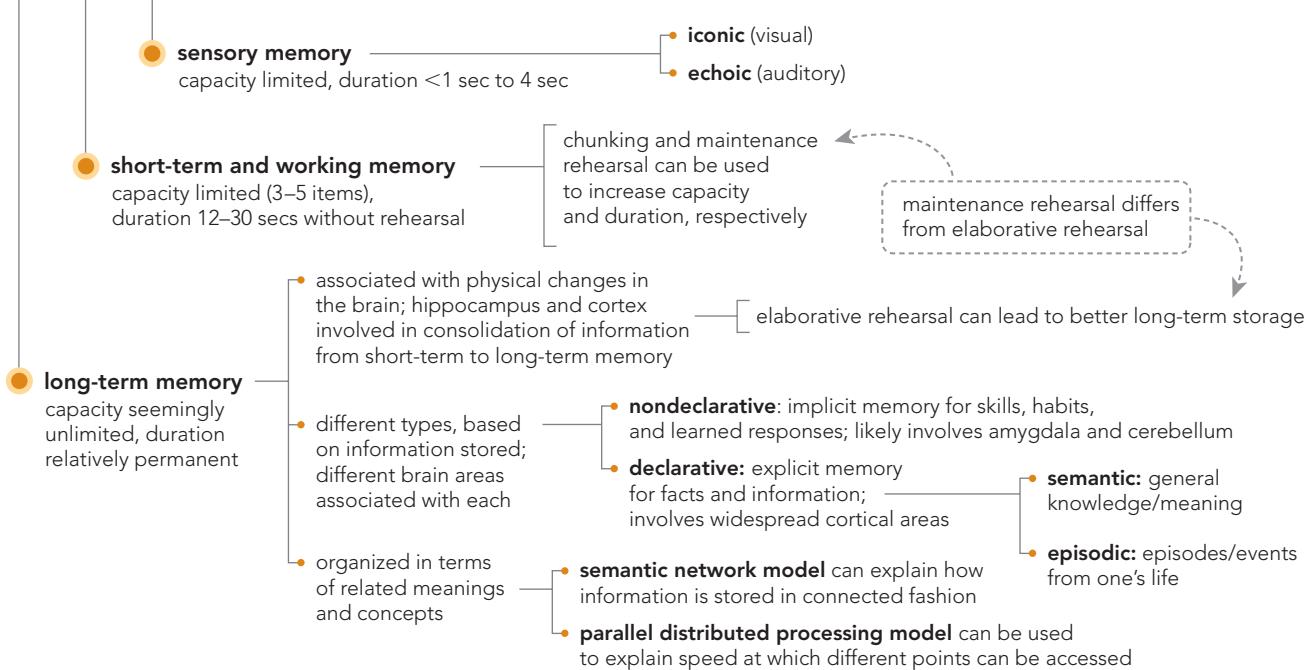
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 Explore the Concept at [MyPsychLab](#)
CONCEPT MAP**The Information-Processing Model**

(proposes three stages that vary both in duration and capacity; information must be processed effectively at earlier stages before long-term storage occurs)

**PRACTICE QUIZ** How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

- memories are said to linger in the mind for a few seconds, allowing people the chance to keep with the flow of conversations and remember what was just said.
 - Iconic
 - Echoic
 - Short-term
 - Long-term
- Information enters into short-term memory through a process known as _____.
 - recency effect
 - primacy effect
 - selective attention
 - repetition
- Of the following, which is the most similar to the concept of long-term memory?
 - a computer hard drive
 - a computer monitor
 - a computer mouse
 - a computer keyboard
- Amber meets a cute guy named Carson at a party. She wants to make sure she remembers his name so she reminds herself that he has the same name as the capital of Nevada (Carson City). This transferring of information from short-term memory to long-term memory is an example of what type of rehearsal?
 - repetitive
 - imagery
 - elaborative
 - maintenance
- Brenda has been able to tie her shoes since she was 4 but now finds it difficult to explain to her baby brother how to tie his shoes but she can easily demonstrate it for him. Brenda's memory for shoe-tying is best characterized as a _____ memory.
 - declarative (explicit)
 - semantic
 - episodic
 - nondeclarative (implicit)
- When you take your final exam in your psychology class, what type of memory will you most certainly need to access to answer each question?
 - procedural
 - semantic
 - episodic
 - working

THINKING CRITICALLY:

In thinking about a typical day, how do you use each type of memory: procedural, episodic, and semantic?

Getting It Out: Retrieval of Long-Term Memories

 My problem isn't so much getting information into my head; it's finding it later that's tough.

Oddly enough, most people's problems with getting information stored in LTM back out again has to do with *how* they put that information *into* LTM. Take the survey *What Do You Remember?* to learn more about what factors influence your own memories of events.

Simulation

What Do You Remember?

This survey asks you about your experience with and attitudes towards different types of memories, various techniques for improving memory, and memory problems

Have you EVER experienced amnesia or memory loss?

- Yes
- No
- Not Sure
- Prefer Not to State

[Go to the Experiment ►](#)

 Simulate the Experiment, *What Do You Remember?*, on [MyPsychLab](#)

RETRIEVAL CUES

What kinds of cues help people remember?

Remember the previous discussion about maintenance rehearsal versus elaborative rehearsal? One of the main reasons that maintenance rehearsal is not a very good way to get information into LTM is that saying something over and over gives only one kind of **retrieval cue** (a stimulus for remembering), the sound of the word or phrase. When people try to remember a piece of information by thinking of what it means and how it fits in with what they already know, they are giving themselves cues for meaning in addition to sound. The more cues stored with a piece of information, the easier the retrieval of that information will be (Roediger, 2000; Roediger & Guynn, 1996).  to Learning Objective PIA.7. Furthermore, we are not always aware of what cues are being associated. Remember from the discussion of nondeclarative memory, *priming* can occur where experience with information or concepts can improve later performance. And in many situations, we are not aware the improvement has taken place.

Although most people would assume that cues for retrieval would have to be directly related to the concepts being studied, the fact is that almost anything in one's surroundings is capable of becoming a cue. If you usually watch a particular television show while eating peanuts, for example, the next time you eat peanuts you might find yourself thinking of the show you were watching. This connection between surroundings and remembered information is called *encoding specificity*.

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When this bride and groom dance together later on in their marriage, they will be able to recall this moment at their wedding and the happiness they felt at that time. State-dependent learning makes it easier for people to recall information stored while in a particular emotional state (such as the happiness of this couple) if the recall occurs in a similar emotional state.



The results of the Godden and Baddeley (1975) study indicated the retrieval of words learned while underwater was higher when the retrieval also took place underwater. Similarly, words learned while out of water (on land) were retrieved at a higher rate out of the water.

ENCODING SPECIFICITY: CONTEXT EFFECTS ON MEMORY RETRIEVAL

Have you ever had to take a test in a different classroom than the one in which you learned the material being tested? Do you think that your performance on that test was hurt by being in a different physical context? Researchers have found strong evidence for the concept of **encoding specificity**, the tendency for memory of any kind of information to be improved if retrieval conditions are similar to the conditions under which the information was encoded (Tulving & Thomson, 1973). These conditions, or cues, can be internal or external. *Context-dependent learning* may refer to the physical surroundings a person is in when they are learning specific information. For example, encoding specificity would predict that the best place to take one's chemistry test is in the same room in which

you learned the material. Also, it's very common to walk into a room and know that there was something you wanted, but in order to remember it, you have to go back to the room you started in to use your surroundings as a cue for remembering.

In one study, researchers had students who were learning to scuba dive in a pool also learn lists of words while they were either out of the pool or in the pool under the water (Godden & Baddeley, 1975). Subjects were then asked to remember the two lists in each of the two conditions. Words that were learned while out of the pool were remembered significantly better when the subjects were out of the pool, and words that were learned underwater were more easily retrieved if the subjects were underwater while trying to remember.

ENCODING SPECIFICITY: STATE-DEPENDENT LEARNING Physical surroundings at the time of encoding a memory are not the only kinds of cues that can help in retrieval. In another form of encoding specificity called *state-dependent learning*, memories formed during a particular physiological or psychological state will be easier to remember while in a similar state. For example, when you are fighting with someone, it's much easier to remember all of the bad things that person has done than to remember the good times. In one study (Eich & Metcalfe, 1989), researchers had subjects try to remember words that they had read while listening to music. Subjects read one list of words while listening to sad music (influencing their mood to be sad) and another list of words while listening to happy music. When it came time to recall the lists, the researchers again manipulated the mood of the subjects. The words that were read while subjects were in a happy mood were remembered better if the manipulated mood was also happy but far less well if the mood was sad. The reverse was also true.

RECALL AND RECOGNITION

How do the retrieval processes of recall and recognition differ, and how reliable are our memories of events?



Why do multiple-choice tests seem so much easier than essay tests?

There are two kinds of retrieval of memories, *recall* and *recognition*. It is the difference between these two retrieval methods that makes some kinds of exams seem harder than others. In **recall**, memories are retrieved with few or no external cues, such as filling in the blanks on an application form. **Recognition**, on the other hand, involves looking at or hearing information and matching it to what is already in memory. A word-search puzzle, in which the words are already written down in the grid and simply need to be circled, is an example of recognition. The following section takes a closer look at these two important processes.

RECALL: HMM ... LET ME THINK When someone is asked a question such as “Where were you born?” the question acts as the cue for retrieval of the answer. This is an example of recall, as are essay question, short-answer, and fill-in-the-blank tests that are used to measure a person’s memory for information (Borges et al., 1977; Gillund & Shiffrin, 1984; Raaijmakers & Shiffrin, 1992).

Retrieval Failure: It’s Right on the Tip of My Tongue Whenever people find themselves struggling for an answer, recall has failed (at least temporarily). Sometimes the answer seems so very close to the surface of conscious thought that it feels like it’s “on the tip of the tongue.” (If people could just get their tongues out there far enough, they could read it.) This is sometimes called the *tip of the tongue (TOT)* phenomenon (Brown & McNeill, 1966; Burke et al., 1991). Although people may be able to say how long the word is or name letters that start or even end the word, they cannot retrieve the sound or actual spelling of the word to allow it to be pulled into the auditory “recorder” of STM so that it can be fully retrieved. This particular memory problem gets more common as we get older, although it should not be taken as a sign of oncoming dementia unless the increase is sudden (Osshera et al., 2012).

How can a person overcome TOT? The best solution is the one “everyone” seems to know: Forget about it. When you “forget about it,” the brain apparently continues to work on retrieval. Sometime later (perhaps when you run across a similar-sounding word in your surroundings), the word or name will just “pop out.” This can make for interesting conversations, because when that particular word does “pop out,” it usually has little to do with the current conversation.

The Serial Position Effect Another interesting feature of recall is that it is often subject to a kind of “prejudice” of memory retrieval, in which information at the beginning and the end of a list, such as a poem or song, tends to be remembered more easily and accurately. This is called the **serial position effect** (Murdock, 1962).

A good demonstration of this phenomenon involves instructing people to listen to and try to remember words that are read to them that are spaced about 4 or 5 seconds apart. People typically use maintenance rehearsal by repeating each word in their heads. They are then asked to write as many of the words down as they can remember. If the frequency of recall for each word in the list is graphed, it will nearly always look like the graph in **Figure 6.7** on the next page. To try this demonstration for yourself, participate in the *Serial Position Effect* experiment.

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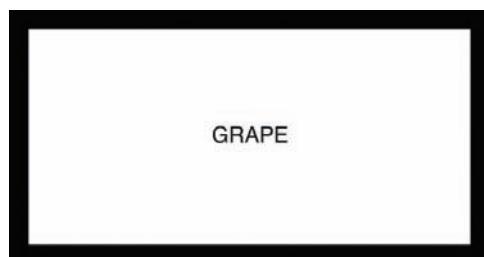
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Simulation

Serial Position Effect

In this experiment, you will view 5 lists of words. Each list will consist of 12 words and each word will appear for 1 second. After all words have been presented for each list, you will be asked to recall as many of the words as possible.



[Go to the Experiment ►](#)

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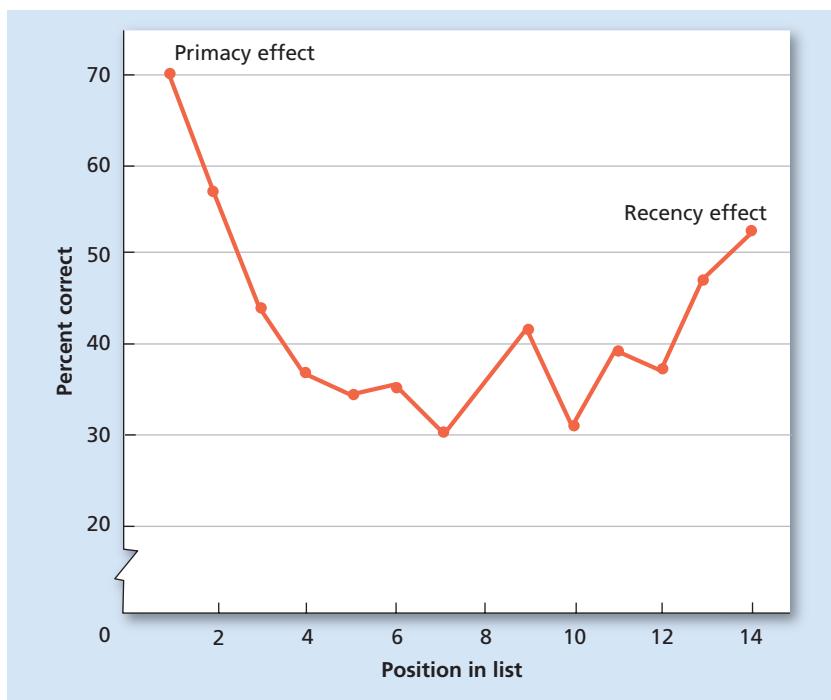


Figure 6.7 Serial Position Effect

In the serial position effect, information at the beginning of a list will be recalled at a higher rate than information in the middle of the list (primacy effect), because the beginning information receives more rehearsal and may enter LTM. Information at the end of a list is also retrieved at a higher rate (recency effect), because the end of the list is still in STM, with no information coming after it to interfere with retrieval.

the information they need for their classes? Yes—students can take advantage of the recency effect by skimming back over their notes just before an exam. Knowing that the middle of a list of information is more likely to be forgotten means that students should pay more attention to that middle, and breaking the study sessions up into smaller segments helps reduce the amount of “middle to muddle.” (Students can also use *mnemonic strategies* to help offset this memory problem, as well as others.  [LINK](#) to Learning Objective PIA.7.)

RECOGNITION: HEY, DON'T I KNOW YOU FROM SOMEWHERE? The other form of memory retrieval is *recognition*, the ability to match a piece of information or a stimulus to a stored image or fact (Borges et al., 1977; Gillund & Shiffrin, 1984; Raaijmakers & Shiffrin, 1992). Recognition is usually much easier than recall because the cue is the actual object, word, sound, and so on, that one is simply trying to detect as familiar and known. Examples of tests that use recognition are multiple-choice, matching, and true-false tests. The answer is right there and simply has to be matched to the information already in memory.

Recognition tends to be very accurate for images, especially human faces. In one study, over 2,500 photographs were shown to participants at the rate of one every 10 seconds. Participants were then shown pairs of photographs in which one member of each pair was one of the previously seen photographs. Accuracy for identifying the previous photos was between 85 to 95 percent (Standing et al., 1970).

Recognition isn't foolproof, however. Sometimes, there is just enough similarity between a stimulus that is not already in memory and one that is in memory so that a *false positive* occurs (Muter, 1978). A false positive occurs when a person thinks that he or she



These people are waiting to audition for a play. The person who auditioned first and the one who auditioned last have the greatest chance of being remembered when the time comes for the director to choose. The serial position effect will cause the impression made by the actors who come in the “middle” to be less memorable.

Words at the very beginning of the list tend to be remembered better than those in the middle of the list. This effect is called the **primacy effect** and is due to the fact that the first few words, when the listener has nothing already in STM to interfere with their rehearsal, will receive far more rehearsal time than the words in the middle, which are constantly being replaced by the next word on the list (Craik, 1970; Murdock, 1962).

At the end of the graph there is another increase in recall. This is the **recency effect**; it is usually attributed to the fact that the last word or two was *just heard* and is still in short-term memory for easy retrieval, with no new words entering to push the most recent word or words out of memory (Bjork & Whitten, 1974; Murdock, 1962). The serial position effect works with many different kinds of information. In fact, business schools often teach their students that they should try not to be “in the middle” for job interviews. Going first or last in the interview process is much more likely to make a person's interview more memorable.

Can knowledge of the serial position effect be of help to students trying to remember

has recognized (or even recalled) something or someone but in fact does not have that something or someone in memory.

False positives can become disastrous in certain situations. In one case, in a series of armed robberies in Delaware, word had leaked out that the suspect sought by police might be a priest. When police put Father Bernard Pagano in a lineup for witnesses to identify, he was the only one in the lineup wearing a priest's collar. Seven eyewitnesses identified him as the man who had robbed them. Fortunately for Father Pagano, the real robber confessed to the crimes halfway through Pagano's trial (Loftus, 1987). Eyewitness recognition can be especially prone to false positives, although most people seem to think that "seeing is believing." For more about the problems with eyewitnesses, see the following Classic Studies in Psychology.



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classic studies in psychology



Elizabeth Loftus and Eyewitnesses



Elizabeth Loftus is a distinguished professor of social ecology, a professor of law, and a professor of cognitive science at the University of California in Irvine. For over 30 years, Dr. Loftus has been one of the world's leading researchers in the area of memory. Her focus has been on the accuracy of recall of memories—or rather, the inaccuracies of memory retrieval. She has been an expert witness or consultant in hundreds of trials, including that of Ted Bundy, the serial killer who eventually was executed in Florida (Neimark, 1996).

Loftus and many others have demonstrated time and again that memory is not an unchanging, stable process but rather is a constantly changing one. People continually update and revise their memories of events without being aware that they are doing so, and they incorporate information gained after the actual event, whether correct or incorrect.

Here is a summary of one of Loftus's classic studies concerning the ways in which eyewitness testimony can be influenced by information given after the event in question (Loftus, 1975).

In this experiment, Loftus showed subjects a 3-minute video clip taken from the movie *Diary of a Student Revolution*. In this clip, eight demonstrators run into a classroom and eventually leave after interrupting the professor's lecture in a noisy confrontation. At the end of the video, two questionnaires were distributed containing one key question and 90 "filler" questions. The key question for half of the subjects was, "Was the leader of the four demonstrators who entered the classroom a male?" The other half were asked, "Was the leader of the twelve demonstrators who entered the classroom a male?" One week later, a new set of questions was given to all subjects in which the key question was, "How many demonstrators did you see entering the classroom?" Subjects who were previously asked the question incorrectly giving the number as "four" stated an average recall of 6.4 people, whereas those who were asked the question incorrectly giving the number as "twelve" recalled an average of 8.9 people. Loftus concluded that subjects were trying to compromise the memory of what they had actually seen—eight



Dr. Elizabeth Loftus is an internationally known expert on the accuracy of eyewitness testimony. She is often called on to testify in court cases.

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demonstrators—with later information. This study, along with the Father Pagano story and many others, clearly demonstrates the heart of Loftus's research: What people see and hear about an event after the fact can easily affect the accuracy of their memories of that event.

Questions for Further Discussion

- How might police officers taking statements about a crime avoid getting inaccurate information from eyewitnesses?
- The Innocence Project (www.innocenceproject.org) helps prisoners prove their innocence through DNA testing. More than 300 people in the United States have been freed by this testing, and the average time they served in prison before release is 13 years. Is eyewitness testimony enough, or should DNA evidence be required for sending someone to prison?

AUTOMATIC ENCODING: FLASHBULB MEMORIES

Although some long-term memories need extensive maintenance rehearsal or effortful encoding in the form of elaborative rehearsal to enter from STM into LTM, many other kinds of long-term memories seem to enter permanent storage with little or no effort at all, in a kind of **automatic encoding** (Kvavilashvili et al., 2009; Mandler, 1967; Schneider et al., 1984). People unconsciously notice and seem able to remember a lot of things, such as the passage of time, knowledge of physical space, and frequency of events. For example, a person might make no effort to remember how many times cars have passed down the street but when asked can give an answer of “often,” “more than usual,” or “hardly any.”

A special kind of automatic encoding takes place when an unexpected event or episode in a person’s life has strong emotional associations, such as fear, horror, or joy. Memories of highly emotional events can often seem vivid and detailed, as if the person’s mind took a “flash picture” of the moment in time. These kinds of memories are called **flashbulb memories** (Neisser, 1982; Neisser & Harsch, 1992; Winningham et al., 2000).

Many people share certain flashbulb memories. People of the “baby boomer” generation remember exactly where they were when the news came that President John F. Kennedy had been shot. Younger generations may remember the explosions of the space shuttles *Challenger* and *Columbia* and certainly remember the horrific events of September 11, 2001, and the disastrous Hurricane Katrina. But personal flashbulb memories also exist. These memories tend to be major emotional events, such as the first date, an embarrassing event, or a particularly memorable birthday party.

Why do flashbulb memories seem so vivid and exact? The answer lies in the emotions felt at the time of the event. Emotional reactions stimulate the release of hormones that have been shown to enhance the formation of long-term memories (Dolcos et al.,

2005; McEwen, 2000; McGaugh, 2004; Sharot et al., 2004). But is this kind of memory really all that accurate? Although some researchers have found evidence for a high degree of accuracy in flashbulb memories of *major events*, such as the election of President Barack Obama in November 2008 or the death of pop legend Michael Jackson in June 2009, others have found that while flashbulb memories are often convincingly real, they are just as subject to decay and alterations over time as other kinds of memories (Neisser & Harsch, 1992). Apparently, no memories are completely accurate after the passage of time. The next section will discuss some of the reasons for faulty memories.  **Watch the Video**, *Thinking Like a Psychologist: Police Line-Up*, at **MyPsychLab**



Fans of entertainer Michael Jackson may remember the moment they heard of his death on June 25, 2009. Events like this are so emotional for many people that the memories for the event are stored automatically, as if the mind had taken a “flash” picture of that moment in time. Such “flashbulb” memories seem to be very accurate but are actually no more accurate than any other memory.

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 Explore the Concept at [MyPsychLab](#)

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getting it out

- retrieval cues
- encoding specificity

- more cues stored with a piece of information, the easier the retrieval
- context-dependent learning
- state-dependent learning

CONCEPT MAP**Retrieval of Long-Term Memories**

- recall vs. recognition
- automatic encoding

- recall: few or no external cues required
- recognition: match incoming sensory information (e.g., see or hear) to what is already in memory
- retrieval failure: (e.g., "tip of the tongue")
- serial position effect: memory improved for items at beginning (primacy) and end (recency) of a list
- false positives can occur (e.g., eyewitness testimony)

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. What concept suggests that the best place to study for your psychology final to ensure good retrieval of concepts is your psychology classroom?
 - a. serial position effect
 - b. encoding specificity
 - c. tip of the tongue phenomenon
 - d. automatic encoding
2. Jaclynn had written a grocery list but accidentally left it at home. Trying to remember the list, Jaclynn remembers what was at the beginning of the list and what was at the end but not those things in the middle. This is an example of the
 - a. encoding specificity effec.
 - b. serial position effect.
 - c. tip-of-the-tongue effect.
 - d. flashbulb memory.
3. Multiple-choice test questions typically rely on _____ while essay questions rely on _____.
 - a. rehearsal; recall
 - b. relearning; rehearsing
 - c. recall; recognition
 - d. recognition; recall
4. Studies by Elizabeth Loftus find that memory
 - a. is like a camera that can take pictures for people to recall and review as needed.
 - b. is surprisingly inaccurate up to age 12, at which time people begin to show vast improvements.
 - c. is highly influenced by culture and that today's technology is having a negative effect on memory.
 - d. is highly fluid and can be altered by the person even when the person is unaware he or she is doing it.
5. Felisha can recall with great detail the day of her wedding and all that occurred. What might psychologists say about these particular flashbulb memories?
 - a. The memories were likely enhanced in part by the hormones released during emotional moments.
 - b. The memories should last up to 15–20 years.
 - c. The memories are unusually accurate.
 - d. The memories are stored as procedural memories.

The Reconstructive Nature of Long-Term Memory

Retrieval: How Reliable Are Memories?

 I think my memory is pretty good, but my brother and I often have arguments about things that happened when we were kids. Why don't we have the same exact memories? We were both there!

People tend to assume that their memories are accurate when, in fact, memories are revised, edited, and altered on an almost continuous basis. The reason for the changes that

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occur in memory has to do with the way in which memories are formed as well as how they are retrieved.

CONSTRUCTIVE PROCESSING OF MEMORIES

How are long-term memories formed, and how can this process lead to inaccuracies in memory?

Many people have the idea that when they recall a memory, they are recalling it as if it were an “instant replay.” As new memories are created in LTM, old memories can get “lost,” but they are more likely to be changed or altered in some way (Baddeley, 1988). In reality, memories (including those very vivid flashbulb memories) are never quite accurate, and the more time that passes, the more inaccuracies creep in. The early twentieth-century memory schema theorist Sir Frederic Bartlett (1932) saw the process of memory as more similar to creating a story than reading one already written. He viewed memory as a problem-solving activity in which the person tries to retrieve the particulars of some past event (the problem) by using current knowledge and inferring from evidence to create the memory (the solution) (Kihlstrom, 2002).

Elizabeth Loftus, along with other researchers (Hyman, 1993; Hyman & Loftus, 1998, 2002), has provided ample evidence for the **constructive processing** view of memory retrieval. In this view, memories are literally “built,” or reconstructed, from the information stored away during encoding. Each time a memory is retrieved, it may be altered or revised in some way to include new information, or to exclude details that may be left out of the new reconstruction.

An example of how memories are reconstructed occurs when people, upon learning the details of a particular event, revise their memories to reflect their feeling that they “knew it all along.” They will discard any incorrect information they actually had and replace it with more accurate information gained after the fact. This tendency of people to falsely believe that they would have accurately predicted an outcome without having been told about it in advance is called **hindsight bias** (Bahrick et al., 1996; Hoffrage et al., 2000). People who have ever done some “Monday morning quarterbacking” by saying that they knew all along who would win the game have fallen victim to hindsight bias.

MEMORY RETRIEVAL PROBLEMS

Some people may say that they have “total recall.” What they usually mean is that they feel that their memories are more accurate than those of other people. As should be obvious by now, true total recall is not a very likely ability for anyone to have. Here are some reasons why people have trouble recalling information accurately.

THE MISINFORMATION EFFECT Police investigators sometimes try to keep eyewitnesses to crimes or accidents from talking with each other. The reason is that if one person tells the other about something she has seen, the other person may later “remember” that same detail, even though he did not actually see it at the time. Such false memories are created by a person being exposed to information after the event. That misleading information can become part of the actual memory, affecting its accuracy (Loftus et al., 1978). This is called the **misinformation effect**. Loftus, in addition to her studies concerning eyewitness testimony, has also done several similar studies that demonstrate the misinformation effect. In one study, subjects viewed a slide presentation of a traffic accident. The actual slide presentation contained a stop sign, but in a written summary of the presentation, the sign was referred to as a yield sign. Subjects who were given this misleading information



These men may engage in “Monday morning quarterbacking” as they apply hindsight to their memories of this game. Their memories of the game may be altered by information they get afterward from the television, newspapers, or their friends.

after viewing the slides were far less accurate in their memories for the kind of sign present than were subjects given no such information. One of the interesting points made by this study is that information that comes not only after the original event but also in an entirely different format (i.e., written instead of visual) can cause memories of the event to be incorrectly reconstructed.

RELIABILITY OF MEMORY RETRIEVAL

What is false-memory syndrome?

If memory gets edited and changed when individuals are in a state of waking consciousness, alert and making an effort to retrieve information, how much more might memory be changed when individuals are being influenced by others or in an altered state of consciousness, such as hypnosis? *False-memory syndrome* refers to the creation of inaccurate or false memories through the suggestion of others, often while the person is under hypnosis (Hochman, 1994).

For example, research has shown that, although hypnosis may make it easier to recall some real memories, it also makes it easier to create false memories. Hypnosis also has been found to increase the confidence people have in their memories, regardless of whether those memories are real or false (Bowman, 1996). False memories have been accidentally created by therapists' suggestions during hypnotic therapy sessions.  [LINK](#) to [Learning Objective 4.6](#). For more information on false-memory syndrome, visit the Web site at www.fmsfonline.org

Research suggests that false memories are created in the brain in much the same way as real memories are formed, especially when visual images are involved (Goncalves et al., 2004). Researchers, using fMRI scans, looked at brain activity of individuals who were looking at real visual images and then were asked to imagine looking at visual images. They found that these same individuals were often unable to later distinguish between the images they had really seen and the imagined images when asked to remember which images were real or imagined. This might explain why asking people if they saw a particular person at a crime scene (causing them to imagine the image of that person) might affect the memories those people have of the crime when questioned sometime later—the person they were asked to think about may be falsely remembered as having been present. Other evidence suggests that false memories have much in common with the confabulations (stories that are made up but not intended to deceive) of people with dementia-related memory problems, and that both forms of false memories involve a lower than normal level of activity in the part of the frontal lobe associated with doubt and skepticism (Mendez & Fras, 2011). Clearly, memories obtained through hypnosis should not be considered accurate without solid evidence from other sources.



But I've heard about people who under hypnosis remember being abused as children. Aren't those memories sometimes real?

The fact that some people recover false memories under certain conditions does not mean that child molestation does not really happen; nor does it mean that a person who was molested might not push that unwanted memory away from conscious thought. Molestation is a sad fact, with one conservative estimate stating that nearly 20 percent of all females and 7 percent of all males have experienced molestation during childhood (Abel & Osborn, 1992). There are also many therapists and psychological professionals who are quite skilled at helping clients remember events of the past without suggesting possible false memories, and they find that clients do remember

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As this young woman observes the activity outside the window, she is storing some of the things she sees into memory while ignoring others. If she were to witness a crime, how would investigators know if her memories of the events were accurate or not? Would hypnotizing her to help her remember be effective? Why or why not?

information and events that were true and able to be verified but were previously unavailable to the client (Dalenberg, 1996). False-memory syndrome is not only harmful to the persons directly involved but also makes it much more difficult for genuine victims of molestation to be believed when they do recover their memories of the painful traumas of childhood.

So can we trust any of our memories at all? There is evidence to suggest that false memories cannot be created for just any kind of memory content. The *memories* must at least be plausible, according to the research of cognitive psychologist and memory expert Kathy Pezdek, who with her colleagues has done several studies demonstrating the resistance of children to the creation of implausible false memories (Hyman et al., 1998; Pezdek et al., 1997; Pezdek & Hodge, 1999).

In the 1999 study, Pezdek and Hodge asked children to read five different summaries of childhood events. Two of these events were false, but only one of the two false events was plausible (e.g., getting lost). Although the children all were told that all of the events happened to them as small children, the results indicated that the plausible false events were significantly more likely to be “remembered” as false memories than were the implausible false events (e.g., getting a rectal enema). A second experiment (Pezdek & Hodge, 1999) found similar results: Children were significantly less likely to form a false memory for an implausible false event than for a plausible false event.

The idea that only plausible events can become false memories runs contrary to the earlier work of Loftus and colleagues and to research concerning some very implausible false memories that have been successfully implanted, such as a memory for satanic rituals and alien abductions (Mack, 1994). Loftus and colleagues (Mazzoni et al., 2001) conducted several experiments in which they found that implausible events could be made more plausible by having the experimenters provide false feedback to the participants, who read articles telling of the implausible events as if they had actually happened to other people. The false feedback involved telling the participants that their responses to a questionnaire about fears were typical of people who had been through one of the false events (much as a well-meaning therapist might suggest to a client that certain anxieties and feelings are typical of someone who has been abused). These manipulations were so successful that participants not only developed false memories for the events but also even contradicted their own earlier statements in which they denied having these experiences in childhood. The researchers concluded that there are two steps that must occur before people will be likely to interpret their thoughts and fantasies about false events as true memories:

1. The event must be made to seem as plausible as possible.
2. Individuals are given information that helps them believe that the event could have happened to them personally.

The personality of the individual reporting such a memory also matters, it seems. In one study, people who claimed to have been abducted by aliens (an implausible event) were compared to a control group with no such memories on a measure of false-memory recall and false recognition. Those who reported recovered memories of alien abduction were far more likely to recall or recognize items that were false than were the controls (Clancy et al., 2002). Other variables that predicted a higher false recall and recognition response were susceptibility to hypnosis, symptoms of depression, and the tendency to exhibit odd behavior and unusual beliefs (such as past-life regression or the healing ability of crystals).

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 Explore the Concept at [MyPsychLab](#)

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CONCEPT MAP**The Reconstructive Nature of Long-Term Memory****constructive processing of memories**

- memories are rarely completely accurate and become less accurate over time
- Loftus and others have suggested that memory retrieval is a constructive process; memories are "built" at time of retrieval

memory retrieval problems

- misinformation effect:** incorporation of inaccurate information into actual memory
 - reliability of memory retrieval:** false memories can result from change in both waking, conscious states and in altered states (e.g., hypnosis)
- influenced by plausibility of event and individual receiving collaborative feedback that makes it easier to believe

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Studies show that as time passes, memories
 - a. tend to become more and more inaccurate.
 - b. increase in accuracy since the body is now calm and relaxed.
 - c. will remain like an "instant replay" no matter what occurs.
 - d. stay the same and show no change in accuracy.
2. In Loftus's 1978 study, subjects viewed a slide presentation of an accident. Later, some of the subjects were asked a question about a yield sign when the actual slides contained pictures of a stop sign. When presented with this inaccurate information, how did these subjects typically respond?
 - a. Most corrected Loftus and recalled seeing a stop sign.
 - b. Many began seeing both a stop sign and a yield sign.
 - c. Many subjects' overall accuracy dropped when confronted with conflicting information.
 - d. Subjects were confused, but only briefly, at which point their accuracy of recalling the event returned.
3. Aaron has no memory of how he got home from a party. He then convinces himself that he must have been abducted by aliens while walking home. Subsequently, he is hypnotized in an attempt to help increase his memories of that evening. Based on the research of memory recall through hypnosis, what might we learn?
 - a. Aaron may unknowingly create false memories of what happened that night to justify his belief.
 - b. Aaron will be less confident of his memories from the evening.
 - c. Hypnosis makes it harder for Aaron to recall memories of the evening in general.
 - d. Aaron will not be able to recall the evening but will have memories of being in the womb.
4. A key component for any person to believe that a false event is in fact true is to make sure that the false information is
 - a. as plausible as possible.
 - b. introduced as soon after the event as possible.
 - c. introduced by a source perceived as trustworthy.
 - d. introduced no sooner than 24 hours after the event but no later than 15 days.

What Were We Talking About? Forgetting

Why do we forget things? And why do we forget some things but not others?

Why do we forget?

You may think that being able to remember everything like Brad Williams, the Human Google of the opening story, would be wonderful. But it's important to consider that people with hyperthymesia not only have the ability to remember nearly everything, but also have the inability to forget. The video *The Big Picture: The Woman Who Cannot Forget* describes the case of Jill Price, a woman who remembers every detail of her life, both the good and the bad.

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Watch the Video, *The Big Picture: The Woman Who Cannot Forget*, at [MyPsychLab](#)

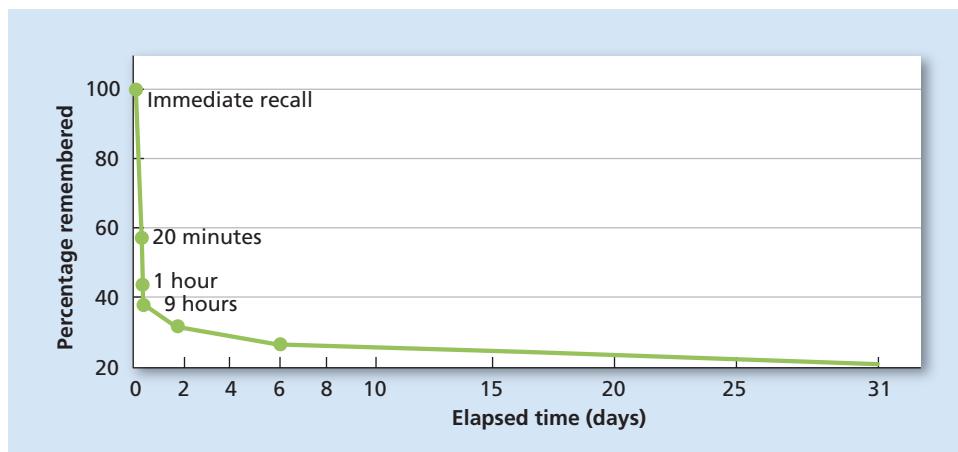
That is the same problem experienced in the case of A. R. Luria's (1968) famous *mnemonist*, Mr. S. (A mnemonist is a memory expert or someone with exceptional memory ability.) Mr. S. was a performing mnemonist, astonishing his audiences with lists of numbers that he memorized in minutes. But Mr. S. found that he *was unable to forget* the lists. He also could not easily separate important memories from trivial ones, and each time he looked at an object or read a word, images stimulated by that object or word would flood his mind. He eventually invented a way to "forget" things—by writing them on a piece of paper and then burning the paper (Luria, 1968).

The ability to forget seems necessary to one's sanity if the experience of Mr. S. is any indicator. But how fast do people forget things? Are there some things that are harder or easier to forget?

EBBINGHAUS AND THE FORGETTING CURVE

Hermann Ebbinghaus (1913) was one of the first researchers to study forgetting. Because he did not want any verbal associations to aid him in remembering, he created several lists of "nonsense syllables," pronounceable but meaningless (such as GEX and WOL). He memorized a list, waited a specific amount of time, and then tried to retrieve the list, graphing his results each time. The result has become a familiar graph: the **curve of forgetting**. This graph clearly shows that forgetting happens quickly within the first hour after learning the lists and then tapers off gradually. (See **Figure 6.8**.) In other words, forgetting is greatest just after learning. This curve can be applied to other types of information as well. Although meaningful material is forgotten much more slowly and much less completely, the pattern obtained when testing for forgetting is similar (Conway et al., 1992).

In his early studies, Ebbinghaus (1885) found that it is also important not to try to "cram" information you want to remember into your brain. Research has found that spacing out one's study sessions, or **distributed practice**, will produce far better retrieval of information studied in this way than does *massed practice*, or the attempt to study a body of material all at once. For example, studying your psychology material for 3 hours may make you feel that you've done some really hard work, and you have. Unfortunately, you won't remember as much of what you studied as you would if you had shorter study times of 30 minutes to an hour followed by short breaks (Cepeda et al., 2006; Dempster & Farris, 1990; Donovan & Radosevich, 1999; Simon & Bjork, 2001). to Learning Objective PIA.5.

**Figure 6.8 Curve of Forgetting**

Ebbinghaus found that his recall of words from his memorized word lists was greatest immediately after learning the list but rapidly decreased within the first hour. After the first hour, forgetting leveled off.

ENCODING FAILURE

There are several reasons why people forget things. One of the simplest is that some things never get encoded in the first place. Your friend, for example, may have said something to you as he walked out the door, and you may have heard him, but if you weren't paying attention to what he said, it would not get past sensory memory. This isn't forgetting so much as it is **encoding failure**, the failure to process information into memory. Researchers (Nickerson & Adams, 1979) developed a test of long-term memory using images of a common object for many people, a penny. Look at **Figure 6.9**. Which view of a stop sign is the correct one? People see stop signs nearly every day, but how many people actually look at them that closely so the information is encoded into long-term memory?

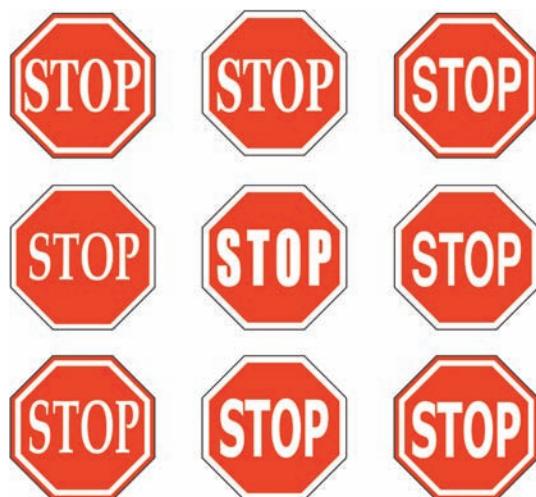
MEMORY TRACE DECAY THEORY

One of the older theories of forgetting involves the concept of a **memory trace**. A memory trace is some physical change in the brain, perhaps in a neuron or in the activity between neurons, which occurs when a memory is formed (Brown, 1958; Peterson & Peterson, 1959). Over time, if these traces are not used, they may **decay**, fading into nothing. It would be similar to what happens when a number of people walk across a particular patch of grass, causing a path to appear in which the grass is trampled down and perhaps turning brown. But if people stop using the path, the grass grows back and the path disappears.

Forgetting in sensory memory and short-term memory seems easy to explain as decay: Information that is not brought to attention in sensory memory or continuously rehearsed in STM will fade away. But is decay a good explanation for forgetting from long-term memory? When referring to LTM, decay theory is usually called **disuse**, and the phrase "use it or lose it" takes on great meaning (Bjork & Bjork, 1992). Although the



The fact that this woman can remember the things shown in the pictures even after many years makes it unlikely that the memory trace decay theory can explain all forgetting in long-term memory.

**Figure 6.9 Stop!**

Many people look at stop signs multiple times a day. Which of these stop signs is closest to an actual stop sign? The answer can be found on the next page.

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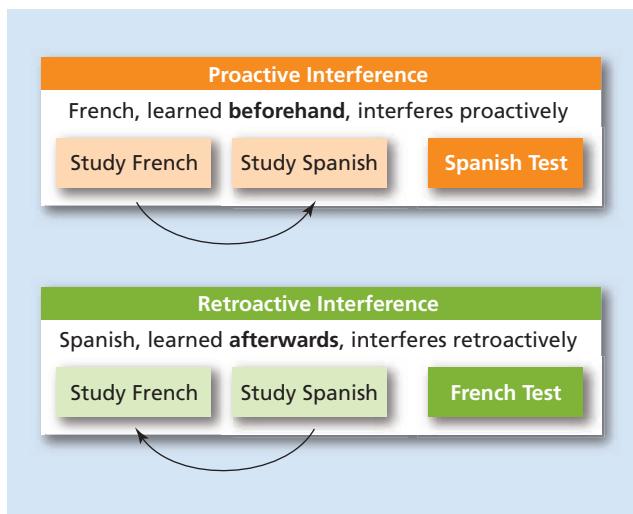


Figure 6.10 Proactive and Retroactive Interference

If a student were to study for a French exam and then a Spanish exam, interference could occur in two directions. When taking the Spanish exam, the French information studied first may proactively interfere with the learning of the new Spanish information. But when taking the French exam, the more recently studied Spanish information may retroactively interfere with the retrieval of the French information.

fading of information from LTM through disuse sounds logical, there are many times when people can recall memories they had assumed were long forgotten. There must be other factors involved in the forgetting of long-term memories.

INTERFERENCE THEORY

A possible explanation of LTM forgetting is that although most long-term memories may be stored more or less permanently in the brain, those memories may not always be accessible to attempted retrieval because other information interferes (Anderson & Neely, 1995). (And even memories that are accessible are subject to constructive processing, which can lead to inaccurate recall.) An analogy might be this: The can of paint that Phillip wants may very well be on some shelf in his storeroom, but there's so much other junk in its way that he can't see it and can't get to it. In the case of LTM, interference can come from two different "directions."

PROACTIVE INTERFERENCE Have you ever switched from driving a car with the gearshift on the wheel to one with the gearshift on the floor of the car? If the answer is yes, you probably found that you had some trouble when you first got into the new car. You may have grabbed at the wheel instead of reaching to the gearshift on the floor. The reason you reached for the gearshift in the "old" place is called **proactive interference**: the tendency for older or previously learned material to interfere with the learning (and subsequent retrieval) of new material. (See **Figure 6.10**.)

Another example of proactive interference often occurs when someone gets a new cell phone number. People in this situation often find themselves remembering their old cell phone number or some of its digits instead of the new cell phone number when they are trying to give the new number to friends.

RETROACTIVE INTERFERENCE When newer information interferes with the retrieval of older information, this is called **retroactive interference**. (See **Figure 6.10**.) What happens when you change back from the car with the gearshift on the floor to the older car with the gearshift on the wheel? You'll probably reach down to the floor at least once or twice because the newer skill retroactively interferes with remembering the old way of doing it.

How might interference work in each of the following cases?

1. Moving from the United States to England, where people drive on the left instead of the right side of the road.
2. Trying to program your old DVR after having the new one for a year.
3. Moving from one operating system to a different one, such as from Windows to Mac.

The different ways that forgetting occurs are summarized in **Table 6.1**.

Table 6.1
Reasons for Forgetting

Reason	Description
Encoding Failure	The information is not attended to and fails to be encoded.
Decay or Disuse	Information that is not accessed decays from the storage system over time.
Proactive Interference	Older information already in memory interferes with the learning of newer information.
Retroactive Interference	Newer information interferes with the retrieval of older information.

The answer to **Figure 6.9** is the middle right image.

Neuroscience of Memory

How and where are memories formed in the brain?

Researchers have evidence that specific areas of the brain may be the places in which memories are physically formed and that these areas are different for different types of memory. For example, procedural memories seem to be stored in the cerebellum (Boyd & Winstein, 2004; Daum & Schugens, 1996). Research involving PET scanning techniques strongly suggests that short-term memories are stored in the prefrontal cortex (the very front of the frontal lobe) and the temporal lobe (Goldman-Rakic, 1998; Rao et al., 1997). Memories of fear seem to be stored in the amygdala (Debiec et al., 2010).  Watch the [Video, The Basics: Do You Remember When? Neural Basis of Memory](#), at [MyPsychLab](#)

As for semantic and episodic long-term memories, evidence suggests that these memories are also stored in the frontal and temporal lobes but not in exactly the same places, nor in the same location as short-term memories (Weis et al., 2004).

 All that explains is the “where” of memory. Did scientists ever find out the “what” or the exact physical change that happens in the brain when memories are stored?

NEURAL ACTIVITY, STRUCTURE, AND PROTEINS IN MEMORY FORMATION

Several studies have offered evidence that memory is not simply one physical change but many: changes in the number of receptor sites, changes in the sensitivity of the synapse through repeated stimulation (called *long-term potentiation*), and changes in the dendrites and specifically in the proteins within the neurons (Alkon, 1989; Kandel & Schwartz, 1982; Squire & Kandel, 1999). Researchers have identified a specific protein in mammals, 4E-BP2, which seems to control the production of new nervous-system proteins (Bidinosti et al., 2010). Protein molecules are necessary for all cellular activity—including the very important one of strengthening the connections and communications between neurons. The mammalian brain modifies 4E-BP2 in a certain way, affecting its normal function. This alteration and the other changes that take place as a memory is forming are called **consolidation** (Deger et al., 2012; Griggs et al., 2013; Krüttner et al., 2012). Consolidation may take only a few minutes for some memories, such as learning a new friend’s name, but may take years for others, such as learning a new language (Dudai, 2004).

THE HIPPOCAMPUS AND MEMORY

In the discussion of the *hippocampus* (a part of the limbic system) in Chapter Two, it was identified as the part of the brain that is responsible for the formation of new long-term declarative memories. One of the clearest pieces of evidence of this function comes from the study of a man known as H.M. (Milner et al., 1968).

H.M. was 16 when he began to suffer from severe epileptic seizures. Eleven years later, H.M.’s hippocampi and adjacent medial temporal lobe structures were removed in an experimental operation that the surgeon hoped would stop his seizures. The last thing H.M. could remember was being rolled to the operating room, and from then on his ability to form new declarative memories was profoundly impaired. The hippocampus was not the source of his problem (his seizures were reduced but not eliminated), but it was apparently the source of his ability to consolidate and store any new factual information he encountered, because without either hippocampus, he was completely unable to remember new events or facts. Consolidation had become impossible. He had a magazine that he carried around, reading and rereading the stories, because each time he did

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so the stories were completely new to him. As with most amnesic patients of this type (although H.M.’s case was quite severe), his procedural memory was still intact. It was only new declarative memory—both semantic and episodic—that was lost. H.M., who can now be revealed as Henry Gustav Molaison, died in December 2008 at the age of 82. His experience and his brain will continue to educate students and neuroscientists, as he agreed many years ago that his brain would be donated for further scientific study upon his death. It has now been cut into 2,401 slices, each about the width of a human hair, in preparation for further study. You can read more about H.M.’s contributions to science at Suzanne Corkin’s Web site at <http://web.mit.edu/bnl/publications.htm>. To learn about the H.M. postmortem project being conducted at the University of California San Diego, watch the video *Special Topics: When Memory Fails* or go to <http://thebrainobservatory.ucsd.edu> (Carey, 2009).



Watch the [Video](#), *Special Topics: When Memory Fails*, at [MyPsychLab](#)

WHEN MEMORY FAILS: ORGANIC AMNESIA

How does amnesia occur?

From movies and TV, many people are familiar with the concept of repression, a type of psychologically motivated forgetting in which a person supposedly cannot remember a traumatic event. [Learning Objective 14.7](#). But what about an inability to remember brought about by some physical cause? There are two forms of severe loss of memory disorders caused by problems in the functioning of the memory areas of the brain. These problems can result from concussions, brain injuries brought about by trauma, alcoholism (Korsakoff’s syndrome), or disorders of the aging brain.

RETROGRADE AMNESIA If the hippocampus is that important to the formation of declarative memories, what would happen if it got temporarily “disconnected”? People who are in accidents in which they received a head injury often are unable to recall the accident itself. Sometimes they cannot remember the last several hours or even days before the accident. This type of amnesia (literally, “without memory”) is called **retrograde amnesia**, which is loss of memory from the point of injury backwards (Hodges, 1994).

What apparently happens in this kind of memory loss is that the consolidation process, which was busy making the physical changes to allow new memories to be stored, gets disrupted and loses everything that was not already nearly “finished.”

Think about this: You are working on your computer, trying to finish a history paper that is due tomorrow. Your computer saves the document every 10 minutes, but you are working so furiously that you’ve written a lot in the last 10 minutes. Then the power goes out—horrors! When the power comes back on, you find that while all the files you had already saved to your disc are still intact,* your history paper is missing that last 10 minutes’ worth of work. This is similar to what happens when someone’s consolidation process is disrupted. All memories that were in the process of being stored—but are not yet permanent—are lost.

One of the therapies for severe depression is *ECT*, or *electroconvulsive therapy*.  [Learning Objective 15.9](#). In one study with depressed patients who were being treated with ECT (Squire et al., 1975), participants were tested for their memory of certain television programs both before and after the treatment. Before treatment, recent programs were recalled in more detail and more often than older ones. But after treatment, these patients seemed to forget the *last 3 years of programs*, remembering only the older ones. Not only does this indicate that memories are lost when consolidation is interrupted (as it is by the seizure caused by the treatment) but also that consolidation may take not just days or months but sometimes years to be completed.

ANTEROGRADE AMNESIA Concussions can also cause a more temporary version of the kind of amnesia experienced by H.M. This kind of amnesia is called *anterograde amnesia*, or the loss of memories from the point of injury or illness forward (Squire & Slater, 1978). People with this kind of amnesia, like H.M., have difficulty remembering anything new. This is also the kind of amnesia most often seen in people with *senile dementia*, a mental disorder in which severe forgetfulness, mental confusion, and mood swings are the primary symptoms. (Dementia patients also may suffer from retrograde amnesia in addition to anterograde amnesia.) If retrograde amnesia is like losing a document in the computer because of a power loss, anterograde amnesia is like discovering that your hard drive has become defective—you can read data that are already on the hard drive, but you can’t store any new information. As long as you are looking at the data in your open computer window (i.e., attending to it), you can access it, but as soon as you close that window (stop thinking about it), the information is lost, because it was never transferred to the hard drive (long-term memory). This makes for some very repetitive conversations, such as being told the same story or being asked the same question numerous times in the space of a 20-minute conversation.

ALZHEIMER’S DISEASE Nearly 5.3 million Americans have Alzheimer’s disease (Alzheimer’s Association, 2010). It is the most common type of dementia found in adults and the elderly, accounting for nearly 60 to 80 percent of all cases of dementia. It is estimated that 1 out of 8 people over the age of 65 has Alzheimer’s disease. It has also become the third leading cause of death in late adulthood, with only heart disease and cancer responsible for more deaths (Alzheimer’s Association, 2010; Antuono et al., 2001).

With Alzheimer’s disease, the primary memory problem, at least in the beginning, is anterograde amnesia. Memory loss may be rather mild at first but becomes more severe over time, causing the person to become more and more forgetful about everyday tasks. Eventually more dangerous forgetting occurs, such as taking extra doses of medication or leaving something cooking on the stove unattended. As Alzheimer’s disease progresses, memories of the past seem to begin “erasing” as retrograde amnesia also takes hold. It is a costly disease to care for, and caregivers often face severe emotional and financial burdens in caring for a loved one who is slowly becoming a stranger.

*intact: whole or complete.

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Major League Baseball outfielder Johnny Damon (seen here colliding with player Damian Jackson) suffered a concussion after this injury. Concussions such as this can “wipe out” whatever was in the process of being consolidated into long-term memory. Which type of amnesia would you expect Johnny Damon to have—retrograde or anterograde?

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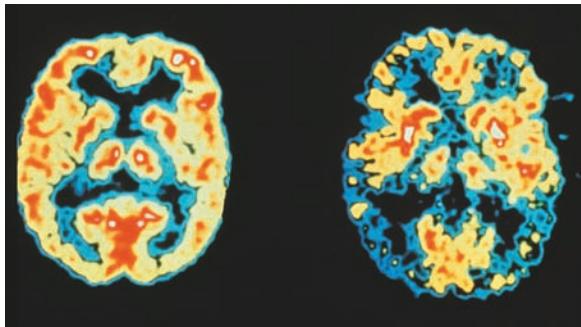
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To track the cell death that occurs in Alzheimer's disease, researchers used MRI technology to scan both patients with Alzheimer's disease and normal elderly subjects. Using supercomputers, the UCLA team created color-coded maps that revealed the degenerative sequence of the disease through novel brain-mapping methods. The wave of gray matter loss was strongly related to the progressive decline in cognitive functioning that is a key feature of the disease. Other researchers have used PET scans, as in the image above, to illustrate differences in brain activity between individuals with and without Alzheimer's disease.

Alzheimer's appears to be genetic and involves several different genetic variations, this seems to be the case for fewer than 5 percent of the total cases of the disease (Alzheimer's Association, 2010; Bertram & Tanzi, 2005). The sad truth is that there is not one cause but many, and even those who do NOT have Alzheimer's disease are not safe from other forms of dementia, such as dementia caused by strokes, dehydration, medications, and so on.

Treatments can slow but not halt or reverse the course of the disease. Five drugs are currently approved for treatment, but as yet only slow down the symptoms for an average of 6 to 12 months. What is known is that the risk factors for Alzheimer's (and many other forms of dementia) are something that can be managed: high cholesterol, high blood pressure, smoking, obesity, Type II diabetes, and lack of exercise all contribute (Alzheimer's Association, 2010; Sweat, 2010). Keeping the brain mentally active is also a way to help prolong good cognitive health. One study's findings indicate that continued everyday learning stimulates brain-derived neurotrophic factors (BDNF), a key protein involved in the formation of memories (L. Y. Chen et al., 2010). A more recent study suggests that a drug intended for use in treating diabetes, AC253, may be able to restore memory to Alzheimer's affected brain cells (Kimura et al., 2012), while another new drug, ORM-12741, also shows promise (Rouru et al., 2013).

People with dementia or traumatic brain injuries may end up with both types of amnesia. In a study of a recent case of anterograde amnesia, a musician suffering brain damage from a bad case of encephalitis (brain inflammation) no longer remembers his past life, friends, or relatives (retrograde amnesia) and can no longer learn new information (anterograde amnesia). Yet he can still play his cello, read music, and can not only play pieces from before his brain injury but can also learn new pieces (Finke et al., 2012). These are procedural skills, and this type of memory is typically unaffected by amnesia, suggesting that a different area of the brain is involved.

I've tried to remember things from when I was a baby, but I don't seem to be able to recall much. Is this some kind of amnesia, too?

INFANTILE AMNESIA What is the earliest memory you have? Chances are you cannot remember much that happened to you before age 3. When a person does claim to

What causes Alzheimer's disease is not completely understood. While it is normal for the brain to begin to form beta-amyloid protein deposits (plaques) and for strands of the protein tau to become twisted ("tangles"), people who suffer from Alzheimer's disease are found to have far more of these physical signs of an aging brain (Chen et al., 2012; Lim et al., 2012). One of the neurotransmitters involved in the formation of memories in the hippocampus is acetylcholine, and the neurons that produce this chemical break down in the early stages of the disease (Martyn et al., 2012).

While one early-onset form of

“remember” some event from infancy, a little investigation usually reveals that the “memory” is really based on what family members have told the person about that event and is not a genuine memory at all. This type of “manufactured” memory often has the quality of watching yourself in the memory as if it were a movie and you were an actor. In a genuine memory, you would remember the event through your own eyes—as if you were the camera.

Why can’t people remember events from the first 2 or 3 years of life? One explanation of **infantile amnesia** involves the type of memory that exists in the first few years of life, when a child is still considered an infant. Early memories tend to be implicit and, as stated earlier in this chapter, implicit memories are difficult to bring to consciousness. Explicit memory, which is the more verbal and conscious form of memory, does not really develop until after about age 2, when the hippocampus is more fully developed and language skills blossom (Carver & Bauer, 2001).  [Watch the Video](#), Kimberley Cuevas: Learning and Memory in Infants, at [MyPsychLab](#)

Katherine Nelson (1993) also gives credit to the social relationships that small children have with others. As children are able to talk about shared memories with adults, they begin to develop their **autobiographical memory**, or the memory for events and facts related to one’s personal life story.

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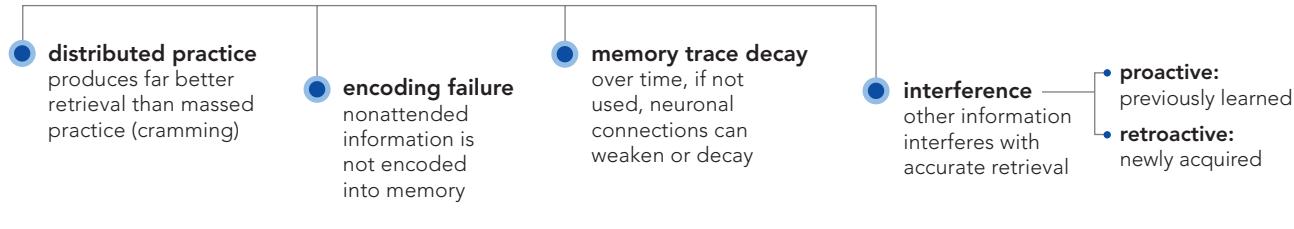
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 Explore the Concept at [MyPsychLab](#)

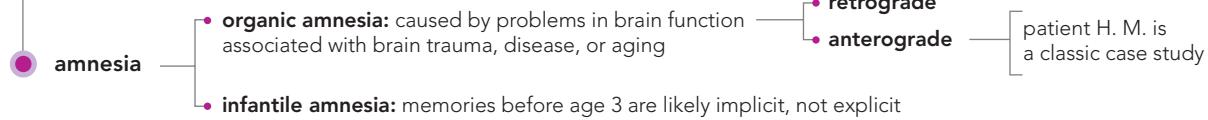
CONCEPT MAP

Forgetting

(originally studied by Ebbinghaus in 1913, research produced forgetting curve)



Neuroscience of Memory



(continued)

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PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Raven has just finished learning a list of nonsense words given to her by her psychology instructor as part of a class activity. She had 100 percent recall at the end of class. According to Ebbinghaus's curve of forgetting, how quickly will Raven likely forget about 40 percent of the information she has just learned?
 - a. within the first 20 minutes after leaving the class
 - b. within the first day after leaving the class
 - c. nearly a week after the class
 - d. nearly a month after the class
2. Collin is asked to repeat what his mother just told him. He says he "forgot" but in reality Collin wasn't paying attention to his mother at all. This is an example of the _____ explanation of forgetting.
 - a. interference
 - b. memory trace
 - c. encoding failure
 - d. repression
3. Shantel spent a year living abroad in Spain. During that time, her ability to read and speak Spanish grew tremendously. However, now, two years later, Shantel feels she can no longer travel there because she can barely remember a thing. Her problem is most likely due to
 - a. encoding failure.
 - b. retroactive interference.
 - c. proactive interference.
 - d. decay theory.
4. Henry Gustav Molaison (H.M.) suffered from profound anterograde amnesia after his _____ were surgically removed in an attempt to control his seizures.
 - a. hippocampi
 - b. amygdalae
 - c. frontal lobes
 - d. thalamus
5. Which neurotransmitter is no longer readily produced in Alzheimer's patients?
 - a. dopamine
 - b. endorphins
 - c. GABA
 - d. acetylcholine

Applying Psychology to Everyday Life: Health and Memory

How do sleep, exercise, and diet affect memory?

Several recent studies highlight three important factors in improving or maintaining your memory's health: getting enough sleep, moderate exercise, and a diet high in DHA.

Sleep: As discussed in the chapter on consciousness, sleep is an important part of how the brain functions, particularly in forming memories. Recent studies have found that:

1. Memories that are rehearsed during sleep as well as during waking are more likely to be consolidated and therefore remembered better later on (Oudiette et al., 2013). This isn't really news for memories that already have high value, such as memories associated with making more money. But researchers found that by pairing lower-value memories with a characteristic sound and then playing that sound back to the sleeping participants, those low-value items were better recalled—even better than when those same sound cues were played during waking periods. Sleep is necessary to rehearse and consolidate the things we want to remember from our waking day.
2. Can you learn while asleep? That has long been a hope of many a college student who has played a recording of lectures while sleeping, but has never worked. It turns out that the mistake was not in trying to learn while asleep, but trying to learn *something new* while asleep. Participants in one study learned how to play two previously unfamiliar tunes. They were then allowed to take a 90-minute nap, during which researchers (using information from an EEG) presented one of the tunes they had practiced during slow-wave sleep, a stage of sleep associated

with memory consolidation. Sure enough, the tune presented during sleep was remembered significantly better than the one that was not presented (Antony et al., 2012).

3. Sleep deprivation severely interferes with the functioning of the hippocampus, the part of the brain that is vital for forming new memories (Basner et al., 2013; Poe et al., 2010).  [LINK](#) to [Learning Objective 2.8](#). People who live a lifestyle that is typically sleepdeprived—such as college students, doctors, nurses, and so on—are doing their memories no favors.

Exercise: It turns out that even brief exercise can be good for your memory. Researchers had people 50 to 85 years old look at pleasant images, such as photos of animals and nature scenes (Segal et al., 2012). Some of these participants also had memory deficits. Immediately after viewing the pictures, half of the participants rode a stationary exercise bicycle for 6 minutes. One hour later all participants were given a surprise recall test on the previously viewed pictures. Regardless of memory impairment, the participants who exercised showed substantially improved memory when compared to those who did not exercise. The possible explanation for this improved memory may lie in the extra norepinephrine released during exercise. Norepinephrine, a neurotransmitter found in the brain, plays a strong role in the formation of memories.

Diet: How many times have you heard that fish is brain food? Well, it turns out that it probably is brain food, at least when it comes to improving memory. Fish, particularly salmon, bluefin or albacore tuna, and swordfish, have high levels of an omega-3 fatty acid called DHA (docosahexaenoic acid). In a recent study, researchers fed a high-DHA diet to lab animals and found that, when compared to lab animals not fed the special diet, there was a 30 percent increase in DHA levels in the hippocampus of the brain (Connor et al., 2012). DHA appears to help memory cells communicate with each other better, resulting in improved memory function. Other foods high in DHA include ground flax seeds, walnuts, grass-fed beef, and soybeans, and of course there are numerous fish oil supplements on the market.

Questions for Further Discussion

1. Why do you think learning something new while asleep does not work?
2. What might be the dangers in using supplements to get DHA in your diet?

Writing Prompt

▼ You are reading your textbook and studying for an upcoming exam in psychology. Identify and describe each step in the process required for remembering information from your textbook in order to do well on the exam. Discuss a strategy for improving memory and provide an example of how it could help you on the exam.

Words: 0

Print

Feedback

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chapter summary

 Listen to the **Audio File** of your chapter **MyPsychLab**

What Is Memory?

6.1 What are the three processes of memory and the different models of how memory works?

- Memory can be defined as an active system that receives information from the senses, organizes and alters it as it stores it away, and then retrieves the information from storage.
- The three processes are encoding, storage, and retrieval.
- In the levels-of-processing model of memory, information that gets more deeply processed is more likely to be remembered.
- In the parallel distributed processing model of memory, information is simultaneously stored across an interconnected neural network that stretches across the brain.

The Information-Processing Model: Three Memory Systems

6.2 How does sensory memory work?

- Iconic memory is the visual sensory memory, in which an after-image or icon will be held in neural form for about one-fourth to one-half second.
- Echoic memory is the auditory form of sensory memory and takes the form of an echo that lasts for up to 4 seconds.

6.3 What is short-term memory, and how does it differ from working memory?

- Short-term memory is where information is held while it is conscious and being used. It holds about three to five items of information and lasts about 30 seconds without rehearsal.
- STM can be lost through failure to rehearse, decay, interference by similar information, and the intrusion of new information into the STM system, which pushes older information out.

6.4 How is long-term memory different from other types of memory?

- Long-term memory is the system in which memories that are to be kept more or less permanently are stored and is unlimited in capacity and relatively permanent in duration.
- Information that is more deeply processed, or processed according to meaning, will be retained and retrieved more efficiently.

6.5 What are the various types of long-term memory, and how is information stored in long-term memory organized?

- Nondeclarative, or implicit, memories are memories for skills, habits, and conditioned responses. Declarative, or explicit,

memories are memories for general facts and personal experiences and include both semantic memories and episodic memories.

- Implicit memories are difficult to bring into conscious awareness, whereas explicit memories are those that a person is aware of possessing.
- LTM is organized in the form of semantic networks, or nodes of related information spreading out from a central piece of knowledge.

Getting It Out: Retrieval of Long-Term Memories

6.6 What kinds of cues help people remember?

- Retrieval cues are words, meanings, sounds, and other stimuli that are encoded at the same time as a new memory.
- Encoding specificity occurs when context-dependent information becomes encoded as retrieval cues for specific memories.
- State-dependent learning occurs when physiological or psychological states become encoded as retrieval cues for memories formed while in those states.

6.7 How do the retrieval processes of recall and recognition differ, and how reliable are our memories of events?

- Recall is a type of memory retrieval in which the information to be retrieved must be “pulled” out of memory with few or no cues, whereas recognition involves matching information with stored images or facts.
- The serial position effect, or primacy or recency effect, occurs when the first items and the last items in a list of information are recalled more efficiently than items in the middle of the list.
- Loftus and others have found that people constantly update and revise their memories of events. Part of this revision may include adding information acquired later to a previous memory. That later information may also be in error, further contaminating the earlier memory.
- Automatic encoding of some kinds of information requires very little effort to place information into long-term memory.
- Memory for particularly emotional or traumatic events can lead to the formation of flashbulb memories, memories that seem as vivid and detailed as if the person were looking at a snapshot of the event but that are no more accurate than any other memories.

The Reconstructive Nature of Long-Term Memory Retrieval: How Reliable Are Memories?

6.8 How are long-term memories formed, and how can this process lead to inaccuracies in memory?

- Memories are reconstructed from the various bits and pieces of information that have been stored away in different places at the time of encoding in a process called constructive processing.
- Hindsight bias occurs when people falsely believe that they knew the outcome of some event because they have included knowledge of the event's true outcome into their memories of the event itself.
- The misinformation effect refers to the tendency of people who are asked misleading questions or given misleading information to incorporate that information into their memories for a particular event.

6.9 What is false-memory syndrome?

- Rather than improving memory retrieval, hypnosis makes the creation of false memories more likely.
- False-memory syndrome is the creation of false or inaccurate memories through suggestion, especially while hypnotized.
- Pezdek and colleagues assert that false memories are more likely to be formed for plausible false events than for implausible ones.

What Were We Talking About? Forgetting

6.10 Why do we forget?

- Ebbinghaus found that information is mostly lost within 1 hour after learning and then gradually fades away. This is known as the curve of forgetting.
- Some “forgetting” is actually a failure to encode information.
- Memory trace decay theory assumes the presence of a physical memory trace that decays with disuse over time.
- Forgetting in LTM is most likely due to proactive or retroactive interference.

Neuroscience of Memory

6.11 How and where are memories formed in the brain?

- Evidence suggests that procedural memories are stored in the cerebellum, whereas short-term memories are stored in the prefrontal and temporal lobes of the cortex.
- Semantic and episodic memories may be stored in the frontal and temporal lobes as well but in different locations than short-term memory, whereas memory for fear of objects is most likely stored in the amygdala.
- Consolidation consists of the physical changes in neurons that take place during the formation of a memory.
- The hippocampus appears to be responsible for the formation of new long-term declarative memories. If it is removed, the ability to store anything new is completely lost.

6.12 How does amnesia occur?

- In retrograde amnesia, memory for the past (prior to the injury) is lost, which can be a loss of only minutes or a loss of several years.
- ECT, or electroconvulsive therapy, can disrupt consolidation and cause retrograde amnesia.
- In anterograde amnesia, memory for anything new becomes impossible, although old memories may still be retrievable.
- The primary memory difficulty in Alzheimer’s disease is anterograde amnesia, although retrograde amnesia can also occur as the disease progresses.
- Alzheimer’s disease has multiple causes, many of which are not yet identified.
- There are various drugs in use or in development for use, with the hopes of slowing, or possibly in the future halting, the progression of Alzheimer’s disease.
- Most people cannot remember events that occurred before age 2 or 3. This is called infantile amnesia and is most likely due to the implicit nature of infant memory.

Applying Psychology to Everyday Life: Health and Memory

6.13 How do sleep, exercise, and diet affect memory?

- Good nutrition, physical exercise, and adequate sleep contribute to memory functions.
- Research results suggest diets high in omega-3s, and especially DHA, may help hippocampal cells communicate better, whereas norepinephrine release during physical exercise appears to strengthen memories. Sleep is a critical component, both in the consolidation of memories and normal functioning of the hippocampus.

test YOURSELF

ANSWERS AVAILABLE IN ANSWER KEY.

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Chapter Test:

1. The steps to memory can best be described as follows:
 - a. finding it, using it, storing it, using it again.
 - b. putting it in, keeping it in, getting it out.
 - c. sensing it, perceiving it, remembering it, forgetting it.
 - d. a series of passive data files.

2. According to Sperling, what is the capacity of iconic memory?
 - a. Everything that can be seen at one time.
 - b. Everything that can be heard in one minute.
 - c. Everything that can be sensed in one second.
 - d. Everything that can be perceived in a lifetime.

3. Which type of memory best explains the "What?" phenomenon?
- iconic sensory memory
 - echoic sensory memory
 - short-term memory
 - tactile sensory memory
4. For information to travel from sensory memory to short-term memory, it must first be _____ and then encoded primarily into _____ form.
- unconsciously chosen; auditory
 - selectively attended to; visual
 - biologically chosen; visual
 - selectively attended to; auditory
5. You are introduced to someone at a party. While talking with the person, you realize that you have already forgotten the person's name. What amount of time does it typically take before such information is lost from short-term memory?
- approximately $\frac{1}{4}$ of a second
 - usually no more than 4 seconds
 - typically between 12 and 30 seconds
 - Short-term memories typically last a lifetime.
6. Early studies of the capacity of short-term memory suggested that most people could remember approximately _____ bits of information.
- two
 - three
 - seven
 - ten
7. Mary has just met an attractive man named Austin at a party. She wants to make sure she remembers his name. What should she do?
- Mary should repeat the name continuously so as to commit it to long-term memory.
 - Mary should chunk it by remembering the first three letters as a set and then remembering the remaining letters as a set.
 - Mary should make it more meaningful. For example, she might remind herself that Austin has the same name as the capital of Texas.
 - Mary should create a song to help her remember his name.
8. _____ memory includes what people can do or demonstrate, whereas _____ memory is about what people know and can report.
- nondeclarative; declarative
 - declarative; nondeclarative
 - semantic; procedural
 - episodic; semantic
9. The semantic network model of memory suggests that the _____ nodes you must pass through to access information, the longer it will take for you to recall information.
- fewer
 - more
 - bigger the
 - more complex the
10. Phineas walks out of his office and into the conference room. However, after he leaves his office, he forgets what he was coming into the conference room for. According to the encoding specificity hypothesis, what should Phineas do to regain his lost memory?
- Phineas should return to his office to help him remember what he had forgotten.
 - Phineas should ask someone else, "What did I come in here for?"
 - Phineas should remain in the conference room and simply relax so that his memory should return.
 - Phineas should consider seeing a doctor, since such memory loss can be a sign of mental illness.
11. Which of the following is an example of a test using recognition?
- short answer
 - essay
 - fill in the blanks
 - true-false
12. When creating a presentation, many public speaking instructors will tell you to develop a strong opening or attention getter to your presentation as well as a good summary and finish. What aspect of memory best explains these suggestions?
- parallel distributing processing model of memory
 - chunking
 - elaborative rehearsal theory
 - serial position phenomenon
13. Your mother tells you to dress for success at your interview because it's all about "first impressions." In other words, she is telling you that people often remember what they see first. This belief is in line with what element of memory?
- the primacy effect
 - the tip of the tongue phenomenon
 - the recency effect
 - the power of false positives
14. Research by Elizabeth Loftus shows that eyewitness recognition is very prone to what psychologists call
- automatic encoding.
 - a false positive.
 - a flashbulb memory.
 - a recency effect
15. The tendency of certain elements to enter long-term memory with little or no effort to encode and organize them is what defines
- encoding specificity.
 - automatic encoding.
 - flashbulb memories.
 - eidetic imagery.
16. The ability to remember where you were and what you were doing when the United States was attacked on September 11, 2001, is an example of
- eyewitness testimony.
 - encoding specificity hypothesis.
 - false-memory syndrome.
 - flashbulb memory.

17. In Hermann Ebbinghaus's classic study on memory and the forgetting curve, how long after learning the lists does most forgetting happen?
- Forgetting started immediately.
 - one hour
 - five hours
 - nine hours
18. You are surprised by the fact that you cannot remember if Abraham Lincoln's head faces the left or the right on a penny. This is all the more surprising given the fact that you work with money at your job on nearly a daily basis. What would best explain such an inability to recall this information?
- encoding failure
 - decay theory
 - interference theory
 - distributed practice effect
19. Henry Gustav Molaison, infamously known as H.M., was unable to form new declarative memories. He suffered from what psychologists call
- psychogenic amnesia.
 - retrograde amnesia.
 - retroactive amnesia.
 - anterograde amnesia.
20. Your English instructor has given you an assignment to write down your most favorite memory from when you were 12 months old. What might you tell him?
- Memories from this time are exceptionally vivid because of the exciting nature of childhood.
 - Students will not be able to recall such memories if they had yet to develop the ability to talk by age one.
 - Students' memories are detailed but often inaccurate.
 - Students will probably not be able to recall events from such an early age.

7

cognition: thinking, intelligence, and language

Think about how you interact with the world around you. How often do you simply respond, without knowing how or why you do the things you do, say, or think? How much of your conscious experience involves effortful, mindful attention, and decision making? These two types of thinking, sometimes referred to as System 1 and System 2, characterize much of how we think and process information (Kahneman, 2011; Stanovich & West, 2000). System 1, which involves making quick decisions and using cognitive shortcuts, is guided by our innate abilities and personal experiences. System 2, which is relatively slow, analytical, and rule-based, is dependent more on our formal educational experiences. Overall, our thinking has to be governed by the interplay between the two.

Do you tend to rely more on instinctual (System 1) or deliberate (System 2) thought processes? How do your thought processes and decision making strategies vary depending on the situation?

Watch the Video at MyPsychLab.com

Why study the nature of thought?

To fully understand how we do any of the things we do (such as learning, remembering, and behaving), we need to understand how we think. How do we organize our thoughts? How do we communicate those thoughts to others? What do we mean by intelligence? Why are some people able to learn so much faster than others?

Learning objectives

- 7.1 How are mental images and concepts involved in the process of thinking?
- 7.2 What are the methods people use to solve problems and make decisions?
- 7.3 Why does problem solving sometimes fail, and what is meant by creative thinking?
- 7.4 How do psychologists define intelligence, and how do various theories of intelligence differ?
- 7.5 How is intelligence measured, how are intelligence tests constructed, and what role do these tests play in neuropsychology?
- 7.6 What is intellectual disability and what are its causes?
- 7.7 What defines giftedness, and how are giftedness and emotional intelligence related to success in life?
- 7.8 What is the influence of heredity and environment on the development of intelligence?
- 7.9 How is language defined, and what are its different elements and structure?
- 7.10 Does language influence the way people think, and are animals capable of learning language?
- 7.11 What are some ways to improve thinking?



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How People Think

What does it mean to think? People are thinking all the time and talking about thinking as well: “What do you think?” “Let me think about that.” “I don’t think so.” So, what does it mean to think? **Thinking**, or **cognition** (from a Latin word meaning “to know”), can be defined as mental activity that goes on in the brain when a person is processing information—organizing it, understanding it, and communicating it to others. Thinking includes memory, but it is much more. When people think, they are not only aware of the information in the brain but also are making decisions about it, comparing it to other information, and using it to solve problems.

Thinking also includes more than just a kind of verbal “stream of consciousness.” When people think, they often have images as well as words in their minds.

MENTAL IMAGERY

How are mental images and concepts involved in the process of thinking?

As stated in Chapter Six, short-term memories are encoded in the form of sounds and also as visual images, forming a mental picture of the world. Thus, **mental images** (representations that stand in for objects or events and have a picturelike quality) are one of several tools used in the thought process.

Here’s an interesting demonstration of the use of mental images. Get several people together and ask them to tell you *as fast as they can* how many windows are in the place where they live. Usually you’ll find that the first people to shout out an answer have fewer windows in their houses than the ones who take longer to respond. You’ll also notice that most of them look up, as if looking at some image that only they can see. If asked, they’ll say that to determine the number of windows, they pictured where they live and simply counted windows as they “walked through” the image they created in their mind.

So more windows means more time to count them in your head? I guess mentally “walking” through a bigger house in your head would take longer than “walking” through a smaller one.

That’s what researchers think, too. They have found that it does take longer to view a mental image that is larger or covers more distance than a smaller, more compact one (Kosslyn et al., 2001; Ochsner & Kosslyn, 1994). In one study (Kosslyn et al., 1978), participants were asked to look at a map of an imaginary island (see **Figure 7.1**). On this map were several landmarks, such as a hut, a lake, and a grassy area. After viewing the map and memorizing it, participants were asked to imagine a specific place on the island, such as the hut, and then to “look” for another place, like the lake. When they mentally “reached” the second place, they pushed a button that recorded reaction time. The greater the physical distance on the map between the two locations, the longer it took participants to scan the image for the second location. The participants were apparently looking at their mental image and scanning it just as if it were a real, physical map.

People are even able to mentally rotate, or turn, images (Shepherd & Metzler, 1971). Kosslyn (1983) asked participants questions such as the following: “Do frogs have lips and a stubby tail?” He found that most participants reported visualizing a frog, starting with the face (“no lips”), then mentally rotating the image so it was facing away from

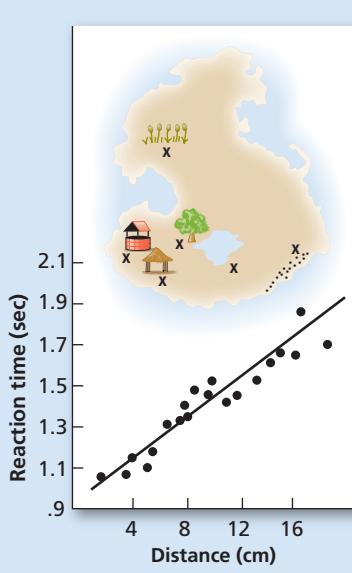


Figure 7.1 Kosslyn’s Fictional Island

In Kosslyn’s 1978 study, participants were asked to push a button when they had imagined themselves moving from one place on the island to another. As the graph below the picture shows, participants took longer times to complete the task when the locations on the image were farther apart.

Source: Kosslyn et al. (1978).

them, and then “zooming in” to look for the stubby tail (“yes, there it is”). A very important aspect of the research on mental rotation is that we tend to engage *mental* images in our mind much like we engage or interact with *physical* objects. When we rotate an object in our minds (or in other ways interact with or manipulate mental images), it is not instantaneous—it takes time, just as it would if we were rotating a physical object with our hands. To see how well you are able to mentally rotate images, try the *Mental Rotation* experiment.

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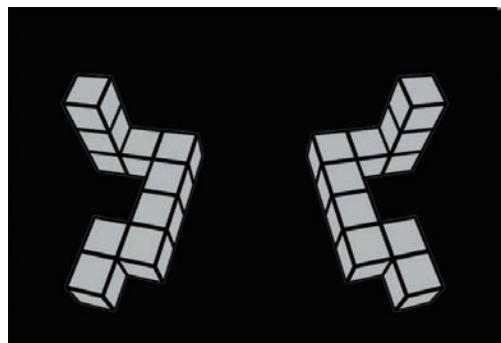
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Simulation

Mental Rotation

In this experiment, we will address your ability to mentally rotate objects in your mind. You will be presented with two objects, and asked to determine if the objects are the same except for their orientation.



[Go to the Experiment ▶](#)

Simulate the Experiment, Mental Rotation, on [MyPsychLab](#)

In the brain, creating a mental image is almost the opposite of seeing an actual image. With an actual image, the information goes from the eyes to the visual cortex of the occipital lobe and is processed, or interpreted, by other areas of the cortex that compare the new information to information already in memory. [LINK](#) to Learning Objective 2.9. In creating a mental image, areas of the cortex associated with stored knowledge send information to the visual cortex, where the image is perceived in the “mind’s eye” (Kosslyn et al., 1993; Sparing et al., 2002). PET scans show areas of the visual cortex being activated during the process of forming an image, providing evidence for the role of the visual cortex in mental imagery (Kosslyn et al., 1993, 1999, 2001). [Watch](#) the [Video](#), Special Topics: Mental Imagery: *In the Mind’s Eye*, at [MyPsychLab](#).

Through the use of functional magnetic resonance imagery (fMRI), researchers have been able to see the overlap that occurs in brain areas activated during visual mental imagery tasks as compared to actual tasks involving visual perception (Ganis et al., 2004). During both types of tasks, activity was present in the frontal cortex (cognitive control), temporal lobes (memory), parietal lobes (attention and spatial memory), and occipital lobes (visual processing). However, the amount of activity in these areas differed between the two types of tasks. For example, activity in the visual cortex was stronger during perception than in imagery, suggesting sensory input activates this area more strongly than memory input. And an important finding overall, those areas activated during visual imagery were a subset of those activated during visual

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perception, with the greatest similarity in the frontal and parietal regions rather than the temporal and occipital regions. What does this mean? Simply that there is commonality between the processes of visual imagery and visual perception but it is *not* a complete overlap, and, as the authors point out, the greater overlap *was not* in the temporal and occipital regions (memory and vision functions) that might be assumed to be the most likely areas of overlap given the visual nature of the tasks (Ganis et al., 2004).

CONCEPTS AND PROTOTYPES



Images are not the only way we think, are they?

Mental images are only one form of mental representation. Another aspect of thought processes is the use of concepts. **Concepts** are ideas that represent a class or category of objects, events, or activities. People use concepts to think about objects or events without having to think about all the specific examples of the category. For example, a person can think about “fruit” without thinking about every kind of fruit there is in the world, which would take far more effort and time. This ability to think in terms of concepts allows us to communicate with each other: If I mention a bird to you, you know what I am referring to, even if we aren’t actually thinking of the same *type* of bird.

Concepts not only contain the important features of the objects or events people want to think about, but also they allow the identification of new objects and events that may fit the concept. For example, dogs come in all shapes, sizes, colors, and lengths of fur. Yet most people have no trouble recognizing dogs as dogs, even though they may never before have seen that particular breed of dog. Friends of the author have a dog called a briard, which is a kind of sheepdog. In spite of the fact that this dog is easily the size of a small pony, the author had no trouble recognizing it as a dog, albeit a huge and extremely shaggy one.

Concepts can have very strict definitions, such as the concept of a square as a shape with four equal sides. Concepts defined by specific rules or features are called *formal concepts* and are quite rigid. To be a square, for example, an object must be a two-dimensional figure with four equal sides and four angles adding up to 360 degrees. Mathematics is full of formal concepts. For example, in geometry there are triangles, squares, rectangles,



Both of these animals are dogs. They both have fur, four legs, a tail—but the similarities end there. With so many variations in the animals we call “dogs,” what is the prototype for “dog”?

polygons, and lines. In psychology, there are double-blind experiments, sleep stages, and conditioned stimuli, to name a few. Each of these concepts must fit very specific features to be considered true examples.

 But what about things that don't easily fit the rules or features? What if a thing has some, but not all, features of a concept?

People are surrounded by objects, events, and activities that are not as clearly defined as formal concepts. What is a vehicle? Cars and trucks leap immediately to mind, but what about a bobsled, or a raft? Those last two objects aren't quite as easy to classify as vehicles immediately, but they fit some of the rules for "vehicle." These are examples of *natural concepts*, concepts people form not as a result of a strict set of rules, but rather as the result of experiences with these concepts in the real world (Ahn, 1998; Barton & Komatsu, 1989; Rosch, 1973). Formal concepts are well defined, but natural concepts are "fuzzy" (Hampton, 1998). Natural concepts are important in helping people understand their surroundings in a less structured manner than school-taught formal concepts, and they form the basis for interpreting those surroundings and the events that may occur in everyday life.

When someone says "fruit," what's the first image that comes to mind? More than likely, it's a specific kind of fruit like an apple, pear, or orange. It's less likely that someone's first impulse will be to say "guava" or "papaya," or even "banana," unless that person comes from a tropical area. In the United States, apples are a good example of a **prototype**, a concept that closely matches the defining characteristics of the concept (Mervis & Rosch, 1981; Rosch, 1977). Fruit is sweet, grows on trees, has seeds, and is usually round—all very applelike qualities. Coconuts are sweet and they also grow on trees, but many people in the Northern Hemisphere have never actually seen a coconut tree. They have more likely seen countless apple trees. So people who do have very different experiences with fruit, for instance, will have different prototypes, which are the most basic examples of concepts.

 What about people who live in a tropical area? Would their prototype for fruit be different? And would people's prototypes vary in other cultures?

More than likely, prototypes develop according to the exposure a person has to objects in that category. So someone who grew up in an area where there are many coconut trees might think of coconuts as more prototypical than apples, whereas someone growing up in the northwestern United States would more likely see apples as a prototypical fruit (Aitchison, 1992). Culture also matters in the formation of prototypes. Research on concept prototypes across various cultures found greater differences and variations in prototypes between cultures that were dissimilar, such as Taiwan and America, than between cultures that are more similar, such as Hispanic Americans and non-Hispanic Americans living in Florida (Lin et al., 1990; Lin & Schwanenflugel, 1995; Schwanenflugel & Rey, 1986).

How do prototypes affect thinking? People tend to look at potential examples of a concept and compare them to the prototype to see how well they match—which is why it takes most people much longer to think about olives and tomatoes as fruit because they aren't sweet, one of the major characteristics of the prototype of fruit (Rosch & Mervis, 1975). As the video *The Basics: The Mind Is What the Brain Does* explains, we use a combination of cognitive processes including concepts, prototypes, and mental images to identify objects in our daily lives.



A duck-billed platypus is classified as a mammal yet shares features with birds, such as webbed feet and a bill, and it also lays eggs. The platypus is an example of a "fuzzy" natural concept. Courtesy of Dave Watts, Nature Picture Library.

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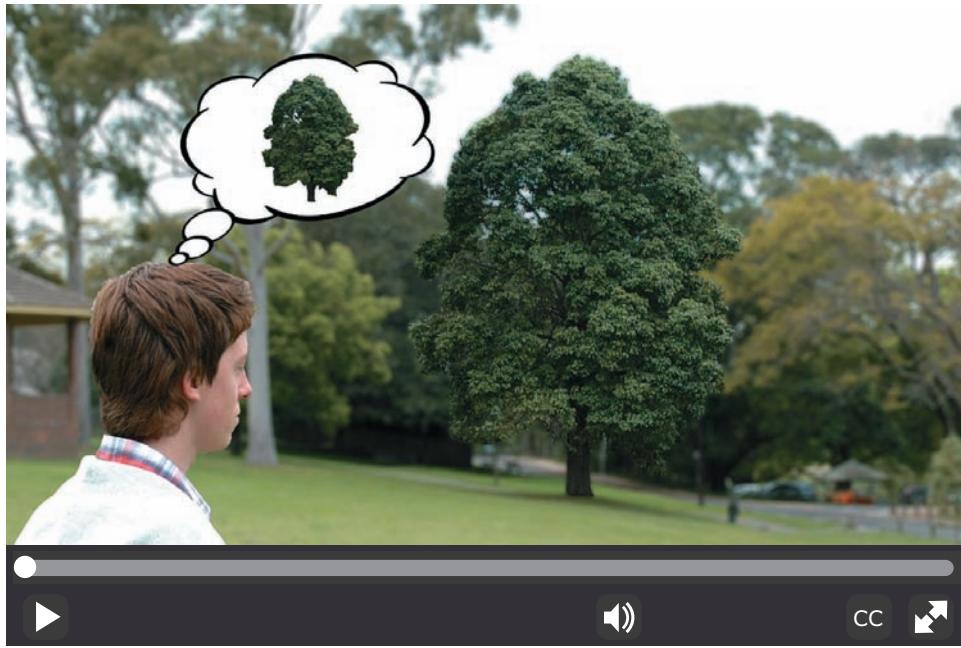
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Watch the Video, *The Basics: The Mind Is What the Brain Does*, at [MyPsychLab](#)

No matter what type, concepts are one of the ways people deal with all the information that bombards* their senses every day, allowing them to organize their perceptions of the world around them. This organization may take the form of *schemas*, mental generalizations about objects, places, events, and people (for example, one's schema for "library" would no doubt include books and bookshelves), or *scripts*, a kind of schema that involves a familiar sequence of activities (for example, "going to a movie" would include traveling there, getting the ticket, buying snacks, finding the right theater, etc.). Concepts not only help people think, but also they are an important tool in *problem solving*, a type of thinking that people engage in every day and in many different situations.

PROBLEM-SOLVING AND DECISION-MAKING STRATEGIES

What are the methods people use to solve problems and make decisions?



Problem solving is certainly a big part of any college student's life. Is there any one "best" way to go about solving a problem?

Think about it as you read on and solve the following: Put a coin in a bottle and then cork the opening. How can you get the coin out of the bottle without pulling out the cork or breaking the bottle? (For the solution, see the section on Insight.)

As stated earlier, images and concepts are mental tools that can be used to solve problems and make decisions. For the preceding problem, you are probably trying to create an image of the bottle with a coin in it. **Problem solving** occurs when a goal must be reached by thinking and behaving in certain ways. Problems range from figuring out how to cut a recipe in half to understanding complex mathematical proofs to deciding what to major in at college. Problem solving is one aspect of **decision making**, or identifying, evaluating, and choosing among several alternatives. There are several different ways in which people can think in order to solve problems. Watch the Video, *In the Real World: Changing Your Mind*, at [MyPsychLab](#)

TRIAL AND ERROR (MECHANICAL SOLUTIONS) One method is to use **trial and error**, also known as a **mechanical solution**. Trial and error refers to trying one solution after another



This child may try one piece after another until finding the piece that fits. This is an example of trial-and-error learning.

*bombards: attacks again and again.

until finding one that works. For example, if Shelana has forgotten the PIN for her online banking Web site, she can try one combination after another until she finds the one that works, if she has only a few such PINs that she normally uses. Mechanical solutions can also involve solving by *rote*, or a learned set of rules. This is how word problems were solved in grade school, for example. One type of rote solution is to use an algorithm.

ALGORITHMS **Algorithms** are specific, step-by-step procedures for solving certain types of problems. Algorithms will always result in a correct solution, if there is a correct solution to be found, and you have enough time to find it. Mathematical formulas are algorithms. When librarians organize books on bookshelves, they also use an algorithm: Place books in alphabetical order within each category, for example. Many puzzles, like a Rubik's Cube®, have a set of steps that, if followed exactly, will always result in solving the puzzle. But algorithms aren't always practical to use. For example, if Shelana didn't have a clue what those four numbers might be, she *might* be able to figure out her forgotten PIN by trying *all possible combinations* of four digits, 0 through 9. She would eventually find the right four-digit combination—but it might take a very long while! Computers, however, can run searches like this one very quickly, so the systematic search algorithm is a useful part of some computer programs.

HEURISTICS Unfortunately, humans aren't as fast as computers and need some other way to narrow down the possible solutions to only a few. One way to do this is to use a heuristic. A **heuristic**, or “rule of thumb,” is a simple rule that is intended to apply to many situations. Whereas an algorithm is very specific and will always lead to a solution, a heuristic is an educated guess based on prior experiences that helps narrow down the possible solutions for a problem. For example, if a student is typing a paper in a word-processing program and wants to know how to format the page, he or she could try to read an entire manual on the word-processing program. That would take a while. Instead, the student could use an Internet search engine or type “format” into the help feature’s search program. Doing either action greatly reduces the amount of information the student will have to look at to get an answer. Using the help feature or clicking on the appropriate toolbar word will also work for similar problems.  **Watch the Video**, *What's in It for Me?: Making Choices*, at **MyPsychLab**

Representativeness Heuristic Will using a rule of thumb always work, like algorithms do? Using a heuristic is faster than using an algorithm in many cases, but unlike algorithms, heuristics will *not* always lead to the correct solution. What you gain in speed is sometimes lost in accuracy. For example, a **representativeness heuristic** is used for categorizing objects and simply assumes that any object (or person) that shares characteristics with the members of a particular category is also a member of that category. This is a handy tool when it comes to classifying plants but doesn't work as well when applied to people. The representativeness heuristic can cause errors due to ignoring base rates, the actual probability of a given event. Are all people with dark skin from Africa? Does everyone with red hair also have a bad temper? Are all blue-eyed blondes from Sweden? See the point? The representativeness heuristic can be used—or misused—to create and sustain stereotypes (Kahneman & Tversky, 1973; Kahneman et al., 1982).

Availability Heuristic Another heuristic that can have undesired outcomes is the **availability heuristic**, which is based on our estimation of the frequency or likelihood of an event based on how easy it is to recall relevant information from memory or how easy it is for us to think of related examples (Tversky & Kahneman, 1973). Imagine, for example, that after you have already read this entire textbook (it could happen!) you are asked to estimate how many words in the book start with the letter *K* and how many have the letter *K* as the third letter in the word. Which place do you think is more frequent, the first letter or as the third letter? Next, what do you think the ratio of the more frequent placement is to the less frequent placement? What is easier to think of, words that begin with the letter *K* or words that have *K* as the third letter? Tversky & Kahneman (1973) asked this same question of 152 participants for five consonants (*K, N, L, R, V*) that appear more frequently in the third position as compared to the first in a typical text. Sixty-nine percent of the participants indicated

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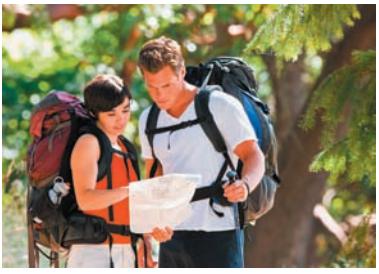
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Smartphones and other portable devices provide tools for easy navigation. How might the use or overuse of these tools affect our ability to navigate when we do not have access to them?



One rule of thumb, or heuristic, involves breaking down a goal into subgoals. This woman is consulting the map to see which of several possible paths she needs to take to get to her goal destination.

that the first position was the more frequent placement and the median estimated ratio was 2:1 for the letter *K*—however, there are typically twice as many words with *K* as the third letter as compared to the first. Can you think of an example where you may have used the availability heuristic and it did not work in your favor?

Working Backward A useful heuristic that *does* work much of the time is to *work backward from the goal*. For example, if you want to know the shortest way to get to the new coffee shop in town, you already know the goal, which is finding the coffee shop. There are probably several ways to get there from your house, and some are shorter than others. Assuming you have the address of the store, for many the best way to determine the shortest route is to look up the location of the store on an Internet map, a GPS, or a smartphone, and compare the different routes by the means of travel (walking versus driving). People actually used to do this with a physical map and compare the routes manually! Think about it, does technology help or hinder some aspects of problem solving? What are, if any, the benefits to using technology for solving some problems as compared to actively engaging in problem solving as a mental challenge?



What if my problem is writing a term paper? Starting at the end isn't going to help me much!

Subgoals Sometimes it's better to break a goal down into *subgoals*, so that as each subgoal is achieved, the final solution is that much closer. Writing a term paper, for example, can seem overwhelming until it is broken down into steps: Choose a topic, research the topic, organize what has been gathered, write one section at a time, and so on, [LINK](#) to Learning Objective PIA.6. Other examples of heuristics include making diagrams to help organize the information concerning the problem or testing possible solutions to the problem one by one and eliminating those that do not work.



Sometimes I have to find answers to problems one step at a time, but in other cases the answer seems to just "pop" into my head all of a sudden. Why do some answers come so easily to mind?

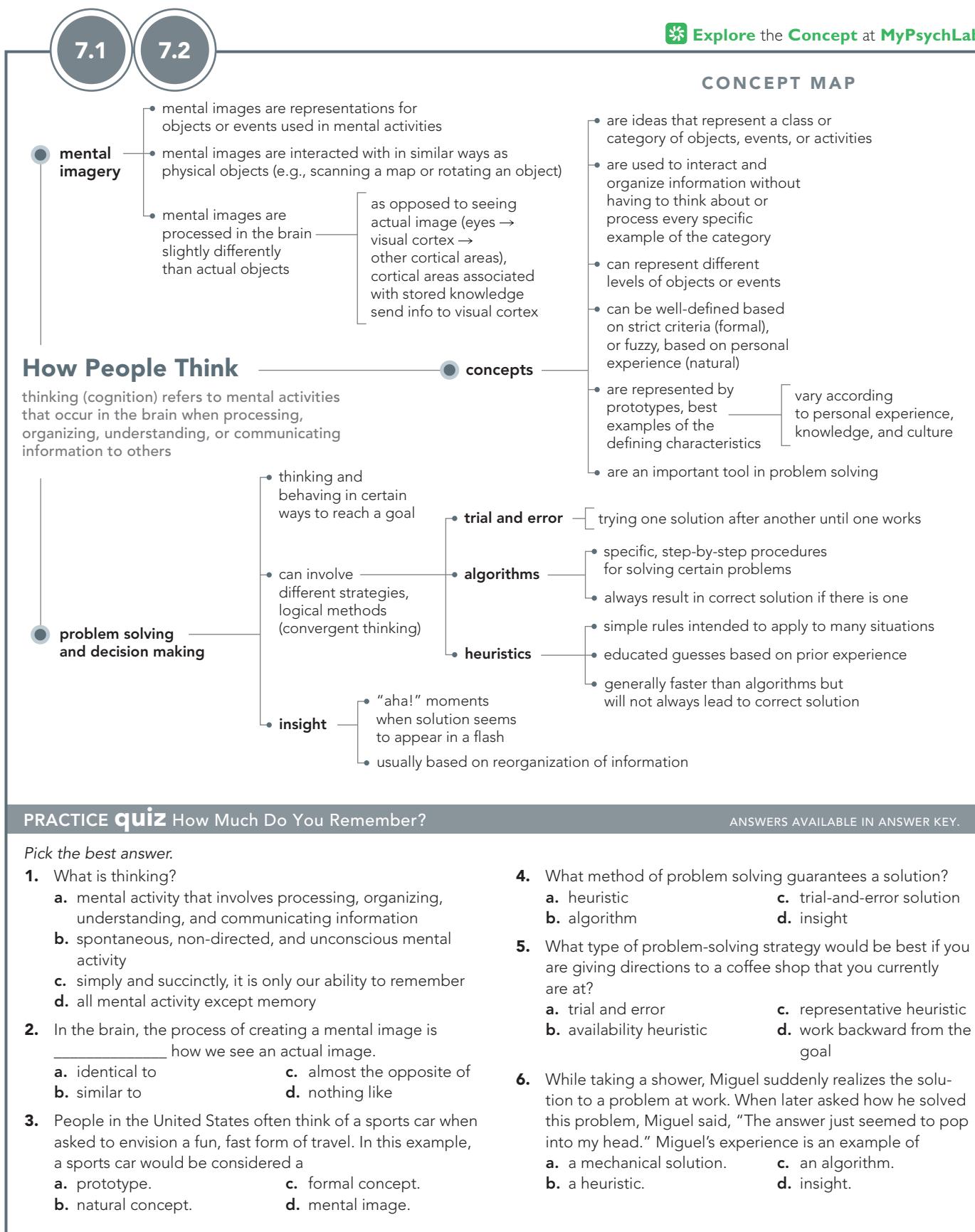
INSIGHT When the solution to a problem seems to come suddenly to mind, it is called insight. Chapter Five contained a discussion of Köhler's (1925) work with Sultan the chimpanzee, which demonstrated that even some animals can solve problems by means of a sudden insight. [LINK](#) to Learning Objective 5.11. In humans, insight often takes the form of an "aha!" moment—the solution seems to come in a flash. A person may realize that this problem is similar to another one that he or she already knows how to solve or might see that an object can be used for a different purpose than its original one, like using a dime as a screwdriver.

Remember the problem of the bottle discussed earlier in this chapter? The task was to get the coin out of the bottle without removing the cork or breaking the bottle. The answer is simple: *Push the cork into the bottle and shake out the coin. Aha!*

Insight is not really a magical process, although it can seem like magic. What usually happens is that the mind simply reorganizes a problem, sometimes while the person is thinking about something else (Durso et al., 1994).

Here's a problem that can be solved with insight: Marsha and Marjorie were born on the same day of the same month of the same year to the same mother and the same father yet they are not twins. How is that possible? Think about it and then look for the answer in the section on Mental Sets.

In summary, thinking is a complex process involving the use of mental imagery and various types of concepts to organize the events of daily life. Problem solving is a special type of thinking that involves the use of many tools, such as trial-and-error thinking, algorithms, and heuristics, to solve different types of problems Watch the Video, The Big Picture: I Am, Therefore I Think, at [MyPsychLab](#).



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**Figure 7.2 The String Problem**

How do you tie the two strings together if you cannot reach them both at the same time?

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Figure 7.3 The Dot Problem

Can you draw four straight lines so that they pass through all nine dots without lifting your pencil from the page and without touching any dot more than once?

PROBLEMS WITH PROBLEM SOLVING AND DECISION MAKING

Why does problem solving sometimes fail, and what is meant by creative thinking?

Using insight to solve a problem is not always foolproof. Sometimes a solution to a problem remains just “out of reach” because the elements of the problem are not arranged properly or because people get stuck in certain ways of thinking that act as barriers to solving problems. Such ways of thinking occur more or less automatically, influencing attempts to solve problems without any conscious awareness of that influence. Here’s a classic example:

Two strings are hanging from a ceiling but are too far apart to allow a person to hold one and walk to the other. (See **Figure 7.2**.) Nearby is a table with a pair of pliers on it. The goal is to tie the two pieces of string together. How? For the solution to this problem, read on.

People can become aware of automatic tendencies to try to solve problems in ways that are not going to lead to solutions and in becoming aware can abandon the “old” ways for more appropriate problem-solving methods. Three of the most common barriers* to successful problem solving are functional fixedness, mental sets, and confirmation bias.

FUNCTIONAL FIXEDNESS One problem-solving difficulty involves thinking about objects only in terms of their typical uses, which is a phenomenon called **functional fixedness** (literally, “fixed on the function”). Have you ever searched high and low for a screwdriver to fix something around the house? All the while there are several objects close at hand that could be used to tighten a screw: a butter knife, a key, or even a dime in your pocket. Because the tendency is to think of those objects in terms of cooking, unlocking, and spending, we sometimes ignore the less obvious possible uses. The string problem introduced before is an example of functional fixedness. The pair of pliers is often seen as useless until the person realizes it can be used as a weight. (See answer in the section on Creativity.)

Alton Brown, renowned chef and star of the Food Network’s *Good Eats* cooking show, is a big fan of what he calls “multitaskers,” kitchen items that can be used for more than one purpose. For example, a cigar-cutter can become a tool for cutting carrots, green onions, and garlic. Obviously, Chef Brown is not a frequent victim of functional fixedness.

MENTAL SETS Functional fixedness is actually a kind of **mental set**, which is defined as the tendency for people to persist in using problem-solving patterns that have worked for them in the past. Solutions that have worked in the past tend to be the ones people try first, and people are often hesitant or even unable to think of other possibilities. Look at **Figure 7.3** and see if you can solve the dot problem.

People are taught from the earliest grades to stay within the lines, right? That tried-and-true method will not help in solving the dot problem. The solution involves drawing the lines beyond the actual dots, as seen in the solution in the section on Creativity.

Answer to insight problem: *Marsha and Marjorie are two of a set of triplets. Gotcha!*

CONFIRMATION BIAS Another barrier to effective decision making or problem solving is **confirmation bias**, the tendency to search for evidence that fits one’s beliefs while ignoring any evidence to the contrary. This is similar to a mental set, except that what is “set” is a belief rather than a method of solving problems. Believers in ESP tend to remember the few studies that seem to support their beliefs and psychic predictions that

*barrier: something that blocks one’s path; an obstacle preventing a solution.

worked out while at the same time “forgetting” the cases in which studies found no proof or psychics made predictions that failed to come true. They remember only that which confirms their bias toward a belief in the existence of ESP. Another example is that people who believe that they are good multitaskers and can safely drive a motor vehicle while talking or texting on their cell phones may tend to remember their own personal experiences, which may not include any vehicle accidents or “near-misses” (that they are aware of). While it might be tempting to think of one’s self as a “supertasker,” recent research suggests otherwise. When tested on driving simulators while having to perform successfully on two attention-demanding tasks, over 97 percent of individuals are unable to do so without significant impacts on their performance. During the dual-task condition, only 2.5 percent of individuals were able to perform without problems (Watson & Strayer, 2010). This specific example can be quite dangerous, as it is estimated that at least 28 percent of all traffic crashes are caused by drivers using their cell phone and/or texting (National Safety Council, 2010).

CREATIVITY



So far, we've only talked about logic and pretty straightforward thinking. How do people come up with totally new ideas, things no one has thought of before?

Not every problem can be answered by using information already at hand and the rules of logic in applying that information. Sometimes a problem requires coming up with entirely new ways of looking at the problem or unusual, inventive solutions. This kind of thinking is called **creativity**: solving problems by combining ideas or behavior in new ways (Csikszentmihalyi, 1996; pronounced chick-sént-mē-HÍ-ē). Before we learn more, take the survey experiment *What Is Creativity?* to examine your own beliefs about creativity.



The driver of this train was texting from his cell phone immediately before this crash that killed 25 people and injured more than 130 others.

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Simulation

What is Creativity?

This survey asks about your experiences with being creative and your beliefs about the creative process and creative people.

Below is a pair of statements about creativity. For each pair, select the sentence with which you MOST AGREE.

- Creativity comes naturally to highly creative people.
- Highly creative people have to work hard to be creative.

Go to the Experiment ►

© Simulate the Experiment, *What Is Creativity?*, on **MyPsychLab**

The logical method for problem solving that has been discussed so far is based on a type of thinking called **convergent thinking**. In convergent thinking, a problem is seen as having only one answer and all lines of thinking will eventually lead to (converge on) that single answer by using previous knowledge and logic (Ciardiello, 1998). For example, the question “In what ways are a pencil and a pen alike?” can be answered by listing the

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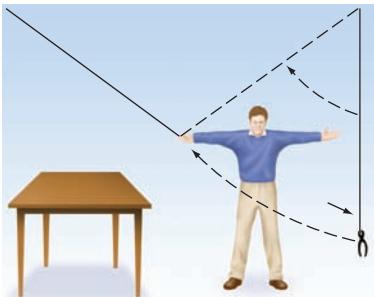
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Solution to the String Problem The solution to the string problem is to use the pliers as a pendulum to swing the second string closer to you.

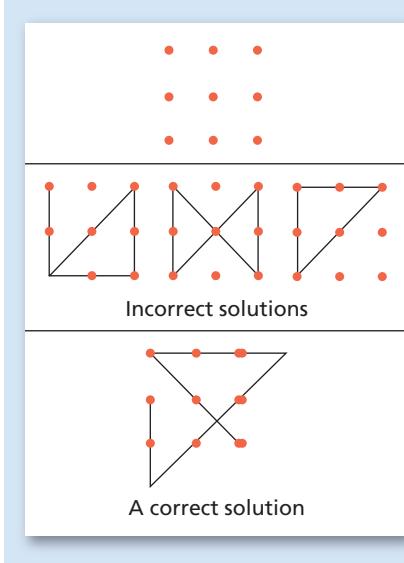
features that the two items have in common: Both can be used to write, have similar shapes, and so on, in a simple comparison process. Convergent thinking works well for routine problem solving but may be of little use when a more creative solution is needed.

Divergent thinking is the reverse of convergent thinking. Here a person starts at one point and comes up with many different, or divergent, ideas or possibilities based on that point (Finke, 1995). For example, if someone were to ask the question, “What is a pencil used for?” the convergent answer would be “to write.” But if the question is put this way: “How many different uses can you think of for a pencil?” the answers multiply: “writing, poking holes, a weight for the tail of a kite, a weapon.” Divergent thinking has been attributed not only to creativity but also to intelligence (Guilford, 1967).

What are the characteristics of a creative, divergent thinker? Theorists in the field of creative thinking have found through examining the habits of highly creative people that the most productive periods of divergent thinking for those people tend to occur when they are doing some task or activity that is more or less automatic, such as walking or swimming (Csikszentmihalyi, 1996; Gardner, 1993a; Goleman, 1995). These automatic tasks take up some attention processes, leaving the remainder to devote to creative thinking. The fact that all of one’s attention is not focused on the problem is actually a benefit, because divergent thinkers often make links and connections at a level of consciousness just below alert awareness, so that ideas can flow freely without being censored* by the higher mental processes (Goleman, 1995). In other words, having part of one’s attention devoted to walking, for example, allows the rest of the mind to “sneak up on” more creative solutions and ideas.

Divergent thinkers will obviously be less prone to some of the barriers to problem solving, such as functional fixedness. For example, what would most people do if it suddenly started to rain while they are stuck in their office with no umbrella? How many people would think of using a see-through vinyl tote bag as a makeshift umbrella?

Creative, divergent thinking is often a neglected topic in the education of young people. Although some people are naturally more creative, it is possible to develop one’s creative ability. The ability to be creative is important—coming up with topics for a research paper, for example, is something that many students have trouble doing. Cross-cultural research (Basadur et al., 2002; Colligan, 1983) has found that divergent thinking and problem-solving skills cannot be easily taught in the Japanese or Omaha Native American cultures, for example. In these cultures, creativity in many areas is not normally prized and the preference is to hold to well-established, cultural traditions, such as traditional dances that have not varied for centuries. See **Table 7.1** for some ways to become a more divergent thinker.



Solution to the Dot Problem When people try to solve this problem, a mental set causes them to think of the dots as representing a box, and they try to draw the line while staying in the box. The only way to connect all nine dots without lifting the pencil from the paper is to draw the lines so they extend out of the box of dots—literally “thinking outside the box.”

Table 7.1
Stimulating Divergent Thinking

Brainstorming	Generate as many ideas as possible in a short period of time, without judging each idea’s merits until all ideas are recorded.
Keeping a Journal	Carry a journal to write down ideas as they occur or a recorder to capture those same ideas and thoughts.
Freewriting	Write down or record everything that comes to mind about a topic without revising or proofreading until all of the information is written or recorded in some way. Organize it later.
Mind or Subject Mapping	Start with a central idea and draw a “map” with lines from the center to other related ideas, forming a visual representation of the concepts and their connections.

*censored: blocked from conscious awareness as unacceptable thoughts.

Many people have the idea that creative people are also a little different from other people. There are artists and musicians, for example, who actually encourage others to see them as eccentric. But the fact is that creative people are actually pretty normal. According to Csikszentmihalyi (1997):

1. Creative people usually have a broad range of knowledge about a lot of subjects and are good at using mental imagery.
2. Creative people aren't afraid to be different—they are more open to new experiences than many people, and they tend to have more vivid dreams and daydreams than others do.
3. Creative people value their independence.
4. Creative people are often unconventional in their work, but not otherwise.

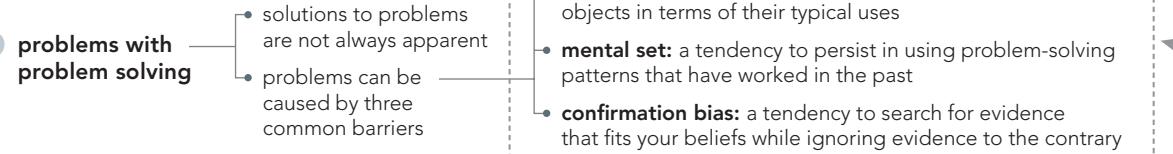


Cynthia Breazeal is a researcher at the Artificial Intelligence Lab at M.I.T. Here she is pictured with the robot she designed called Kismet. Designed to help with the study of infant emotional expressions, Kismet can display several "moods" on its face as emotional expressions. This is divergent thinking at its best—a "baby" that won't cry, wet, or demand to be fed.

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Explore the Concept at [MyPsychLab](#)

CONCEPT MAP



Problem Solving and Decision Making



Practice quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Alicia leaves her office building only to find it is raining. She returns to her office and gets a trash bag out of the supply cabinet. Using a pair of scissors, she cuts the bag so that she can put her head and arms through the bag without getting wet. In using the trash bag as a makeshift rain jacket, Alicia has overcome
 - functional fixedness.
 - confirmation bias.
 - creativity bias.
 - confirmation fixedness.
2. Randall believes that aliens are currently living deep under the ocean. When looking for information about this on the Internet, he ignores any sites that are skeptical of his belief and only visits sites that support his belief. This is an example of
 - functional fixedness.
 - confirmation bias.
 - creativity bias.
 - confirmation fixedness.
3. If you ask someone to give you as many uses as possible for a piece of paper, what type of thinking is being used?
 - divergent
 - functional fixedness
 - convergent
 - mental-set
4. Which of the following is the best way to encourage divergent, creative thinking?
 - Go for a walk or engage in some other automatic activity.
 - Stare at a blank sheet of paper until a new, innovative solution comes to mind.
 - Engage in many activities simultaneously.
 - Force yourself to think of something new and creative.

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Intelligence

What does it mean to be “smart”? Is this the same as being intelligent? It is likely the answer depends on the immediate task or context. What exactly do we mean by the term *intelligence*? Before we attempt to answer these questions, take the survey experiment *What Is Intelligence?* to discover more about your own notions of intelligence.

Simulation

What is Intelligence?

This survey asks you about your experiences exploring your own intelligence as well as your attitudes about the nature of intelligence and its outcomes.

[Go to the Experiment ►](#)

Psychological theory suggests there are many different types of intelligences. Which of the following types of intelligence do you agree exist?

- Please check all that apply
- Linguistic (intelligence involved in speaking, reading, writing)
 - Logical/Mathematical (ability to do abstract reasoning)
 - Spatial (ability to mentally visualize objects)
 - Musical (ability to appreciate the tonal qualities of sound, compose, play an instrument)
 - Analytic (ability to apply mental steps to solve problems)
 - Creative (use of experience in ways that foster insight; ability to deal with new and different concepts)
 - Practical (ability to read and adapt to the contexts of everyday life; street smarts)
 - Emotional (self-control of emotions, empathy for own and others emotions)

☞ Simulate the Experiment, *What Is Intelligence?*, on [MyPsychLab](#)

DEFINITION

How do psychologists define intelligence, and how do various theories of intelligence differ?

Is intelligence merely a score on some test, or is it practical knowledge of how to get along in the world? Is it making good grades or being a financial success or a social success? Ask a dozen people and you will probably get a dozen different answers. Psychologists have come up with a workable definition that combines many of the ideas just mentioned: They define **intelligence** as the ability to learn from one's experiences, acquire knowledge, and use resources effectively in adapting to new situations or solving problems (Sternberg & Kaufman, 1998; Wechsler, 1975). These are the characteristics that individuals need in order to survive in their culture. ☝ Watch the Video, *The Big Picture: What Is Intelligence?* at [MyPsychLab](#)

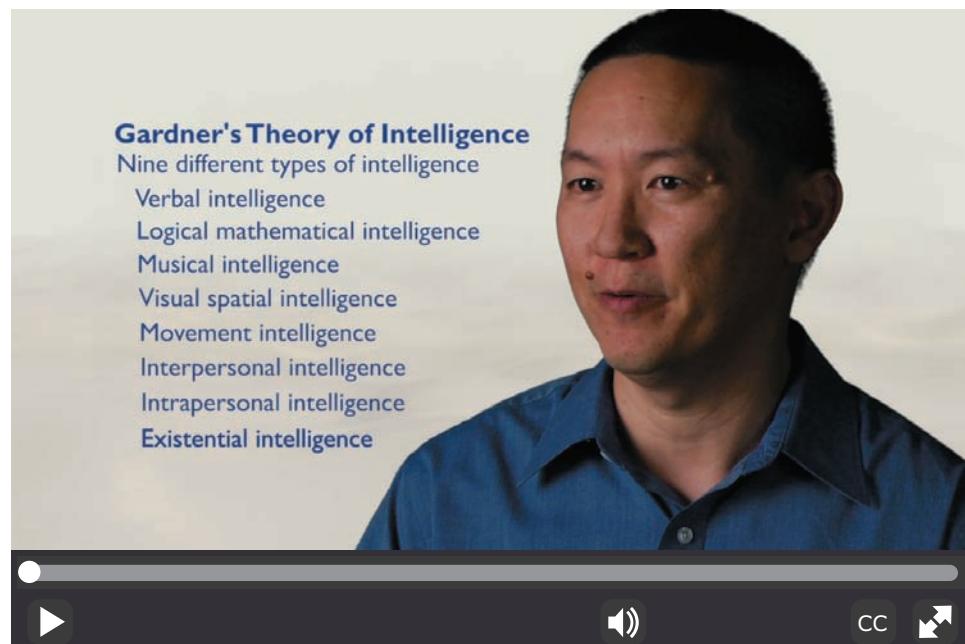
THEORIES OF INTELLIGENCE

Although we have defined intelligence in a general way, there are differing opinions of the specific knowledge and abilities that make up the concept of intelligence. In the following section, we will discuss three theories that offer different explanations of the nature and number of intelligence-related abilities.

SPEARMAN'S G FACTOR Charles Spearman (1904) saw intelligence as two different abilities. The ability to reason and solve problems was labeled **g factor** for *general intelligence*, whereas task-specific abilities in certain areas such as music, business, or art are labeled **s factor** for *specific intelligence*. A traditional IQ test would most likely measure g factor, but Spearman believed that superiority in one type of intelligence predicts superiority overall. Although his early research found some support for specific intelligences, other researchers (Guilford, 1967; Thurstone, 1938) felt that Spearman had oversimplified the concept of intelligence. Intelligence began to be viewed as composed of numerous factors. In fact, Guilford (1967) proposed that there were 120 types of intelligence.

GARDNER'S MULTIPLE INTELLIGENCES One of the later theorists to propose the existence of several kinds of intelligence is Howard Gardner (1993b, 1999a). Although many people use the terms *reason*, *logic*, and *knowledge* as if they are the same ability, Gardner believes that they are different aspects of intelligence, along with several other abilities. He originally listed seven different kinds of intelligence but later added an eighth type and then proposed a tentative ninth (Gardner, 1998, 1999b). The nine types of intelligence are described in the video *The Basics: Theories of Intelligence: Gardner's Theory* and summarized in **Table 7.2**.

The idea of multiple intelligences has great appeal, especially for educators. However, some argue that there are few scientific studies providing evidence for the concept of multiple intelligences (Waterhouse, 2006a, 2006b), while others claim that the evidence does exist (Gardner & Moran, 2006). Some critics propose that such intelligences are no more than different abilities and that those abilities are not necessarily the same thing as what is typically meant by *intelligence* (E. Hunt, 2001).



Gardner's Theory of Intelligence
Nine different types of intelligence

- Verbal intelligence
- Logical mathematical intelligence
- Musical intelligence
- Visual spatial intelligence
- Movement intelligence
- Interpersonal intelligence
- Intrapersonal intelligence
- Existential intelligence

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 Watch the Video, *The Basics: Theories of Intelligence: Gardner's Theory*, at [MyPsychLab](#)

Table 7.2

Gardner's Nine Intelligences

TYPE OF INTELLIGENCE	DESCRIPTION	SAMPLE OCCUPATION
Verbal/linguistic	Ability to use language	Writers, speakers
Musical	Ability to compose and/or perform music	Musicians, even those who do not read musical notes but can perform and compose
Logical/mathematical	Ability to think logically and to solve mathematical problems	Scientists, engineers
Visual/spatial	Ability to understand how objects are oriented in space	Pilots, astronauts, artists, navigators
Movement	Ability to control one's body motions	Dancers, athletes
Interpersonal	Sensitivity to others and understanding motivation of others	Psychologists, managers
Intrapersonal	Understanding of one's emotions and how they guide actions	Various people-oriented careers
Naturalist	Ability to recognize the patterns found in nature	Farmers, landscapers, biologists, botanists
Existentialist (a candidate intelligence)	Ability to see the "big picture" of the human world by asking questions about life, death, and the ultimate reality of human existence	Various careers, philosophical thinkers

Source: Gardner, 1998, 1999b.



This child is displaying only one of the many forms that intelligence can take, according to Gardner's multiple intelligences theory.

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Sternberg's practical intelligence is a form of "street smarts" that includes the ability to adapt to one's environment and solve practical problems. These girls are giving their younger brother a drink of water by using a folded leaf as an impromptu cup.

STERNBERG'S TRIARCHIC THEORY Robert Sternberg (1988, 1997b) has theorized that there are three kinds of intelligence. Called the **triarchic theory of intelligence** (*triarchic* means three), this theory includes *analytical*, *creative*, and *practical intelligence*. **Analytical intelligence** refers to the ability to break problems down into component parts, or analysis, for problem solving. This is the type of intelligence that is measured by intelligence tests and academic achievement tests, or "book smarts" as some people like to call it. **Creative intelligence** is the ability to deal with new and different concepts and to come up with new ways of solving problems (divergent thinking, in other words); it also refers to the ability to automatically process certain aspects of information, which frees up cognitive resources to deal with novelty (Sternberg, 2005). **Practical intelligence** is best described as "street smarts," or the ability to use information to get along in life. People with a high degree of practical intelligence know how to be tactful, how to manipulate situations to their advantage, and how to use inside information to increase their odds of success.

How might these three types of intelligence be illustrated? All three might come into play when planning and completing an experiment. For example:

- *Analytical*: Being able to run a statistical analysis on data from the experiment.
- *Creative*: Being able to design the experiment in the first place.
- *Practical*: Being able to get funding for the experiment from donors.

Practical intelligence has become a topic of much interest and research. Sternberg (1996, 1997a, b) has found that practical intelligence predicts success in life but has a surprisingly low relationship to academic (analytical) intelligence. In fact, the higher one's degree of practical intelligence, the less likely that person is to succeed in a university or other academic setting.  [Watch the Video, The Basics: Theories of Intelligence: Sternberg's Theory, at MyPsychLab](#)

MEASURING INTELLIGENCE

How is intelligence measured, how are intelligence tests constructed, and what role do these tests play in neuropsychology?

The history of intelligence testing spans the twentieth century and has at times been marked by controversies and misuse. A full history of how intelligence testing developed would take at least an entire chapter, so this section will discuss only some of the better known forms of testing and how they came to be.  [Watch the Video, Special Topics: Intelligence Testing, Then and Now, at MyPsychLab](#)

 It doesn't sound like intelligence would be easy to measure on a test—how do IQ tests work, anyway?

The measurement of intelligence by some kind of test is a concept that is less than a century old. It began when educators in France realized that some students needed more help with learning than others did. They thought that if a way could be found to identify these students more in need, they could be given a different kind of education than the more capable students.

BINET'S MENTAL ABILITY TEST In those early days, a French psychologist named Alfred Binet was asked by the French Ministry of Education to design a formal test of intelligence that would help identify children who were unable to learn as quickly or as well as others, so that they could be given remedial education. Eventually, he and colleague Théodore Simon came up with a test that not only distinguished between fast and slow learners but also between children of different age groups as well (Binet & Simon, 1916). They noticed that the fast learners seemed to give answers to questions that older children might give, whereas the slow learners gave answers that were more typical of a younger child. Binet decided that the key element to be tested was a child's *mental age*, or the average age at which children could successfully answer a particular level of questions.

STANFORD-BINET AND IQ Lewis Terman (1916), a researcher at Stanford University, adopted German psychologist William Stern's method for comparing mental age and *chronological age* (number of years since birth) for use with the translated and revised Binet test. Stern's (1912) formula was to divide the mental age (MA) by the chronological age (CA) and multiply the result by 100 to get rid of any decimal points. The resulting score is called an **intelligence quotient**, or **IQ**. (A *quotient* is a number that results from dividing one number by another.)

$$IQ = MA/CA \times 100$$

For example, if a child who is 10 years old takes the test and scores a mental age of 15 (is able to answer the level of questions typical of a 15-year-old), the IQ would look like this:

$$IQ = 15/10 \times 100 = 150$$

The quotient has the advantage of allowing testers to compare the intelligence levels of people of different age groups. While this method works well for children, it produces IQ scores that start to become meaningless as the person's chronological age passes 16 years. (Once a person becomes an adult, the idea of questions that are geared for a particular age group loses its power. For example, what kind of differences would there be between questions designed for a 30-year-old versus a 40-year-old?) Most intelligence tests today, such as the *Stanford-Binet Intelligence Scales, Fifth Edition* (SB5) (Roid, 2003) and the Wechsler tests (see the following section), use age-group comparison norms instead. The SB5 is often used by educators to make decisions about the placement of students into special educational programs, both for those with disabilities and for those with exceptionalities. Many children are given this test in the second grade, or age 7 or 8. The SB5 yields an overall estimate of intelligence, verbal and nonverbal domain scores, all comprised of five primary areas of cognitive ability—fluid reasoning, knowledge, quantitative processing, visual-spatial processing, and working memory (Roid, 2003). See **Table 7.3** for descriptions of some items similar to those from the SB5.

Table 7.3

Paraphrased Sample Items From the Stanford-Binet Intelligence Test

AGE*	TYPE OF ITEM	PARAPHRASED SAMPLE ITEM
2	Board with three differently shaped holes	Child can place correct shape into matching hole on board.
4	Building block bridge	Child can build a simple bridge out of blocks after being shown a model.
7	Similarities	Child can answer such questions as "In what way are a ship and a car alike?"
9	Digit reversal	Child can repeat four digits backward.
Average adult	Vocabulary	Child can define 20 words from a list.

*Age at which item typically is successfully completed.

Source: Roid, G. H. (2003).

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THE WECHSLER TESTS Although the original Stanford-Binet Test is now in its fifth edition and includes different questions for people of different age groups, it is not the only IQ test that is popular today. David Wechsler (Wechsler, 2002, 2003, 2008) was the first to devise a series of tests designed for specific age groups. Originally dissatisfied with the fact that the Stanford-Binet was designed for children but being administered to adults, he developed an IQ test specifically for adults. He later designed tests specifically for older school-age children and preschool children, as well as those in the early grades. The Wechsler Adult Intelligence Scale (WAIS-IV), Wechsler Intelligence Scale for Children (WISC-IV), and the Wechsler Preschool and Primary Scale of Intelligence (WPPSI-IV) are the three versions of this test, and in the United States these tests are now used more frequently than the Stanford-Binet. In earlier editions, another way these tests differed from the Stanford-Binet was by having both a verbal and performance (nonverbal) scale, as well as providing an overall score of intelligence (the original Stanford-Binet was composed predominantly of verbal items). While still using both verbal and nonverbal items, the WISC-IV and WAIS-IV organize items into four index scales that provide an overall score of intelligence and index scores related to four specific cognitive domains—verbal comprehension, perceptual reasoning, working memory, and processing speed. **Table 7.4** has sample items for each of the four index scales from the WAIS-IV.

TEST CONSTRUCTION: GOOD TEST, BAD TEST? All tests are not equally good tests. Some tests may fail to give the same results on different occasions for the same person when that

Table 7.4**Simulated Sample Items From the Wechsler Adult Intelligence Scale (WAIS-IV)****SIMULATED SAMPLE TEST ITEMS****Verbal Comprehension Index**

Similarities In what way are a circle and a triangle alike? In what way are a saw and a hammer alike?

Vocabulary What is a hippopotamus? What does “resemble” mean?

Information What is steam made of? What is pepper? Who wrote *Tom Sawyer*?

Perceptual Reasoning Index

Block Design After looking at a pattern or design, try to arrange small cubes in the same pattern.

Matrix Reasoning After looking at an incomplete matrix pattern or series, select an option that completes the matrix or series.

Visual Puzzles Look at a completed puzzle and select three components from a set of options that would re-create the puzzle, all within a specified time limit.

Working Memory Index

Digit Span Recall lists of numbers, some lists forward and some lists in reverse order, and recall a mixed list of numbers in correct ascending order.

Arithmetic Three women divided 18 golf balls equally among themselves. How many golf balls did each person receive? If two buttons cost \$0.15, what will be the cost of a dozen buttons?

Processing Speed Index

Symbol Search Visually scan a group of symbols to identify specific target symbols, within a specified time limit.

Coding Learn a different symbol for specific numbers and then fill in the blank under the number with the correct symbol. (This test is timed.)

Simulated items and descriptions similar to those in the Wechsler Adult Intelligence Scale—Fourth Edition (2008).

person has not changed—making the test useless. These would be considered unreliable tests. **Reliability** of a test refers to the test producing consistent results each time it is given to the same individual or group of people. For example, if Nicholas takes a personality test today and then again in a month or so, the results should be very similar if the personality test is reliable. Other tests might be easy to use and even reliable, but if they don't actually measure what they are supposed to measure, they are also useless. These tests are thought of as “invalid” (untrue) tests. **Validity** is the degree to which a test actually measures what it's supposed to measure. Another aspect of validity is the extent that an obtained score accurately reflects the intended skill or outcome in real-life situations, or *ecological validity*, not just validity for the testing or assessment situation. For example, we hope that someone who passes his or her test for a driver's license will also be able to safely operate a motor vehicle when they are actually on the road. When evaluating a test, consider what a specific test score means and to what, or to whom, it is compared.

Take the hypothetical example of Professor Stumpwater, who—for reasons best known only to him—believes that intelligence is related to a person's golf scores. Let's say that he develops an adult intelligence test based on golf scores. What do we need to look at to determine if his test is a good one?

Standardization of Tests First of all, we would want to look at how he tried to standardize his test. *Standardization* refers to the process of giving the test to a large group of people that represents the kind of people for whom the test is designed. One aspect of standardization is in the establishment of consistent and standard methods of test administration. All test subjects would take the test under the same conditions. In the professor's case, this would mean that he would have his sample members play the same number of rounds of golf on the same course under the same weather conditions, and so on. Another aspect addresses the comparison group whose scores will be used to compare individual test results. Standardization groups are chosen randomly from the population for whom the test is intended and, like all samples, must be representative of that population.  to Learning Objectives A.1 and 1.8. If a test is designed for children, for example, then a large sample of randomly selected children would be given the test.

Norms The scores from the standardization group would be called the *norms*, the standards against which all others who take the test would be compared. Most tests of intelligence follow a *normal curve*, or a distribution in which the scores are the most frequent around the *mean*, or average, and become less and less frequent the further from the mean they occur (see Figure 7.4).  to Learning Objectives A.2, A.3, and A.4.

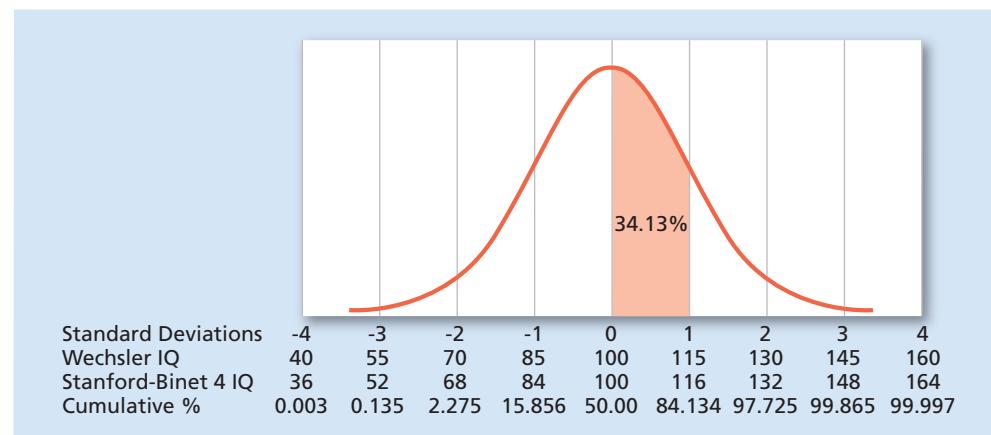


Figure 7.4 The Normal Curve

The percentages under each section of the normal curve represent the percentage of scores falling within that section for each standard deviation (*SD*) from the mean. Scores on intelligence tests are typically represented by the normal curve. The dotted vertical lines each represent one standard deviation from the mean, which is always set at 100. For example, an IQ of 115 on the Wechsler represents one standard deviation above the mean, and the area under the curve indicates that 34.13 percent of the population falls between 100 and 115 on this test.

 to Learning Objectives A.2, A.3, A.4 and 1.8. Note: The figure shows the mean and standard deviation for the Stanford-Binet Fourth Edition (Stanford-Binet 4). The Stanford-Binet Fifth Edition was published in 2003 and now has a mean of 100 and a standard deviation of 15 for composite scores.

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On the Wechsler IQ test, the percentages under each section of the normal curve represent the percentage of scores falling within that section for each *standard deviation* (*SD*) from the mean on the test. The standard deviation is the average variation of scores from the mean. [LINK](#) to Learning Objective A.4.

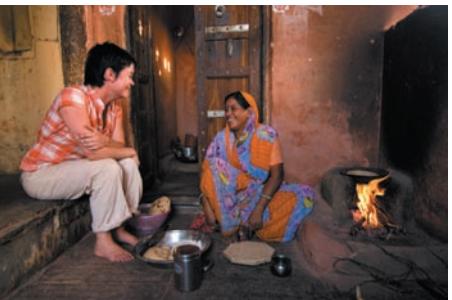
In the case of the professor's golf test, he might find that a certain golf score is the average, which he would interpret as average intelligence. People who scored extremely well on the golf test would be compared to the average, as well as people with unusually poor scores.

The normal curve allows IQ scores to be more accurately estimated than the old IQ scoring method formula devised by Stern. Test designers replaced the old ratio IQ of the earlier versions of IQ tests with **deviation IQ scores**, which are based on the normal curve distribution (Eysenck, 1994): IQ is assumed to be normally distributed with a mean IQ of 100 and a typical standard deviation of about 15 (the standard deviation can vary according to the particular test). An IQ of 130, for example, would be two standard deviations above the mean, whereas an IQ of 70 would be two standard deviations below the mean, and in each case the person's score is being compared to the population's average score.

With respect to validity and reliability, the professor's test fares poorly. If the results of the professor's test were compared with other established intelligence tests, there would probably be no relationship at all. Golf scores have nothing to do with intelligence, so the test is not a valid, or true, measure of intelligence.

On the other hand, his test might work well for some people and poorly for others on the question of reliability. Some people who are good and regular golfers tend to score about the same for each game that they play, so for them, the golf score IQ would be fairly reliable. But others, especially those who do not play golf or play infrequently, would have widely varying scores from game to game. For those people, the test would be very unreliable, and if a test is unreliable for some, it's not a good test.

A test can fail in validity but still be reliable. If for some reason Professor Stumpwater chose to use height as a measure of intelligence, an adult's score on Stumpwater's "test" would always be the same, as height does not change by very much after the late teens. But the opposite is not true. If a test is unreliable, how can it accurately measure what it is supposed to measure? For example, adult intelligence remains fairly constant. If a test meant to measure that intelligence gave different scores at different times, it's obviously not a valid measure of intelligence.

 Just because an IQ test gives the same score every time a person takes it doesn't mean that the score is actually measuring real intelligence, right?

That's right—think about the definition of intelligence for a moment: the ability to learn from one's experiences, acquire knowledge, and use resources effectively in adapting to new situations or solving problems. How can anyone define what "effective use of resources" might be? Does everyone have access to the same resources? Is everyone's "world" necessarily perceived as being the same? Intelligence tests are useful measuring devices but should not necessarily be assumed to be measures of all types of intelligent behavior, or even good measures for all groups of people, as the next section discusses.

IQ TESTS AND CULTURAL BIAS The problem with trying to measure intelligence with a test that is based on an understanding of the world and its resources is that not everyone comes from the same "world." People raised in a different culture, or even a different economic situation, from the one in which the designer of an IQ test is raised are not likely to perform well on such a test—not to mention the difficulties of taking a test that

How might these two women, apparently from different cultures, come to an agreement on what best defines intelligence?

is written in an unfamiliar language or dialect. In the early days of immigration, people from non-English-speaking countries would score very poorly on intelligence tests, in some cases being denied entry to the United States on the basis of such tests (Allen, 2006).

It is very difficult to design an intelligence test that is completely free of *cultural bias*, a term referring to the tendency of IQ tests to reflect, in language, dialect, and content, the culture of the person or persons who designed the test. A person who comes from the same culture (or even socioeconomic background) as the test designer may have an unfair advantage over a person who is from a different cultural or socioeconomic background (Helms, 1992). If people raised in an Asian culture are given a test designed within a traditional Western culture, many items on the test might make no sense to them. For example, one kind of question might be: Which one of the five is least like the other four?

DOG—CAR—CAT—BIRD—FISH

The answer is supposed to be “car,” which is the only one of the five that is not alive. But a Japanese child, living in a culture that relies on the sea for so much of its food and culture, might choose “fish,” because none of the others are found in the ocean. That child’s test score would be lower but not because the child is not intelligent.

In 1971, Adrian Dove designed an intelligence test to highlight the problem of cultural bias. Dove, an African American sociologist, created the Dove Counterbalance General Intelligence Test (later known as the Chitling Test) in an attempt to demonstrate that a significant language/dialect barrier exists among children of different backgrounds. Questions on this test were derived from the African-American culture and asked for information that would not be knowledge readily available to non-African-Americans. For example, one question asks about the proper length of time for cooking chitlings (the answer is 24 hours, just so you know).

Anyone not part of the African American culture of the southeastern United States in the 1960s and 1970s will probably score very poorly on this test, including African American people from different geographical regions. The point is simply this: Tests such as these are created by people who are from a particular culture and background. Test questions and answers that the creators might think are common knowledge may relate to their own experiences and not to people of other cultures, backgrounds, or socioeconomic levels.

Attempts have been made to create intelligence tests that are as free of cultural influences as is humanly possible. Many test designers have come to the conclusion that it may be impossible to create a test that is completely free of cultural bias (Carpenter et al., 1990). Instead, they are striving to create tests that are at least *culturally fair*. These tests use questions that do not create a disadvantage for people whose culture differs from that of the majority. Many items on a “culture-fair” test require the use of nonverbal abilities, such as rotating objects, rather than items about verbal knowledge that might be culturally specific.



If intelligence tests are so flawed, why do people still use them?

USEFULNESS OF IQ TESTS IQ tests are generally valid for predicting academic success and job performance (Sackett et al., 2008). This may be more true for those who score at the higher and lower ends of the normal curve. (For those who score in the average range of IQ, the predictive value is less clear.) The kinds of tests students are given in school are often similar to intelligence tests, and so people who do well on IQ tests typically do well on other kinds of academically oriented tests as well, such as the SAT, the

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American College Test (ACT), the Graduate Record Exam (GRE), and actual college examinations. These achievement tests are very similar to IQ tests but are administered to groups of people rather than to individuals. However, recent research suggests skills in self-regulation or levels of motivation may impact IQ measures and raises concerns about situations or circumstances where IQ scores may not be unbiased predictors of academic or job success (Duckworth et al., 2011; Duckworth & Seligman, 2005; Nisbett et al., 2012).  [Watch the Video](#), *Thinking Like a Psychologist: Intelligence Tests and Success*, at [MyPsychLab](#)

Intelligence testing also plays an important role in neuropsychology, where specially trained psychologists use intelligence tests and other forms of cognitive and behavioral testing to assess neurobehavioral disorders in which cognition and behavior are impaired as the result of brain injury or brain malfunction (National Academy of Neuropsychology, 2001). As part of their profession, neuropsychologists use intelligence testing in diagnosis (e.g., head injury, learning disabilities, neuropsychological disorders), tracking progress of individuals with such disorders, and in monitoring possible recovery. For more on neuropsychological assessment, see the Psychology in the News section.

psychology in the news



Neuropsychology Sheds Light on Head Injuries



Many of the topics in this chapter are related to the interests of cognitive psychologists, cognitive neuroscientists, and neuropsychologists alike, but here we will expand on the work of clinical neuropsychologists  to [Learning Objective B.5](#), who often work with individuals who have traumatic brain injury (TBI). Unlike a broken limb or other bodily injury that might result in a temporary loss of function, many traumatic brain injuries not only have immediate effects but can also be permanent, impacting the day-to-day functioning of both individuals and their loved ones for the rest of their lives. Depending on the area or areas of the brain injured and the severity of the trauma, some possible outcomes might include difficulty thinking, speech disturbances, memory problems, reduced attention span, headaches, sleep disturbances, frustration, mood swings, and personality changes. Not only do these outcomes negatively impact formal tests of intelligence, the deficits from such injuries may also affect thinking, problem solving, and cognition in general.

Mild traumatic brain injury, or concussion, is an impairment of brain function for minutes to hours following a head injury. Concussions may include a loss of consciousness for up to 30 minutes, “seeing stars,” headache, dizziness, and sometimes nausea or vomiting (Blumenfeld, 2011; Ruff et al., 2009). Amnesia for the events immediately before or after the accident is also a primary symptom and more likely to be anterograde in nature.  to [Learning Objective 6.5 and 6.12](#). With regard to concussions and other levels of traumatic brain injury, athletes and military personnel have been of particular interest to neuropsychologists, as they have been a vehicle for new findings about different types of injuries and the effects of repeated injury on long-term outcomes.

Athletics In high school athletes, concussions account for approximately 9 percent of all high school sports-related injuries; a recent survey of 15 college-level sports over a 16-year period found the rate of concussions has increased significantly (Gessel et al., 2007; Hootman et al., 2007). Cheerleading also has its share of head injuries, as concussions are among the five most common injuries reported in a sample of 412 cheerleading teams ranging from elementary school to college (Shields & Smith, 2009).

The effects of repeated concussions and the long-term effects of head injuries in general are of particular interest to neuropsychologists and other health professionals because the potential issues (memory problems, changes in personality, etc.) may not be evident until many years later. American football is one sport in which athletes may have extended playing careers. The possibility of an increased risk for depression, dementia, or other neurological risks for these athletes after they have quit playing has spawned ongoing research with professional football players (Guskiewicz et al., 2007; G. Miller, 2009; Hazrati et al., 2013). Former players who had three or more concussions were 3 times more likely to have significant memory problems and 5 times more likely to be diagnosed with mild cognitive impairment, often a precursor to Alzheimer's disease. Additional research suggests that some players develop high concentrations of the protein tau ( to [Learning Objective 6.12](#)), which has also been associated with Alzheimer's disease (Guskiewicz et al., 2005; McKee et al., 2009). Increased body weight is also being investigated as a dangerous combination for professional football players, as this can interfere with normal blood brain flow and may increase the negative consequences of repeated brain trauma (Willeumier et al., 2012). Researchers are also working to determine if there is something unique in the type of brain pathology that results in dementia as the result of a traumatic brain injury (TBI) when compared to the type of neuronal degeneration that results in Alzheimer's disease--in addition to professional athletes, individuals in the military are also at higher risk of TBI-related dementia (Goldstein et al., 2012; Shively et al., 2012).

Military Historically, many military conflicts have been associated with a "signature wound," which is an injury that is suffered by a substantial number of veterans from that particular war. The wound may be physical or psychological in nature. For instance, "shell shock" is often associated with many veterans of World War I. For the Vietnam War, post-traumatic stress disorder is the pervasive injury that comes to mind. In the ongoing conflicts in Iraq and Afghanistan, the signature wound may be TBI (E. Jones et al., 2007; Okie, 2005). The degree of brain injuries being sustained range from mild to moderate to severe, and over 50 percent are considered to be moderate to severe (Okie, 2005). In some studies, more than 15 percent of soldiers returning from Iraq report experiencing a mild traumatic brain injury, most likely the result of high intensity combat or a blast mechanism (Hoge et al., 2008). Many of these blast injuries are caused by IEDs, or "improvised explosive devices." The prevalence of IEDs is currently greater in Iraq than it is in Afghanistan, with troops in Iraq being approximately 1.7 times more likely to be hospitalized with traumatic brain injury. Unfortunately, it is a trend that appears to be increasing (Wojcik et al., 2010). The pervasiveness of IEDs in Iraq has generated new areas of research with the goal of improving the lives of the injured by understanding the unique outcomes and consequences associated with this particular type of head injury, as it appears to impact the brain in ways not seen in other types of head injury. For example, both resting state and specific task-based fMRI protocols may prove beneficial in understanding the brain and functional changes that occur in blast TBI (Graner et al., 2013).

To learn more about traumatic brain injury:

National Institute of Neurological Disorders and Stroke www.ninds.nih.gov/disorders/tbi/tbi.htm

To learn more about blast injuries:

Centers for Disease Control and Prevention
www.bt.cdc.gov/masscasualties/explosions.asp

Questions for Further Thought

1. Do you know someone with a TBI? How has the injury affected his or her life?
2. Who do you think has a better chance of recovery from a TBI, a child or an adult? Why?

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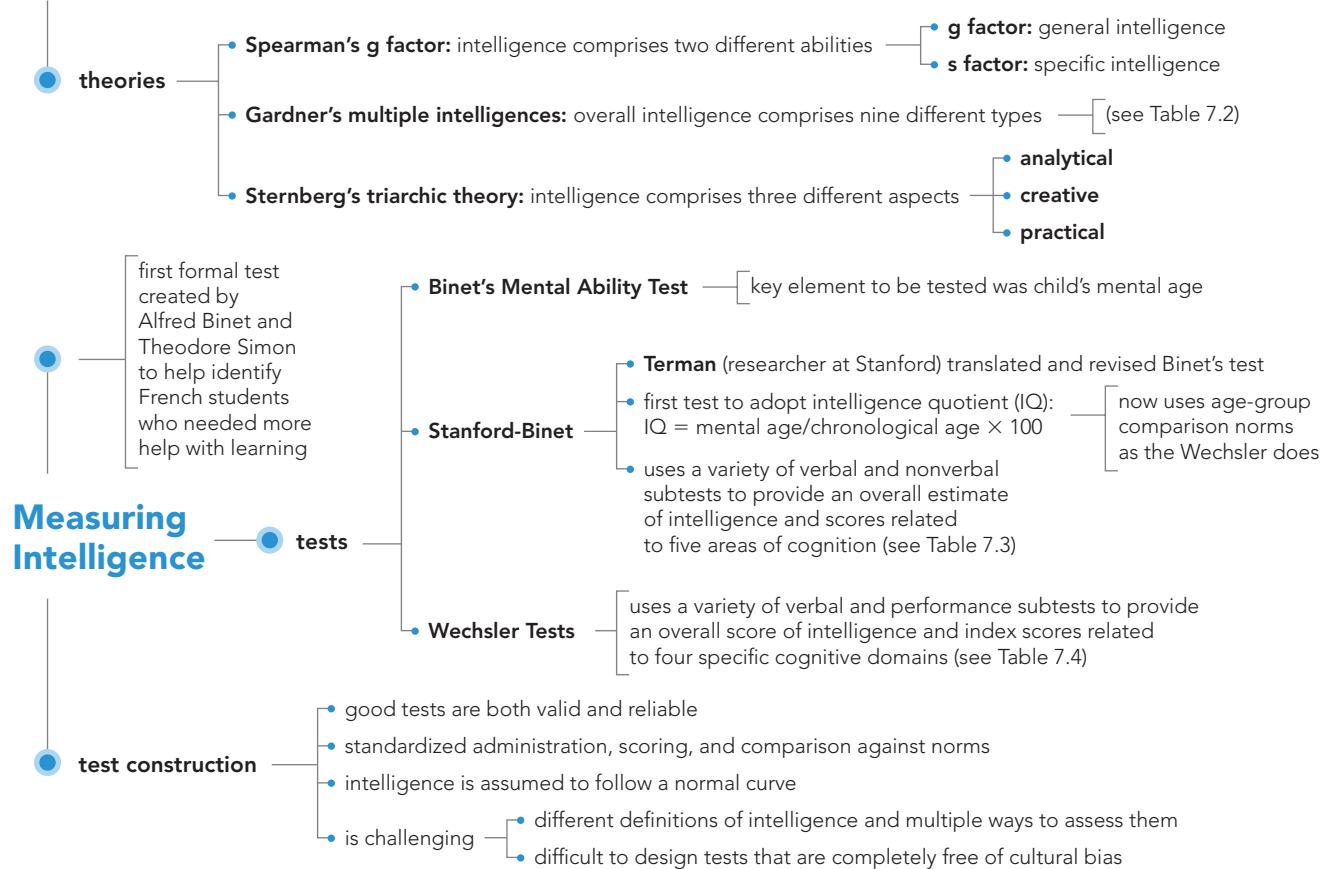
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 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP

Intelligence

(the ability to learn from one's experiences, acquire knowledge, and use resources effectively)



PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. In Gardner's view, effective counseling psychologists and managers would likely be high in _____ intelligence.
 - a. verbal/linguistic
 - b. visual-spatial
 - c. interpersonal
 - d. intrapersonal
2. According to Sternberg, which type of intelligence has a low relationship to academic success and would be the most difficult to measure in the classroom?
 - a. practical
 - b. creative
 - c. analytical
 - d. verbal
3. By what age do IQ scores start to become meaningless?
 - a. 5
 - b. 10
 - c. 16
 - d. 30
4. Liv is 4 years old. The intelligence test that would most likely be used to determine her IQ is the
 - a. WAIS-IV.
 - b. WISC-IV.
 - c. WPPSI-IV.
 - d. Dove Test.
5. Professor Becker designed an IQ test. To validate this test, the professor should be careful to do which of the following?
 - a. Give the test at least twice to the same group to ensure accuracy.
 - b. Select the people in the sample from the population of people for whom the test is designed.
 - c. Select only university professors to take the test so that they can critique the questions on the test.
 - d. Strive to make sure that the test measures what it is supposed to measure.
6. In terms of differing cultures, what should be the goal of every test designer?
 - a. to create a test free of cultural bias
 - b. to create a test that is culturally fair
 - c. to create a test with no questions involving culture
 - d. to create a series of culture-varied tests

THINKING CRITICALLY:

What kind of questions would you include on an intelligence test to minimize cultural bias?

EXTREMES OF INTELLIGENCE

Another use of IQ tests is to help identify people who differ from those of average intelligence by a great degree. Although one such group is composed of those who are sometimes called “geniuses” (who fall at the extreme high end of the normal curve for intelligence), the other group is made up of people who, for various reasons, are considered intellectually disabled and whose IQ scores fall well below the mean on the normal curve.

INTELLECTUAL DISABILITY

What is intellectual disability and what are its causes?

Intellectual disability (intellectual developmental disorder) (formerly *mental retardation* or *developmentally delayed*) is a neurodevelopmental disorder and is defined in several ways. First, the person exhibits deficits in mental abilities, which is typically associated with an IQ score approximately two standard deviations below the mean on the normal curve, such as below 70 on a test with a mean of 100 and standard deviation of 15. Second, the person’s *adaptive behavior* (skills that allow people to live independently, such as being able to work at a job, communicate well with others, and grooming skills such as being able to get dressed, eat, and bathe with little or no help) is severely below a level appropriate for the person’s age. Finally, these limitations must begin in the developmental period. Intellectual disability occurs in about 1 percent of the population (American Psychiatric Association, 2013).

So how would a professional go about deciding whether or not a child has an intellectual disability? Is the IQ test the primary method?

Diagnosis Previous editions of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* relied heavily on IQ tests for determining the diagnosis of *mental retardation* and level of severity. This has changed with the release of the newest edition in 2013, the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* (American Psychiatric Association, 2013) and is consistent with recommendations from the American Association on Intellectual and Developmental Disabilities (AAIDD) (AAIDD, 2009; Schalock et al., 2010). Recognizing tests of IQ are less valid as one approaches the lower end of the IQ range, and the importance of adaptive living skills in multiple life areas, levels of severity are now based on level of adaptive functioning and level of support the individual requires (American Psychiatric Association, 2013). Thus, a *DSM-5* diagnosis of intellectual disability is based on deficits in intellectual functioning, determined by standardized tests of intelligence and clinical assessment, which impact adaptive functioning across three domains. The domains include: conceptual (memory, reasoning, language, reading, writing, math, and other academic skills), social (empathy, social judgement, interpersonal communication, and other skills that impact the ability to make and maintain friendships), and practical (self-management skills that affect personal care, job responsibilities, school, money management, and other areas) (American Psychiatric Association, 2013). Previous editions indicated these deficits must occur prior to 18 years of age, but the *DSM-5* removes the specific age criteria, specifying symptoms must begin during the developmental period.

Intellectual disability can vary from mild to profound. According to the *DSM-5* (American Psychiatric Association, 2013), individuals with mild intellectual disability may not be recognized as having deficits in the conceptual domain until they reach school age where learning difficulties become apparent; as an adult, they are likely to be fairly concrete thinkers. In the social domain, they are at risk of being manipulated as social judgment and interactions are immature as compared to same-age peers. In the practical

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This middle-aged man, named Jack, lives in a small town in Arkansas and serves as a deacon in the local church. He is loved and respected and leads what, for him, is a full and happy life. Jack also has Down syndrome but he has managed to find his place in the world.

domain, they are capable of living independently with proper supports in place but will likely require assistance with more complex life skill such as health care decisions, legal issues, or raising a family (American Psychiatric Association, 2013). This category makes up the vast majority of those with intellectual disabilities. Other classifications in order of severity are moderate, severe, and profound. Conceptually, individuals with profound intellectual disability have a very limited ability to learn beyond simple matching and sorting tasks and socially, have very poor communication skills, although they may recognize and interact nonverbally with well-known family members and other caretakers. In the practical domain, they may be able to participate by watching or assisting, but are likely totally dependent upon others for all areas of their care (American Psychiatric Association, 2013). All of these skill deficits are likely compounded by multiple physical or sensory impairments.

Causes What causes intellectual disability? Unhealthy living conditions can affect brain development. Examples of such conditions are lead poisoning from eating paint chips (Lanphear et al., 2000), exposure to PCBs (Darvill et al., 2000), prenatal exposure to mercury (Grandjean et al., 1997), as well as other toxicants (Ericksson et al., 2001; Eskenazi et al., 1999; Schroeder, 2000). Deficits may also be attributed to factors resulting in inadequate brain development or other health risks associated with poverty. Examples include malnutrition, health consequences as the result of not having adequate access to health care, or lack of mental stimulation through typical cultural and educational experiences.

Some of the biological causes of intellectual disability include Down syndrome ([LINK](#) to Learning Objective 8.3), fetal alcohol syndrome, and fragile X syndrome. *Fetal alcohol syndrome* is a condition that results from exposing a developing embryo to alcohol, and intelligence levels can range from below average to levels associated with intellectual disability (Olson & Burgess, 1997). In *fragile X syndrome*, a male has a defect in a gene on the X chromosome of the 23rd pair, leading to a deficiency in a protein needed for brain development. Depending on the severity of the damage to this gene, symptoms of fragile X syndrome can range from mild to severe or profound intellectual disability (Dykens et al., 1994; Valverde et al., 2007).

There are many other causes of intellectual disability (Murphy et al., 1998). Lack of oxygen at birth, damage to the fetus in the womb from diseases, infections, or drug use by the mother, and even diseases and accidents during childhood can lead to intellectual disability.

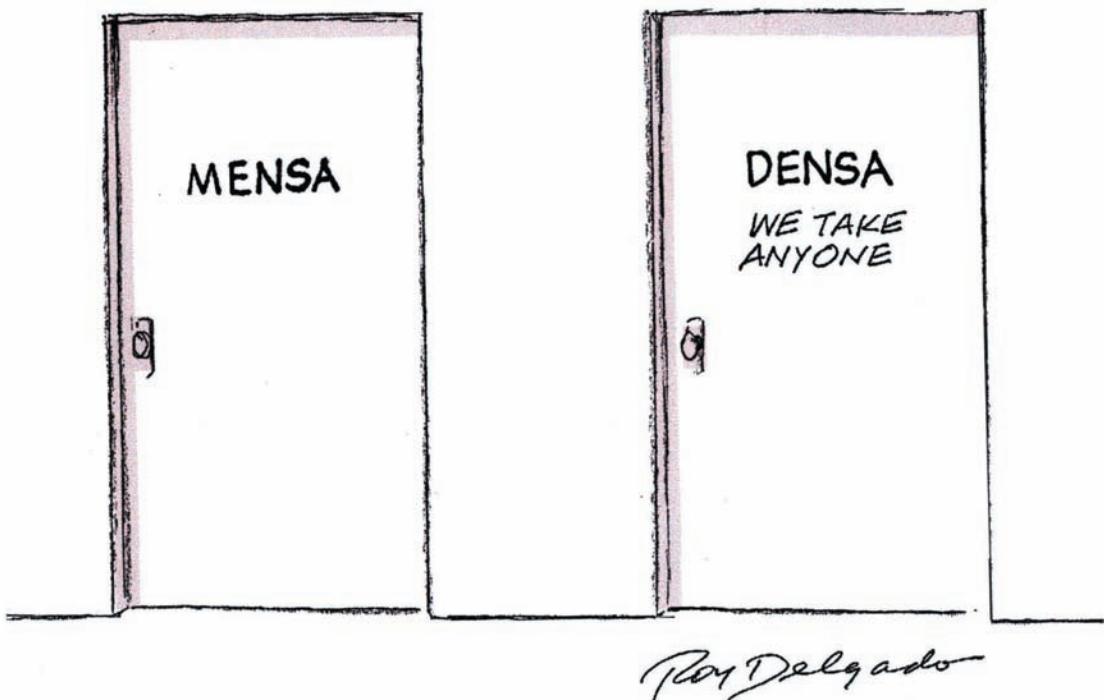
One thing should always be remembered: Intellectual disability affects a person's *intellectual* capabilities and adaptive behaviors. Individuals with an intellectual disability are just as responsive to love and affection as anyone else and need to be loved and to have friends just as all people do. Intelligence is only one characteristic; warmth, friendliness, caring, and compassion also count for a great deal and should not be underrated.

GIFTEDNESS

What defines giftedness, and how are giftedness and emotional intelligence related to success in life?

At the other end of the intelligence scale* are those who fall on the upper end of the normal curve (see Figure 7.4), above an IQ of 130 (about 2 percent of the population). The term applied to these individuals is **gifted**, and if their IQ falls above 140 to 145 (less than half of 1 percent of the population), they are often referred to as highly advanced or *geniuses*.

*scale: a graded series of tests or performances used in rating individual intelligence or achievement.



 I've heard that geniuses are sometimes a little "nutty" and odd. Are geniuses, especially the really high-IQ ones, "not playing with a full deck," as the saying goes?

People have long held many false beliefs about people who are very, very intelligent. Such beliefs have included that gifted people are weird and socially awkward, physically weak, and more likely to suffer from mental illnesses. From these beliefs come the "mad scientist" of the cinema and the "evil geniuses" of literature.

These beliefs were shattered by a groundbreaking study that was initiated in 1921 by Lewis M. Terman, the same individual responsible for the development of the Stanford-Binet Test. Terman (1925) selected 1,528 children to participate in a longitudinal study.  to Learning Objective 8.1. These children, 857 boys and 671 girls, had IQs (as measured by the Stanford-Binet) ranging from 130 to 200. The early findings of this major study (Terman & Oden, 1947) demonstrated that the gifted were socially well adjusted and often skilled leaders. They were also above average in height, weight, and physical attractiveness, putting an end to the myth of the weakling genius. Terman was able to demonstrate not only that his gifted children were *not* more susceptible to mental illness than the general population, but he was also able to show that they were actually more resistant to mental illnesses than those of average intelligence. Only those with the highest IQs (180 and above) were found to have some social and behavioral adjustment problems *as children* (Janos, 1987).

Terman's "Termites," as they came to be called, were also typically successful as adults. They earned more academic degrees and had higher occupational and financial success than their average peers (at least, the men in the study had occupational success—women at this time did not typically have careers outside the home). Researchers Zuo and Cramond (2001) examined some of Terman's gifted people to see if their identity formation as adolescents was related to later occupational success.  to Learning Objective 8.8. They found that most of the more successful "Termites" had in fact successfully achieved a consistent sense of self, whereas those who were less successful had not done so. For more on Terman's famous study, see Classic Studies in Psychology.



Stanford University psychologist Lewis Terman is pictured at his desk in 1942. Terman spent a good portion of his career researching children with high IQ scores and was the first to use the term *gifted* to describe these children.

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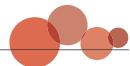
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classic studies in psychology



Terman's "Termites"



Terman's (1925) longitudinal study is still going on today, although many of his original subjects have passed away and those who remain are in their 90s. Terman himself died in 1956, but several other researchers (including Robert Sears, one of the original "Termites") have kept track of the remaining "Termites" over the years (Holahan & Sears, 1996).

As adults, the "Termites" were relatively successful, with a median income in the 1950s of \$10,556, compared to the national median at that time of \$5,800 a year. Most of them graduated from college, many earning advanced degrees. Their occupations included doctors, lawyers, business executives, university professors, scientists, and even one famous science fiction writer and an Oscar-winning director (Edward Dmytryk, director of *The Caine Mutiny* in 1954, among others).

By 2000, only about 200 "Termites" were still living. Although the study was marred by several flaws, it still remains one of the most important and rich sources of data on an entire generation. Terman's study was actually the first truly longitudinal study ([LINK](#) to Learning Objective 8.1) ever to be accomplished, and scientists have gotten data about the effects of phenomena such as World War II and the influence of personality traits on how long one lives from the questionnaires filled out by the participants over the years.

Terman and Oden (1959) compared the 100 most successful men in the group to the 100 least successful by defining "successful" as holding jobs that related to or used their intellectual skills. The more successful men earned more money, had careers with more prestige, and were healthier and less likely to be divorced or alcoholics than the less successful men. The IQ scores were relatively equal between the two groups, so the differences in success in life had to be caused by some other factor or factors. Terman and Oden found that the successful adults were different from the others in three ways: They were more goal oriented, more persistent in pursuing those goals, and were more self-confident than the less successful "Termites."

What were the flaws in this study? Terman acquired his participants by getting recommendations from teachers and principals, not through random selection, so that there was room for bias in the pool of participants from the start. It is quite possible that the teachers and principals were less likely, especially in 1921, to recommend students who were "troublemakers" or different from the majority. Consequently, Terman's original group consisted of almost entirely White, urban, and middle-class children, with the majority (857 out of 1,528) being male. There were only 2 African Americans, 6 Japanese Americans, and 1 Native American.

Another flaw is the way Terman interfered in the lives of his "children." In any good research study, the investigator should avoid becoming personally involved in the lives of the participants in the study to reduce the possibility of biasing the results. Terman seemed to find it nearly impossible to remain objective (Leslie, 2000). He became like a surrogate father to many of them.

Flawed as it may have been, Terman's groundbreaking study did accomplish his original goal of putting to rest the myths that existed about genius in the early part of the twentieth century. Gifted children and adults are no more prone to mental illnesses or odd behavior than any other group, and they also have their share of failures as well as successes. Genius is obviously not the only factor that influences success in life—personality and experiences are strong factors as well. For example, the homes of the children in the top 2 percent of Terman's group had an average of 450 books in their libraries, a sign that the parents of these children valued books and learning, and these parents were also more likely to be teachers, professionals, doctors, and lawyers. The experiences of these gifted children growing up would have been vastly different from those in homes with less emphasis on reading and lower occupational levels for the parents.

Questions for Further Discussion

1. In Terman and Oden's 1959 study of the successful and unsuccessful "Termites," what might be the problems associated with the definition of "successful" in the study?
2. Thinking back to the discussion of research ethics in Chapter One ([LINK](#) to Learning Objective 1.13), what ethical violations may Terman have committed while involved in this study?
3. If gifted children thrive when growing up in more economically sound and educationally focused environments, what should the educational system strive to do to nourish the gifted? Should the government get involved in programs for the gifted?

A book by Joan Freeman called *Gifted Children Grown Up* (Freeman, 2001) describes the results of a similar longitudinal study of 210 gifted and nongifted children in Great Britain. One of the more interesting findings from this study is that gifted children who are "pushed" to achieve at younger and younger ages, sitting for exams long before their peers would do so, often grow up to be disappointed, somewhat unhappy adults. Freeman points to differing life conditions for the gifted as a major factor in their success, adjustment, and well-being: Some lived in poverty and some in wealth, for example. Yet another longitudinal study (Torrance, 1993) found that in both gifted students and gifted adults there is more to success in life than intelligence and high academic achievement. In that study, liking one's work, having a sense of purpose in life, a high energy level, and persistence were also very important factors. If the picture of the genius as mentally unstable is a myth, so, too, is the belief that being gifted will always lead to success, as even Terman found in his original study.

EMOTIONAL INTELLIGENCE What about people who have a lot of "book smarts" but not much common sense? There are some people like that, who never seem to get ahead in life, in spite of having all that so-called intelligence. It is true that not everyone who is intellectually able is going to be a success in life (Mehrabian, 2000). Sometimes the people who are most successful are those who didn't do all that well in the regular academic setting.

One explanation for why some people who do poorly in school succeed in life and why some who do well in school don't do so well in the "real" world is that success relies on a certain degree of **emotional intelligence**, the accurate awareness of and ability to manage one's own emotions to facilitate thinking and attain specific goals, and the ability to understand what others feel (Mayer & Salovey, 1997; Mayer, Salovey, et al., 2008).

The concept of emotional intelligence was first introduced by Peter Salovey and John Mayer (1990) and later popularized by Dan Goleman (1995). And while Goleman originally suggested emotional intelligence was a more powerful influence on success in life than more traditional views of intelligence, his work and the work of others used the term in a variety of different ways than originally proposed, and claims by some were not backed by scientific evidence. For example, emotional intelligence is not the same as having high self-esteem or being optimistic. One who is emotionally intelligent possesses self-control of emotions such as anger, impulsiveness, and anxiety. Empathy, the ability to understand what others feel, is also a component, as are an awareness of one's own emotions, sensitivity, persistence even in the face of frustrations, and the ability to motivate oneself (Salovey & Mayer, 1990; Mayer & Salovey, 1997).

 That all sounds very nice, but how can anything like this be measured?

Is there research to support this idea? In one study, researchers asked 321 participants to read passages written by nonparticipants and try to guess what the

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Emotional intelligence includes empathy, which is the ability to feel what others are feeling. This doctor is not only able to listen to her patient's problems but also is able to show by her facial expression, body language, and gestures that she understands how the patient feels.

nonparticipants were feeling while they were writing (Mayer & Geher, 1996). The assumption was that people who were good at connecting thoughts to feelings would also have a high degree of empathy and emotional intelligence. The participants who more correctly judged the writers' emotional experiences (assessed by both how well each participant's emotional judgments agreed with a group consensus and the nonparticipant's actual report of feelings) also scored higher on the empathy measure and lower on the defensiveness measure. These same participants also had higher SAT scores (self-reported), leading Mayer and colleagues to conclude not only that emotional intelligence is a valid and measurable concept but also that general intelligence and emotional intelligence may be related: Those who are high in emotional intelligence are also smarter in the traditional sense (Mayer et al., 2000). A more recent review found individuals with higher emotional intelligence tended to have better social relationships for both children and adults, better family and intimate relationships, were perceived more positively by others, had better academic achievement, were more successful at work, and experienced greater psychological well-being (Mayer, Roberts, et al., 2008).

THE NATURE/NURTURE CONTROVERSY REGARDING INTELLIGENCE

What is the influence of heredity and environment on the development of intelligence?

Are people born with all of the “smarts” they will ever have, or does experience and learning count for something in the development of intellect? The influence of nature (heredity or genes) and nurture (environment) on personality traits has long been debated in the field of human development, and intelligence is one of the traits that has been examined closely. [LINK](#) to Learning Objective 8.2. [Watch](#) the Video, *What's in It for Me?: How Resilient Are You?*, at [MyPsychLab](#)

TWIN AND ADOPTION STUDIES The problem with trying to separate the role of genes from that of environment is that controlled, perfect experiments are neither practical nor ethical. Instead, researchers find out what they can from *natural experiments*, circumstances existing in nature that can be examined to understand some phenomenon. *Twin studies* are an example of such circumstances.

Identical twins are those who originally came from one fertilized egg and, therefore, share the same genetic inheritance. Any differences between them on a certain trait, then, should be caused by environmental factors. Fraternal twins come from two different eggs, each fertilized by a different sperm, and share only the amount of genetic material that any two siblings would share. [LINK](#) to Learning Objective 8.3. By comparing the IQs of these two types of twins reared together (similar environments) and reared apart (different environments), as well as persons of other degrees of relatedness, researchers can get a general, if not exact, idea of how much influence heredity has over the trait of intelligence (see **Figure 7.5**). As can be easily seen from the chart, the greater the degree of genetic relatedness, the stronger the correlation is between the IQ scores of those persons. The fact that genetically identical twins show a correlation of 0.86 means that the environment must play a part in determining some aspects of intelligence as measured by IQ tests. If heredity alone were responsible, the correlation between genetically identical twins should be 1.00. At this time, researchers have determined that the estimated **heritability** (proportion of change in IQ within a population that is caused by hereditary factors) for intelligence is about .50 or 50 percent (Plomin & DeFries, 1998; Plomin & Spinath, 2004). Furthermore, the impact of genetic factors increases with increasing age, but the set of genes or genetic factors remain the same. The effects of the same set of genes becomes larger with increasing age (Posthuma et al., 2009).

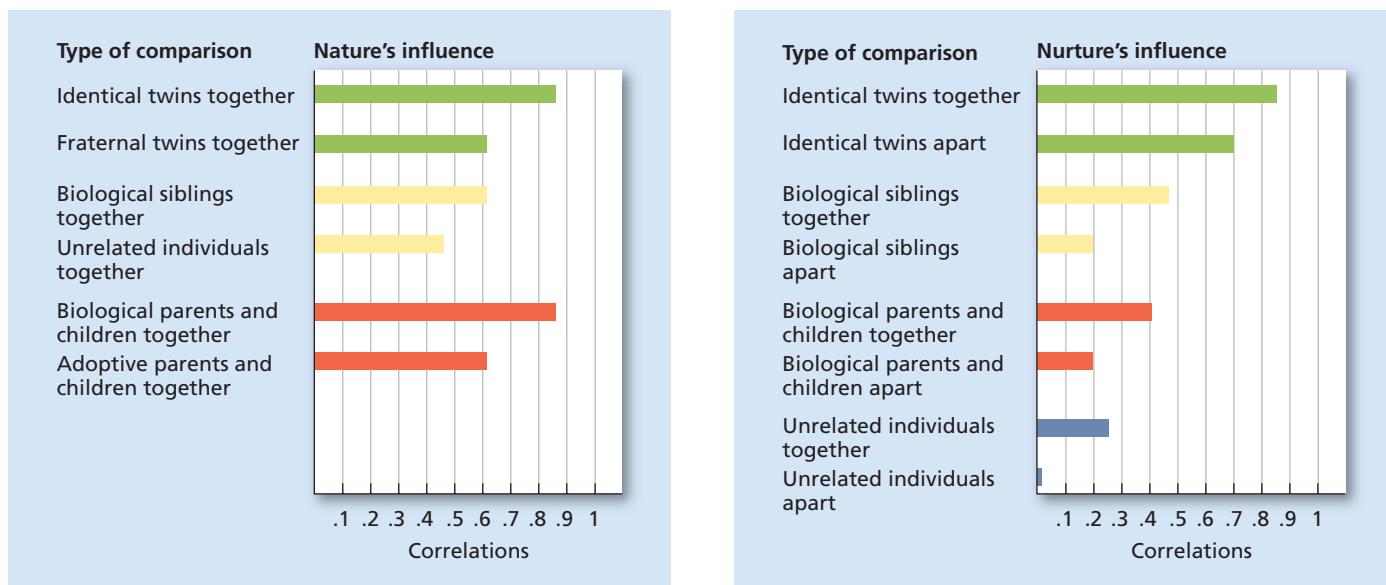


Figure 7.5 Correlations Between IQ Scores of Persons With Various Relationships

In the graph on the left, the degree of genetic relatedness seems to determine the agreement (correlation) between IQ scores of the various comparisons. For example, identical twins, who share 100 percent of their genes, are more similar in IQ than fraternal twins, who share only about 50 percent of their genes, even when raised in the same environment. In the graph on the right, identical twins are still more similar to each other in IQ than are other types of comparisons, but being raised in the same environment increases the similarity considerably.



Wait a minute—if identical twins have a correlation of .86, wouldn't that mean that intelligence is 86 percent inherited?

Although the correlation between identical twins is higher than the estimated heritability of .50, that similarity is not entirely due to the twin's genetic similarity. Twins who are raised in the same household obviously share very similar environments as well. Even twins who are reared apart, as seen in adoption studies, are usually placed in homes that are similar in socioeconomic and ethnic background—more similar than one might think. So when twins who are genetically similar are raised in similar environments, their IQ scores are also going to be similar. However, similar environmental influences become less important over time (where genetic influences increase over time), accounting for only about 20 percent of the variance in intelligence by age 11 or 12 (Posthuma et al., 2009). In turn, environmental influences tend not to be a factor by adolescence, and with the increasing impact of genetic factors, it has been suggested that the heritability of intelligence might be as high as .91 or 91 percent by the age of 65 (Posthuma et al., 2009).

One of the things that people need to understand about heritability is that estimates of heritability apply only to changes in IQ within a group of people, *not to the individual people themselves*. Each individual is far too different in experiences, education, and other nongenetic factors to predict exactly how a particular set of genes will interact with those factors in that one person. Only differences among people *in general* can be investigated for the influence of genes (Dickens & Flynn, 2001). Genes always interact with environmental factors, and in some cases extreme environments can modify even very heritable traits, as would happen in the case of a severely malnourished child's growth pattern. Enrichment, on the other hand, could have improved outcomes. Some observations suggest IQ scores are steadily increasing over time, from generation to generation, in modernized countries, a phenomena called the *Flynn effect* (Flynn, 2009).

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THE BELL CURVE AND MISINTERPRETATION OF STATISTICS One of the other factors that has been examined for possible heritable differences in performance on IQ tests is the concept of race. (The term *race* is used in most of these investigations as a way to group people with common skin colors or facial features, and one should always be mindful of how suspect that kind of classification is. Cultural background, educational experiences, and socioeconomic factors typically have far more to do with similarities in group performances than does the color of one's skin.) In 1994, Herrnstein and Murray published the controversial book *The Bell Curve*, in which they cite large numbers of statistical studies (never published in scientific journals prior to the book) that led them to make the claim that IQ is largely inherited. These authors go further by also implying that people from lower economic levels are poor because they are unintelligent.

In their book, Herrnstein and Murray made several statistical errors and ignored the effects of environment and culture. First, they assumed that IQ tests actually do measure intelligence. As discussed earlier, IQ tests are not free of cultural or socioeconomic bias. Furthermore, as the video *In the Real World: Intelligence Tests and Stereotypes* explains, just being aware of negative stereotypes can result in an individual scoring poorly on intelligence tests, a response called **stereotype threat** (Steele & Aronson, 1995). So all they really found was a correlation between race and IQ, not race and *intelligence*. Second, they assumed that intelligence itself is very heavily influenced by genetics, with a heritability factor of about .80. The current estimate of the heritability of intelligence is about .50 (Plomin & DeFries, 1998).



Watch the Video. *In the Real World: Intelligence Tests and Stereotypes*, at [MyPsychLab](#)

Herrnstein and Murray also failed to understand that heritability only applies to differences that can be found *within* a group of people as opposed to those *between* groups of people or individuals (Gould, 1981). Heritability estimates can only be made truly from a group that was exposed to a similar environment.

One of their findings was that Japanese Americans are at the top of the IQ ladder, a finding that they attribute to racial and genetic characteristics. They seem to ignore the cultural influence of intense focus on education and achievement by Japanese American parents (Neisser et al., 1996). Scientists (Beardsley, 1995; Kamin, 1995) have concluded that, despite the claims of *The Bell Curve*, there is no real scientific evidence for genetic differences in intelligence *between* different racial groups. A series of studies, using blood-group testing for racial grouping (different racial groups have different rates of certain blood groups, allowing a statistical estimation of ancestry), found no significant relationship between ethnicity and IQ (Neisser et al., 1996).



Although *The Bell Curve* stated that Japanese Americans are genetically superior in intelligence, the book's authors overlook the influence of cultural values. Many Japanese American parents put much time and effort into helping their children with schoolwork.

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 Explore the Concept at [MyPsychLab](#)

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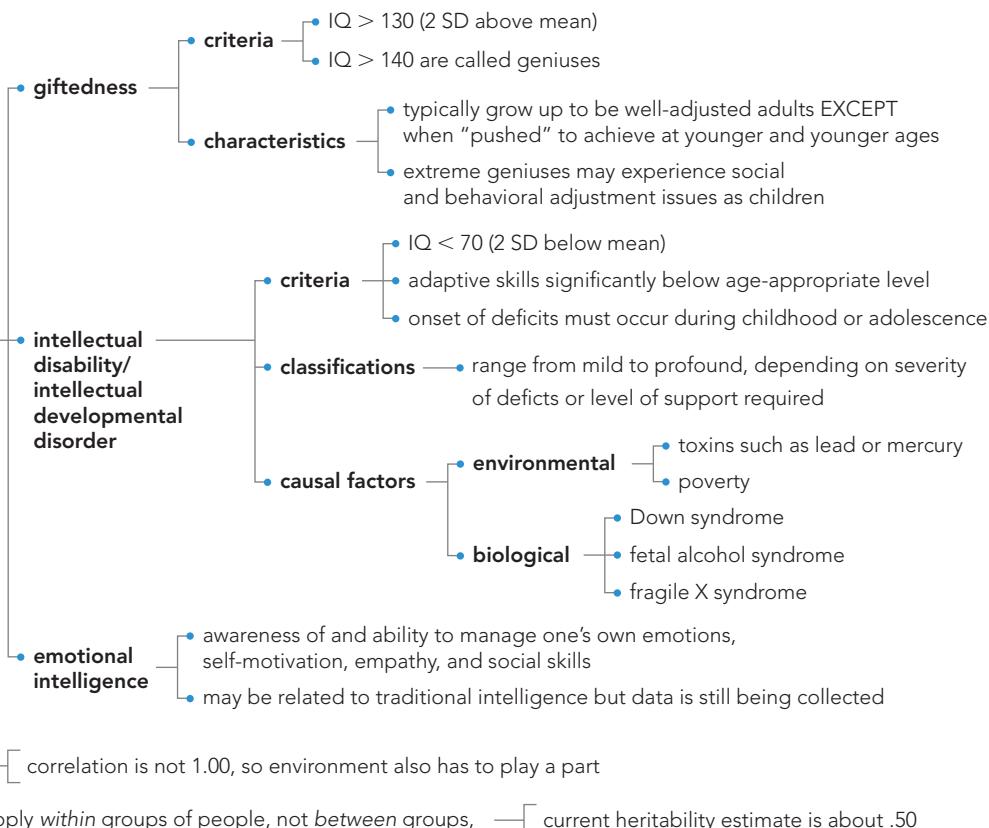
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Intelligence

nature vs. nurture

- identical twins reared together show a correlation of .86 between their IQs
- heritability estimates apply *within* groups of people, not *between* groups, not to individuals, and only in a general sense



PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

- Kyle, age 13, has an intellectual disability complicated by multiple physical and sensory impairments that significantly impact his skills of daily living and ability to communicate. He is unable to take care of himself in any area of life. Kyle would most likely be classified with _____ intellectual disability.
 - mild
 - moderate
 - severe
 - profound
- Lewis Terman's study provided evidence that individuals with high IQs
 - are generally weaker and lack social skills.
 - are no better at excelling in their careers than others with average IQs.
 - show little to no signs of mental illness or adjustment problems.
 - have more problems with interpersonal relationships except for those with IQs over 180.
- What were some of the differences between the 100 most successful men and the 100 least successful men in Terman's study?
 - The successful men had higher IQ scores and better parental upbringing.
 - The successful men had higher IQ scores and no family history of mental illness.
- The successful men had no family history of mental illness and were more motivated in general.
- The successful men had clearly defined goals and more motivation to achieve them.
- In recent studies, what do some researchers argue is a more accurate means of gauging success in relationships and careers?
 - intellectual intelligence
 - emotional intelligence
 - heredity studies
 - stress surveys
- Which of the following would be an example of a stereotype threat?
 - Joaquim, who believes IQ tests are unfair to Hispanics, something that his IQ score seems to reflect
 - Jasmine, who feels she must excel on her IQ test
 - Tiana, who believes that all testing, no matter the type, is stereotypical and biased
 - Malik, who believes that tests are equal but must excel so as not to be stereotyped by his friends

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Language

7.9 How is language defined, and what are its different elements and structure?

Language is a system for combining symbols (such as words) so that an infinite* number of meaningful statements can be made for the purpose of communicating with others. Language allows people not only to communicate with one another but also to represent their own internal mental activity. In other words, language is a very important part of how people think.

THE LEVELS OF LANGUAGE ANALYSIS

The structures of languages all over the world share common characteristics. They consist of the sounds that exist within a language, word meanings, word order, the rules for making words into other words, the meanings of sentences and phrases, and the rules for practical communication with others.

GRAMMAR **Grammar** is the system of rules governing the structure and use of a language. According to famed linguist Noam Chomsky (Chomsky, 2006; Chomsky et al., 2002), humans have an innate ability to understand and produce language through a device he calls the *language acquisition device*, or *LAD*. He defined the LAD as an innate “program” that contained a *schema* for human language. The children matched the language they heard against this schema and, thus, language developed in a well-researched sequence (Chomsky, 1957, 1964, 1981, 1986). While humans may learn the *specific* language (English, Spanish, Mandarin, etc.) through the processes of imitation, reinforcement, and shaping,  to Learning Objectives 5.5, 5.9, and 5.12, the complexities of the grammar of a language are, according to Chomsky, to some degree “wired in” to the developing brain. The LAD “listens” to the language input of the infant’s world and then begins to produce language sounds and eventually words and sentences in a pattern found across cultures. This pattern is discussed in greater detail in the next chapter.  to Learning Objective 8.6. Grammar includes phonemes (the basic sounds of language), morphology (the study of the formation of words), rules for the order of words known as syntax, and pragmatics (the practical social expectations and uses of language).

PHONEMES **Phonemes** are the basic units of sound in a language. The *a* in the word *car* is a very different phoneme from the *a* in the word *day*, even though it is the same letter of the alphabet. The difference is in how we say the sound of the *a* in each word. Phonemes are more than just the different ways in which we pronounce single letters, too. *Th*, *sh*, and *au* are also phonemes. Phonemes for different languages are also different, and one of the biggest problems for people who are trying to learn another language is the inability to both hear and pronounce the phonemes of that other language. Although infants are born with the ability to recognize all phonemes (Werker & Lalonde, 1988), after about 9 months, that ability has deteriorated and the infant recognizes only the phonemes of the language to which the infant is exposed (Boyson-Bardies et al., 1989).

MORPHEMES **Morphemes** are the smallest units of meaning within a language. For example, the word *playing* consists of two morphemes, *play* and *ing*.

SYNTAX **Syntax** is a system of rules for combining words and phrases to form grammatically correct sentences. Syntax is quite important, as just a simple mix-up can cause sentences to be completely misunderstood. For example, “John kidnapped the boy” has a different meaning from “John, the kidnapped boy,” although all four words are the same (Lasnik, 1990). Another example of the importance of syntax can be found in the lobby

*infinite: unlimited, without end.

of a Moscow hotel across from a monastery: “You are welcome to visit the cemetery where famous composers, artists, and writers are buried daily except Thursday.” So if people want to watch famous composers, artists, and writers being buried, they should not go to this monastery on Thursday.

SEMANTICS **Semantics** are rules for determining the meaning of words and sentences. Sentences, for example, can have the same semantic meaning while having different syntax: “Johnny hit the ball” and “the ball was hit by Johnny.”

PRAGMATICS The **pragmatics** of language has to do with the practical aspects of communicating with others, or the social “niceties” of language. Simply put, pragmatics involves knowing things like how to take turns in a conversation, the use of gestures to emphasize a point or indicate a need for more information, and the different ways in which one speaks to different people (Yule, 1996). For example, adults speak to small children differently than they do to other adults by using simpler words. Both adults and children use higher pitched voices and many repeated phrases when talking to infants; such child-directed speech plays

an important role in the development of language in children. Part of the pragmatics of language includes knowing just what rhythm and emphasis to use when communicating with others, called *intonation*. When speaking to infants, adults and children are changing the inflection when they use the higher pitch and stress certain words differently than others. Some languages, such as Japanese, are highly sensitive to intonation, meaning that changing the stress or pitch of certain words or syllables of a particular word can change its meaning entirely (Beckman & Pierrehumbert, 1986). For example, the Japanese name “Yoshiko” should be pronounced with the accent or stress on the first syllable: YO-she-koh. This pronunciation of the name means “woman-child.” But if the stress is placed on the second syllable (yo-SHE-ko), the name means “woman who urinates.”  **Watch** the [Video](#), Susan Goldwin-Meadow: *The Role of Gesture in Thinking*, at [MyPsychLab](#)

THE RELATIONSHIP BETWEEN LANGUAGE AND THOUGHT

7.10 Does language influence the way people think, and are animals capable of learning language?

As with the controversy of nature versus nurture, researchers have long debated the relationship between language and thought. Does language actually influence thought, or does thinking influence language?

Two very influential developmental psychologists, Jean Piaget and Lev Vygotsky, often debated the relationship of language and thought (Duncan, 1995). Piaget (1926, 1962) theorized that concepts preceded and aided the development of language. For example, a child would have to have a concept or mental schema for “mother” before being able to learn the word “mama.” In a sense, concepts become the “pegs” upon which words are “hung.” Piaget also noticed that preschool children seemed to spend a great deal of time talking to themselves—even when playing with another child. Each child would be talking about something totally unrelated to the speech of the other, in a process Piaget called *collective monologue*. Piaget believed that this kind of nonsocial speech was very egocentric (from the



Pragmatics involves the practical aspects of communicating. This young mother is talking and then pausing for the infant's response. In this way, the infant is learning about taking turns, an important aspect of language development. What kinds of games do adults play with infants that also aid the development of language?

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child's point of view only, with no regard for the listener), and that as the child became more socially involved and less egocentric, these nonsocial speech patterns would reduce.

Vygotsky, however, believed almost the opposite. He theorized that language actually helped develop concepts and that language could also help the child learn to control behavior—including social behavior (Vygotsky, 1962, 1978, 1987). For Vygotsky, the word helped form the concept: Once a child had learned the word "mama," the various elements of "mama-ness"—*warm, soft, food, safety*, and so on—could come together around that word. Vygotsky also believed that the "egocentric" speech of the preschool child was actually a way for the child to form thoughts and control actions. This "private speech" was a way for children to plan their behavior and organize actions so that their goals could be obtained. Since socializing with other children would demand much more self-control and behavioral regulation on the part of the preschool child, Vygotsky believed that private speech would actually increase as children became more socially active in the preschool years. This was, of course, the opposite of Piaget's assumption, and the evidence seems to bear out Vygotsky's view: Children, especially bright children, do tend to use more private speech when learning how to socialize with other children or when working on a difficult task (Berk, 1992; Berk & Spuhl, 1995; Bivens & Berk, 1990).

LINGUISTIC RELATIVITY HYPOTHESIS The hypothesis that language shapes and influences thoughts was accepted by many theorists, with a few notable exceptions, such as Piaget. One of the best-known versions of this view is the Sapir-Whorf hypothesis (named for the two theorists who developed it, Edward Sapir and his student, Benjamin Lee Whorf). This hypothesis assumes that the thought processes and concepts within any culture are determined by the words of the culture (Sapir, 1921; Whorf, 1956). It has come to be known as the **linguistic relativity hypothesis**, meaning that thought processes and concepts are controlled by (relative to) language. That is, the words people use determine much of the way in which they think about the world around them.

One of the most famous examples used by Whorf to support this idea was that of the Inuits, Native Americans living in the Arctic. Supposedly, the Inuits have many more words for *snow* than do people in other cultures. One estimate was 23 different words, whereas other estimates have ranged in the hundreds. Unfortunately, this anecdotal evidence has turned out to be false, being more myth than reality (Pullum, 1991). In fact, English speakers also have many different words for snow (*sleet, slush, powder, dusting, and yellow* to name a few).

Is there evidence for the linguistic relativity hypothesis? Neither Sapir nor Whorf provided any scientific studies that would support their proposition. There have been numerous studies by other researchers, however. For example, in one study researchers assumed that a language's color names would influence the ability of the people who grew up with that language to distinguish among and perceive colors. The study found that basic color terms did directly influence color recognition memory (Lucy & Shweder, 1979). But an earlier series of studies of the perception of colors by Eleanor Rosch-Heider and others (Rosch-Heider, 1972; Rosch-Heider & Olivier, 1972) had already found just the opposite effect: Members of the Dani tribe, who have only two names for colors, were no different in their ability to perceive all of the colors than were the English speakers in the study. More recent studies (Davies et al., 1998a, 1998b; Laws et al., 1995; Pinker & Bloom, 1990) support Rosch-Heider's findings and the idea of a **cognitive universalism** (concepts are universal and influence the development of language) rather than linguistic relativity.

Other research suggests that although the linguistic relativity hypothesis may not work for fine perceptual discriminations such as those in the Rosch-Heider studies, it may be an appropriate explanation for concepts of a higher level. In one study, researchers showed pictures of two animals to preschool children (Gelman & Markman, 1986). The pictures were of a flamingo and a bat. The children were told that the flamingo feeds its baby mashed-up food but the bat feeds its baby milk. Then they were shown a picture of

a blackbird (which looked more like the bat than the flamingo). Half of the children were told that the blackbird was a bird, while the other children were not. When asked how the blackbird fed its baby, the children who had been given the bird label were more likely to say that it fed its baby mashed-up food than were the children who were not given the label, indicating that the preschoolers were making inferences about feeding habits based on category membership rather than perceptual similarity—the word *bird* helped the children who were given that label to place the blackbird in its proper higher level category.

Research continues in the investigation of relationships between language and thought, and appears to support linguistic relativity and how language can shape our thoughts about space, time, colors, and objects (Boroditsky, 2001, 2009). However, researchers do not always agree, and for some studies that offer support, there are others that reinterpret the data, fail to replicate, or offer critiques of the original studies, so findings are sometimes still in question (J. Y. Chen, 2007; January & Kako, 2007).

Psychologists cannot deny the influence of language on problem solving, cognition, and memory. Sometimes a problem can simply be worded differently to have the solution become obvious, and memory ( to Learning Objective 6.5) is certainly stored in terms of the semantics of language. Language can definitely influence the perception of others as well—“computer geek” and “software engineer” might be used to describe the same person, but one phrase is obviously less flattering and the image brought to mind is different for the two terms. In the end, trying to determine whether language influences thoughts or thoughts influence language may be like trying to determine which came first, the chicken or the egg.

 I've heard that chimpanzees can be taught to use sign language. Is this for real, or are the chimps just performing tricks like the animals in the circus or the zoo?

ANIMAL STUDIES IN LANGUAGE There are really two questions about animals and language. The first is “Can animals communicate?” and the second is “Can animals use language?” The answer to the first question is a definite “Yes.” Animals communicate in many ways. They use sounds such as the rattle of a rattlesnake or the warning growl of an angry dog. There are also physical behaviors, such as the “dance” of honeybees that tells the other bees where a source of pollen is (Gould & Gould, 1994). But the answer to the second question is more complicated, because language is defined as the use of symbols, and symbols are things that stand for something else. Words are symbols, and gestures can be symbols. But the gestures used by animals are instinctual, meaning they are controlled by the animal’s genetic makeup. The honeybee doing the “dance” is controlled completely by instinct, as is the growling dog. In human language, symbols are used quite deliberately and voluntarily, not by instinct, and abstract symbols have no meaning until people assign meaning to them. (Although Chomsky’s innate language acquisition device might lead some to think that language for humans is instinctual, it should be noted that the infant’s production of speech sounds becomes quite deliberate within a short period of time.)

Can animals be taught to use symbols that are abstract? There have been attempts to teach animals (primates and dolphins) how to use sign language (as animals lack the vocal structure to form spoken words), but many of these attempts were simply not “good science.” The most successful of these experiments (which is not without its critics as well) has been with Kanzi, a bonobo chimpanzee trained to press abstract symbols on a computer keyboard (Savage-Rumbaugh & Lewin, 1994). Kanzi actually was not the original subject of the study—his mother, Matata, was the chimp being trained. She did not learn many of the symbols, but Kanzi watched his mother use the keyboard and appeared to learn how to use the symbols through that observation. At last count, Kanzi could understand about 150 spoken English words. Trainers who speak to him are not in his view,

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Kanzi looks at the keyboard used in teaching language to chimpanzees. Kanzi's language abilities were learned through watching researchers train his mother rather than directly—much as a human infant learns through listening to the speech of adults.

so he is not responding to physical cues or symbols. He has managed to follow correctly complex instructions up to the level of a 2-year-old child (Savage-Rumbaugh et al., 1998). The most recent studies with Kanzi have him making sounds that seem to have consistent meaning across different situations (Tagliatela et al., 2003). Nearly 100 videotaped hours of Kanzi engaged in day-to-day activities were analyzed for these sounds. The researchers were able to identify four sounds that seemed to represent banana, grapes, juice, and the word *yes*. (However, remember that four sounds do not come close to making an entire language.)

[Watch the Video, Classic Footage of Chimpanzees and Sign Language, at MyPsychLab](#)

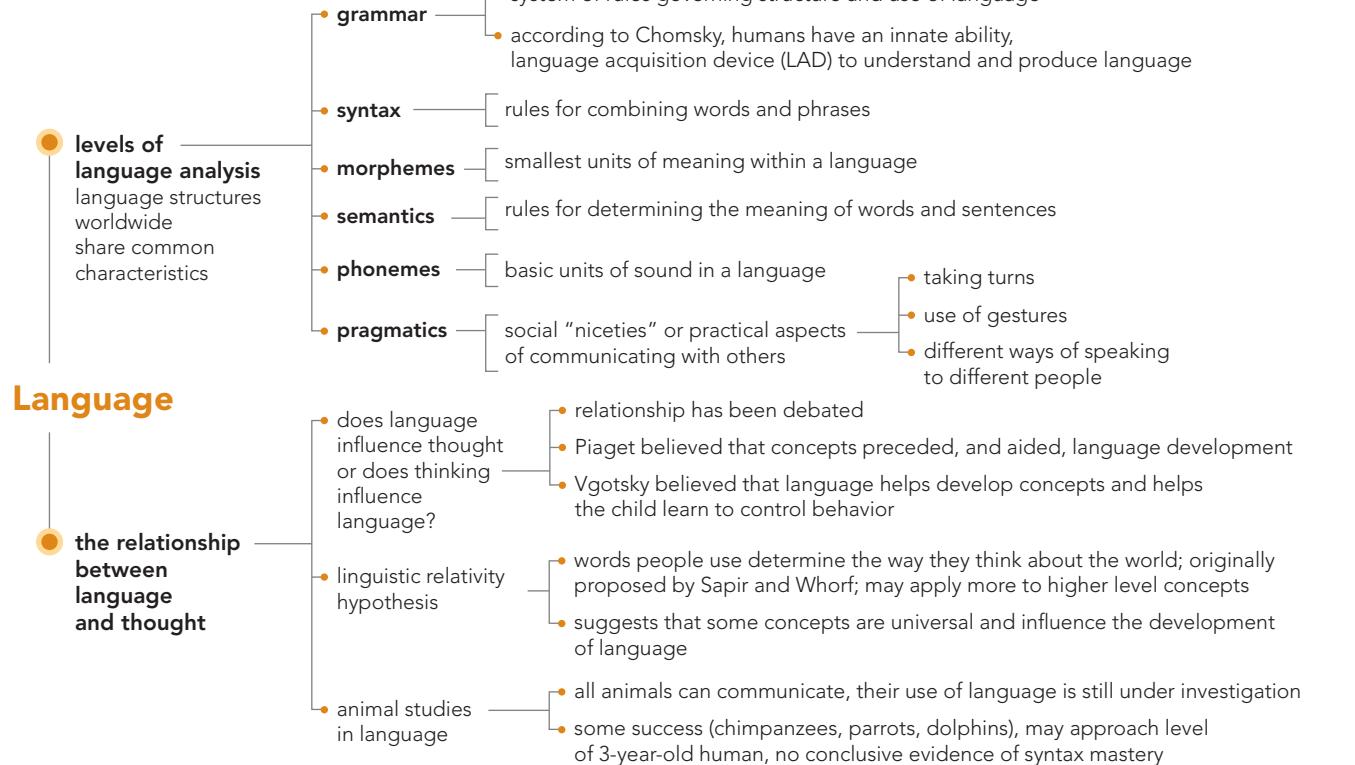
Other studies, with dolphins (Herman et al., 1993) and with parrots (Pepperberg, 1998, 2007), have also met with some success. Is it real language? The answer seems to be a qualified “yes.” The qualification is that none of the animals that have achieved success so far can compare to the level of language development of a 3-year-old human child (Pinker, 1995). However, linguists still debate whether these animals are truly learning language if they are not also learning how to use syntax—combining words into grammatically correct sentences as well as being able to understand the differences between sentences such as “The girl kissed the boy” and “The boy kissed the girl.” As yet, there is no conclusive evidence that any of the animals trained in language have been able to master syntax (Demers, 1988; Johnson, 1995; Pinker, 1995).

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[Explore the Concept at MyPsychLab](#)

CONCEPT MAP



PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. The basic units of sound in a language are known as
 - a. grammar.
 - b. morphemes.
 - c. syntax.
 - d. phonemes.
2. According to Noam Chomsky, what is a language acquisition device?
 - a. an environmental entity that allows people to learn foreign languages
 - b. a biological element of the brain that allows us to learn language
 - c. a learning method that many can use to understand the language of infants and small children
 - d. a part of the brain that develops during puberty that allows teens and adults to formulate questions and engage others
3. Researchers believe that up to the age of _____, individuals possess the ability to understand phonemes of all languages.
 - a. 3 months
 - b. 9 months
 - c. 2 years
 - d. 7 years
4. _____ believed that language helps to develop concepts, whereas _____ believed that concepts must be developed first if language is to follow.
 - a. Vygotsky; Piaget
 - b. Chomsky; Sapir and Whorf
 - c. Piaget; Rosch-Heider
 - d. Sapir and Whorf; Vygotsky

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Applying Psychology to Everyday Life: Mental and Physical Exercises Combine for Better Cognitive Health

What are some ways to improve thinking?

You may have heard the saying “use it or lose it” and likely think of it in terms of maintaining physical fitness. But it is not limited to that; in many regards, the saying applies as well to our ability to maintain cognitive fitness. However, just as there is a difference between physical activity and physical exercise, there is a difference in mental *activity* and mental *exercise*.

Quite a few computerized brain-training programs and devices have hit the market in the last few years. In addition, a lot of attention in the media has focused on the benefits of specific computer-based brain exercises you can do to improve your cognitive fitness. While some are more scientifically grounded and offer the possibility of real benefits, many more appear to be riding the current wave of interest and may not be useful. For some individuals, practicing certain mental skills through cognitive exercises appears to help with those same skills when tested later. In general, however, research has not identified any benefits that transfer to untrained areas (A. M. Owen et al., 2010). Just as being physically active in general will not make you an Olympic athlete, to tune up your cognitive fitness you have to perform proper, focused cognitive exercises.

Wait a minute! You just said most skills don’t transfer. That’s correct, some do not, but just as in physical training, if you select the proper foundational exercises, you can benefit higher-level cognitive functions. For example, impaired verbal working memory is one of the cognitive dysfunctions in schizophrenia. Deficits in early auditory processing are also present and have negative implications for both verbal learning and memory, and for understanding the semantics and emotional content of speech (M. Fisher et al., 2009). Imagine the difficulty you would have if you could not follow a conversation with another person because you could not remember what they just said or because you could not comprehend the meaning or the emotions they were expressing in their speech.

In a recent study, it was found that for a group of individuals with schizophrenia, computerized cognitive exercises that placed increasing demands on auditory perception (a foundational skill) were beneficial (M. Fisher et al., 2009). Those same individuals later

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demonstrated significant progress in verbal working memory and global cognition tasks (higher-level skills). Although the cognitive exercise group originally received daily training for 10 weeks, when some participants were studied 6 months later, the researchers found that some of the gains were still evident and that gains overall were positively correlated with improved quality of life at the 6-month assessment point (Fisher et al., 2009). The authors acknowledged that some of the positive effects might have been due to the number of hours of training and the amount of repetition (the authors noted that each exercise was practiced for thousands of trials!). Furthermore, approximately 16 hours were devoted to tasks that had word stimuli or a learning/memory component, while over 30 hours were spent performing tasks that focused on auditory perception, which also engaged working memory.

The noting of the auditory perception tasks involving *working memory* ([LINK](#)) to Learning Objective 6.3 in the M. Fisher et al. (2009) study is very interesting, especially in light of research suggesting challenging, adaptive training in working memory appears to improve *fluid intelligence* in young adults (Jaeggi et al., 2008). However, recent research suggests training in working memory may improve *working memory capacity* on related tasks, but on measures of fluid intelligence, these improvements do not generalize (Harrison et al., 2013). Fluid intelligence is the ability to adapt and deal with new problems or challenges the first time you encounter them, without having to depend on knowledge you already possess.

What else can you do more generally to benefit your cognitive health? Exercise! And this time, we are referring to physical exercise. Physical activity and specifically aerobic fitness has repeatedly been demonstrated to be associated with improved cognitive function across the life span. A physically active lifestyle and greater aerobic fitness has been implicated with better executive control and memory processes in preadolescent children (Chaddock et al., 2010; Hillman et al., 2009), better educational outcomes later in life and improved affect and visuospatial memory in young adults (Åberg et al., 2009; Stroth et al., 2009), increased hippocampal volume (associated with better memory) in elderly adults (Erickson et al., 2009), and as a useful intervention in a group of individuals at high risk of cognitive decline or impairment, especially for females in the group (Baker et al., 2010).

At least one possible benefit of regular aerobic activity is promoting or maintaining functional connectivity among key brain areas of the frontal, temporal, and parietal lobes (Voss et al., 2010). The increases in oxygen and blood flow to the brain play key roles. Other benefits include increased levels of mood-related neurotransmitters including serotonin, norepinephrine, and dopamine, along with neurogenesis in specific brain areas including the hippocampus (Ratey & Hagerman, 2008). In another study, 3 months of aerobic activity and increased fitness were associated with small increases in the size of the hippocampus and improved memory in individuals with schizophrenia. Interestingly, controls without schizophrenia in this research *also* showed increases in their hippocampi associated with increases in aerobic fitness (Pajonk et al., 2010).

So instead of “use it or lose it,” perhaps a better saying to keep in mind is “what is good for the heart or body is also good for the mind.” If you want to learn more, an interesting overview of research related to exercise and brain health can be found in the book *Spark: The Revolutionary New Science of Exercise and the Brain* by John Ratey and Eric Hagerman (2008).

Questions for Further Discussion

1. Aside from those involving working memory, what other kinds of focused mental exercises might help to keep the brain fit?
2. Should doctors suggest aerobic exercise for their patients interested in maintaining or improving their cognitive functions? What about psychologists working with individuals who have mood or anxiety disorders, or clients with attention problems?
3. Based on this information, what might the implications be for schools that are reducing or eliminating their physical education requirements? What about college students who may experience a decrease in physical activity as compared to when they were in high school?

Writing Prompt

▼ How might you determine whether flute-playing ability is a highly heritable trait? If you want to improve your flute playing and someone tells you that musical ability is heritable, should you stop practicing?

Words: 0

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 Write the Response on **MyPsychLab**

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chapter summary

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How People Think

- Thinking (cognition) is mental activity that occurs in the brain when information is being organized, stored, communicated, or processed.

7.1 How are mental images and concepts involved in the process of thinking?

- Mental images represent objects or events and have a picturelike quality.
- Concepts are ideas that represent a class or category of events, objects, or activities.
- Prototypes are examples of a concept that more closely match the defining characteristics of that concept.

7.2 What are the methods people use to solve problems and make decisions?

- Problem solving consists of thinking and behaving in certain ways to reach a goal.
- Mechanical solutions include trial-and-error learning and rote solutions.
- Algorithms are a type of rote solution in which one follows step-by-step procedures for solving certain types of problems.
- A heuristic or “rule of thumb” is a strategy that narrows down the possible solutions for a problem.
- Insight is the sudden perception of a solution to a problem.

7.3 Why does problem solving sometimes fail, and what is meant by creative thinking?

- Functional fixedness is the tendency to perceive objects as having only the use for which they were originally intended and, therefore, failing to see them as possible tools for solving other problems.
- Confirmation bias is the tendency to search for evidence that confirms one’s beliefs, ignoring any evidence to the contrary.

- Divergent thinking involves coming up with as many different answers as possible. This is a kind of creativity (combining ideas or behavior in new ways).
- Creative people are usually good at mental imagery and have knowledge on a wide range of topics, are unafraid to be different, value their independence, and are often unconventional in their work but not in other areas.

Intelligence

7.4 How do psychologists define intelligence, and how do various theories of intelligence differ?

- Intelligence is the ability to understand the world, think rationally or logically, and use resources effectively when faced with challenges or problems.
- Spearman proposed general intelligence, or g factor, as the ability to reason and solve problems, whereas specific intelligence, or s factor, includes task-specific abilities in certain areas such as music, business, or art.
- Gardner proposed nine different types of intelligence, ranging from verbal, linguistic, and mathematical to interpersonal and intrapersonal intelligence.
- Sternberg proposed three types of intelligence: analytical, creative, and practical.

7.5 How is intelligence measured, how are intelligence tests constructed, and what role do these tests play in neuropsychology?

- The Stanford-Binet Intelligence Test yields an IQ score that was once determined by dividing the mental age of the person by the chronological age and multiplying that quotient by 100 but now involves comparing a person’s score to a standardized norm.

- The Wechsler Intelligence Tests yield four index scores derived from both verbal and nonverbal subtests and an overall score of intelligence.
- Standardization, validity, and reliability are all important factors in the construction of an intelligence test.
- Deviation IQs are based on the normal curve, defining different levels of intelligence based on the deviation of scores from a common mean.
- IQ tests are often criticized for being culturally biased.
- Neuropsychologists play an important role in the care of individuals with traumatic brain injury and other conditions where brain functioning has been negatively impacted.
- Concussion, or mild traumatic brain injury, affects the lives of many athletes and military personnel.

7.6 What is intellectual disability and what are its causes?

- Intellectual disability is a neurodevelopmental condition in which IQ falls below 70 and adaptive behavior across conceptual, social, and practical domains of life is severely deficient for a person of a particular chronological age. Symptoms must also first be present during the developmental period.
- The four levels of intellectual disability are mild, moderate, severe, and profound. These are determined by the level of adaptive functioning and level of supports the individual needs in their daily life.
- Causes of intellectual disability include deprived environments as well as chromosome and genetic disorders and dietary deficiencies.

7.7 What defines giftedness, and how are giftedness and emotional intelligence related to success in life?

- Gifted persons are defined as those having IQ scores at the upper end of the normal curve (130 or above).
- Emotional intelligence involves being able to reach goals and engage in productive thinking through accurate awareness and effective management of our own emotions. It also involves our ability to understand what others feel.
- Teran conducted a longitudinal study that demonstrated that gifted children grow up to be successful adults for the most part.
- Teran's study has been criticized for a lack of objectivity because Teran became too involved in the lives of several of his participants, even to the point of intervening on their behalf.

7.8 What is the influence of heredity and environment on the development of intelligence?

- Stronger correlations are found between IQ scores as genetic relatedness increases. Heritability of IQ is estimated at .50.

- In 1994, Herrnstein and Murray published *The Bell Curve*, in which they made widely criticized claims about the heritability of intelligence.

Language

7.9 How is language defined, and what are its different elements and structure?

- Language is a system for combining symbols so that an infinite number of meaningful statements can be created and communicated to others.
- Grammar is the system of rules by which language is governed and includes the rules for using phonemes, morphemes, and syntax. Pragmatics refers to practical aspects of language.

7.10 Does language influence the way people think, and are animals capable of learning language?

- Sapir and Whorf originally proposed that language controls and helps the development of thought processes and concepts, an idea that is known as the linguistic relativity hypothesis.
- Other researchers have found evidence that concepts are universal and directly influence the development of language, called the cognitive universalism viewpoint.
- Studies with chimpanzees, parrots, and dolphins have been somewhat successful in demonstrating that animals can develop a basic kind of language, including some abstract ideas.
- Controversy exists over the lack of evidence that animals can learn syntax, which some feel means that animals are not truly learning and using language.

Applying Psychology to Everyday Life: Mental and Physical Exercises Combine for Better Cognitive Health

7.11 What are some ways to improve thinking?

- Both specific mental exercises (such as those involving working memory) and physical exercise promoting aerobic fitness are important for optimal cognitive functioning.

test YOURSELF

ANSWERS AVAILABLE IN ANSWER KEY.

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Pick the best answer.

- Kahneman describes System 1 processes as
 - mental actions that are completely involuntary.
 - mental actions that require conscious focus.
 - mental actions that result from unconscious forces.
 - mental actions that are based off internal biological changes.
- Research suggests we engage mental images in our mind _____ the way we engage or interact with physical objects.
 - a little like
 - much like
 - not at all like
 - randomly and completely different than

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development across the life span

At a time when many teenagers are hanging out at the mall with friends, 16-year-old Jessica Watson was on a mission to become the youngest individual to sail nonstop and unassisted around the world. She left Sydney, Australia, on October 18, 2009 and returned seven months later, on May 15, 2010, unofficially breaking the previous record (Marks, 2010; Munoz, 2010). Watson's record will remain unrecognized, however. The World Speed Sailing Record Council did away with its "youngest" category to discourage what it considers dangerous and foolhardy attempts by those who are too young. Adolescence is one among many stages of life that we will explore in this chapter. While we will focus on several of the common features of human development in all of those stages, the story of Jessica Watson should be a reminder that each of us is an individual, with different motivations, goals, and desires.

How have you changed since your early teenage years? In what ways are you similar to other individuals of your age and in what ways are you different and unique?

A video player interface featuring a portrait of a young man with dark hair and a warm smile. He is wearing a long-sleeved, button-down shirt with vertical stripes in shades of brown, tan, and white. The background is plain white. The video player includes a play button, volume control, closed captioning (CC), and a share icon. Floating around the video frame are several large, semi-transparent blue circles of varying sizes, some overlapping the video content. The overall design is clean and modern, with a white border around the video frame.

Watch the Video at [MyPsychLab.com](#)

Why study human development?

Beginning to understand how we come to be the people we are is a critical step in understanding ourselves as we are today, and who we may become as we grow older. From the moment of conception, each of us is headed down a pathway of change, influenced by our biology, environment, and social interactions, to a final destination that is the same for all of us. The twists and turns of the pathway are what make each of us unique individuals. In this chapter, we'll look at the influences that help determine our developmental pathway through life.

Learning objectives

- 8.1** What are some of the special research designs used to study development?
- 8.2** What is the relationship between heredity and environmental factors in determining development?
- 8.3** How do chromosomes, genes, and DNA determine a person's characteristics or disorders?
- 8.4** What happens during conception and prenatal development and what are some prenatal hazards?
- 8.5** What kind of physical changes take place in infancy and childhood?
- 8.6** What are two ways of looking at cognitive development, how does language develop, and what is autism spectrum disorder?
- 8.7** How do infants and children develop personalities and form relationships with others, and what are Erikson's stages of psychosocial development for children?
- 8.8** What are the physical, cognitive, and personality changes that occur in adolescence, including concepts of morality and Erikson's search for identity?
- 8.9** What are the physical, cognitive, and personality changes that occur during adulthood and aging, including Erikson's last three psychosocial stages, and patterns of parenting?
- 8.10** How do psychologists explain why aging occurs, and what are the stages of death and dying?
- 8.11** What are some cross-cultural differences in views of death and dying?



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Issues in Studying Human Development

What is development? In the context of life, **human development** is the scientific study of the changes that occur in people as they age, from conception until death. This chapter will touch on almost all of the topics covered in the other chapters of this text, such as personality, cognition, biological processes, and social interactions. But here, all of those topics will be studied in the context of changes that occur as a result of the process of human development.

RESEARCH DESIGNS

What are some of the special research designs used to study development?

As briefly discussed in Chapter One, research in human development is affected by the problem of age. In any experiment, the participants who are exposed to the independent variable (the variable in an experiment that is deliberately manipulated by the experimenter) should be randomly assigned to the different experimental conditions. The challenge in developmental research is that the age of the people in the study should always be an independent variable, but people cannot be randomly assigned to different age-groups.

There are some special designs that are used in researching age-related changes: the **longitudinal design**, in which one group of people is followed and assessed at different times as the group ages; the **cross-sectional design**, in which several different age-groups are studied at one time; and the **cross-sequential design**, which is a combination of the longitudinal and cross-sectional designs (Baltes et al., 1988; Schaie & Willis, 2010).

The longitudinal design has the advantage of looking at real age-related changes as those changes occur in the same individuals. Disadvantages of this method are the lengthy amount of time, money, and effort involved in following participants over the years, as well as the loss of participants when they move away, lose interest, or die. The cross-sectional design has the advantages of being quick, relatively inexpensive, and easier to accomplish than the longitudinal design. Its main disadvantage is that the study no longer compares an individual to that same individual as he or she ages; instead, individuals of different ages are being compared to one another. Differences between age-groups are often a problem in developmental research. For example, if comparing the IQ scores of 30-year-olds to 80-year-olds to see how aging affects intelligence, questions arise concerning the differing educational experiences and opportunities those two age-groups have had that might affect IQ scores, in addition to any effects of aging. This is known as the **cohort effect**, the particular impact on development that occurs when a group of people share a common time period or common life experience (for example, having been born in the same time period or having gone through a specific historical event together). **Table 8.1** shows a comparison between examples of a longitudinal design, a cross-sectional design, and a cross-sequential design.

In studying human development, developmental psychologists have outlined many theories of how these age-related changes occur. There are some areas of controversy, however, and one of these is the issue of nature versus nurture.

NATURE VERSUS NURTURE

What is the relationship between heredity and environmental factors in determining development?

Nature refers to heredity, the influence of inherited characteristics on personality, physical growth, intellectual growth, and social interactions. **Nurture** refers to the influence

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Table 8.1**A Comparison of Three Developmental Research Designs**

CROSS-SECTIONAL DESIGN		
Different participants of various ages are compared at one point in time to determine age-related differences.	Group One: 20-year-old participants Group Two: 40-year-old participants Group Three: 60-year-old participants	Research done in 2014
LONGITUDINAL DESIGN		
The same participants are studied at various ages to determine age-related changes.	Study One: 20-year-old participants Study Two: Same participants at 40 years old Study Three: Same participants are now 60 years old	Research done in 1974 Research done in 1994 Research done in 2014
CROSS-SEQUENTIAL DESIGN		
Different participants of various ages are compared at several points in time, to determine both age-related differences and age-related changes.	Study One: Group One: 20-year-old participants Group Two: 40-year-old participants Study Two: Group One: Participants will be 25 years old Group Two: Participants will be 45 years old	Research done in 2014 Research to be done in 2019

of the environment on all of those same things and includes parenting styles, physical surroundings, economic factors, and anything that can have an influence on development that does not come from within the person.  [Watch the Video](#), *The Big Picture: Genes, Evolution, and Human Behavior*, at [MyPsychLab](#)



So, is a person like Hitler born that way, or did something happen to make him the person he was?

How much of a person's personality and behavior is determined by nature and how much is determined by nurture? This is a key question, and the answer is quite complicated. It is also quite important: Are people like Hitler, or Dzhokhar Tsarnaev (the youngest of the two brothers responsible for the bombings at the 2013 Boston Marathon) the result of bad genes, bad parenting, or life-altering experiences in childhood? How much of Stephen Hawking's genius is due to his genetic inheritance? What part did the parenting choices of his family play? Or are his cognitive abilities the unique combination of both hereditary and environmental influences? After many years of scientific research, most developmental psychologists now agree that the last possibility is the most likely explanation for most of human development: All that people are and all that people become is the product of an interaction between nature and nurture (Davis et al., 2012; Insel & Wang, 2010; Ridley, 1999; Sternberg & Grigorenko, 2006). This does not mean that the nature versus nurture controversy no longer exists; for example, intelligence is still a "hot topic" with regard to how much is inherited and how much is learned. Researchers and theorists assume a large genetic influence (Bouchard & Segal, 1985; Herrnstein & Murray, 1994; Jensen, 1969; Johnson et al., 2007; Kristensen & Bjerkedal, 2007), whereas many believe that culture, economics, nutrition in early childhood, and educational opportunities have a greater impact (Gardner et al., 1996; Gould, 1996; Rose et al., 1984; Wahlsten, 1997).

Behavioral genetics is a field in the investigation of the origins of behavior in which researchers try to determine how much of behavior is the result of genetic inheritance and how much is due to a person's experiences. As the video *The Basics: Genetic Mechanisms and Behavioral Genetics : Use of Family and Twin Studies* explains, behavioral geneticists use a variety of methods to determine this, including family, twin, and adoption studies. For more information on the influence of genetics on behavior, go to the National Institutes of Health Office of Behavioral and Social Sciences Research site at obssr.od.nih.gov.

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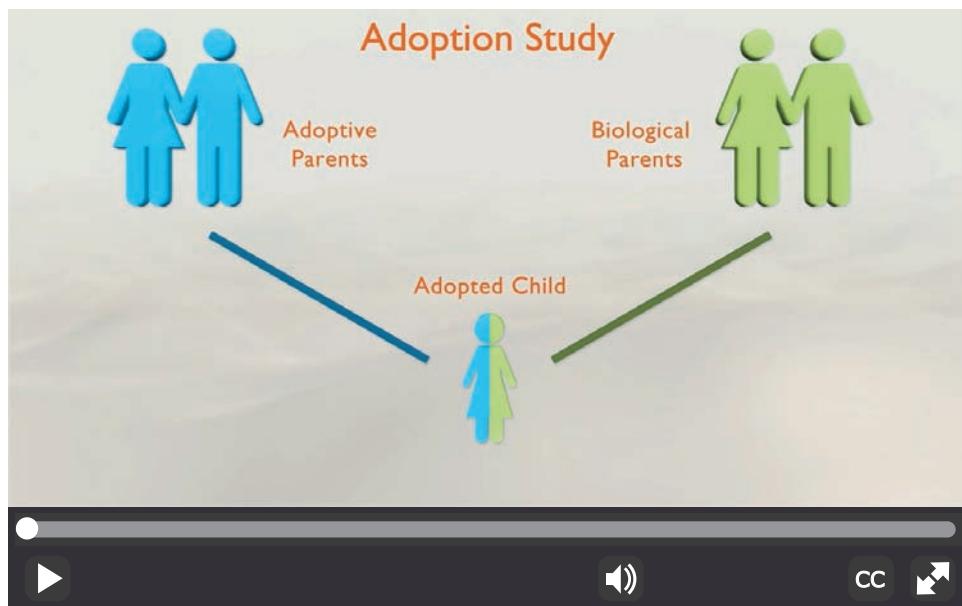
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[Watch the Video](#), *The Basics: Genetic Mechanisms and Behavioral Genetics: Use of Family and Twin Studies*, at [MyPsychLab](#)

The Basic Building Blocks of Development

How do chromosomes, genes, and DNA determine a person's characteristics or disorders?

Any study of the human life span must begin with looking at the complex material contained in the cells of the body that carries the instructions for life itself. After discussing the basic building blocks of life, we will discuss how the processes of conception and the development of the infant within the womb take place.

CHROMOSOMES, GENES, AND DNA

Genetics is the science of heredity. Understanding how genes transmit human characteristics and traits involves defining a few basic terms.

DNA (deoxyribonucleic acid) is a very special kind of molecule (the smallest particle of a substance that still has all the properties of that substance). DNA consists of two very long sugar-phosphate strands, each linked together by certain chemical elements called *amines* or *bases* arranged in a particular pattern. (See **Figure 8.1** for a representation of DNA.) The amines are organic structures that contain the genetic codes for building the proteins that make up organic life (hair coloring, muscle, and skin, for example) and that control the life of each cell. Each section of DNA containing a certain sequence (ordering) of these amines is called a **gene**. These genes are located on rod-shaped structures called **chromosomes**, which are found in the nucleus of a cell.

Humans have a total of 46 chromosomes in each cell of their bodies (with the exception of the egg and the sperm). Twenty-three of these chromosomes come from the mother's egg and the other 23 from the father's sperm. Most characteristics are determined by 22 such pairs, called the *autosomes*. The last pair determines the sex of the person. The two chromosomes of this pair are called the *sex chromosomes*. Two X-shaped chromosomes indicate a female while an X and a Y indicate a male.

DOMINANT AND RECESSIVE GENES

The 46 chromosomes can be arranged in pairs, with one member of each pair coming from the mother and the other member from the father. Let's consider just one of these pairs for the moment.

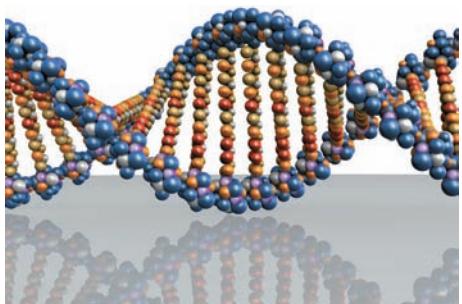
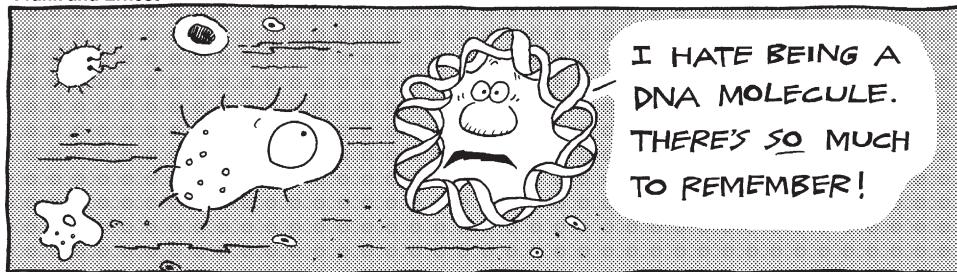


Figure 8.1 DNA Molecule

In this model of a DNA molecule, the two strands making up the sides of the "twisted ladder" are composed of sugars and phosphates. The "rungs" of the ladder that link the two strands are amines. Amines contain the genetic codes for building the proteins that make up organic life.

In this particular pair of chromosomes, assume that there is a gene for hair color on each chromosome. The observable color of the person's hair will be determined by those two genes, one gene from each parent. If both genes are for brown hair, the person will obviously have brown hair, right? And if both are for blond hair, the person's hair will be blond.

Frank and Ernest



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But what if one gene is for brown hair and the other is for blond hair?

The answer lies in the nature of each gene. Some genes that are more active in influencing the trait are called **dominant**. A dominant gene will always be expressed in the observable trait, in this case, hair color. A person with a dominant gene for brown hair color will have brown hair, no matter what the other gene is, because brown is the most dominant of all the hair colors.

Some genes are less active in influencing the trait and will only be expressed in the observable trait if they are paired with another less active gene. These genes tend to recede, or fade, into the background when paired with a more dominant gene, so they are called **recessive**. Blond is the most recessive hair color and it will only show up as a trait if that person receives a blond-hair-color gene from each parent.



What about red hair? And how come some people have a mixed hair color, like strawberry blond?

In reality, the patterns of genetic transmission of traits are usually more complicated. Almost all traits are controlled by more than one pair of genes in a process called *polygenic inheritance*. (*Polygenic* means “many genes.”) Sometimes certain kinds of genes tend to group themselves with certain other genes, like the genes for blond hair and blue eyes. Other genes are so equally dominant or equally recessive that they combine their traits in the organism. For example, genes for blond hair and red hair are recessive. When a child inherits one of each from his or her parents, instead of one or the other controlling the child’s hair color, they may blend together to form a strawberry-blond mix.

GENETIC AND CHROMOSOME PROBLEMS

Several genetic disorders are carried by recessive genes. Diseases carried by recessive genes are inherited when a child inherits two recessive genes, one from each parent. Examples of disorders inherited in this manner are cystic fibrosis (a disease of the respiratory and digestive tracts), sickle-cell anemia (a blood disorder), Tay-Sachs disorder (a fatal neurological disorder), and phenylketonuria (PKU), in which an infant is born without the ability to break down phenylalanine, an amino acid controlling coloring of the skin and hair. If levels of phenylalanine build up, brain damage can occur; if untreated, it can result in severe intellectual disabilities. **Figure 8.2** on the next page illustrates a typical pattern of inheritance for dominant and recessive genes using the example of PKU.

Sometimes the chromosome itself is the problem. Although each egg and each sperm are only supposed to have 23 chromosomes, in the creation of these cells a

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Figure 8.2 Dominant and Recessive Genes and PKU

This figure shows the variation of one or two parents carrying recessive genes and the result of this in their offspring.

- (a) If only one parent carries the PKU gene, their children might be carriers, but will not have PKU.
- (b) Only if both parents are carriers of PKU will a child have the 1 in 4 possibility of having PKU.

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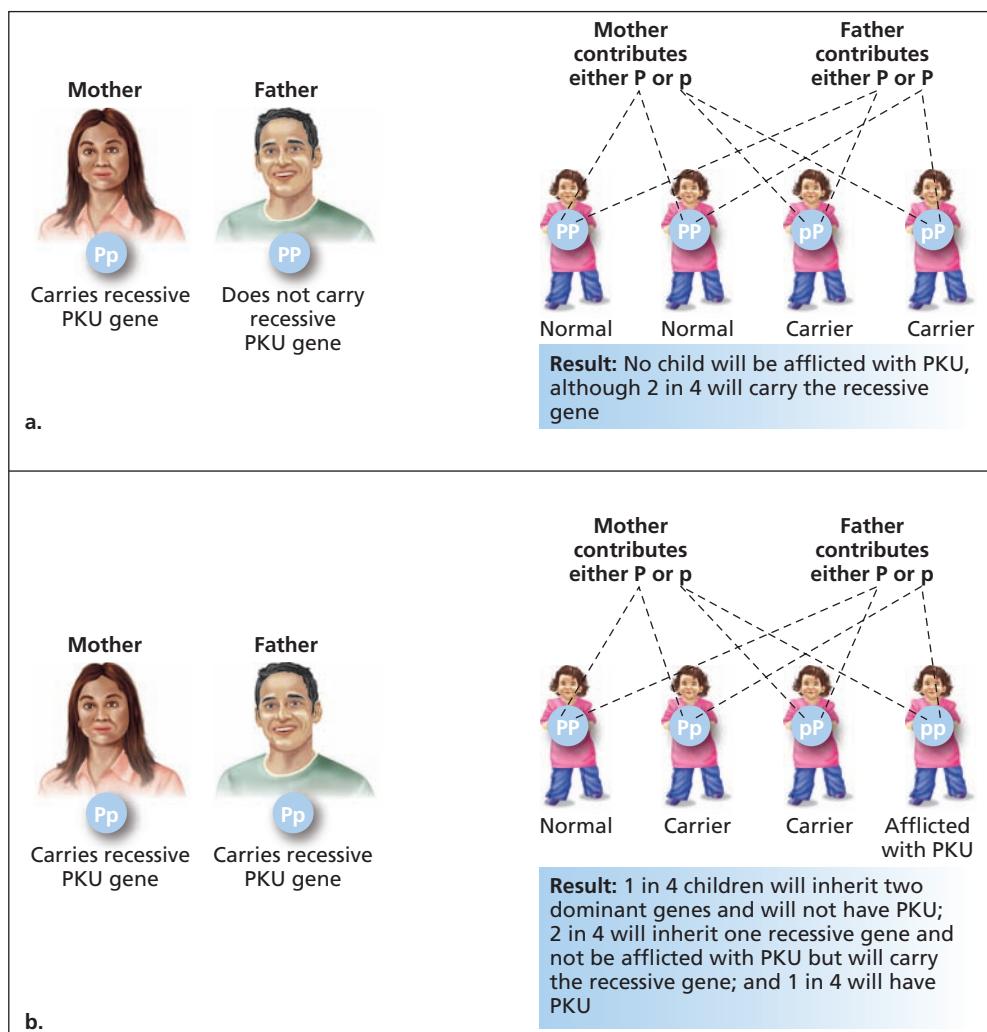
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chromosome can end up in the wrong cell, leaving one cell with only 22 and the other with 24. If either of these cells survives to “mate,” the missing or extra chromosome can cause mild to severe problems in development (American Academy of Pediatrics, 1995; Barnes & Carey, 2002; Centers for Disease Control and Prevention, 2009c; Gardner & Sutherland, 1996).

Examples of chromosome disorders include *Down syndrome*, a disorder in which there is an extra chromosome in what would normally be the 21st pair. Symptoms commonly include the physical characteristics of almond-shaped, wide-set eyes, as well as intellectual disability (Barnes & Carey, 2002; Hernandez & Fisher, 1996). Other chromosome disorders occur when there is an extra sex chromosome in the 23rd pair, such as *Klinefelter’s syndrome*, in which the 23rd set of sex chromosomes is XXY, with the extra X producing a male with reduced masculine characteristics, enlarged breasts, obesity, and excessive height (Bock, 1993); and *Turner’s syndrome*, in which the 23rd pair is actually missing an X, so that the result is a lone X chromosome (Ranke & Saenger, 2001). These females tend to be very short, infertile, and sexually underdeveloped (American Academy of Pediatrics, 1995; Hong et al., 2009; Rovet, 1993).



Down syndrome is a form of intellectual disability caused by an extra chromosome 21.

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 Explore the Concept at [MyPsychLab](#)

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research designs

- **longitudinal:** one group of people is followed and assessed at different times as they age
- **cross-sectional:** several different age-groups are studied at one time
- **cross-sequential:** combination of longitudinal and cross-sectional

Issues in Studying Human Development

(scientific study of changes that occur in people as they age)

nature vs. nurture debate

- **nature** refers to heredity and the influence of inherited characteristics on personality, growth, intellect, social skills, etc.; behavioral genetics is relatively new field that attempts to identify genetic basis of behavior
- **nurture** refers to influence of the environment on inherited traits including parenting styles, socioeconomic status, physical surroundings, etc.
- most developmental psychologists agree that the most likely explanation for most human development is based on the interaction between nature and nurture

Basic Building Blocks of Development

- **genetics** is the science of heredity
- **DNA (deoxyribonucleic acid):** contains genetic codes and chromosomes
 - aside from egg and sperm, humans have 46 chromosomes in each cell of the body
 - individual gets 23 chromosomes from mother's egg and 23 from father's sperm
 - most characteristics are determined by 22 such pairs (autosomes); the last pair determines sex of the person (sex chromosomes)
- both dominant and recessive genes determine physical and behavioral traits
 - specific physical and behavioral traits are dependent upon pairing of genes; more active genes are dominant, others are recessive (see Figure 8.2)
 - most traits are polygenic
- genetic and chromosome problems can cause a variety of disorders
 - genetic disorders carried by recessive genes are expressed when a child gets two recessive genes
 - issue may also occur if chromosomes having an extra or a missing pair

PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. In a _____ design, one group of people is followed and assessed at different times as the group ages.
 - a. longitudinal
 - b. cross-sectional
 - c. cross-sequential
 - d. cross-longitudinal
2. The cognitive and social changes students go through because they are born and grow up in an age of smartphones would be referred to as a(n)
 - a. experimental group.
 - b. control group.
 - c. dominance effect.
 - d. cohort effect.
3. Brandy has naturally blond hair. Based on this information, what do we know about Brandy's parents?
 - a. At least one of her parents has a recessive gene for blond hair.
 - b. Each of her parents must have one recessive gene for blond hair.
 - c. Each of her parents must have one dominant gene for brown hair.
 - d. Neither of her parents has a recessive gene for blond hair.
4. When sets of genes group together, the result can be multiple traits expressed as a single dominant trait. This is best explained by the process known as
 - a. dominant inheritance.
 - b. recessive inheritance.
 - c. polygenic inheritance.
 - d. amines.
5. Which of the following is a disorder resulting from recessive inheritance?

<ol style="list-style-type: none"> a. Turner's syndrome b. Klinefelter's syndrome 	<ol style="list-style-type: none"> c. cystic fibrosis d. Down syndrome
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6. Which disorder is characterized by having only one X chromosome in the 23rd pairing?

<ol style="list-style-type: none"> a. Tay-Sachs b. Turner's syndrome 	<ol style="list-style-type: none"> c. Klinefelter's syndrome d. PKU
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THINKING CRITICALLY:

The time is coming when choosing the genetic traits of your child is going to be possible. What kinds of ethical and practical problems may arise from this development?

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Prenatal Development

What happens during conception and prenatal development and what are some prenatal hazards?

From conception to the actual birth of the baby is a period of approximately 9 months, during which a single cell becomes a complete infant. It is also during this time that many things can have a positive or negative influence on the developing infant.

FERTILIZATION, THE ZYGOTE, AND TWINNING

When an egg (also called an **ovum**) and a sperm unite in the process of **fertilization**, the resulting single cell will have a total of 46 chromosomes and is called a **zygote**. Normally, the zygote will begin to divide, first into two cells, then four, then eight, and so on, with each new cell also having 46 chromosomes, because the DNA molecules produce duplicates, or copies, of themselves before each division. (This division process is called *mitosis*.) Eventually, the mass of cells becomes a baby. Sometimes this division process doesn't work exactly this way, and twins or multiples are the result.

There are actually two kinds of twins (see **Figure 8.3**). Twins who are commonly referred to as "identical" are **monozygotic twins**, meaning that the two babies come from one (mono) fertilized egg (zygote). Early in the division process, the mass of cells splits completely—no one knows exactly why—into two separate masses, each of which will develop into a separate infant. The infants will be the same sex and have identical features because they each possess the same set of 46 chromosomes. The other type of twin is more an accident of timing and is more common in women who are older and who are from certain ethnic groups (Allen & Parisi, 1990; Bonnelykke, 1990; Imaizumi, 1998). A woman's body may either release more than one egg at a time or release an egg in a later ovulation period after a woman has already conceived once. If two eggs are fertilized, the woman may give birth to fraternal or **dizygotic twins** (two zygotes), or possibly triplets or some other multiple number of babies (Bryan & Hallett, 2001). This is also more likely to happen to women who are taking fertility drugs to help them get pregnant.

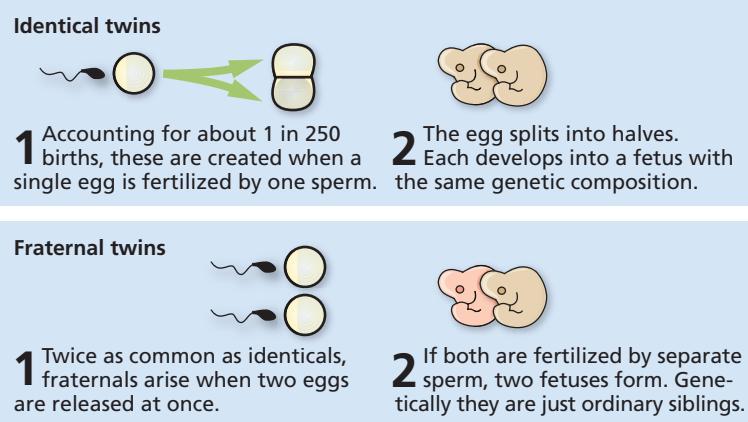
For developmental psychologists, twins provide an important way to look at the contribution of nature and nurture to human development. Researchers may seek out genetically identical twins who have been separated at birth, looking at all the ways those twins are alike in spite of being raised in different environments. It should be noted that the environments in which children are raised within a particular culture are not necessarily that much different, so twin studies are not a perfect method. Researchers may also

compare children who are adopted to their adoptive parents (an environmental influence) and to their biological parents (the genetic influences).  [LINK](#) to Learning Objective 13.7.

Sometimes in the twinning process, the mass of cells does not completely split apart. When this occurs, *conjoined twins* will result, and they will be joined at the point where the two cell masses remained "stuck." This joining may involve only soft tissues or may involve the sharing of certain body parts, like in the case of Abby and Brittany, who are discussed in the Psychology in the News section that follows. It is estimated that conjoined twins are born in only 1 in 100,000 births, and their survival is also rare (Martínez-Frías et al., 2009).

Figure 8.3 Monozygotic and Dizygotic Twins

Because identical twins come from one fertilized egg (zygote), they are called monozygotic. Fraternal twins, who come from two different fertilized eggs, are called dizygotic.



psychology in the news

Abby and Brittany Hensel, Together for Life



While growing up Brittany loved milk. Her twin sister, Abigail (Abby), despised milk and preferred orange juice. Abby liked blue, Brittany liked pink. Abby liked oyster crackers in her soup but Brittany hated them. Brittany liked a full-course meal, Abby preferred pasta. Both were good with academics: Abby preferred math and Brittany preferred reading.

Abby and Brittany Hensel sound like many other siblings, each with separate likes and dislikes as well as different interests. But Abby and Brittany are not separate and can never truly be separate, for they share one lower body. No more than four sets of surviving conjoined twins in recorded history have this condition, called *dicephaly*. In the case of Abby and Brittany, each girl has her own heart, stomach, and pair of lungs. Their spines are joined at the pelvis, and below the waist they have only one set of organs. Each controls one arm and one leg on one side of the body, yet they somehow manage to move as one (Kaveny, 2001; Miller & Doman, 1996).

As teenagers, the girls played sports, swam, and put on makeup just like any other girls their age. In 2012, they became the stars of their own reality television show, *Abby & Brittany: Joined for Life* (Camacho, 2012). In Season One, the show followed them as they graduated from college with teaching degrees, vacationed in London, England, went on job interviews, moved to a new house, and prepared for their first teaching job. They are healthy and seem to be both happy and well adjusted, surrounded by friends and a loving mother, father, younger brother, and sister.

Questions for Further Discussion

1. What kinds of challenges might Abby and Brittany have as they enter the workforce?
2. How can conjoined twins have different personalities?

THE GERMINAL PERIOD

Once fertilization has taken place, the zygote begins dividing and moving down to the *uterus*, the muscular organ that will contain and protect the developing organism. This process takes about a week, followed by about a week during which the mass of cells, now forming a hollow ball, firmly attaches itself to the wall of the uterus. This 2-week period is called the **germinal period** of pregnancy. The *placenta* also begins to form during this period. The placenta is a specialized organ that provides nourishment and filters away the developing baby's waste products. The *umbilical cord* also begins to develop at this time, connecting the organism to the placenta.

How does a mass of cells become a baby, with eyes, nose, hands, feet, and so on? How do all those different things come from the same original single cell?

During the germinal period, the cells begin to differentiate, or develop into specialized cells, in preparation for becoming all the various kinds of cells that make up



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Abby and Brittany Hensel are conjoined twins who share one body from the waist down but are two distinctly different individuals.

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the human body—skin cells, heart cells, and so on. Perhaps the most important of these cells are the *stem cells*, which stay in a somewhat immature state until needed to produce more cells. Researchers are looking into ways to use stem cells found in the umbilical cord to grow new organs and tissues for transplant or to repair neurological damage (Chen & Ende, 2000; Holden & Vogel, 2002; Lu & Ende, 1997).  [LINK](#) to Learning Objective 2.3.

THE EMBRYONIC PERIOD

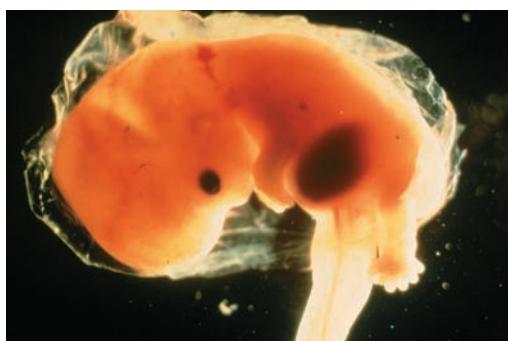
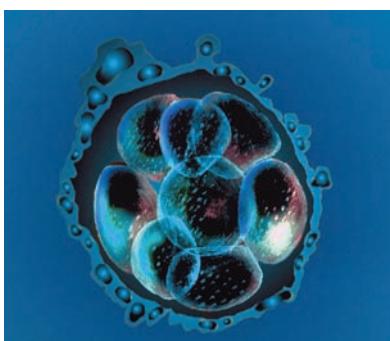
Once firmly attached to the uterus, the developing organism is called an **embryo**. The **embryonic period** will last from 2 weeks after conception to 8 weeks, and during this time the cells will continue to specialize and become the various organs and structures of a human infant. By the end of this period, the embryo is about 1-inch long and has primitive eyes, nose, lips, teeth, and little arms and legs, as well as a beating heart. Although no organ is fully developed or completely functional at this time, nearly all are “there.”

CRITICAL PERIODS As soon as the embryo begins to receive nourishment from the mother through the placenta, it becomes vulnerable to hazards such as diseases of the mother, drugs, and other toxins that can pass from the mother through the placenta to the developing infant. Because of this direct connection between mother and embryo and the fact that all major organs are in the process of forming, we can clearly see the effects of **critical periods**, times during which some environmental influences can have an impact—often devastating—on the development of the infant. The structural development of the arms and legs, for example, is only affected during the time that these limbs are developing (3 to 8 weeks), whereas the heart’s structure is most affected very early in this period (2 to 6 weeks). Other physical and structural problems can occur with the central nervous system (2 to 5 weeks), eyes (3 to 8 weeks), and the teeth and roof of the mouth (about 7 to 12 weeks).

PRENATAL HAZARDS: TERATOGENS Any substance such as a drug, chemical, virus, or other factor that can cause a birth defect is called a **teratogen**. **Table 8.2** shows some common teratogens and their possible negative effects on the developing embryo.

One of the more common teratogens is alcohol. Consumption of alcohol during pregnancy, particularly during the critical embryonic period, can lead to **fetal alcohol syndrome (FAS)**, a series of physical and mental defects including stunted growth, facial deformities, and brain damage (Ethen et al., 2008; Guerri, 2002). Exposure to alcohol in early pregnancy is the leading known cause of intellectual disability (previously called mental retardation) in the Western hemisphere (Abel & Sokol, 1987; Caley et al., 2005). FAS is part of a larger category of permanent birth defects due to maternal alcohol use

The three periods of pregnancy are the germinal period, lasting about 2 weeks, the embryonic period, from about 2 to 8 weeks, and the fetal period, which lasts from 8 weeks until the end of pregnancy.



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Table 8.2**Common Teratogens**

TERATOGENIC AGENT	EFFECT ON DEVELOPMENT
Measles, Mumps, and Rubella	Blindness, deafness, heart defects, brain damage
Marijuana	Irritability, nervousness, tremors; infant is easily disturbed, startled
Cocaine	Decreased height, low birth weight, respiratory problems, seizures, learning difficulties; infant is difficult to soothe
Alcohol	Fetal alcohol syndrome (intellectual disability, delayed growth, facial malformation), learning difficulties, smaller than normal heads
Nicotine	Miscarriage, low birth weight, stillbirth, short stature, intellectual disability, learning disabilities
Mercury	Intellectual disability, blindness
Vitamin A (high doses)	Facial, ear, central nervous system, and heart defects
Caffeine	Miscarriage, low birth weight
Toxoplasmosis	Brain swelling, spinal abnormalities, deafness, blindness, intellectual disability
High Water Temperatures	Increased chance of neural tube defects

Sources: March of Dimes Foundation (2009); Organization of Teratology Information Specialists (2011); Shepard, T. H. (2001).

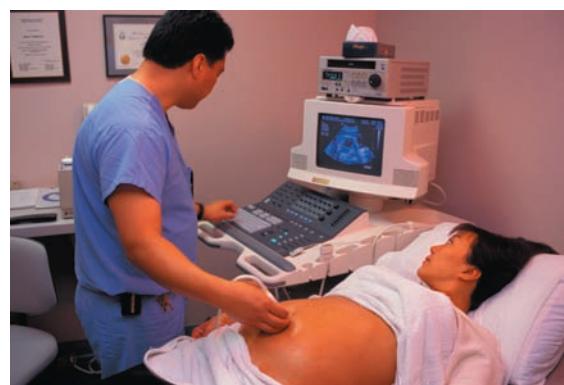
during pregnancy called *fetal alcohol spectrum disorders (FASD)*. So how much alcohol is safe to drink while pregnant? The answer is clearly “none!”

THE FETAL PERIOD: GROW, BABY, GROW

The **fetal period** is a period of tremendous growth lasting from about 8 weeks after conception until birth. The length of the developing organism (now referred to as a **fetus**) increases by about 20 times and its weight increases from about 1 ounce at 2 months to an average of a little over 7 pounds at birth. The organs, while accomplishing most of their differentiation in the embryonic period, continue to develop and become functional. At this time, teratogens will more likely affect the physical functioning (physiology) of the organs rather than their structure. The functioning of the central nervous system, for example, is vulnerable throughout the fetal period, as are the eyes and the external sexual organs.

The last few months continue the development of fat and the growth of the body, until about the end of the 38th week. At 38 weeks, the fetus is considered full term. Most babies are born between 38 and 40 weeks. Babies born before 38 weeks are called *preterm* and may need life support to survive. This is especially true if the baby weighs less than 5½ pounds at birth. How early can an infant be born and still survive? The age of viability (the point at which it is possible for an infant to survive outside the womb) is between 22 and 26 weeks, with the odds of survival increasing from 10 percent at 22 weeks up to about 85 percent at 26 weeks (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 2006).

The most likely time for a *miscarriage*, or *spontaneous abortion*, is in the first 3 months, as the organs are forming and first becoming functional (Katz, 2007; Speroff et al., 1999). Some 15 to 20 percent of all pregnancies end in miscarriage, many so early that the mother may not have even known she was pregnant (Hill, 1998; Medical Economics Staff, 1994). When a miscarriage occurs, it is most likely caused by a genetic defect in the way the embryo or fetus is developing that will not allow the infant to survive. In other words, there isn’t anything that the mother did wrong or that could have been done to prevent the miscarriage.



This pregnant woman is getting a sonogram. Sonograms allow doctors to see any physical deformities and make accurate measurements of gestational age without risk to the mother or the fetus.

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 Explore the Concept at [MyPsychLab](#)
CONCEPT MAP

from conception to birth of the baby is approximately 9 months in humans

Prenatal Development**fertilization, the zygote, and twinning**

- egg and sperm unite through process of fertilization, resulting in a single cell (zygote) that has 46 chromosomes
- through mitosis, zygote begins to divide, into two cells, then four, etc., until baby is formed
- alterations in mitosis can result in twins or multiples

germinal period
(2-week period following fertilization)

- zygote continues dividing and moving toward the uterus; the placenta and umbilical cord also develop during this time
- cell differentiation is the process that results in specialized cells for all of the various parts of the body

embryonic period
(2 weeks after conception to 8 weeks)

- once attached to the uterus, developing organism is called an embryo
- cell specialization continues to occur, resulting in the preliminary versions of various organs
- embryo is vulnerable to hazards such as diseases and substances ingested by the mother as it receives nourishment through the placenta

fetal period
(from about 8 weeks to birth)

- developing organism now called a fetus; time of tremendous growth and development
- organs continue to develop and become fully functional
- full-term birth occurs around end of 38th week
- miscarriages (spontaneous abortions) are most likely to occur in the first three months

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Which term best describes Abby and Brittany Hensel?
 - a. They are monozygotic twins.
 - b. They are dicephalic twins.
 - c. They are dizygotic twins.
 - d. They are technically not twins at all.
2. What is the function of the placenta?
 - a. It helps the zygote to divide.
 - b. It assists the zygote in its movement towards the uterus.
 - c. It provides nourishment to the developing baby.
 - d. It effectively keeps out all teratogens.
3. The 2nd week through the 8th week of pregnancy is commonly referred to as the _____ stage.

a. fetal	c. placental
b. embryonic	d. germinal
4. Which of the following is one of the most common teratogens and can result in a malformed head and brain damage?
 - a. alcohol
 - b. caffeine
 - c. cocaine
 - d. mercury
5. When do most miscarriages occur?
 - a. In the last three months
 - b. In the first three months
 - c. After the 5th month
 - d. In the first week after conception

Infancy and Childhood Development

What can babies do? Aren't they pretty much unaware of what's going on around them at first?

Surprisingly, babies can do a lot more than researchers used to believe they could. A lot of the early research on infants just after birth was done on babies who were still very drowsy from the general anesthesia that was administered to their mothers during the labor process. Drowsy babies don't tend to respond well, as one might imagine. Since

those early days, researchers have developed ways of studying what infants cannot tell us in words. Two common methods are the use of *preferential looking* and *habituation*. Preferential looking assumes that the longer an infant spends looking at a stimulus, the more the infant prefers that stimulus over others (Fantz, 1961). Habituation is the tendency for infants (and adults) to stop paying attention to a stimulus that does not change. By exposing the infant to an unchanging sound or picture, for example, researchers can wait for the infant to habituate (look away) and then change the stimulus. If the infant reacts (dishabituates), the infant is capable of detecting that change (Columbo & Mitchell, 2009). In the next few sections, it becomes obvious that infants accomplish a great deal throughout infancy, even in the first few days of life on the “outside.”

PHYSICAL DEVELOPMENT

What kind of physical changes take place in infancy and childhood?

Immediately after birth, several things start to happen. The respiratory system begins to function, filling the lungs with air and putting oxygen into the blood. The blood now circulates only within the infant’s system because the umbilical cord has been cut. Body temperature is now regulated by the infant’s own activity and body fat (which acts as insulation), rather than by the amniotic fluid. The digestive system probably takes the longest to adjust to life outside the womb. This is another reason for the baby’s excess body fat. It provides fuel until the infant is able to take in enough nourishment on its own. That is why most babies lose a little weight in the first week after birth.

REFLEXES Babies come into this world able to interact with it. Infants have a set of *innate* (existing from birth), involuntary behavior patterns called *reflexes*. Until a baby is capable of learning more complex means of interaction, reflexes help the infant to survive. **Figure 8.4** on the next page shows five infant reflexes. Pediatricians use these and other reflexes to determine whether or not a newborn’s nervous system is working properly.

MOTOR DEVELOPMENT: FROM CRAWLING TO A BLUR OF MOTION Infants manage a tremendous amount of development in motor skills from birth to about 2 years of age. **Figure 8.5** (which appears a couple of pages later) shows some of the major physical milestones of infancy. When looking at the age ranges listed, remember that even these ranges are averages based on large samples of infants. An infant may reach these milestones earlier or later than the average and still be considered to be developing normally.

BRAIN DEVELOPMENT At birth, an infant’s brain consists of over 100 billion neurons. Rapid and extensive growth of these neurons occurs as the brain triples in weight from birth to age 3 years, with much of the increase caused by growth of new dendrites, axon terminals, and increasing numbers of synaptic connections (Nelson, 2011). Surprisingly, the development of the infant brain after birth involves a necessary loss of neurons called *synaptic pruning*, as unused synaptic connections and nerve cells are cleared away to make way for functioning connections and cells (Couperus & Nelson, 2006; Graven & Browne, 2008; Kozberg et al., 2013). This process is similar to weeding your garden—you take out the weeds to make room for the plants that you want.

BABY, CAN YOU SEE ME? BABY, CAN YOU HEAR ME? SENSORY DEVELOPMENT

 I’ve heard that babies can’t see or hear very much at birth. Is that true?

Although most infant sensory abilities are fairly well developed at birth, some require a bit more time to reach “full power.” By using techniques such as the

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Figure 8.4 Five Infant Reflexes

Shown here are (a) grasping reflex; (b) startle reflex (also known as the Moro reflex); (c) rooting reflex (when you touch a baby's cheek it will turn toward your hand, open its mouth, and search for the nipple); (d) stepping reflex; and (e) sucking reflex. These infant reflexes can be used to check the health of an infant's nervous system. If a reflex is absent or abnormal, it may indicate brain damage or some other neurological problem.

habituation method discussed earlier, researchers have found that the sense of touch is the most well developed, which makes perfect sense when one realizes how much skin-to-womb contact the baby has had in the last months of pregnancy. The sense of smell is also highly developed. Breast-fed babies can actually tell the difference between their own mother's milk scent and another woman's milk scent within a few days after birth.

Taste is also nearly fully developed. At birth, infants show a preference for sweets (and human breast milk is very sweet) and by 4 months have developed a preference for salty tastes (which may come from exposure to the salty taste of their mother's skin). Sour and bitter, two other taste sensations, produce spitting up and the making of horrible faces (Ganchrow et al., 1983).

Hearing is functional before birth but may take a little while to reach its full potential after the baby is born. The fluids of the womb first must clear out of the auditory canals completely. From birth, newborns seem most responsive to high pitches, as in a woman's voice, and low pitches, as in a man's voice.

The least functional sense at birth is vision. The eye is quite a complex organ.  to Learning Objective 3.2. The rods, which see in black and white and have little visual acuity, are fairly well developed at birth, but the cones, which see color and provide sharpness of vision, will take about another 6 months to fully develop. So, the newborn has relatively poor color perception when compared to sharply contrasting lights and darks until about 2 months of age (Adams, 1987) and has fairly "fuzzy" vision, much as a nearsighted person would have. The lens of the newborn stays fixed until the



Figure 8.5 Six Motor Milestones

Shown here are (a) raising head and chest—2 to 4 months, (b) rolling over—2 to 5 months, (c) sitting up with support—4 to 6 months, (d) sitting up without support—6 to 7 months, (e) crawling—7 to 8 months, and (f) walking—8 to 18 months. The motor milestones develop as the infant gains greater voluntary control over the muscles in its body, typically from the top of the body downward. This pattern is seen in the early control of the neck muscles and the much later development of control of the legs and feet.

muscles that hold it in place mature. Until then the newborn is unable to shift what little focus it has from close to far. Thus, newborns actually have a fixed distance for clear vision of about 7 to 10 inches, which is the distance from the baby's face to the mother's face while nursing (Slater, 2000).

Newborns also have visual preferences at birth, as discovered by researchers using preferential looking, measures of the time that infants spent looking at certain visual stimuli (Fantz, 1961). They found that infants prefer to look at complex patterns rather than simple ones, three dimensions rather than two, and that the most preferred visual stimulus was a human face. The fact that infants prefer human voices and human faces (DeCasper & Fifer, 1980; DeCasper & Spence, 1986; Fantz, 1964; Maurer & Young, 1983) makes it easier for them to form relationships with their caregivers and to develop language later on. Infants' preference for seeing things in three dimensions suggests that they possess depth perception. The following classic experiment provided evidence for that assumption.

classic studies in psychology



The Visual Cliff



Eleanor Gibson and her fellow researcher, Michael Walk, wondered if infants could perceive the world in three dimensions, and so they devised a way to test babies for depth perception (Gibson & Walk, 1960). They built a special table (see **Figure 8.6**, on the next page) that had a big drop on one side. The surface of the table on both the top

Figure 8.6 The Visual Cliff Experiment

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In the visual cliff experiment, the table has both a shallow and a “deep” side, with glass covering the entire table. When an infant looks down at the deep-appearing side, the squares in the design on the floor look smaller than the ones on the shallow side, forming a visual cue for depth. Notice that this little girl seems to be very reluctant to cross over the deep-appearing side of the table, gesturing to be picked up, instead.

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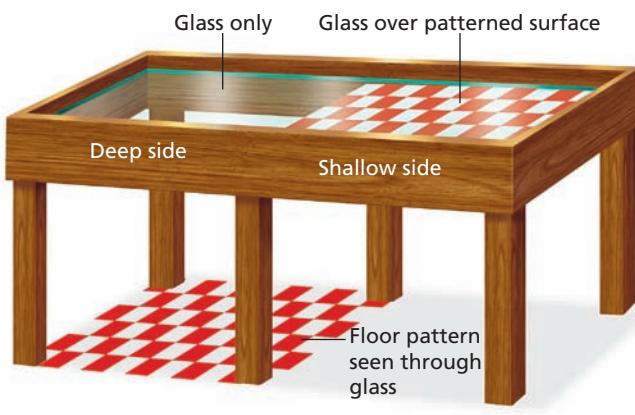
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and the drop to the floor were covered in a patterned tablecloth, so that the different size of the patterns would be a cue for depth (remember, in size constancy, if something looks smaller, people assume it is farther away from them) [LINK](#) to Learning Objective 3.8. The whole table was then covered by a clear glass top, so that a baby could safely be placed on or crawl across the “deep” side.

The infants tested in this study ranged from 6 months to 14 months in age. They were placed on the middle of the table and then encouraged (usually by their mothers) to crawl over either the shallow side or the deep side. Most babies—81 percent—refused to crawl over the deep side, even though they could touch it with their hands and feel that it was solid. They were upset and seemed fearful when encouraged to crawl across. Gibson and Walk interpreted this as a very early sign of the concept of depth perception.

Questions for Further Discussion

1. Does the fact that 19 percent of the infants did crawl over the deep side of the visual cliff necessarily mean that those infants could not perceive the depth?
2. What other factors might explain the willingness of the 19 percent to crawl over the deep side?
3. Are there any ethical concerns in this experiment?
4. Ducks aren’t bothered by the visual cliff at all—why might that be?

COGNITIVE DEVELOPMENT

What are two ways of looking at cognitive development, how does language develop, and what is autism spectrum disorder?

By the time the average infant has reached the age of 1 year, it has tripled its birth weight and added about another foot to its height. The brain triples its weight in the first 2 years, reaching about 75 percent of its adult weight. By age 5, the brain is at 90 percent of its adult weight. This increase makes possible a tremendous amount of major advances in **cognitive development**, including the development of thinking, problem solving, and memory.

PIAGET’S THEORY: FOUR STAGES OF COGNITIVE DEVELOPMENT One of the three ways of examining the development of cognition that we will discuss in this chapter is found in the work of Jean Piaget. Early researcher Jean Piaget developed his theory from detailed

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Table 8.3**Piaget's Stages of Cognitive Development**

STAGE	AGE	COGNITIVE DEVELOPMENT
Sensorimotor	Birth to 2 years old	Children explore the world using their senses and ability to move. They develop object permanence and the understanding that concepts and mental images represent objects, people, and events.
Preoperational	2 to 7 years old	Young children can mentally represent and refer to objects and events with words or pictures and they can pretend. However, they can't conserve, logically reason, or simultaneously consider many characteristics of an object.
Concrete Operations	7 to 12 years old	Children at this stage are able to conserve, reverse their thinking, and classify objects in terms of their many characteristics. They can also think logically and understand analogies but only about concrete events.
Formal Operations	12 years old to adulthood	People at this stage can use abstract reasoning about hypothetical events or situations, think about logical possibilities, use abstract analogies, and systematically examine and test hypotheses. Not everyone can eventually reason in all these ways.

observations of infants and children, most especially his own three children. Piaget made significant contributions to the understanding of how children think about the world around them; his theory shifted the commonly held view that children's thinking was that of "little adults" toward recognition that it was actually quite different from adult thinking. Piaget believed that children form mental concepts or **schemes** as they experience new situations and events. For example, if Sandy points to a picture of an apple and tells her child, "that's an apple," the child forms a scheme for "apple" that looks something like that picture. Piaget also believed that children first try to understand new things in terms of schemes they already possess, a process called *assimilation*. The child might see an orange and say "apple" because both objects are round. When corrected, the child might alter the scheme for apple to include "round" and "red." The process of altering or adjusting old schemes to fit new information and experiences is *accommodation* (Piaget, 1952, 1962, 1983).

Piaget also proposed that there are four distinct stages of cognitive development that occur from infancy to adolescence, as shown in the video *The Basics: How Thinking Develops: Piaget's Stages* and in **Table 8.3** (Piaget, 1952, 1962, 1983).



[Watch the Video](#), *The Basics: How Thinking Develops : Piaget's Stages*, at [MyPsychLab](#)

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The Sensorimotor Stage The **sensorimotor stage** is the first of Piaget's stages. It concerns infants from birth to age 2. In this stage, infants use their senses and motor abilities to learn about the world around them. At first, infants only have the involuntary reflexes present at birth to interact with objects and people. As their sensory and motor development progresses, they begin to interact deliberately with objects by grasping, pushing, tasting, and so on. Infants move from simple repetitive actions, such as grabbing their toes, to complex patterns, such as trying to put a shape into a sorting box.

By the end of the sensorimotor stage, infants have fully developed a sense of **object permanence**, the knowledge that an object exists even when it is not in sight. For example, the game of “peek-a-boo” is important in teaching infants that Mommy’s smiling face is always going to be behind her hands. This is a critical step in developing language (and eventually abstract thought), as words themselves are symbols of things that may not be present. Symbolic thought, which is the ability to represent objects in one’s thoughts with symbols such as words, becomes possible by the end of this stage, with children at 2 years old capable of thinking in simple symbols and planning out actions.



Why is it so easy for children to believe in Santa Claus and the Tooth Fairy when they’re little?

The Preoperational Stage The **preoperational stage** (ages 2–7) is a time of developing language and concepts. Children, who can now move freely about in their world, no longer have to rely only on senses and motor skills but now can ask questions and explore their surroundings more fully. Pretending and make-believe play become possible because children at this stage can understand, through symbolic thinking, that a line of wooden blocks can “stand in” for a train. They are limited, however, in several ways. They are not yet capable of logical thought—they can use simple mental concepts but are not able to use those concepts in a more rational, logical sense. They believe that anything that moves is alive, a quality called *animism*. They tend to believe that what they see is literally true, so when children of this age see Santa Claus in a book, on television, or at the mall, Santa Claus becomes real to them. It doesn’t occur to them to think about how Santa might get to every child’s house in one night or why those toys he delivers are the same ones they saw in the store just last week.

Another limitation is **egocentrism**, the inability to see the world through anyone else’s eyes but one’s own. For the preoperational child, everyone else must see what the child sees, and what is important to the child must be important to everyone else. For example, 2-year-old Hiba, after climbing out of her crib for the third time, was told by her mother, “I don’t want to see you in that living room again tonight!” So Hiba’s next appearance was made with her hands over her eyes—if she couldn’t see her mother, her mother couldn’t see *her*. Egocentrism is not the same as being egotistical or selfish—it would also be egocentric, but completely unselfish, if 4-year-old Jamal wants to give his grandmother an action figure for her birthday because that’s what *he* would want.

Remember that children in this stage are also overwhelmed by appearances. A child who complains that his piece of pie is smaller than his brother’s may be quite happy once his original piece is cut into two pieces—now he thinks he has “more” than his brother. He has focused only on the number of pieces, not the actual amount of the pie. Focusing only on one feature of some object rather than taking all features into consideration is called **centration**. In the coin example in **Figure 8.7**, children of this stage will focus (or center) on the *length* of the top line of coins only and ignore the *number* of coins. Centration is one of the reasons that children in this stage often fail to understand that changing the way something looks does not change its substance. The ability to understand that altering the appearance of something does not change its amount (as in the coin example), its volume, or its mass is called **conservation**.

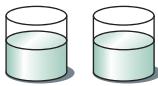
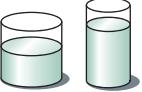
Type of conservation	Initial presentation	Transformation	Question	Preoperational child's answer
Liquids	Two equal glasses of liquid 	Pour one into a taller, narrower glass. 	Which glass contains more?	The taller one.
Number	Two equal lines of pennies 	Increase spacing of pennies in one line. 	Which line has more pennies?	The longer one. 

Figure 8.7 Conservation Experiment

A typical conservation task consists of pouring equal amounts of water into two glasses of the same size and shape. When the water from one of these glasses is poured into a taller, narrower glass, children who cannot yet conserve tend to focus (centrate) on the height of the water in the second glass, assuming that the second glass now has more water than the first one. In the second example, pennies are laid out in two equal lines. When the pennies in the top line are spaced out, the child who cannot yet conserve will centrate on the top line and assume that there are actually more pennies in that line.

Preoperational children fail at conservation not only because they *centrate* (focus on just one feature, such as the number of pieces of pie) but also because they are unable to “mentally reverse” actions. This feature of preoperational thinking is called **irreversibility**. For example, if a preoperational child sees liquid poured from a short, wide glass into a tall, thin glass, the child will assume that the second glass holds more liquid. This failure to “conserve” (save) the volume of liquid as it takes on a different shape in the tall, thin glass is not only caused by the child’s centration on the height of the liquid in the second glass but also by the inability of the child to imagine pouring the liquid back into the first glass and having it be the same amount again. Similar “reasoning” causes children of this age to assume that a ball of clay, when rolled out into a “rope” of clay, is now greater in mass.

Concrete Operations In the **concrete operations stage** (ages 7–12), children finally become capable of conservation and reversible thinking. Centration no longer occurs as children become capable of considering all the relevant features of any given object. They begin to think more logically about beliefs such as Santa Claus and to ask questions, eventually coming to their own more rational conclusions about the fantasies of early childhood. They are in school, learning all sorts of science and math, and are convinced that they know more than their parents at this point.

The major limitation of this stage is the inability to deal effectively with *abstract concepts*. Abstract concepts are those that do not have some physical, *concrete*, touchable reality. For example, “freedom” is an abstract concept. People can define it, they can get a good sense of what it means, but there is no “thing” that they can point to and say, “This is freedom.” *Concrete concepts*, which are the kind of concepts understood by children of this age, are about objects, written rules, and real things. Children need to be able to see it, touch it, or at least “see” it in their heads to be able to understand it.

Formal Operations In the last of Piaget’s stages, **formal operations** (age 12 to adulthood), abstract thinking becomes possible. Teenagers not only understand concepts that have no physical reality, but also they get deeply involved in hypothetical thinking, or thinking about possibilities and even impossibilities. “What if everyone just got along?” “If women were in charge of countries, would there be fewer wars?”



These concrete operational children, seen in a science class, have begun to think logically and are able to solve many kinds of problems that were not possible for them to solve while in the preoperational stage.

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Piaget did not believe that everyone would necessarily reach formal operations, and studies show that only about half of all adults in the United States reach this stage (Sutherland, 1992). Adults who do not achieve formal operations tend to use a more practical, down-to-earth kind of intelligence that suits their particular lifestyle. Successful college students, however, need formal-operational thinking to succeed in their college careers, as most college classes require critical thinking, problem-solving abilities, and abstract thinking based on formal-operational skills (Powers, 1984).

Others have proposed another stage beyond formal operations, a relativistic thinking stage found in young adults, particularly those who have found their old ways of thinking in “black and white” terms challenged by the diversity they encounter in the college environment (LaBouvie-vief, 1980, 1992; Perry, 1970). In this kind of thinking, young adults recognize that all problems cannot be solved with pure logic, and there can be multiple points of view for a single problem.

Evaluating Piaget’s Theory Piaget saw children as active explorers of their surroundings, engaged in the discovery of the properties of objects and organisms within those surroundings. Educators have put Piaget’s ideas into practice by allowing children to learn at their own pace, by “hands-on” experience with objects, and by teaching concepts that are at the appropriate cognitive level for those children (Brooks & Brooks, 1993). But Piaget’s theory has also been criticized on several points. Some researchers believe that the idea of distinct stages of cognitive development is not completely correct and that changes in thought are more continuous and gradual rather than abruptly jumping from one stage to another (Courage & Howe, 2002; Feldman, 2003; Schwitzgebel, 1999; Siegler, 1996). Others point out that preschoolers are not as egocentric as Piaget seemed to believe (Flavell, 1999) and that object permanence exists much earlier than Piaget thought (Aguiar & Baillargeon, 2003; Baillargeon, 1986).

VYGOTSKY’S THEORY: THE IMPORTANCE OF BEING THERE Russian psychologist Lev Vygotsky’s pioneering work in developmental psychology has had a profound influence on school education in Russia, and interest in his theories continues to grow throughout the world (Bodrova & Leong, 1996; Duncan, 1995). Vygotsky wrote about children’s cognitive development but differed from Piaget in his emphasis on the role of others in cognitive development (Vygotsky, 1934/1962, 1978, 1987). Whereas Piaget stressed the importance of the child’s interaction with objects as a primary factor in cognitive development, Vygotsky stressed the importance of social and cultural interactions with other people, typically more highly skilled children and adults. Vygotsky believed that children develop cognitively when someone else helps them by asking leading questions and providing examples of concepts in a process called **scaffolding**. In scaffolding, the more highly skilled person gives the learner more help at the beginning of the learning process and then begins to withdraw help as the learner’s skills improve (Rogoff, 1994).

Vygotsky also proposed that each developing child has a **zone of proximal development (ZPD)**, which is the difference between what a child can do alone versus what a child can do with the help of a teacher. For example, if little Jenny can do math problems up to the fourth-grade level on her own but with the help of a teacher can successfully work problems at a sixth-grade level, her ZPD is 2 years. Suzi might be the same age as Jenny (and might even score the same on a traditional IQ test), but if Suzi can only work math problems at a fifth-grade level with the help of the teacher, Suzi’s ZPD is not as great as Jenny’s. This might be a better way of thinking about intelligence: It isn’t what you know (as measured by traditional tests), it’s what you *can do*.

Other researchers have applied Vygotsky’s social focus on learning to the development of a child’s memory for personal (autobiographical) events, finding evidence that children learn the culturally determined structures and purposes of personal stories from the early conversations they have with their parents. This process begins with the parent telling the story to the very young child, followed by the child repeating elements of the



This boy is helping his younger sister learn to read a book. Vygotsky’s view of cognitive development states that the help of skilled others aids in making cognitive advances such as this one.

story as the child's verbal abilities grow. The child reaches the final stage at around age 5 or 6 when the child creates the personal story entirely—an excellent example of scaffolding (Fivush et al., 1996; Fivush & Nelson, 2004; Nelson, 1993). Unlike Piaget, who saw a child's talking to himself or herself as egocentric, Vygotsky thought that private speech was a way for the child to "think out loud" and advance cognitively. As adults, we still do this when we talk to ourselves to help solve a particular problem. Vygotsky's ideas have been put into practice in education through the use of cooperative learning, in which children work together in groups to achieve a common goal, and in reciprocal teaching, in which teachers lead students through the basic strategies of reading until the students themselves become capable of teaching the strategies to others.

STAGES OF LANGUAGE DEVELOPMENT The development of language is a very important milestone in the cognitive development of a child because language allows children to think in words rather than just images, to ask questions, to communicate their needs and wants to others, and to form concepts (L. Bloom, 1974; P. Bloom, 2000). Language development in infancy is influenced by the language they hear, a style of speaking known as *child-directed speech* (the way adults and older children talk to infants and very young children, with higher pitched, repetitious, sing-song speech patterns). Infants and toddlers attend more closely to this kind of speech, which creates a learning opportunity in the dialogue between caregiver and infant (Dominey & Dodane, 2004; Fernald, 1984, 1992; Küntay & Slobin, 2002). Other researchers are looking at the infant's use of gestures and signs (Behne et al., 2005; Lizskowski et al., 2006; Moll & Tomasello, 2007; Tomasello et al., 2007).

 **Watch the Video**, Thinking Like a Psychologist: Multilingualism: Speaking One's Mind, at [MyPsychLab](#)

Infants also seem to understand far more than they can produce, a phenomenon known as the *receptive-productive lag* (Stevenson et al., 1988). They may be able to only produce one or two words, but they understand much longer sentences from their parents and others.

There are several stages of language development that all children experience, no matter what culture they live in or what language they will learn to speak (Brown, 1973):

1. **Cooing:** At around 2 months of age, babies begin to make vowel-like sounds.
2. **Babbling:** At about 6 months, infants add consonant sounds to the vowels to make a babbling sound, which at times can almost sound like real speech. Deaf children actually decrease their babbling after 6 months while increasing their use of primitive hand signs and gestures (Petitto & Marentette, 1991; Petitto et al., 2001).
3. **One-word speech:** Somewhere just before or around age 1, most children begin to say actual words. These words are typically nouns and may seem to represent an entire phrase of meaning. They are called *holophrases* (whole phrases in one word) for that reason. For example, a child might say "Milk!" and mean "I want some milk!" or "I drank my milk!"
4. **Telegraphic speech:** At around a year and a half, toddlers begin to string words together to form short, simple sentences using nouns, verbs, and adjectives. "Baby eat," "Mommy go," and "Doggie go bye-bye" are examples of telegraphic speech. Only the words that carry the meaning of the sentence are used.
5. **Whole sentences:** As children move through the preschool years, they learn to use grammatical terms and increase the number of words in their sentences, until by age 6 or so they are nearly as fluent as an adult, although the number of words they know is still limited when compared to adult vocabulary.

AUTISM SPECTRUM DISORDER Before leaving the topic of cognitive development in infancy, let's briefly discuss a topic that has been making the news lately: the causes underlying autism spectrum disorder. Autism spectrum disorder (ASD) is a neurodevelopmental disorder that actually encompasses a whole range of previous disorders (with what may be an equally broad range of causes), which cause problems in thinking, feeling, language, and social skills in relating to others (American Psychiatric Association, 2013);

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This infant has already learned some of the basics of language, including the use of gestures to indicate meaning and enhance communication.

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Atladóttir et al., 2009; Johnson & Myers, 2007). Rumors and misinformation about the causes of autism have been circulating on the Internet for many years.

The major source of misinformation began in 1998, when British gastroenterologist Dr. Andrew Wakefield published the results of two studies that seemed to link the MMR (measles, mumps, and rubella) vaccine to autism and bowel disease in children (Wakefield et al., 1998). With a sample size of only 12 children, no control groups, and with neither study being blind—single or double—the studies were quickly denounced as inadequate and dangerous by autism specialists and others (Fitzpatrick, 2004; Judelsohn, 2007; Matthew & Dallery, 2007; Novella, 2007; Stratton et al., 2001a, 2001b). [LINK](#) to [Learning Objectives 1.10](#) and [1.11](#). Nevertheless, Wakefield's publication was followed by measles epidemics due to parents refusing the MMR inoculation for their children. The myth of a link persists, in spite of numerous studies that have consistently failed to show any link between the MMR vaccine and autism (Burns, 2010; Gilberg & Coleman, 2000; Johnson & Myers, 2007; Madsen et al., 2002; Mars et al., 1998; Taylor et al., 1999; Thompson et al., 2007). In 2004, the other authors listed on the study formally retracted the 1998 paper. In 2009, the final blow came to Wakefield's credibility when it was discovered that he had falsified his data.

As a result of the British Medical Council's investigation into Wakefield's actions, Wakefield's medical license was revoked in May of 2010, after the council found him guilty of "serious professional misconduct" (Meikle & Bosley, 2010).

The following section dispels a number of other myths about vaccinations and their safety.

issues in psychology



The Facts and Myths About Immunizations



Many parents have become aware of misinformation that has been placed on the Internet and handed out by concerned but uninformed people, information that highlights the dangers of immunization (CDC, 2013; Stratton et al., 2001a, 2001b). What are some of the myths parents now believe, and what are the facts?

- Myth: Children who are given an immunization can get the disease itself.
- Fact: Most vaccines are made from dead viruses, and it is impossible to get the disease in this way. Vaccines that use very weak live viruses (like the chicken pox vaccine) might cause a child to develop a mild version of the disease, but the risk is very small and the full-blown disease is far more serious and deadly (Centers for Disease Control and Prevention, 2004, 2011, 2013; Offit & Bell, 1998; National Institutes of Health, 1998).
- Myth: If all the other children in a school are immunized, there's no harm in not immunizing one's own child.
- Fact: If one parent is thinking like this, others are also, and this can lead to an epidemic. One such epidemic of measles happened between 1989 and 1991 in the United States, causing rates of death due to measles to increase by a large number during that period, as well as increases in rates of brain damage due to high fevers (Centers for Disease Control and Prevention, 2004, 2013; Offit & Bell, 1998; National Institutes of Health, 1998). Measles alone causes the death of 1 million children under the age of 5 each year (Centers for Disease Control and Prevention, 1999, 2000, 2004, 2013).
- Myth: The vaccine isn't 100 percent effective, so why subject a child to a painful injection?
- Fact: Vaccines are one of the most effective weapons we have against disease. They work in 85 percent to 99 percent of cases and greatly reduce your child's risk of serious illness, particularly when more and more people use them (Centers for Disease Control and Prevention, 2000, 2013).
- Myth: Immunizations cause bad reactions.
- Fact: The most common reactions to vaccines are minor, including redness and swelling where the shot was given, fever, and rash. In rare cases immunizations can trigger



One of the most important things parents can do for the continued health and safety of their infant is to have the baby immunized, following an approved schedule for each type of vaccine. Immunizations today are safe and effective and prevent dangerous and often deadly childhood diseases, such as rubella.

seizures or severe allergic reactions, but the risk of these is much lower than that of catching the disease if a child is not immunized (Centers for Disease Control and Prevention, 2011; Offit & Bell, 1998).

Myth: Immunization is not needed because these diseases have been eliminated.

Fact: Even though these diseases are rare or nonexistent in the United States, they still flourish in other parts of the world. Children must continue to be vaccinated against them because it is easy to come into contact with illnesses through travel (Centers for Disease Control and Prevention, 1994, 2011, 2013).

Questions for Further Discussion

1. What advice concerning vaccinations would you give a friend who is having a baby?
2. Should children who are not vaccinated be allowed to attend public schools?
3. What can be done to encourage parents to have their children immunized?

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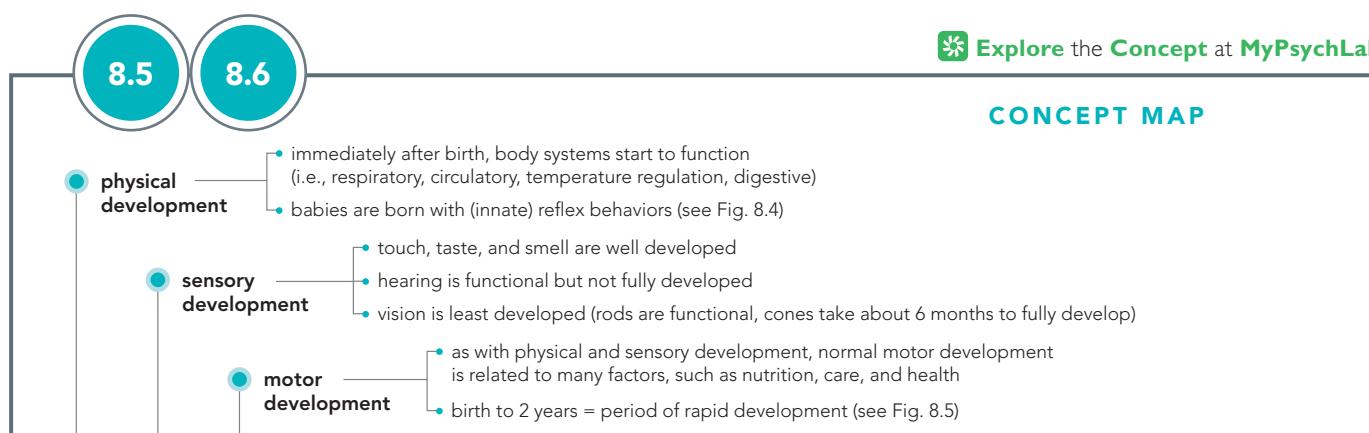
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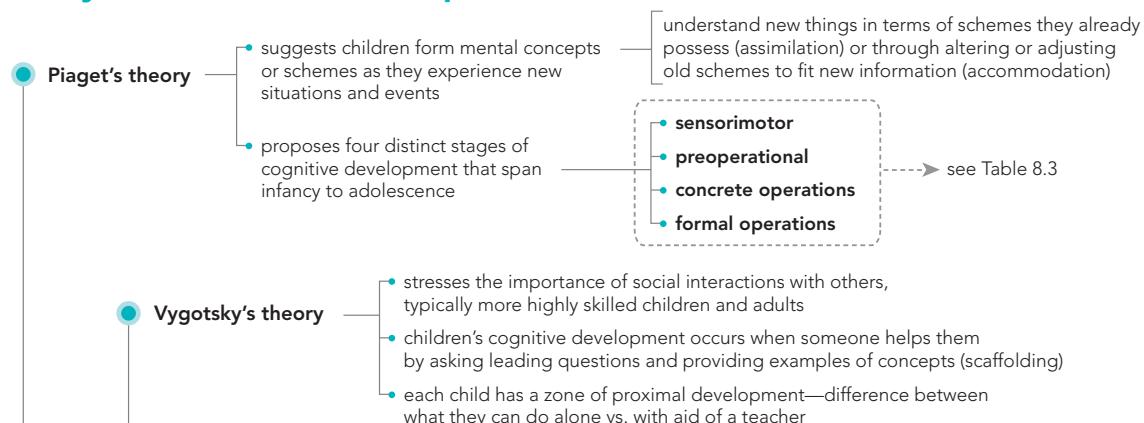
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 Explore the Concept at [MyPsychLab](#)

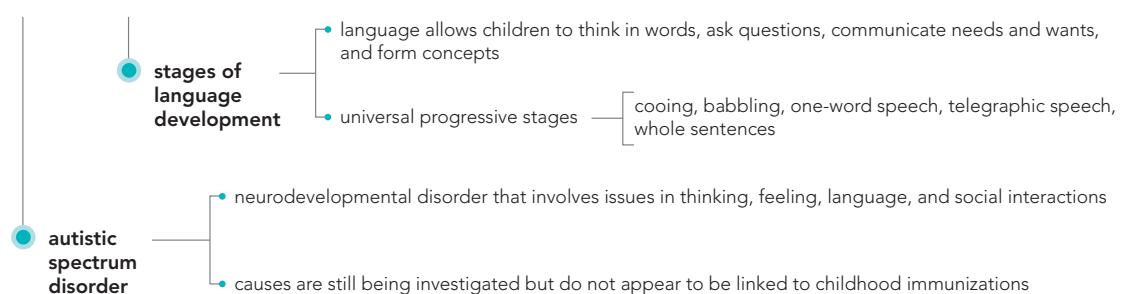
CONCEPT MAP



Infancy and Childhood Development



Infancy and Childhood Development: Cognitive Development



(continued)

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

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Pick the best answer.

1. One way researchers study newborn development involves measuring how long infants continue to focus upon a non-changing stimulus. This technique is referred to as
 - a. adaptation.
 - b. habituation
 - c. longitudinal study.
 - d. a cross-sectional design.

2. Which of a baby's senses is the most well developed at birth?
 - a. vision
 - b. touch
 - c. hearing
 - d. smell

3. In which of Piaget's stages would a child be who has just developed the ability to conserve?
 - a. sensorimotor
 - b. preoperational
 - c. concrete operations
 - d. formal operations

4. Vygotsky defines _____ as the process of helping less as the learner improves at a given task.
 - a. scaffolding
 - b. habituation
 - c. zone of proximal development
 - d. metamemory

5. Which of the following tends to occur first in a child's language development?
 - a. telegraphic speech
 - b. babbling
 - c. a holophrase
 - d. cooing

PSYCHOSOCIAL DEVELOPMENT

How do infants and children develop personalities and form relationships with others, and what are Erikson's stages of psychosocial development for children?

The psychological and social development of infants and children involves the development of personality, relationships, and a sense of being male or female. Although these processes begin in infancy, they will continue, in many respects, well into adulthood.



Why are some children negative and whiny while others are sweet and good natured?

TEMPERAMENT One of the first ways in which infants demonstrate that they have different personalities (i.e., the long-lasting characteristics that make each person different from others) is in their **temperament**, the behavioral and emotional characteristics that are fairly well established at birth. Researchers (Chess & Thomas, 1986; Thomas & Chess, 1977) have identified three basic temperament styles of infants:

1. **Easy:** "Easy" babies are regular in their schedules of waking, sleeping, and eating and are adaptable to change. Easy babies are happy babies and when distressed are easily soothed.
2. **Difficult:** "Difficult" babies are almost the opposite of easy ones. Difficult babies tend to be irregular in their schedules and are very unhappy about change of any kind. They are loud, active, and tend to be crabby rather than happy.
3. **Slow to warm up:** This kind of temperament is associated with infants who are less grumpy, quieter, and more regular than difficult children but who are slow to adapt to change. If change is introduced gradually, these babies will "warm up" to new people and new situations.

Of course, not all babies will fall neatly into one of these three patterns—some children may be a mix of two or even all three patterns of behavior, as Chess and Thomas (1986)

discovered. Even so, longitudinal research strongly suggests that these temperament styles last well into adulthood and are strongly influenced by heredity (Kagan, 1998; Kagan et al., 2007; Korn, 1984; Scarpa et al., 1995; Schwartz et al., 2010), although they are somewhat influenced by the environment in which the infant is raised. For example, a “difficult” infant who is raised by parents who are themselves very loud and active may not be perceived as difficult by the parents, whereas a child who is slow to warm up might be perceived as difficult if the parents themselves like lots of change and noise. The first infant is in a situation in which the “goodness of fit” of the infant’s temperament to the parents’ temperament is very close, but the parents of the second infant are a “poor fit” in temperament for that less active child (Chess & Thomas, 1986). A poor fit can make it difficult to form an attachment, the important psychosocial-emotional bond we will discuss next.

ATTACHMENT The emotional bond that forms between an infant and a primary caregiver is called **attachment**. Attachment is an extremely important development in the social and emotional life of the infant, usually forming within the first 6 months of the infant’s life and showing up in a number of ways during the second 6 months, such as *stranger anxiety* (wariness of strangers) and *separation anxiety* (fear of being separated from the caregiver). Although attachment to the mother is usually the primary attachment, infants can attach to fathers and to other caregivers as well. Participate in the survey experiment *What Has Your Father Done for You?* to reflect back on the relationship you had with your father while you were growing up.

Simulation

What Has Your Father Done for You?

This survey asks you about your attitudes towards and experiences with the father figure(s) in your life (no matter what their gender or actual biological relationship to you) and how the role they’ve played in your life has affected your life-span development.

[Go to the Experiment ➔](#)

How satisfied are you today with the frequency with which you were able to interact with your father while you were growing up?

- Very dissatisfied
- Dissatisfied
- Neither satisfied nor dissatisfied
- Satisfied
- Very satisfied
- Prefer Not to State

Simulate the Experiment, *What Has Your Father Done for You?*, on [MyPsychLab](#)

Attachment Styles Mary Ainsworth (Ainsworth, 1985; Ainsworth et al., 1978) devised a special experimental design to measure the attachment of an infant to the caregiver; she called it the “Strange Situation” (exposing an infant to a series of leave-takings and returns of the mother and a stranger). Through this measurement technique, Ainsworth and another colleague identified four attachment styles:  [Watch the Video](#), *The Basics: Attachment*, at [MyPsychLab](#)

- Secure:** Infants labeled as secure were willing to get down from their mother’s lap soon after entering the room with their mothers. They explored happily, looking back at their mothers and returning to them every now and then (sort of like “touching base”). When the stranger came in, these infants were wary but calm

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as long as their mother was nearby. When the mother left, the infants got upset. When the mother returned, the infants approached her, were easily soothed, and were glad to have her back.

2. **Avoidant:** In contrast, avoidant babies, although somewhat willing to explore, did not “touch base.” They did not look at the stranger or the mother, and reacted very little to her absence or her return, seeming to have no interest or concern.
3. **Ambivalent:** The word *ambivalent* means to have mixed feelings about something. Ambivalent babies in Ainsworth’s study were clinging and unwilling to explore, very upset by the stranger regardless of the mother’s presence, protested mightily when the mother left, and were hard to soothe. When the mother returned, these babies would demand to be picked up, but at the same time push the mother away or kick her in a mixed reaction to her return.
4. **Disorganized-disoriented:** In subsequent studies, other researchers (Main & Hesse, 1990; Main & Solomon, 1990) found that some babies seemed unable to decide just how they should react to the mother’s return. These disorganized-disoriented infants would approach her but with their eyes turned away from her, as if afraid to make eye contact. In general, these infants seemed fearful and showed a dazed and depressed look on their faces.

It should come as no surprise that the mothers of each of the four types of infants also behaved differently from one another. Mothers of secure infants were loving, warm, sensitive to their infant’s needs, and responsive to the infant’s attempts at communication. Mothers of avoidant babies were unresponsive, insensitive, and coldly rejecting. Mothers of ambivalent babies tried to be responsive but were inconsistent and insensitive to the baby’s actions, often talking to the infant about something totally unrelated to what the infant was doing at the time. Mothers of disorganized-disoriented babies were found to be abusive or neglectful in interactions with the infants.

Attachment is not necessarily the result of the behavior of the mother alone, however. The temperament of the infant may play an important part in determining the reactions of the mother (Goldsmith & Campos, 1982; Skolnick, 1986). For example, an infant with a difficult temperament is hard to soothe. A mother with this kind of infant might come to avoid unnecessary contact with the infant, as did the mothers of the avoidant babies in Ainsworth’s studies.

Critics of Ainsworth’s Strange Situation research focus on the artificial nature of the design and wonder if infants and mothers would behave differently in the more familiar surroundings of home, even though Ainsworth’s experimental observers also observed the infants and mothers in the home prior to the Strange Situation setting (Ainsworth, 1985). Other research has found results supporting Ainsworth’s findings in home-based assessments of attachment (Blanchard & Main, 1979). Other studies have also found support for the concept of attachment styles and stability of attachment over the first 6 years of life (Lutkenhaus et al., 1985; Main & Cassidy, 1988; Owen et al., 1984; Wartner et al., 1994). Even adult relationships can be seen as influenced by the attachment style of the adult—those who are avoidant tend to have numerous shallow and brief relationships with different partners, whereas those who are ambivalent tend to have repeated breakups and makeups with the same person (Bartholomew, 1990; Hazan & Shaver, 1987).

Influences on Attachment As day care has become more widely acceptable and common, many parents have been concerned about the effect of day care on attachment. Psychologist Jay Belsky and colleagues (Belsky, 2005; Belsky & Johnson, 2005; Belsky et al., 2007) have studied the attachment of infants in day care and concluded that although higher quality of day care (small child-to-caregiver ratio, low turnover in caregivers, and caregivers educated in child-care techniques and theory) is important, especially for cognitive development, positive development including attachment was more clearly related to the quality of parenting that the infants and toddlers received at home.



This toddler shows reluctance to explore his environment, instead clinging to his father’s leg. Such clinging behavior, if common, can be a sign of an ambivalent attachment.

Although there are some cultural differences in attachment—such as the finding that mothers in the United States tend to wait for a child to express a need before trying to fulfill that need, while Japanese mothers prefer to anticipate the child's needs (Rothbaum et al., 2000), attachment does not seem to suffer in spite of the differences in sensitivity. Evidence that similar attachment styles are found in other cultures demonstrates the need to consider attachment as an important first step in forming relationships with others, one which may set the stage for all relationships that follow (Hu & Meng, 1996; Juffer & Rosenboom, 1997; Keromoian & Leiderman, 1986; Rothbaum et al., 2010).

Before leaving the topic of attachment, let's take a look at one of the first studies that examined the key factors necessary for attachment.

classic studies in psychology



Harlow and Contact Comfort

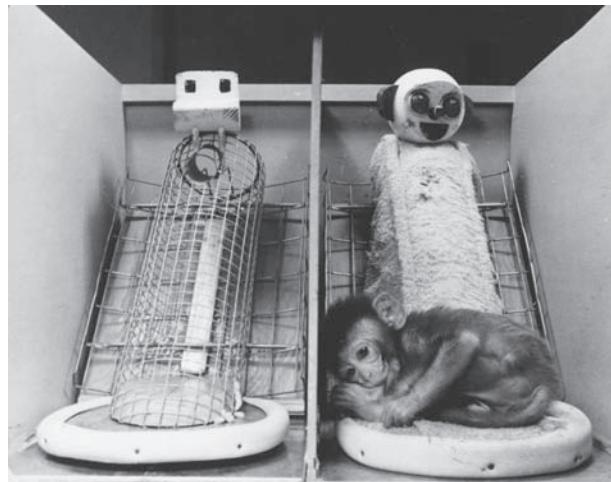


As psychologists began to study the development of attachment, they at first assumed that attachment to the mother occurred because the mother was associated with satisfaction of primary drives such as hunger and thirst. The mother is always present when the food (a primary reinforcer) is presented, so the mother becomes a secondary reinforcer capable of producing pleasurable feelings. [LINK](#) to Learning Objective 5.5.

Psychologist Harry Harlow felt that attachment had to be influenced by more than just the provision of food. He conducted a number of studies of attachment using infant rhesus monkeys (Harlow, 1958). Noticing that the monkeys in his lab liked to cling to the soft cloth pad used to line their cages, Harlow designed a study to examine the importance of what he termed *contact comfort*, the seeming attachment of the monkeys to something soft to the touch.

He isolated eight baby rhesus monkeys shortly after their birth, placing each in a cage with two surrogate (substitute) "mothers." The surrogates were actually a block of wood covered in soft padding and terry cloth and a wire form, both heated from within. For half of the monkeys, the wire "mother" held the bottle from which they fed, while for the other half the soft "mother" held the bottle. Harlow then recorded the time each monkey spent with each "mother." If time spent with the surrogate is taken as an indicator of attachment, then learning theory would predict that the monkeys would spend more time with whichever surrogate was being used to feed them.

The results? Regardless of which surrogate was feeding them, all of the infant monkeys spent significantly more time with the soft, cloth-covered surrogate. In fact, all monkeys spent very little time with the wire surrogate, even if this was the one with the bottle. Harlow and his



The wire surrogate "mother" provides the food for this infant rhesus monkey. But the infant spends all its time with the soft, cloth-covered surrogate. According to Harlow, this demonstrates the importance of contact comfort in attachment.

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colleagues concluded that “contact comfort was an important basic affectional or love variable” (Harlow, 1958, p. 574).

Harlow’s work represents one of the earliest investigations into the importance of touch in the attachment process and remains an important study in human development.

Questions for Further Discussion

- Even though the cloth surrogate was warm and soft and seemed to provide contact comfort, do you think that the monkeys raised in this way would behave normally when placed into contact with other monkeys? How might they react?
- What might be the implications of Harlow’s work for human mothers who feed their infants with bottles rather than breast-feeding?

WHO AM I?: THE DEVELOPMENT OF THE SELF-CONCEPT Infants begin life without understanding that they are separate from their surroundings, and also from the other people in their social world. The **self-concept** is the image you have of yourself, and it is based on your interactions with the important people in your life. As infants experience the world around them, they slowly learn to separate “me” from both physical surroundings and the other people in their world.

One way to demonstrate a child’s growing awareness of self is known as the rouge test. A spot of red rouge or lipstick is put on the end of the child’s nose and the child is then placed in front of a mirror. Infants from about 6 months to a little over a year will reach out to touch the image of the baby in the mirror, reacting as if to another child (Amsterdam, 1972; Courage & Howe, 2002). In fact, some infants crawl or walk to the other side of the mirror to look for the “other.” But at about 15 to 18 months of age, the infant begins to touch his or her own nose when seeing the image in the mirror, indicating an awareness that the image in the mirror is the infant’s own (Nielsen et al., 2005). As the child grows, the self-concept grows to include gender (“I’m a boy” or “I’m a girl”), physical appearances (“I have brown hair and blue eyes”), and in middle childhood, personality traits and group memberships (Stipek et al., 1990).

 I’ve heard that you shouldn’t pick a baby up every time it cries—that if you do, it might spoil the baby.

ERIKSON’S THEORY Unfortunately, a lot of people have not only heard this advice but also acted on it by frequently ignoring an infant’s crying, which turns out to be a very bad thing for babies. When a baby under 6 months of age cries, it is an instinctive reaction meant to get the caregiver to tend to the baby’s needs—hunger, thirst, pain, and even loneliness. Research has shown that babies whose cries are tended to consistently (that is, the infant is fed when hungry, changed when wet, and so on) in the early months are more securely attached at age 1 than those infants whose caregivers frequently allow the infants to cry when there is a need for attention—hunger, pain, or wetness, for example (Brazelton, 1992; Heinicke et al., 2000). Erik Erikson, a psychodynamic theorist who emphasized the importance of social relationships in the development of personality, would certainly disagree with letting a baby “cry it out,” although allowing an infant who has been fed, changed, burped, and checked to cry on occasion will not damage attachment.

Erikson, who trained as a Freudian psychoanalyst but became convinced that social interactions were more important in development than Freud’s emphasis on sexual development, believed that development occurred in a series of eight stages, with the first four of these stages occurring in infancy and childhood (Erikson, 1950; Erikson & Erikson, 1997). (Freud’s stages of psychosexual development are covered in detail in a later chapter.)  to Learning Objective 13.2. Each of Erikson’s stages is an emotional *crisis*,

or a kind of turning point, in personality, and the crisis in each stage must be successfully met for normal, healthy psychological development.

Erikson focused on the relationship of the infant and the child to significant others in the immediate surroundings—parents and then later teachers and even peers. **Table 8.4** summarizes the conflict in each of Erikson's eight stages and some of the implications for future development (Erikson, 1950; Erikson & Erikson, 1997). For now, look at the first four stages in particular.

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Table 8.4**Erikson's Psychosocial Stages of Development**

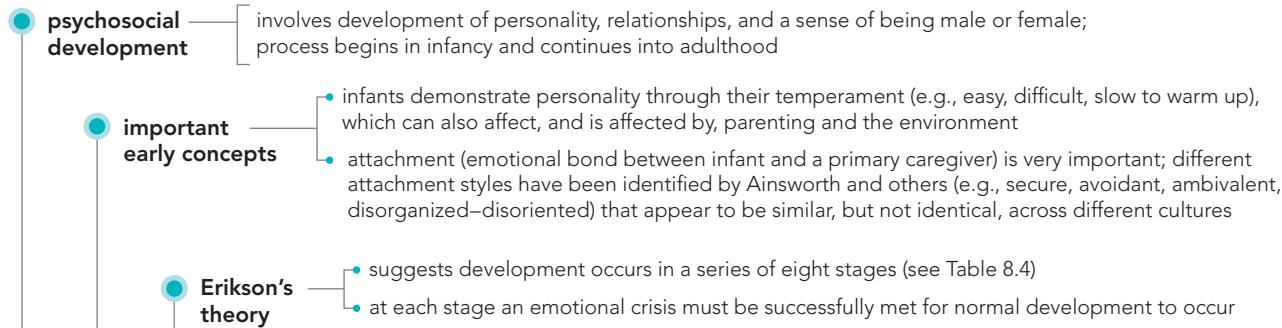
STAGE	DEVELOPMENTAL CRISIS	SUCCESSFUL DEALING WITH CRISIS	UNSUCCESSFUL DEALING WITH CRISIS
1. Infant Birth to 1 year old	Trust Versus Mistrust Infants learn a basic sense of trust dependent upon how their needs are met.	If babies' needs for food, comfort, and affection are met, they develop a sense of trust in people and expect those needs to be met in future.	If babies' needs for food, comfort, and affection are not met, they develop a sense of mistrust and do not expect their needs to be met in future.
2. Toddler 1 to 3 years old	Autonomy Versus Shame and Doubt Toddlers begin to understand that they can control their own actions.	Toddlers who are successful in controlling their own actions develop independence.	Toddlers whose attempts at being independent are blocked develop a sense of self-doubt and shame for failing.
3. Preschool Age 3 to 5 years old	Initiative Versus Guilt Preschool children learn to take responsibility for their own behavior as they develop self-control.	If preschoolers succeed in controlling their reactions and behavior, they feel capable and develop a sense of initiative.	If preschoolers fail in controlling their reactions and behavior, they feel irresponsible, anxious, and develop a sense of guilt.
4. Elementary School Age 5 to 12 years old	Industry Versus Inferiority The school-aged child must learn new skills in both the academic world and the social world. They compare themselves to others to measure their success or failure.	When children feel they have succeeded at learning these skills, they develop a sense of industry, making them feel competent and improving their self-esteem.	When children fail or feel that they have failed in learning these skills, they feel inferior when compared to others.
5. Adolescence 13 to early 20s	Identity Versus Role Confusion Adolescents must decide who they are, what they believe, and what they want to be as an adult.	Adolescents who are able to define their values, goals, and beliefs will develop a stable sense of identity.	Adolescents who are unable to define themselves remain confused and may isolate themselves from others or try to be like everyone else instead of themselves.
6. Early Adulthood 20s and 30s	Intimacy Versus Isolation Young adults face the task of finding a person with whom they can share their identity in an ongoing, close, personal relationship.	Young adults who successfully find someone and share their identities will have a fulfilling relationship founded on psychological intimacy.	Young adults who are unable to find someone (often because they do not yet have a stable identity to share) will isolate themselves and may experience loneliness, even when involved in shallow relationships with others.
7. Middle Adulthood 40s and 50s	Generativity Versus Stagnation The focus of this task is to find a way to be a creative, productive person who is nurturing the next generation.	Adults who are able to focus on the next generation will be productive and creative, leaving a legacy for the future.	Adults who are unable to focus outside themselves will remain stagnated, self-centered, and feeling that they have not made a difference.
8. Late Adulthood 60s and beyond	Ego Integrity Versus Despair The task in this stage involves coming to terms with the end of life, reaching a sense of wholeness and acceptance of life as it has been.	Older adults who are able to come to terms with their lives, things they have done and left undone, and able to "let go" of regrets will have a sense of completion and will see death as simply the last stage of a full life.	Older adults who have not been able to achieve identity or intimacy or generativity, who cannot let go of their regrets, will feel a sense of having left things too late and see death as coming too soon.

Derived from Erikson, 1950.

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 Explore the Concept at MyPsychLab

CONCEPT MAP



Infancy and Childhood Development: Psychosocial Development

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. According to Thomas and Chess, temperament styles often last _____ and are often influenced by _____.
 - a. into early childhood; the unconscious
 - b. into early adolescence; the environment
 - c. into early adulthood; family
 - d. throughout adulthood; heredity
2. What kind of attachment, according to Ainsworth, is shown by a baby who clings to his or her mother, gets upset when the mother leaves, and demands to be picked up but at the same time kicks and pushes her away?
 - a. secure
 - b. avoidant
 - c. ambivalent
 - d. disorganized-disoriented
3. Studies by Harry Harlow showed that the most important element to developing attachment is
 - a. feeding.
 - b. physical contact.
 - c. mental challenges.
 - d. sleep.
4. Baby Lisa is beginning to learn more about herself. When she sees herself in a mirror, she smiles and laughs but no longer needs to touch the mirror or look behind it to find the baby that she sees. Researchers would say that baby Lisa is developing
 - a. trust versus mistrust.
 - b. autonomy versus shame and doubt.
 - c. awareness of herself.
 - d. her internal identity.
5. According to Erikson, which stage results in a sense of independence because of one's ability to control their own actions?
 - a. trust versus mistrust
 - b. autonomy versus shame and doubt
 - c. initiative versus guilt
 - d. generativity versus stagnation

Adolescence

What are the physical, cognitive, and personality changes that occur in adolescence, including concepts of morality and Erikson's search for identity?

Adolescence is the period of life from about age 13 to the early 20s, during which a young person is no longer physically a child but is not yet an independent, self-supporting adult. Although in the past, adolescence was always defined as the “teens,” from ages 13 to 19, adolescence isn’t necessarily determined by chronological age. It also concerns how a person deals with life issues such as work, family, and relationships. So although there is a clear age of onset, the end of adolescence may come earlier or later for different individuals.

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PHYSICAL DEVELOPMENT

Isn't adolescence just the physical changes that happen to your body?

The clearest sign of the beginning of adolescence is the onset of **puberty**, the physical changes in both *primary sex characteristics* (growth of the actual sex organs such as the penis or the uterus) and *secondary sex characteristics* (changes in the body such as the development of breasts and body hair) that occur in the body as sexual development reaches its peak. [LINK](#) to Learning Objective 10.1. Puberty occurs as the result of a complex series of glandular activities, stimulated by the “master gland” or the pituitary gland, when the proper genetically determined age is reached. The thyroid gland increases the rate of growth, and the adrenal glands and sex glands stimulate the growth of characteristics such as body hair, muscle tissue in males, and the menstrual cycle in girls, for example (Grumbach & Kaplan, 1990; Grumbach & Styne, 1998). Puberty often begins about 2 years after the beginning of the *growth spurt*, the rapid period of growth that takes place at around age 10 for girls and around age 12 for boys.

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In addition to an increase in height, physical characteristics related to being male or female undergo rapid and dramatic change. In fact, the rate of growth and development in puberty approaches that of development in the womb. [LINK](#) to Learning Objective 10.1. After about 4 years, the changes of puberty are relatively complete. The development of the brain, however, continues into adulthood. In particular, the prefrontal cortex of the brain, which is responsible in part for impulse control, decision making, and the organization and understanding of information, does not stabilize in its development until we are in our 30s (Petanjek et al., 2011). It is easy to understand, then, why adolescents may engage in risky behavior even when they know better. [Watch the Video](#), Special Topics: Risky Behavior and Brain Development, at [MyPsychLab](#)

COGNITIVE DEVELOPMENT

If I'm remembering correctly, teenagers should be in Piaget's formal operations stage. So why don't many teenagers think just like adults?

The cognitive development of adolescents is less visible than the physical development but still represents a major change in the way adolescents think about themselves, their peers and relationships, and the world around them.

PIAGET'S FORMAL OPERATIONS REVISITED Adolescents, especially those who receive a formal high school education, may move into Piaget's final stage of formal operations, in

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which abstract thinking becomes possible. Teenagers begin to think about hypothetical situations, leading to a picture of what an “ideal” world would be like.

Piaget’s theory has had a tremendous impact in the education of children and in stimulating research about children’s cognitive development (Satterly, 1987). Children in different cultures usually come to understand the world in the way that Piaget described, although the age at which this understanding comes varies from one child to another.

Although headed into an adult-style of thinking, adolescents are not yet completely free of egocentric thought. At this time in life, however, their egocentrism shows up in their preoccupation* with their own thoughts. They do a lot of introspection (turning inward) and may become convinced that their thoughts are as important to others as they are to themselves. Two ways in which this adolescent egocentrism emerges are the personal fable and the imaginary audience (Elkind, 1985; Lapsley et al., 1986; Vartanian, 2000).

In the **personal fable**, adolescents have spent so much time thinking about their own thoughts and feelings that they become convinced that they are special, one of a kind, and that no one else has ever had these thoughts and feelings before them. “You just don’t understand me, I’m different from you” is a common feeling of teens. The personal fable is not without a dangerous side. Because they feel unique, teenagers may feel that they are somehow protected from the dangers of the world and so do not take the precautions that they should. This may result in an unwanted pregnancy, severe injury or death while racing in a car, drinking (or texting) and driving, and drug use, to name a few possibilities. “It can’t happen to me, I’m special” is a risky but common thought.

The **imaginary audience** shows up as extreme self-consciousness in adolescents. They become convinced that *everyone is looking at them* and that they are always the center of everyone else’s world, just as they are the center of their own. This explains the intense self-consciousness that many adolescents experience concerning what others think about how the adolescent looks or behaves.

MORAL DEVELOPMENT Another important aspect in the cognitive advances that occur in adolescence concerns the teenager’s understanding of “right” and “wrong.” Harvard University professor Lawrence Kohlberg was a developmental psychologist who, influenced by Piaget and others, outlined a theory of the development of moral thinking through looking at how people of various ages responded to stories about people caught up in moral dilemmas (see **Figure 8.8** for an example of a dilemma). Kohlberg (1973) proposed three levels of moral development, or the knowledge of right and wrong behavior. These levels are summarized in **Table 8.5**, along with an example of each type of thinking. Although these stages are associated with certain age-groups, adolescents and adults can

*preoccupation: extreme or excessive concern with something.

Example of a Moral Dilemma

The ant worked long and hard over the summer to gather food for himself and his family. The grasshopper, who preferred to play and be lazy all summer, laughed at the ant for working so hard. The ant said, “you will be sorry this winter when you have no food.” Sure enough, when winter came the very sorry grasshopper, cold and hungry, came to the ant and begged for food and shelter. Should the ant give food and shelter to the grasshopper?

Figure 8.8 Example of a Moral Dilemma

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Table 8.5**Kohlberg's Three Levels of Morality**

LEVEL OF MORALITY	HOW RULES ARE UNDERSTOOD	EXAMPLE
Preconventional morality (very young children)	Morality of an action is based on the consequences; actions that get rewarded are right and those that earn punishment are wrong.	A child who takes money from a parent's wallet and does not get caught does not see that action as wrong.
Conventional* morality (older children, adolescents, and most adults)	An action is morally right if it conforms to the rules of the society and wrong if it does not.	A child scolds a parent for littering because there is a sign saying not to do so.
Postconventional morality (about one fifth of the adult population)	Morality is now determined by the experiences and judgment of the person, even if that judgment disagrees with society's rules.	A husband helps his dying wife commit suicide to end her pain, even though society considers that action to be murder.

*The term *conventional* refers to general standards or norms of behavior for a particular society, which will differ from one social group or culture to another.

be found at all three levels. For example, a juvenile delinquent tends to be preconventional in moral thinking.

Kohlberg's theory has been criticized as being male-oriented and biased toward Western cultures, especially since he used only males in his studies (Gilligan, 1982; Snarey, 1985). Carol Gilligan (1982) proposed that men and women have different perspectives on morality: Men tend to judge as moral the actions that lead to a fair or just end, whereas women tend to judge as moral the actions that are nonviolent and hurt the fewest people. Researchers, however, have not found consistent support for gender differences in moral thinking (Walker, 1991). Another criticism is that Kohlberg's assessment of moral development involves asking people what they think should be done in hypothetical moral dilemmas. What people say they will do and what people actually do when faced with a real dilemma are often two different things.

PSYCHOSOCIAL DEVELOPMENT

The development of personality and social relationships in adolescence primarily concerns the search for a consistent sense of self or personal identity.  [Watch the Video](#), *What's in It for Me?: Identity*, at [Mypsychlab](#)

ERIKSON'S IDENTITY VERSUS ROLE CONFUSION The psychosocial crisis that must be faced by the adolescent, according to Erikson, is that of **identity versus role confusion**. In this stage, the teenager must choose from among many options for values in life and beliefs concerning things such as political issues, career options, and marriage (Feldman, 2003). From those options, a consistent sense of self must be found. Erikson believed that teens who have successfully resolved the conflicts of the earlier four stages are much better "equipped" to resist peer pressure to engage in unhealthy or illegal activities and find their own identity during the adolescent years. Those teens who are not as successful come into the adolescent years with a lack of trust in others, feelings of guilt and shame, low self-esteem, and dependency on others. Peer pressure is quite effective on teenagers who desperately want to "fit in" and have an identity of a certain sort, and who feel that others will not want to be with them unless they conform to the expectations and demands of the peer group. They play the part of the model child for the parents, the good student for the teachers, and the "cool" juvenile delinquent to their friends and will be confused about which of the many roles they play really represent their own identity.

PARENT-TEEN CONFLICT Even for the majority of adolescents who end up successfully finding a consistent sense of self, there will be conflicts with parents. Many researchers



Actresses Lindsay Lohan, Amanda Seyfried, Lacey Chabert, and Rachel McAdams on the set of Mark S. Waters's comedy movie *Mean Girls*. This movie portrays the ins and outs of peer pressure and the desire to fit in that many adolescents face.

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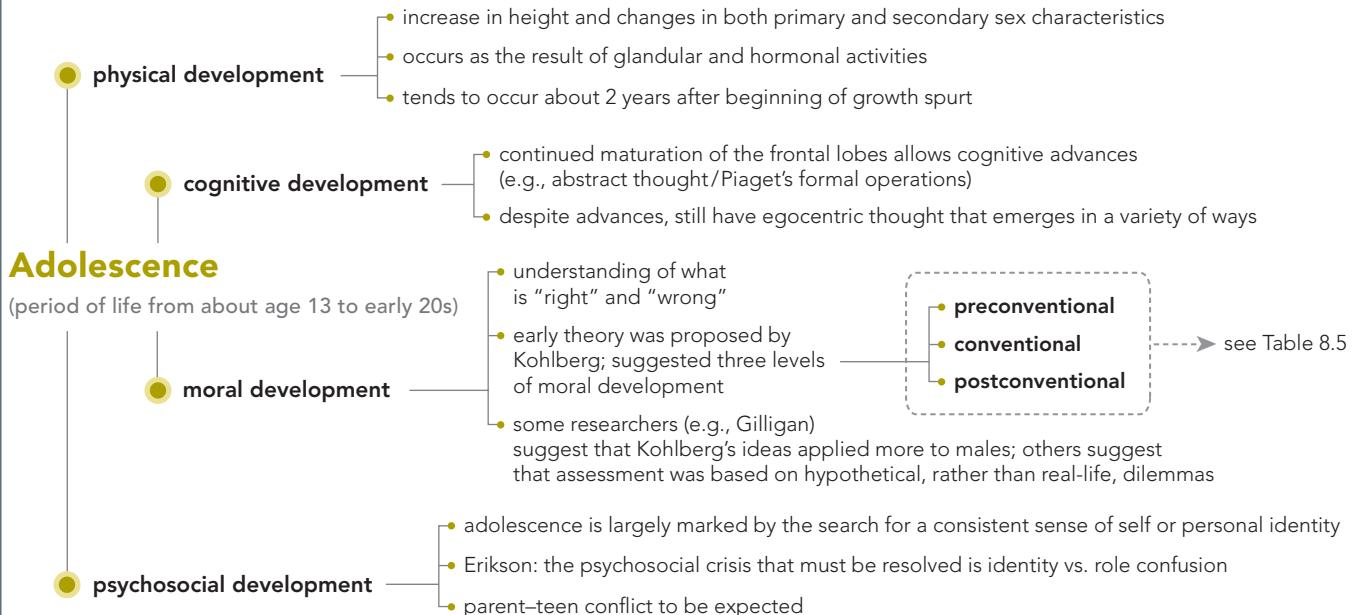
believe that a certain amount of “rebellion” and conflict is a necessary step in breaking away from childhood dependence on the parents and becoming a self-sufficient* adult (Bengston, 1970; Lynott & Roberts, 1997). Although many people think that these conflicts are intense and concern very serious behavior, the reality is that most parent–teen conflict is over trivial issues—hair, clothing, taste in music, and so on. On the really big moral issues, most parents and teens would be quite surprised to realize that they are in agreement (Giancola, 2006).  [Watch the Video, The Big Picture: Different Perspectives on the World, at MyPsychLab](#)

*self-sufficient: able to function without outside aid; capable of providing for one's own needs.

8.8

 [Explore the Concept at MyPsychLab](#)

CONCEPT MAP



PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Changes in the body of young boys such as the appearance and growth of body hair is considered
 - a. a primary sex characteristic.
 - b. a secondary sex characteristic.
 - c. the final stage of puberty.
 - d. a sign of postconventional morality.
2. “It can’t happen to me. I’m special” is a common attitude found in adolescents who have developed
 - a. a self-concept.
 - b. an imaginary audience.
 - c. a personal fable.
 - d. a preconventional morality.
3. According to Kohlberg, about one-fifth of the adult population is at the _____ level of morality.
 - a. preconventional
 - b. conventional
 - c. postconventional
 - d. preliminary
4. According to Erikson, the task of the adolescent is to
 - a. find a consistent sense of self.
 - b. develop a sense of initiative.
 - c. find intimacy with another.
 - d. develop a sense of industry.
5. If Colin is going to argue and disagree with his parents, which of the following topics will he typically be arguing over?
 - a. political beliefs
 - b. religious beliefs
 - c. social values
 - d. his taste in clothes

Adulthood

What are the physical, cognitive, and personality changes that occur during adulthood and aging, including Erikson's last three psychosocial stages, and patterns of parenting?



When exactly does adulthood begin?

Adulthood can be thought of as the period of life from the early 20s until old age and death. Exactly when adulthood begins is not always easy to determine. In some cultures, adulthood is reached soon after puberty (Bledsoe & Cohen, 1993; Ocholla-Ayayo et al., 1993). Some people feel that it begins after graduation from high school, whereas others would say adulthood doesn't begin until after graduation from college. Others define it as the point when a person becomes totally self-sufficient with a job and a home separate from his or her parents. In that case, some people are not adults until their late 30s.

Many developmental psychologists now talk about "emerging adulthood" as a time from late adolescence through the 20s and referring to mainly those in developed countries who are childless, do not live in their own home, and are not earning enough money to be independent (Arnett, 2000; Azmitia et al., 2008; Nelson et al., 2008). Decisions about identity, values, and the preparation for a career have begun to take longer and longer, and together with the downturn in the economy, many young people who would have been working and raising families a few decades ago now find that they cannot "leave the nest" so easily.

PHYSICAL DEVELOPMENT: USE IT OR LOSE IT

Adulthood can also be divided into at least three periods: young adulthood, middle age, and late adulthood. Physical changes in young adulthood are relatively minimal. The good news is that the 20s are a time of peak physical health, sharp senses, fewer insecurities, and mature cognitive abilities. The bad news is that even in the early 20s, the signs of aging are already beginning. Oil glands in the neck and around the eyes begin to malfunction, contributing to wrinkles in those areas near the end of the 20s and beginning of the 30s. The 30s may not bring noticeable changes, but vision and hearing are beginning to decline and by around age 40, bifocal lenses may become necessary as the lens of the eye hardens, becoming unable to change its shape to shift focus. Hearing loss may begin in the 40s and 50s but often does not become noticeable until the 60s or 70s, when hearing aids may become necessary.

In the 40s, while most adults are able to experience some security and stability without the worries and concerns of adolescence and young adulthood, physical aging continues: Skin begins to show more wrinkles, hair turns gray (or falls out), vision and hearing decline further, and physical strength may begin to decline (Frontera et al., 1991). In the 50s, these changes continue. Throughout middle age, weight may increase as the rate at which the body functions slows down but eating increases and less time is spent exercising. Height begins to decrease, with about half an inch of height lost for every 10 years past age 40, although people with the bone-loss disease osteoporosis may lose up to 8 inches or more (Cummings & Melton, 2002). Although sexual functioning usually does not decline in middle age, opportunities for sexual activity may be fewer than in the days of young adulthood (Hodson & Skeen, 1994; Williams, 1995). Children, mortgages, and career worries can put a damper on middle-age romance.

MENOPAUSE In a woman's 40s, the levels of the female hormone estrogen decline as the body's reproductive system prepares to cease that function. Some women begin to experience "hot flashes," a sudden sensation of heat and sweating that may keep them awake at night. Interestingly, in some cultures, particularly those in which the diet contains high

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amounts of soy products, hot flashes are almost nonexistent (Cassidy et al., 1994; Lock, 1994). However, a recent study suggests soy intake is not a primary factor (Gold, et al., 2013). The changes that happen at this time are called the *climacteric*, and the period of 5 to 10 years over which these changes occur is called *perimenopause*. At an average age of 51, most women will cease ovulation altogether, ending their reproductive years. The cessation of ovulation and the menstrual cycle is called **menopause** (Mishell, 2001). Many women look forward to the freedom from monthly menstruation and fear of unplanned pregnancies (Adler et al., 2000; Hvas, 2001; Leon et al., 2007).

 Do men go through anything like menopause?

Men also go through a time of sexual changes, but it is much more gradual and less dramatic than menopause. In males, **andropause** (Carruthers, 2001) usually begins in the 40s with a decline in several hormones, primarily testosterone (the major male hormone). Physical symptoms are also less dramatic but no less troubling: fatigue, irritability, possible problems in sexual functioning, and reduced sperm count. Males, however, rarely lose all reproductive ability.

EFFECTS OF AGING ON HEALTH It is in middle age that many health problems first occur, although their true cause may have begun in the young adulthood years. Young adults may smoke, drink heavily, stay up late, and get dark tans, and the wear and tear that this lifestyle causes on their bodies will not become obvious until their 40s and 50s.

Some of the common health problems that may show up in middle age are high blood pressure, skin cancer, heart problems, arthritis, and obesity. High blood pressure can be caused by lifestyle factors such as obesity and stress but may also be related to hereditary factors (Rudd & Osterberg, 2002). Sleep problems, such as loud snoring and sleep apnea (in which breathing stops for 10 seconds or more), may also take their toll on physical health. There is some evidence that high blood pressure and apnea are linked, although the link very well may be the common factor of obesity (Nieto et al., 2000). Statistically, the most frequent causes of death in middle age are heart disease, cancer, and stroke—in that order (McGinnis & Foege, 1993).

COGNITIVE DEVELOPMENT

During this time, intellectual abilities do not decline overall, although speed of processing (or reaction time) does slow down. Compared to a younger adult, a middle-aged person may take a little longer to solve a problem. However, a middle-aged person also has more life experience and knowledge to bring to bear on a problem, which counters the lack of speed. In one study (Salthouse, 1984), for example, older typists were found to outperform younger typists, even though they typed more slowly than the younger subjects. The older typists, because of years of practice, had developed a skill of looking farther ahead in the document they were typing, so that they could type more continuously without looking back at the document. This allowed them to complete their typing more quickly than the younger typists.

CHANGES IN MEMORY Changes in memory ability are probably the most noticeable changes in middle-aged cognition. People find themselves having a hard time recalling a particular word or someone's name. This difficulty in retrieval is probably not evidence of a physical decline (or the beginning of Alzheimer's disease:  to Learning Objective 6.12) but is more likely caused by the stresses a middle-aged person experiences and the sheer amount of information that a person of middle years must try to keep straight (Craik, 1994; Launer et al., 1995; Sands & Meredith, 1992). A recent study even suggests that thinking about the positive events of the past aids the formation of newer memories—the areas of the brain that are linked to processing emotional content seem to have a strong connection to the areas of the brain responsible for memory formation (Addis et al., 2010). Think positive!

HOW TO KEEP YOUR BRAIN YOUNG People who exercise their mental abilities have been found to be far less likely to develop memory problems or even more serious senile dementias, such as Alzheimer's, in old age (Ball et al., 2002; Colcombe et al., 2003; Fjatarone, 1996). "Use it or lose it" is the phrase to remember. Working challenging crossword puzzles, for example, can be a major factor in maintaining a healthy level of cognitive functioning. Reading, having an active social life, going to plays, taking classes, and staying physically active can all have a positive impact on the continued well-being of the brain (Bosworth & Schaie, 1997; Cabeza et al., 2002; Singh-Manoux et al., 2003).

PSYCHOSOCIAL DEVELOPMENT

In adulthood, concerns involve career, relationships, family, and approaching old age. The late teens and early 20s may be college years for many, although other young people go to work directly from high school. The task of choosing and entering a career is very serious and a task that many young adults have difficulty accomplishing. A college student may change majors more than once during the first few years of college, and even after obtaining a bachelor's degree many may either get a job in an unrelated field or go on to a different type of career choice in graduate school. Those who are working may also change careers several times (perhaps as many as five to seven times) and may experience periods of unemployment while between jobs.

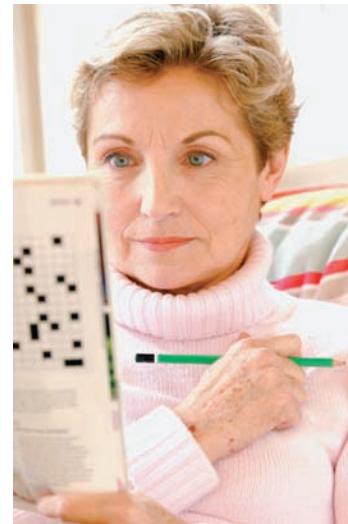
ERIKSON'S INTIMACY VERSUS ISOLATION: FORMING RELATIONSHIPS Erikson saw the primary task in young adulthood to be that of finding a mate. True **intimacy** is an emotional and psychological closeness that is based on the ability to trust, share, and care (an ability developed during the earlier stages such as trust versus mistrust), while still maintaining one's sense of self.  [Learning Objective 12.10](#). Young adults who have difficulty trusting others and who are unsure of their own identities may find isolation instead of intimacy—loneliness, shallow relationships with others, and even a fear of real intimacy. For example, many marriages end in divorce within a few years, with one partner leaving the relationship—and even the responsibilities of parenting—to explore personal concerns and those unfinished issues of identity.

ERIKSON'S GENERATIVITY VERSUS STAGNATION PARENTING In middle adulthood, persons who have found intimacy can now turn their focus outward, toward others. Erikson saw this as parenting the next generation and helping them through their crises, a process he called **generativity**. Educators, supervisors, health-care professionals, doctors, and community volunteers might be examples of positions that allow a person to be generative.

Other ways of being generative include engaging in careers or some major life work that can become one's legacy to the generations to come. Those who are unable to focus outward and are still dealing with issues of intimacy, or even identity, are said to be *stagnated*. People who frequently hand the care of their children over to grandparents or other relatives so that they can go out and "have fun" may be unable to focus on anyone else's needs but their own.

 What kind of parent is the best parent—one who's really strict or one who's pretty easygoing?

PARENTING STYLES Parenting children is a very important part of most people's middle adulthood. Diana Baumrind (1967) outlined three basic styles of parenting, each of which may be related to certain personality traits in the child raised by that style of parenting. The video *In the Real World: Parenting Styles and Socialization* describes each of these parenting styles in more detail and explains why goodness-of-fit, or matching the parenting style to the child's needs, may be most important.



This middle-aged woman works on a crossword puzzle. Mental exercises such as this are one way to keep the brain healthy and fit. What might be some other ways to exercise one's brain?

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Watch the Video, *In the Real World: Parenting Styles and Socialization*, at [MyPsychLab](#)

Authoritarian parenting tends to be overly concerned with rules. This type of parent is stern, rigid, controlling, and uncompromising,* demands perfection, and has a tendency to use physical punishment. Children raised in this way are often insecure, timid, withdrawn, and resentful. As teenagers, they will very often rebel against parental authority in very negative and self-destructive ways, such as delinquency (criminal acts committed by minor children), drug use, or premarital sex (Baumrind, 1991, 2005; Sleddens et al., 2011).

Permissive parenting occurs when parents put very few demands on their children for behavior. **Permissive neglectful** parents simply aren't involved with their children, ignoring them and allowing them to do whatever they want, until it interferes with what the parent wants. At that point, this relationship may become an abusive one. **Permissive indulgent** parents seem to be too involved with their children, allowing their "little angels" to behave in any way they wish, refusing to set limits on the child's behavior or to require any kind of obedience. Children from both kinds of permissive parenting tend to be selfish, immature, dependent, lacking in social skills, and unpopular with peers (Baumrind, 1991, 2005; Dwairy, 2004; Sleddens et al., 2011).

Authoritative parenting involves combining firm limits on behavior with love, warmth, affection, respect, and a willingness to listen to the child's point of view. Authoritative parents are more democratic, allowing the child to have some input into the formation of rules but still maintaining the role of final decision maker. Punishment tends to be nonphysical, such as restrictions, time-out, or loss of privileges. Authoritative parents set limits that are clear and understandable, and when a child crosses the limits, they allow an explanation and then agree upon the right way to handle the situation. Children raised in this style of parenting tend to be self-reliant and independent (Baumrind, 1991, 2005; Dwairy, 2004; Sleddens et al., 2011; Sorkhabi, 2005; Underwood et al., 2009).

ERIKSON'S EGO INTEGRITY VERSUS DESPAIR: DEALING WITH MORTALITY As people enter the stage known as late adulthood, life becomes more urgent as the realities of physical aging and the approaching end of life become harder and harder to ignore. Erikson (1980)

*uncompromising: not making or accepting any viewpoint other than one's own, allowing no other viewpoints.

believed that at this time, people look back on the life they have lived in a process called a life review. In the life review people must deal with mistakes, regrets, and unfinished business. If people can look back and feel that their lives were relatively full and are able to come to terms with regrets and losses, then a feeling of **ego integrity** or wholeness results. Integrity is the final completion of the identity, or ego. If people have many regrets and lots of unfinished business, they feel despair, a sense of deep regret over things that will never be accomplished because time has run out.

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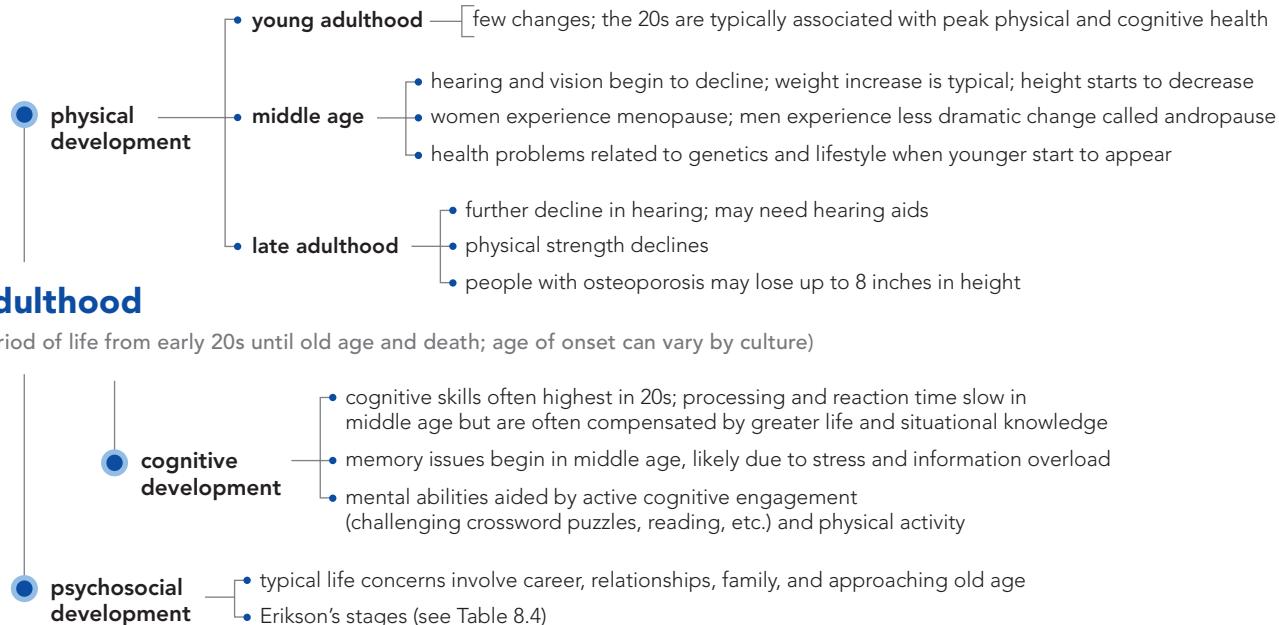
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 Explore the Concept at [MyPsychLab](#)
CONCEPT MAP**PRACTICE quiz How Much Do You Remember?**

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

- At which age does an adult's physical senses begin to hit their peak?
 - 20s
 - 30s
 - 40s
 - 50s
- What is the most frequent cause of death in middle age?
 - accidents
 - stroke
 - excessive risk taking
 - heart disease
- As Conrad has gotten older, he finds that it is becoming more difficult to remember certain words or the name of a new acquaintance. What is the most likely explanation for this change in memory?
 - Alzheimer's disease
 - the aging process
 - stress
 - heredity
- According to Erikson, the primary task of early adulthood is
 - completing your education.
 - finding a mate.
 - starting a career.
 - taking care of aging parents.
- According to Baumrind, which type of parent would most likely say, "Because I said so" or "It's my way or the highway!"?
 - authoritarian
 - authoritative
 - permissive neglectful
 - permissive indulgent
- As William celebrates his 70th birthday, he finds that he is happy with how things have turned out with his life. According to Erikson, William's life review will cause him
 - to develop a sense of ego integrity.
 - a sense of despair, since such reviews often result in depression.
 - to develop an urgency to begin new projects.
 - to put to writing many of his accomplishments.

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THEORIES OF PHYSICAL AND PSYCHOLOGICAL AGING

How do psychologists explain why aging occurs, and what are the stages of death and dying?



Why do people age? What makes us go through so many physical changes?

There are a number of theories of why people physically age. Some theories of physical aging point to biological changes in cellular structure, whereas others focus on the influence of external stresses on body tissues and functioning.

CELLULAR-CLOCK THEORY One of the biologically based theories is the *cellular-clock theory* (Hayflick, 1977). In this theory, cells are limited in the number of times they can reproduce to repair damage. Evidence for this theory is the existence of *telomeres*, structures on the ends of chromosomes that shorten each time a cell reproduces (Martin & Buckwalter, 2001). When telomeres are too short, cells cannot reproduce and damage accumulates, resulting in the effects of aging. (Sounds almost like what happens when the warranty is up on a car, doesn't it?)

WEAR-AND-TEAR THEORY The theory that points to outside influences such as stress, physical exertion, and bodily damage is known as the *wear-and-tear theory of aging*. In this theory, the body's organs and cell tissues simply wear out with repeated use and abuse. Damaged tissues accumulate and produce the effects of aging. *Collagen*, for example, is a natural elastic tissue that allows the skin to be flexible. As people age, the collagen "wears out," becoming less and less "stretchy" and allowing skin to sag and wrinkle (Cua et al., 1990; Kligman & Balin, 1989). (This process is not unlike what happens to the elastic in the waistband of one's underwear over time.)

FREE-RADICAL THEORY The *free-radical theory* is actually the latest version of the wear-and-tear theory in that it gives a biological explanation for the damage done to cells over time. *Free radicals* are oxygen molecules that have an unstable electron (negative particle). They bounce around the cell, stealing electrons from other molecules and increasing the damage to structures inside the cell. As people get older, more and more free radicals do more and more damage, producing the effects of aging (Hauck & Bartke, 2001; Knight, 1998).

Why do people age? What makes us go through so many physical changes?



One way to age successfully and maintain psychological health is to remain active and involved in life. This woman is volunteering in a grade-school classroom as a teacher's aide. This not only allows her to feel useful but also helps her to stay mentally alert and socially involved.

ACTIVITY THEORY **Activity theory** (Havighurst et al., 1968) proposes that an elderly person adjusts more positively to aging when remaining active in some way. Even if a career must end, there are other ways to stay active and involved in life. Elderly people who volunteer at hospitals or schools, those who take up new hobbies or throw themselves full time into old ones, and those who maintain their friendships with others and continue to have social activities have been shown to be happier and live longer than those who withdraw themselves from activity. Contrary to the view of the elderly as voluntarily withdrawing from activities, the withdrawal of many elderly people is not voluntary at all; their lack of involvement is often because others simply stop inviting elderly people to social activities and including them in their lives.

STAGES OF DEATH AND DYING

There are several ways of looking at the process of dying. One of the more well-known theories is that of Elisabeth Kübler-Ross (Kübler-Ross, 1997), who conducted extensive interviews with dying persons and their caregivers.

Elisabeth Kübler-Ross theorized that people go through five stages of reaction when faced with death (Backer et al., 1994; Kübler-Ross, 1997). These stages are *denial*,

in which people refuse to believe that the diagnosis of death is real; anger, which is really anger at death itself and the feelings of helplessness to change things; *bargaining*, in which the dying person tries to make a deal with doctors or even with God; *depression*, which is sadness from losses already experienced (e.g., loss of a job or one's dignity) and those yet to come (e.g., not being able to see a child grow up); and finally acceptance, when the person has accepted the inevitable* and quietly awaits death.

Obviously, some people do not have time to go through all of these stages or even go through them in the listed order (Schneidman, 1983, 1994). Some theorists do not agree with the stage idea, seeing the process of dying as a series of ups and downs, with hope on the rise at times and then falling, to be replaced by a rise in despair or disbelief (Corr, 1993; Maciejewski et al., 2007; Schneidman, 1983, 1994; Weisman, 1972). Still others question the idea of common reactions among dying people, stating that the particular disease or condition and its treatment, the person's personality before the terminal diagnosis, and other life history factors make the process of dying unique and unpredictable (Kastenbaum & Costa, 1977; Zlatin, 1995). The danger in holding too strictly to a stage theory is that people may feel there is a "right" way to face death and a "wrong" way, when in fact each person's dying process is unique. In fact, attitudes and rituals associated with death and the dying process vary from culture to culture, as discussed in the Applying Psychology section at the end of this chapter.

*inevitable: something that cannot be avoided or escaped.

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Adulthood: Aging

 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP



PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. The structures on the ends of chromosomes that shorten each time a cell reproduces are called
 - a. telomeres.
 - b. collagen.
 - c. free radicals.
 - d. DNA.
2. Which theory of aging is compared to the limited number of repairs you can have before your car's warranty runs out?
 - a. wear-and-tear theory
 - b. cellular-clock theory
 - c. free-radical theory
 - d. activity theory
3. According to research, the reason many older people are no longer involved in their community is because
 - a. they are not asked to take part.
 - b. they quite often are unable to take part.
 - c. they do not wish to be involved.
 - d. they die.
4. What stage might terminally ill patients be in if they refuse to write a last will and testament because they believe that in doing so, they are admitting they will die?
 - a. bargaining
 - b. anger
 - c. depression
 - d. denial

THINKING CRITICALLY:

What are your thoughts on the need for closure in dealing with someone's death? Do you think it is always necessary?

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Applying Psychology to Everyday Life: Cross-Cultural Views on Death

What are some cross-cultural differences in views of death and dying?

In the 1987 movie *The Princess Bride*, a character called Miracle Max (wonderfully played by comedian and actor Billy Crystal) says, “It just so happens that your friend here is only MOSTLY dead. There’s a big difference between mostly dead and all dead. Mostly dead is slightly alive.” As it turns out, that far-fetched idea of “mostly dead” is not unheard of in other cultures. While Westerners see a person as either dead or alive, in some cultures a person who, by Western standards is clearly alive, is mourned as already dead—as is the case in many Native American cultures. Let’s take a look at three diverse cultures and their views on death and dying, remembering to contrast them with what you know of death and funeral rites common in your own culture.

- In a wealthy Hindu family in India, the dying person is surrounded by family members, even while in the hospital. In addition, many visitors will attend to the dying person, creating a nearly constant flow of visitors in and out of the room. Once the person has passed away, preparations for the funeral period—which can take nearly 2 weeks—are begun. The body is not sent to a funeral home, but rather is taken into the family home until the actual day of the funeral, where a cremation will take place. During the funeral preparation period, visitors and family stream in and out of the deceased’s home and an abundance of food—all vegetarian at this time—is prepared and eaten. Until the day of the funeral, mattresses are placed on the floor, and all but the very old and infirm are expected to sleep there; the body of the deceased is also placed on the floor. The family members themselves will eventually wash the body in preparation for wrapping and the trip to the crematorium (Parkes et al., 1997). In Hinduism, it is believed that the dead person’s soul will be reincarnated at either a higher level or a lower level of status, depending upon how the person lived his or her life.



The washed and wrapped body of a Hindu man is being carried to the crematorium by his family members.

- In the culture of the Northern Cheyenne Native American tribe, death is considered only the end of the physical body, while the self and one’s Cheyenne nature will persist. The very old and the very young are said to be “close to the spirit,” meaning that the infant has just come from the nonphysical world and the aged person is close to returning to it. The Cheyenne, like the Hindu, also believe in reincarnation, so many infants are seen to be the living embodiment of ancestors. Death itself is a long process, with various aspects of one’s spirit leaving at different times. The first such “leaving” results in changes in the behavior and the mental activity of the dying person, but the person may still be able to walk and communicate. The second leads to loss of the senses, then consciousness, and finally, breathing. The very last essence to leave is the life principle, the first life given into an infant but the last to leave. This life principle stays in the skeleton until the bones begin to crumble into dust. Thus some Cheyenne believe that bones can become alive again (Strauss, 2004).
- In Navajo culture, a person who has died is believed to be in the underworld. Thus it is deemed possible for a dead person to visit the living; this is a feared situation, so the living try to avoid looking at the dead, and only a few people are permitted

to touch or handle the body. A dying person is usually taken to a place removed from others, with only one or two very close relatives staying with the dying person—because to do so is to risk exposure to evil spirits. If a person dies in his or her own home, the home is destroyed—no one is allowed to live there afterward. At the time of death, two men prepare the body for burial, but prior to that ritual they must strip down to only their moccasins, and then cover themselves in ashes, which serves to protect them from the evil spirits. The body is then washed and dressed. Two additional men dig the grave; only these four men will attend the burial, which is held as quickly as possible—usually the next day. The men carry the body on their shoulders to the grave, warning others to stay away from the area. The deceased is then buried along with all his or her belongings, the dirt is returned to the grave, and all footprints are swept away. Even the tools used to dig the grave are destroyed (Downs, 1984).

Questions for Further Discussion

1. How has your own experience with death, if any, affected you and your outlook on life? What were the cultural trappings of the days leading up to the death and/or the funeral arrangements?
2. How do the customs of the wealthy Hindu family differ from those of the Cheyenne, and how are they alike? How do the two Native American cultures differ?

Writing Prompt

- ▼ Using specific examples, differentiate between the thinking patterns of a 3-year-old preschooler and a 9-year-old student, according to Piaget's theory of cognitive development.

Words: 0

Print

Feedback

 Write the Response on MyPsychLab

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chapter summary

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Issues in Studying Human Development

8.1 What are some of the special research designs used to study development?

- Three special methods used in developmental research are the longitudinal design, the cross-sectional design, and the cross-sequential design.

8.2 What is the relationship between heredity and environmental factors in determining development?

- Behavioral genetics is a field investigating the relative contributions to development of heredity (nature) and environment (nurture). Most developmental psychologists agree that development is a product of an interaction between nature and nurture.

The Basic Building Blocks of Development

8.3 How do chromosomes, genes, and DNA determine a person's characteristics or disorders, and what causes multiple births?

- Dominant genes control the expression of a trait, whereas recessive gene traits are only expressed when paired with another recessive gene for the same trait. Almost all traits are the result of combinations of genes working together in a process called polygenic inheritance.
- Chromosome disorders include Down syndrome, Klinefelter's syndrome, and Turner's syndrome, whereas genetic disorders include PKU, cystic fibrosis, sickle-cell anemia, and Tay-Sachs disease.

Prenatal Development

8.4 What happens during conception and prenatal development and what are some prenatal hazards?

- The fertilized egg cell is called a zygote and divides into many cells, eventually forming the baby.
- Monozygotic twins are formed when the zygote splits into two separate masses of cells, each of which will develop into a baby identical to the other. When the two masses do not fully separate, conjoined twins occur.
- Dizygotic twins are formed when the mother's body releases multiple eggs and at least two are fertilized, or when another ovulation occurs even though the mother has already become pregnant.
- The germinal period is the first 2 weeks of pregnancy in which the dividing mass of cells moves into the uterus.
- The embryonic period begins at 2 weeks after conception and ends at 8 weeks. The vital organs and structures of the baby form during this period, making it a critical one when teratogens may adversely affect the development of those developing organs and structures.
- The fetal period is from the beginning of the 9th week until the birth of the baby. During the fetal period, tremendous growth occurs, length and weight increase, and organs continue to become fully functional.

Infancy and Childhood Development

8.5 What kind of physical changes take place in infancy and childhood?

- Four critical areas of adjustment for the newborn are respiration, digestion, circulation, and temperature regulation.
- Infants are born with reflexes that help the infant survive until more complex learning is possible. These reflexes include sucking, rooting, Moro (startle), grasping, and stepping.
- The senses, except for vision, are fairly well developed at birth. Vision is blurry and lacking in full color perception until about 6 months of age. Gross and fine motor skills develop at a fast pace during infancy and early childhood.

8.6 What are two ways of looking at cognitive development, how does language develop, and what is autism spectrum disorder?

- Piaget's stages include the sensorimotor stage of sensory and physical interaction with the world, preoperational thought in which language becomes a tool of exploration, concrete operations in which logical thought becomes possible, and formal operations in which abstract concepts are understood and hypothetical thinking develops.
- Vygotsky believed that children learn best when being helped by a more highly skilled peer or adult in a process called scaffolding. The zone of proximal development is the difference between the mental age of tasks the child performs without help and those the child can perform with help.
- The stages of language development are cooing, babbling, one-word speech (holophrases), telegraphic speech, and whole sentences.
- Autism spectrum disorder (ASD) is a neurodevelopmental disorder, which involves impairments in thinking, feeling, language, and social skills in relating to others.

8.7 How do infants and children develop personalities and form relationships with others, and what are Erikson's stages of psychosocial development for children?

- The three basic infant temperaments are easy (regular, adaptable, and happy), difficult (irregular, nonadaptable, and irritable), and slow to warm up (need to adjust gradually to change).
- The four types of attachment are secure, avoidant (unattached), ambivalent (insecurely attached), and disorganized-disoriented (insecurely attached and sometimes abused or neglected).
- Harlow's classic research with infant rhesus monkeys demonstrated the importance of contact comfort in the attachment process, contradicting the earlier view that attachment was merely a function of associating the mother with the delivery of food.
- In trust versus mistrust, the infant must gain a sense of predictability and trust in caregivers or risk developing a mistrustful nature; in autonomy versus shame and doubt the toddler needs to become physically independent.
- In initiative versus guilt, the preschool child is developing emotional and psychological independence; in industry versus inferiority, school-age children are gaining competence and developing self-esteem.

Adolescence

8.8 What are the physical, cognitive, and personality changes that occur in adolescence, including concepts of morality and Erikson's search for identity?

- Adolescence is the period of life from about age 13 to the early 20s during which physical development reaches completion.
- Puberty is a period of about 4 years during which the sexual organs and systems fully mature and during which secondary

sex characteristics such as body hair, breasts, menstruation, deepening voices, and the growth spurt occur.

- Adolescents engage in two kinds of egocentric thinking called the imaginary audience and the personal fable.
- Kohlberg proposed three levels of moral development: preconventional morality, conventional morality, and postconventional morality. Gilligan suggested that Kohlberg's ideas applied more to males.
- In Erikson's identity versus role confusion crisis, the job of the adolescent is to achieve a consistent sense of self from among all the roles, values, and futures open to him or her.

Adulthood

8.9 What are the physical, cognitive, and personality changes that occur during adulthood and aging, including Erikson's last three psychosocial stages, and patterns of parenting?

- Adulthood begins in the early 20s and ends with death in old age. It can be divided into young adulthood, middle adulthood, and late adulthood.
- The 20s are the peak of physical health; in the 30s the signs of aging become more visible, and in the 40s visual problems may occur, weight may increase, strength may decrease, and height begins to decrease.
- Women experience a physical decline in the reproductive system called the climacteric, ending at about age 50 with menopause, when a woman's reproductive capabilities are at an end. Men go through andropause, a less dramatic change in testosterone and other male hormones, beginning in the 40s.
- Many health problems such as high blood pressure, skin cancers, and arthritis begin in middle age, with the most common causes of death in middle age being heart disease, cancer, and stroke.
- Reaction times slow down, but intelligence and memory remain relatively stable.
- Erikson's crisis of young adulthood is intimacy versus isolation, in which the young adult must establish an intimate relationship, usually with a mate.
- The crisis of middle adulthood is generativity versus stagnation, in which the task of the middle-aged adult is to help the next generation through its crises, either by parenting, mentoring, or a career that leaves some legacy to the next generation.

- Baumrind proposed three parenting styles: authoritarian (rigid and uncompromising), authoritative (consistent and strict but warm and flexible), and permissive (either indifferent and unconcerned with the daily activities of the child or indulgent and unwilling to set limits on the child).
- Erikson's final crisis is integrity versus despair, in which an older adult must come to terms with mortality.

8.10 How do psychologists explain why aging occurs, and what are the stages of death and dying?

- Research strongly indicates that remaining active and involved results in the most positive adjustment to aging; this is a component of activity theory.
- The cellular-clock theory is based on the idea that cells only have so many times that they can reproduce; once that limit is reached, damaged cells begin to accumulate.
- The wear-and-tear theory of physical aging states that as time goes by, repeated use and abuse of the body's tissues cause it to be unable to repair all the damage.
- The free-radical theory states that oxygen molecules with an unstable electron move around the cell, damaging cell structures as they go.
- The five stages of reaction to death and dying are denial, anger, bargaining, depression, and acceptance.

Applying Psychology to Everyday Life: Cross-Cultural Views on Death

8.11 What are some cross-cultural differences in views of death and dying?

- In wealthy Hindu families, a dying person is surrounded by family and friends and then honored with a funeral process of nearly 2 weeks.
- In Northern Cheyenne culture, death is seen as part of the process of the life cycle, and takes place in three stages.
- In Navajo culture, the dead are believed to move to the underworld, and contact with the body is strictly limited for fear of luring evil spirits to the world of the living.

test YOURSELF

ANSWERS AVAILABLE IN ANSWER KEY.

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Pick the best answer.

- The thinking and attitudes of many who survived the Depression of the 1930s changed them for the rest of their lives. This would be an example of a
 - cohort effect.
 - cultural group.
 - longitudinal group.
 - cross-sequential group.
- If a person has one gene for blue eyes but actually has brown eyes, blue eyes must be a _____ trait.
 - dominant
 - recessive
 - sex-linked
 - polygenic

- 3.** In _____ syndrome, the 23rd pair of chromosomes consists of an XXY pairing, resulting in reduced masculine characteristics and excessive height.
- PKU
 - Down
 - Klinefelter's
 - Turner's
- 4.** Which of the following represents the fertilization process for monozygotic twins?
- One egg is fertilized by two different sperm.
 - One egg splits and is then fertilized by two different sperm.
 - One egg is fertilized by one sperm and then splits.
 - Two eggs are fertilized by the same sperm.
- 5.** What part of an infant's body is said to stay in an immature state until needed to produce more cells?
- uterus
 - stem cells
 - umbilical cord
 - placenta
- 6.** Based on today's science and medicine, when does the age of viability begin?
- between 8 and 12 weeks
 - between 12 and 18 weeks
 - between 22 and 26 weeks
 - between 28 and 36 weeks
- 7.** Dr. Kahn measures how long baby Lydia looks at a particular stimulus. The technique is known as
- preferential looking.
 - dishabituation.
 - habituation.
 - stimulus discrimination.
- 8.** At what age can the typical infant roll over?
- 2 months
 - 5 weeks
 - 8 months
 - 12 months
- 9.** Studies of the infant brain show signs of what scientists call synaptic pruning. What occurs during this process?
- The brain creates additional neural connections by removing parts of the surrounding bone.
 - Unused synaptic connections and nerve cells are cleared out to make way for new cells.
 - New cells work to "rewrite" old cells and ultimately change their functioning.
 - New cells will not develop until the body makes sufficient physical space within the brain.
- 10.** In which of Piaget's stages does the child become capable of understanding conservation?
- sensorimotor
 - preoperational
 - formal operations
 - concrete operations
- 11.** Monique says "milk" when she wants her milk from the kitchen counter. Subsequently, she says "milk" after she has had a drink. Using a single phrase to mean different things is an example of
- telephrase.
 - private speech.
 - holophrase.
 - public speech.
- 12.** Which of the following is a myth regarding immunizations?
- Most immunizations are made up of dead viruses.
 - If all the other children in a school are immunized, there is really no harm in not immunizing one's own child.
 - Vaccines work in up to 99 percent of cases.
 - Only in rare cases do immunizations trigger seizures.
- 13.** In the Strange Situation, _____ babies would cry when their mother left the room but were happy upon her return.
- secure
 - avoidant
 - ambivalent
 - disorganized-disoriented
- 14.** What is a new explanation as to why teenagers and young adults may engage in risky and dangerous behavior?
- Such behavior is due to the tremendous pressure applied by peers.
 - Such behavior is actually hereditary.
 - Such behavior may be due to unbalanced levels of hormones in the body.
 - Such behavior may be due to the incomplete development of the prefrontal cortex.
- 15.** Samantha enters a classroom where two students are talking. When they stop their discussion, Samantha is certain they must have been talking about her. Such a belief is an example of
- the imaginary audience.
 - the personal fable.
 - abstract egocentrism.
 - formal operations.
- 16.** What cognitive changes occurring during middle adulthood are the most noticeable?
- Changes in memory begin to occur.
 - Problem-solving skills diminish.
 - Hearing begins to decline.
 - Hair begins to turn gray.
- 17.** Independence and self-reliance in the teenage years is the most likely due to _____ parenting.
- authoritarian
 - authoritative
 - permissive neglectful
 - permissive indulgent
- 18.** The crisis of late adulthood, according to Erikson, is
- identity versus role confusion.
 - generativity versus stagnation.
 - intimacy versus isolation.
 - integrity versus despair.

- 19.** Which theory of aging states that unstable oxygen molecules tend to steal electrons as they bounce around, thus causing damage to surrounding cells?
- a. cellular-clock theory
 - b. wear-and-tear theory
 - c. free-radical theory
 - d. activity theory
- 20.** Kip is worried that he is losing his mind because he finds himself angry at a friend who died in an automobile accident. Based on Kübler-Ross's research, what might you tell him?
- a. Anger of this type is self-destructive and unhealthy.
 - b. Anger is usually a mask to your true feelings of sadness.
 - c. Anger towards a deceased individual is simply not normal and may require psychological counseling.
 - d. Anger is a normal reaction to death and not a sign of mental illness.

9

motivation and emotion

Jennifer got excellent grades in high school. She was involved in a variety of activities, but her classes always came first and she earned an academic scholarship to college. The scholarship required her to maintain a 3.0 GPA—something that she didn’t think would be too difficult. Jennifer really enjoyed her college courses as well as the newfound freedoms of college life. With the abundance of social opportunities, she found several new activities to pursue and devoted less time to studying. She was shocked when she got a D on her first exam. She vowed to do better, but finished the semester with only a 2.0 GPA and lost her scholarship.

With the help of her academic advisor, Jennifer was able to identify time-management and study strategies and learn to balance her academic and social lives. Her renewed focus enabled her to raise her GPA, later regain and maintain her scholarship, and ultimately graduate.

As a busy college student, how do you stay motivated to succeed?

A video player interface featuring a woman with long brown hair smiling. To her left is a blue bullseye target with three blue darts hitting it. The video player includes a progress bar at the bottom left, a play button, volume and subtitle icons, and a share icon at the bottom right. The background is white with several large, semi-transparent blue circles of varying sizes scattered around the video frame. A small blue circle is also visible on the far left edge of the slide.

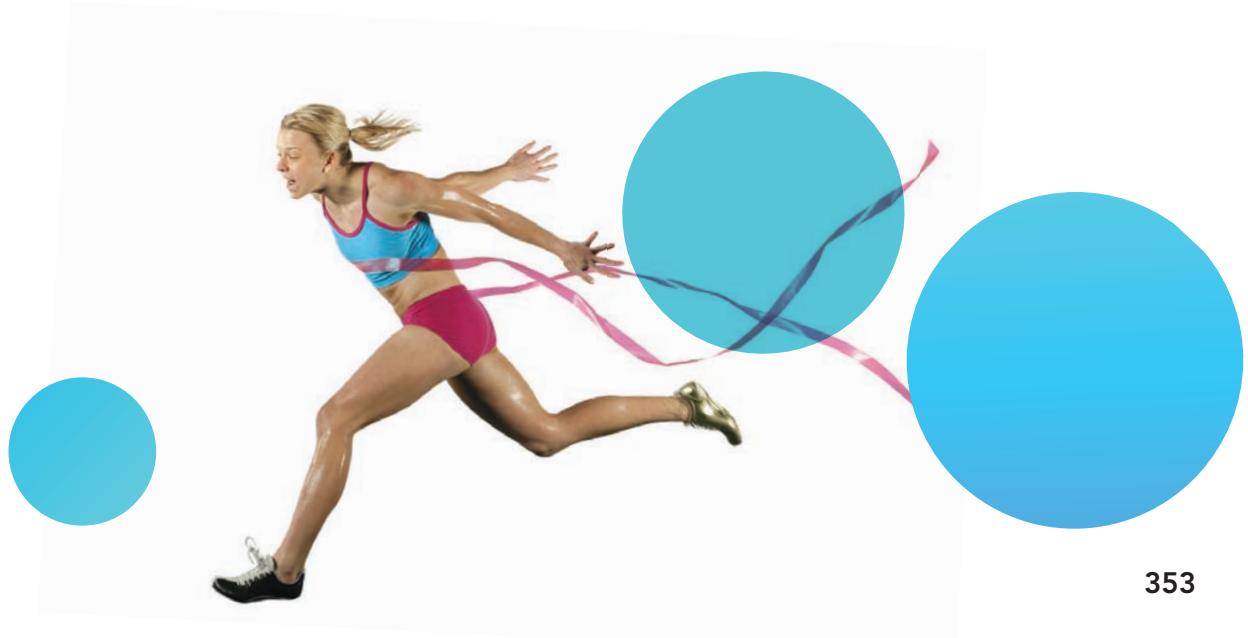
Watch the Video at MyPsychLab.com

Why study motivation and emotion?

The study of motivation not only helps us understand why we do the things we do but also why our behaviors can change when our focus shifts or gets redirected. Emotions are a part of everything we do, affecting our relationships with others and our own health, as well as influencing important decisions. In this chapter, we will explore the motives behind our actions and the origins and influences of emotions.

Learning objectives

- 9.1** How do psychologists define motivation, and what are the key elements of the early instinct and drive-reduction approaches to motivation?
- 9.2** What are the characteristics of the three types of needs?
- 9.3** What are the key elements of the arousal and incentive approaches to motivation?
- 9.4** How do Maslow's hierarchy of needs and self-determination theories explain motivation?
- 9.5** What happens in the body to cause hunger, and how do social factors influence a person's experience of hunger?
- 9.6** What are some biological, social, and cultural factors that contribute to obesity?
- 9.7** What are the three elements of emotion?
- 9.8** How do the James-Lange and Cannon-Bard theories of emotion differ?
- 9.9** What are the key elements in cognitive arousal theory, the facial feedback hypothesis, and the cognitive-mediation theory of emotion?
- 9.10** What are the stages of the GTD method?



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Approaches to Understanding Motivation

How do psychologists define motivation, and what are the key elements of the early instinct and drive-reduction approaches to motivation?

Motivation is the process by which activities are started, directed, and continued so that physical or psychological needs or wants are met (Petri, 1996). The word itself comes from the Latin word *moveare*, which means “to move.” Motivation is what “moves” people to do the things they do. For example, when a person is relaxing in front of the television and begins to feel hungry, the physical need for food might cause the person to get up, go into the kitchen, and search for something to eat. The physical need of hunger caused the action (getting up), directed it (going to the kitchen), and sustained the search (finding or preparing something to eat). Hunger is only one example, of course. Loneliness may lead to calling a friend or going to a place where there are people. The desire to get ahead in life motivates many people to go to college. Just getting out of bed in the morning is motivated by the need to keep a roof over one’s head and food on the table by going to work.  Watch the Video, *The Big Picture: Motivation and Emotion*, at [MyPsychLab](#)

There are different types of motivation. Sometimes people are driven to do something because of an external reward of some sort (or the avoidance of an unpleasant consequence, as when someone goes to work at a job to make money and avoid losing possessions such as a house or a car).  to [Learning Objective 5.5](#). In **extrinsic motivation**, a person performs an action because it leads to an outcome that is separate from the person (Ryan & Deci, 2000). Other examples would be giving a child money for every A received on a report card, offering a bonus to an employee for increased performance, or tipping a server in a restaurant for good service. The child, employee, and server are motivated to work for the external or extrinsic rewards. In contrast, **intrinsic motivation** is the type of motivation in which a person performs an action because the act itself is fun, rewarding, challenging, or satisfying in some internal manner. Both outcome and level of effort can vary depending on the type of motivation. Psychologist Teresa Amabile (Amabile et al., 1976) found that children’s creativity was affected by the kind of motivation for which they worked: Extrinsic motivation decreased the degree of creativity shown in an experimental group’s artwork when compared to the creativity levels of the children in an intrinsically motivated control group. To learn more about the factors motivating your behavior, participate in the survey experiment *What Motivates You?*

Simulation

What Motivates You?

A motive is a specific need or desire, such as hunger, thirst, or achievement that prompts goal-directed behavior. This survey asks about the types of things that motivate you to work, play, and live.

[Go to the Experiment ►](#)

Sometimes we intentionally behave in a way that creates an emotional or physical imbalance, that put us into a state of tension (the opposite of homeostasis). For example, we do things for the thrill of it or because they’re exciting or scary. Which of these tension-producing activities have you engaged in over the past 12 months?

- Please check all that apply
- Exercised at a high cardio rate (e.g., running, spinning)
 - Watched a scary movie
 - Got a tattoo or piercing
 - Rode a roller coaster
 - Went skydiving
 - Raced a car / motorcycle
 - Did martial arts/boxing/extreme fighting
 - Did a sport that requires a helmet (skiing, cycling, etc.)

 Simulate the Experiment, *What Motivates You?*, on [MyPsychLab](#)

INSTINCTS AND THE EVOLUTIONARY APPROACH

Early attempts to understand motivation focused on the biologically determined and innate patterns of behavior called **instincts** that exist in both people and animals. Just as animals are governed by their instincts to perform activities such as migrating, nest building, mating, and protecting their territory, evolutionary theorists proposed that human beings may also be governed by similar instincts (James, 1890; McDougall, 1908). For instance, according to these theorists, the human instinct to reproduce is responsible for sexual behavior, and the human instinct for territorial protection may be related to aggressive behavior.

William McDougall (1908) actually proposed a total of 18 instincts for humans, including curiosity, flight (running away), pugnacity (aggressiveness), and acquisition (gathering possessions). As the years progressed, psychologists added more and more instincts to the list until there were thousands of proposed instincts. However, none of these early theorists did much more than give names to these instincts. Although there were plenty of descriptions, such as “submissive people possess the instinct of submission,” there was no attempt to explain why these instincts exist in humans, if they exist at all (Petri, 1996).

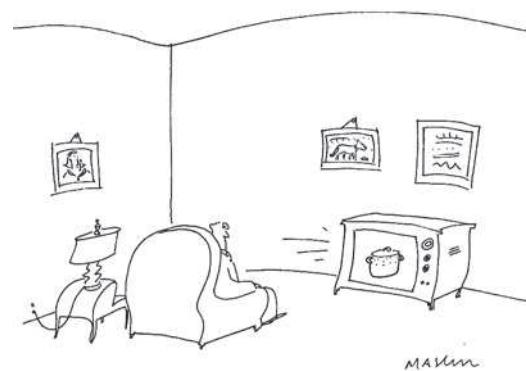
Instinct approaches have faded away because, although they could describe human behavior, they could not explain it. But these approaches did accomplish one important thing by forcing psychologists to realize that some human behavior is controlled by hereditary factors. This idea remains central in the study of human behavior today. For example, research on the genetics of both cognitive and behavioral traits suggests that hereditary factors can account for more than 50 percent of the variance in some aspects of human cognition, temperament, and personality; and much of this variance is due to the influence of multiple genes or hereditary factors, not just one (Kempf & Weinberger, 2009; Plomin et al., 1994; Plomin & Spinath, 2004).

APPROACHES BASED ON NEEDS AND DRIVES

The next approach to understanding motivation focuses on the concepts of needs and drives. A **need** is a requirement of some material (such as food or water) that is essential for survival of the organism. When an organism has a need, it leads to a psychological tension as well as a physical arousal that motivates the organism to act in order to fulfill the need and reduce the tension. This tension is called a **drive** (Hull, 1943).

DRIVE-REDUCTION THEORY Drive-reduction theory proposes just this connection between internal physiological states and outward behavior. In this theory, there are two kinds of drives. **Primary drives** are those that involve survival needs of the body such as hunger and thirst, whereas **acquired (secondary) drives** are those that are learned through experience or conditioning, such as the need for money or social approval, or the need of recent former smokers to have something to put in their mouths. If this sounds familiar, it should. The concepts of primary and secondary reinforcers from Chapter Five are related to these drives. Primary reinforcers satisfy primary drives, and secondary reinforcers satisfy acquired, or secondary, drives.  to Learning Objective 5.5.

This theory also includes the concept of **homeostasis**, or the tendency of the body to maintain a steady state. One could think of homeostasis as the body's version of a thermostat—thermostats keep the temperature of a house at a constant level, and homeostasis does the same thing for the body's functions. When there is a primary drive need, the body is in a state of imbalance. This stimulates behavior that brings the body back into balance, or homeostasis. For example, if Jarrod's body needs food, he feels hunger and the state of tension/arousal associated with that need. He will then seek to restore his homeostasis by eating something, which is the behavior stimulated to reduce the hunger drive (see Figure 9.1).



"How much would you pay for all the secrets of the universe? Wait, don't answer yet. You also get this six-quart covered combination spaghetti pot and clam steamer. Now, how much would you pay?"

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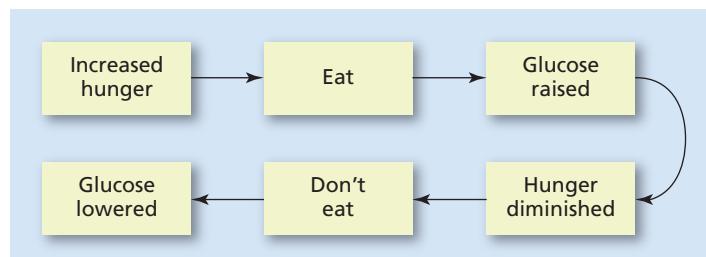


Figure 9.1 Homeostasis

In homeostasis, the body maintains balance in its physical states. For example, this diagram shows how increased hunger (a state of imbalance) prompts a person to eat. Eating increases the level of glucose (blood sugar), causing the feelings of hunger to reduce. After a period without eating, the glucose levels become low enough to stimulate the hunger drive once again, and the entire cycle is repeated.

9.1

(left) The human body needs water, especially when a person is working hard or under stress, as this man appears to be. Thirst is a survival need of the body, making it a primary drive, according to drive-reduction theory. What other kinds of needs might be primary drives?

9.2

(right) Some people are driven to do strenuous, challenging activities even when there is no physical need to do so. When a drive is acquired through learning, it is called an acquired or secondary drive. Fulfilling an acquired drive provides secondary reinforcement. What might this rock climber find reinforcing about scaling this steep cliff?

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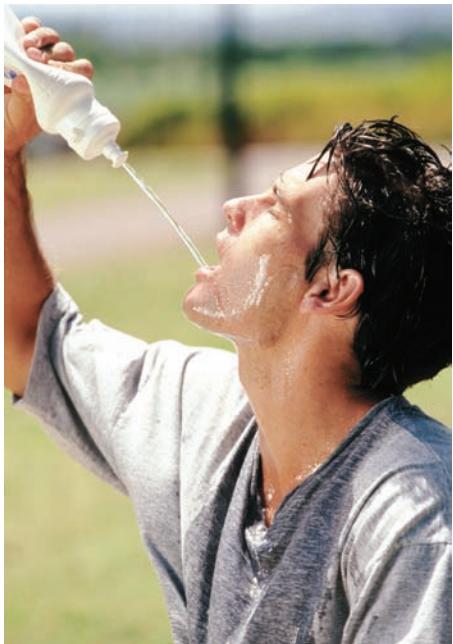
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Although drive-reduction theory works well to explain the actions people take to reduce tension created by needs, it does not explain all human motivation. Why do people eat when they are not really hungry? People don't always seek to reduce their inner arousal either—sometimes they seek to increase it. Bungee-jumping, parachuting as a recreation, rock climbing, and watching horror movies are all activities that increase the inner state of tension and arousal, and many people love doing these activities. Why would people do such things if they don't reduce some need or restore homeostasis? The answer is complex: There are different types of needs, different effects of arousal, different incentives, and different levels of importance attached to many forms of behavior. The following theories explore some of these factors in motivation. [Watch the Video, The Basics: Theories of Emotion and Motivation: Two Theories of Motivation, at MyPsychLab](#)

DIFFERENT STROKES FOR DIFFERENT FOLKS: PSYCHOLOGICAL NEEDS

What are the characteristics of the three types of needs?

Obviously, motivation is about needs. Drive-reduction theory talks about needs, and other theories of motivation include the concept of needs. In many of these theories, most needs are the result of some inner physical drive (such as hunger or thirst) that demands to be satisfied, but other theories examine our psychological needs.

McClelland's Theory: Affiliation, Power, and Achievement Needs Harvard University psychologist David C. McClelland (1961, 1987) proposed a theory of motivation that highlights the importance of three psychological needs not typically considered by the other theories: affiliation, power, and achievement.

According to McClelland, human beings have a psychological need for friendly social interactions and relationships with others. Called the **need for affiliation** (abbreviated as **nAff** in McClelland's writings), people high in this need seek to be liked by others and to be held in high regard by those around them. This makes high affiliation people good team players, whereas a person high in achievement just might run over a few team members on the way to the top.

A second psychological need proposed by McClelland is the **need for power** (**nPow**). Power is not about reaching a goal but about having control over other

people. People high in this need would want to have influence over others and make an impact on them. They want their ideas to be the ones that are used, regardless of whether or not their ideas will lead to success. Status and prestige are important, so these people wear expensive clothes, live in expensive houses, drive fancy cars, and dine in the best restaurants. Whereas someone who is a high achiever may not need a lot of money to validate the achievement, someone who is high in the need for power typically sees the money (and cars, houses, jewelry, and other “toys”) as the achievement.

The **need for achievement (nAch)** involves a strong desire to succeed in attaining goals, not only realistic ones but also challenging ones. People who are high in nAch look for careers and hobbies that allow others to evaluate them because these high achievers also need to have feedback about their performance in addition to the achievement of reaching the goal. Although many of these people do become wealthy, famous, and publicly successful, others fulfill their need to achieve in ways that lead only to their own personal success, not material riches—they just want the challenge. Achievement motivation appears to be strongly related to success in school, occupational success, and the quality and amount of what a person produces (Collins et al., 2004; Gillespie et al., 2002; Spangler, 1992).

How do people get to be high achievers?

Personality and nAch: Carol Dweck's Self-Theory of Motivation According to motivation and personality psychologist Carol Dweck (1999), the need for achievement is closely linked to personality factors, including a person's view of how *self* (the beliefs a person holds about his or her own abilities and relationships with others) can affect the individual's perception of the success or failure of his or her actions. This concept is related to the much older notion of *locus of control*, in which people who assume that they have control over what happens in their lives are considered to be *internal* in locus of control, and those who feel that their lives are controlled by powerful others, luck, or fate are considered to be *external* in locus of control (A. P. MacDonald, 1970; Rotter, 1966).

Dweck has amassed a large body of empirical research, particularly in the field of education, to support the idea that people's “theories” about their own selves can affect their level of achievement motivation and their willingness to keep trying to achieve success in the face of failure (Dweck, 1986; Dweck & Elliott, 1983; Dweck & Leggett, 1988; Elliott & Dweck, 1988). According to this research, people can form one of two belief systems about intelligence, which in turn affects their motivation to achieve. Those who believe intelligence is fixed and unchangeable often demonstrate an external locus of control when faced with difficulty, leading them to give up easily or avoid situations in which they might fail—often ensuring their own failure in the process (Dweck & Molden, 2008). They are prone to developing learned helplessness, the tendency to stop trying to achieve a goal because past failure has led them to believe that they cannot succeed.  to [Learning Objective 5.11](#). Their goals involve trying to “look smart” and to outperform others (“See, at least I did better than she did”). For example, a student faced with a big exam may avoid coming to class that day, even though that might mean getting an even lower score on a makeup exam.  [Watch the Video](#), Carol Dweck: Mixed Emotions, at [MyPsychLab](#)

This does not mean that students with this view of intelligence are always unsuccessful. In fact, Dweck's research (1999) suggests that students who have had a long history of successes may be most at risk for developing a learned helplessness after a big failure, precisely because their previous successes have led them to believe in their own fixed intelligence. For example, a child who had never earned anything less than an A in



Sean Combs at the Cannes International Film Festival. Many people who are as wealthy as him continue to buy new houses, businesses, clothing, and cars (among other things) even though they do not need them. Such actions are examples of the need for power. How might this need for power be expressed in a person's relationships with others, such as a spouse, employee, or friend?

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Many people are driven by a need to attain both realistic and challenging goals. This young girl seems eager to provide an answer to the teacher's question, and the teacher's positive feedback will help foster the girl's need for achievement.

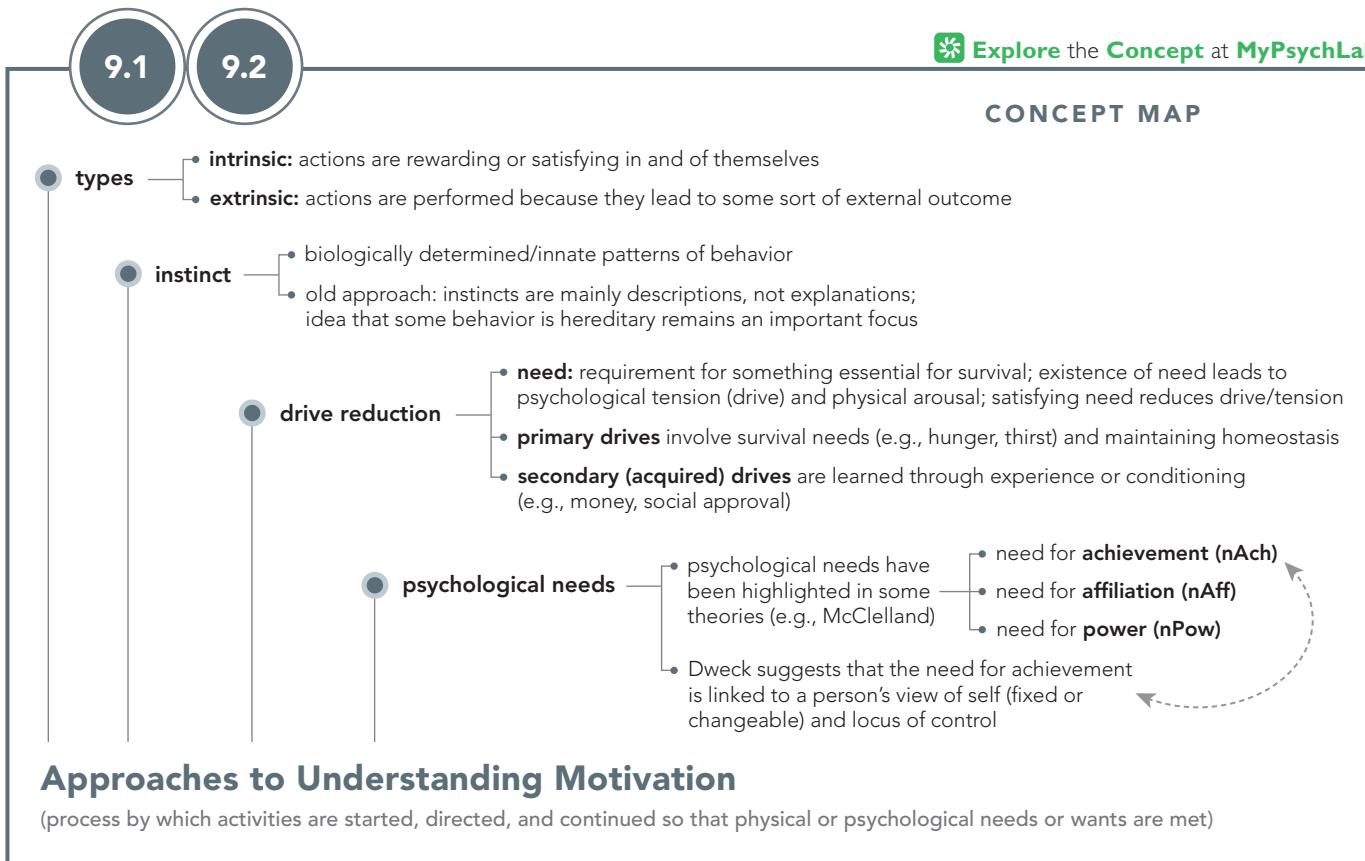
school who then receives his first C might become depressed and refuse to do any more homework, ensuring future failure.

The other type of person believes that intelligence is changeable and can be shaped by experiences and effort in small increases, or increments. These people also tend to show an internal locus of control, both in believing that their own actions and efforts will improve their intelligence, and in taking control or increasing their efforts when faced with challenges (Dweck & Molden, 2008). They work at developing new strategies and get involved in new tasks, with the goal of increasing their "smarts." They are motivated to master tasks and don't allow failure to destroy their confidence in themselves or prevent them from trying again and again, using new strategies each time.

Based on this and other research, Dweck recommends that parents and teachers praise efforts and the methods that children use to make those efforts, not just successes or ability. Instead of saying, "You're right, how smart you are," the parent or teacher should say something such as, "You are really thinking hard," or "That was a very clever way to think about this problem." In the past, teachers and parents have been told that praise is good and criticism is bad—it might damage a child's self-esteem. Dweck believes that constructive criticism, when linked with praise of effort and the use of strategies, will be a better influence on the child's self-esteem and willingness to challenge themselves than endless praise that can become meaningless when given indiscriminately (Gunderson et al., 2013).

Explore the Concept at [MyPsychLab](#)

CONCEPT MAP



PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Motivation is the process by which activities are _____, _____, and _____ to meet a person's physical or psychological requirements.
 - a. started; directed; continued
 - b. sensed; perceived; created
 - c. created; developed; acted upon
 - d. desired; directed; developed
2. If a person carries out a behavior to receive an outcome that is separate from the person, this is known as
 - a. intrinsic motivation.
 - b. extrinsic motivation.
 - c. drive-reduction motivation.
 - d. instinctual motivation.
3. William McDougall's original research on instinctual motivation proposed a total of _____ instincts for humans, whereas later researchers believed there were _____.

a. 5; 25	c. 18; thousands
b. 18; 50	d. 100; millions
4. What motivational theory relies heavily on the concept of homeostasis?
 - a. instinctual theory
 - b. need for affiliation theory
 - c. drive-reduction theory
 - d. need for achievement theory
5. People high in the need for _____ want to be liked by others and are good team players.

a. achievement	c. power
b. affiliation	d. emotion
6. According to research by Carol Dweck, which of the following would be the best phrase to reinforce a child's behavior?
 - a. I'm proud of the way you tried to solve that problem.
 - b. Good job. You got the right answer.
 - c. Well done. But you must try even harder next time.
 - d. Excellent. Now go out and do it again.

THINKING CRITICALLY:

Which of the three types of needs currently drive you? Will that have to change once you find a career-oriented job?

AROUSAL APPROACHES

What are the key elements of the arousal and incentive approaches to motivation?

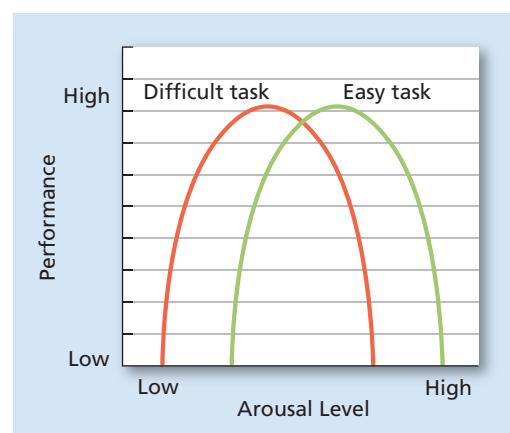
Another explanation for human motivation involves the recognition of yet another type of need, the need for stimulation. A **stimulus motive** is one that appears to be unlearned but causes an increase in stimulation. Examples would be curiosity, playing, and exploration.

OPTIMUM AROUSAL In **arousal theory**, people are said to have an optimal (best or ideal) level of tension. Task performances, for example, may suffer if the level of arousal is too high (such as severe test anxiety) or even if the level of arousal is too low (such as boredom). For many kinds of tasks, a moderate level of arousal seems to be best. This relationship between task performance and arousal has been explained by the **Yerkes-Dodson law** (Teigen, 1994; Yerkes & Dodson, 1908), although Yerkes and Dodson formulated the law referring to stimulus intensity, not arousal level (Winton, 1987).

Of special interest to both sports psychologists and social psychologists, this arousal effect appears to be modified by the difficulty level of the task: Easy tasks demand a somewhat "high-moderate" level for optimal performance, whereas difficult tasks require a "low-moderate" level. **Figure 9.2** shows this relationship in graphic form. A sports psychologist might work with an athlete to help them get "in the zone," where they are in that specific zone of arousal (not too low and not too high) and state of mental focus so as to maximize their athletic skills and performance. Social psychologists also examine the effect of the presence of other people on the facilitation or impairment of an individual's performance.  to Learning Objective 12.1. For example, imagine someone in a classroom speaking to a classmate seated nearby. The act of speaking directly to another person is a fairly easy task for many people and is accomplished without any difficulty or errors. However, ask that same individual to stand, turn, and address the entire classroom of students, and all of a sudden his or her arousal level spikes; many individuals

Figure 9.2 Arousal and Performance

The optimal level of arousal for task performance depends on the difficulty of the task. We generally perform easy tasks well if we are at a high-moderate level of arousal (green) and accomplish difficult tasks well if we are at a low-moderate level.



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Does this look fun? If so, you may score relatively higher in sensation seeking.

in a similar situation may find themselves unable to put words together well enough to form coherent sentences, or to pronounce words correctly—in essence, they may become “tongue-tied,” all because their arousal level has gotten too high.

Maintaining an optimal level of arousal, then, may involve reducing tension or creating it (Hebb, 1955). For example, husbands or wives who are underaroused may pick a fight with their spouse. Students who experience test anxiety (a high level of arousal) may seek out ways to reduce that anxiety to improve their test performance. Students who are not anxious at all may not be motivated to study well, thus lowering their test performance. Many arousal theorists believe that the optimal level of arousal for most people under normal circumstances is somewhere in the middle, neither too high nor too low.



If people are supposed to be seeking a level of arousal somewhere around the middle, why do some people love to do things like bungee-jumping?

Even though the average person might require a moderate level of arousal to feel content, there are some people who need less arousal and some who need more. The person who needs more arousal is called a **sensation seeker** (Zuckerman, 1979, 1994). Sensation seekers seem to need more complex and varied sensory experiences than do other people. The need does not always have to involve danger. For example, students who travel to other countries to study tend to score higher on scales of sensation seeking than do students who stay at home (Schroth & McCormack, 2000). Sensation seeking may be related to temperament.  **Learning Objective 8.7.** **Table 9.1** has some sample items from a typical sensation-seeking scale.

In one study (Putnam & Stifter, 2002), researchers found evidence of “sensation-seeking” behavior in children as young as age 2. In this study, 90 children were studied at the ages of 6, 12, 24, and 25 months. In a test of the youngest participants, the babies were shown two sets of toys: a block, a plate, and a cup; or a flashing light, a toy beeper, and a wind-up dragon. The first set was considered a low-intensity stimulus whereas the second set was labeled a high-intensity stimulus. The infants who reached out for the toys more quickly, and reached for the high-intensity toys in particular, were high sensation seekers.

Is the tendency to be a sensation seeker something people have when they are born? Although it is tempting to think of 6-month-old children as having little in the way of experiences that could shape their personalities, the fact is that the first

Table 9.1

Sample Items From the Zuckerman-Kuhlman Personality Questionnaire

SCALE ITEM	SENSATION SEEKING
I sometimes do “crazy” things just for fun.	High
I prefer friends who are excitingly unpredictable.	High
I am an impulsive person.	High
Before I begin a complicated job, I make careful plans.	Low
I usually think about what I am going to do before doing it.	Low

Source: Adapted from Zuckerman, M. (2002).

6 months of life is full of experiences that might affect children's choices in the future. For example, a very young infant might, while being carried, stick a hand into some place that ends up causing pain. This experience might affect that infant's willingness in the future to put his or her hand in something else through the simple learning process of operant conditioning.  to Learning Objective 5.5. In a longitudinal study taking place over about 4 years, researchers found that adolescents who played video games in which high risk-taking is positively presented became more likely to engage in risky behavior and had increased scores on levels of sensation seeking (Hull et al., 2012).

INCENTIVE APPROACHES

 Last Thanksgiving, I had eaten about all I could. Then my aunt brought out a piece of her wonderful pumpkin pie and I couldn't resist—I ate it, even though I was not at all hungry. What makes us do things even when we don't have the drive or need to do them?

It's true that sometimes there is no physical need present, yet people still eat, drink, or react as if they did have a need. Even though that piece of pie was not necessary to reduce a hunger drive, it was very rewarding, wasn't it? And on past occasions, that pie was also delicious and rewarding, so there is anticipation of that reward now. The pie, in all its glorious promise of flavor and sweetness, becomes, in itself, an incentive to eat. **Incentives** are things that attract or lure people into action.

In **incentive approaches**, behavior is explained in terms of the external stimulus and its rewarding properties. These rewarding properties exist independently of any need or level of arousal and can cause people to act only upon the incentive. Thus, incentive theory is actually based, at least in part, on the principles of learning that were discussed in Chapter Five.  to Learning Objective 5.5.

By itself, the incentive approach does not explain the motivation behind all behavior. Many theorists today see motivation as a result of both the "push" of internal needs or drives and the "pull" of a rewarding external stimulus. For example, sometimes a person may actually be hungry (the push) but choose to satisfy that drive by selecting a candy bar instead of a celery stick. The candy bar has more appeal to most people, and it, therefore, has more pull than the celery. (Frankly, to most people, just about anything has more pull than celery.)

HUMANISTIC APPROACHES

How do Maslow's hierarchy of needs and self-determination theories explain motivation?

Some final approaches to the study of motivation are humanistic in nature. One of the classic humanistic approaches is that of Maslow, while a more modern approach is represented by self-determination theory.

MASLOW'S HIERARCHY OF NEEDS The first humanistic theory is based on the work of Abraham Maslow (1943, 1987). As explained in the video *What's In It For Me?: Meeting Our Needs: Maslow's Hierarchy*, Maslow proposed that there are several levels of needs that a person must strive to meet before achieving the highest level of personality fulfillment. According to Maslow, **self-actualization** is the point that is seldom reached—at which people have satisfied the lower needs and achieved their full human potential.

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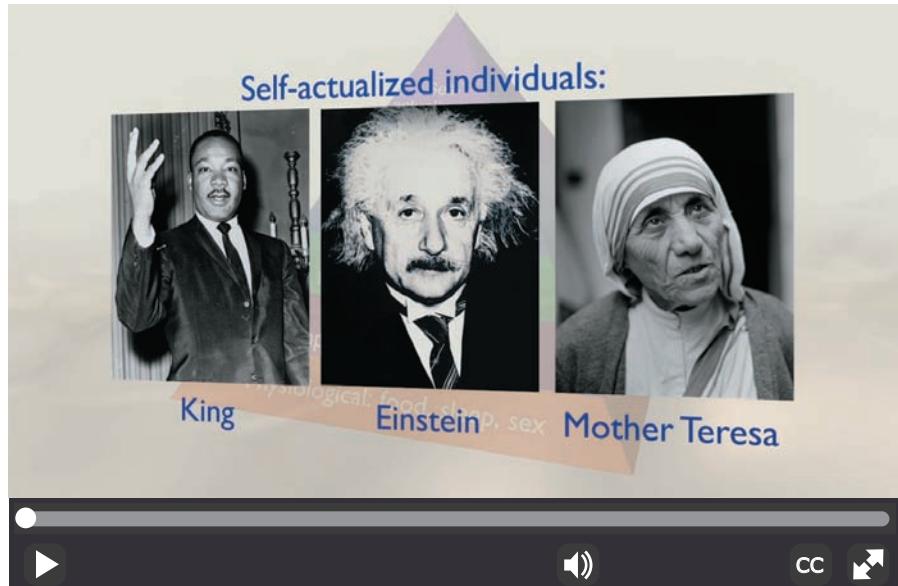
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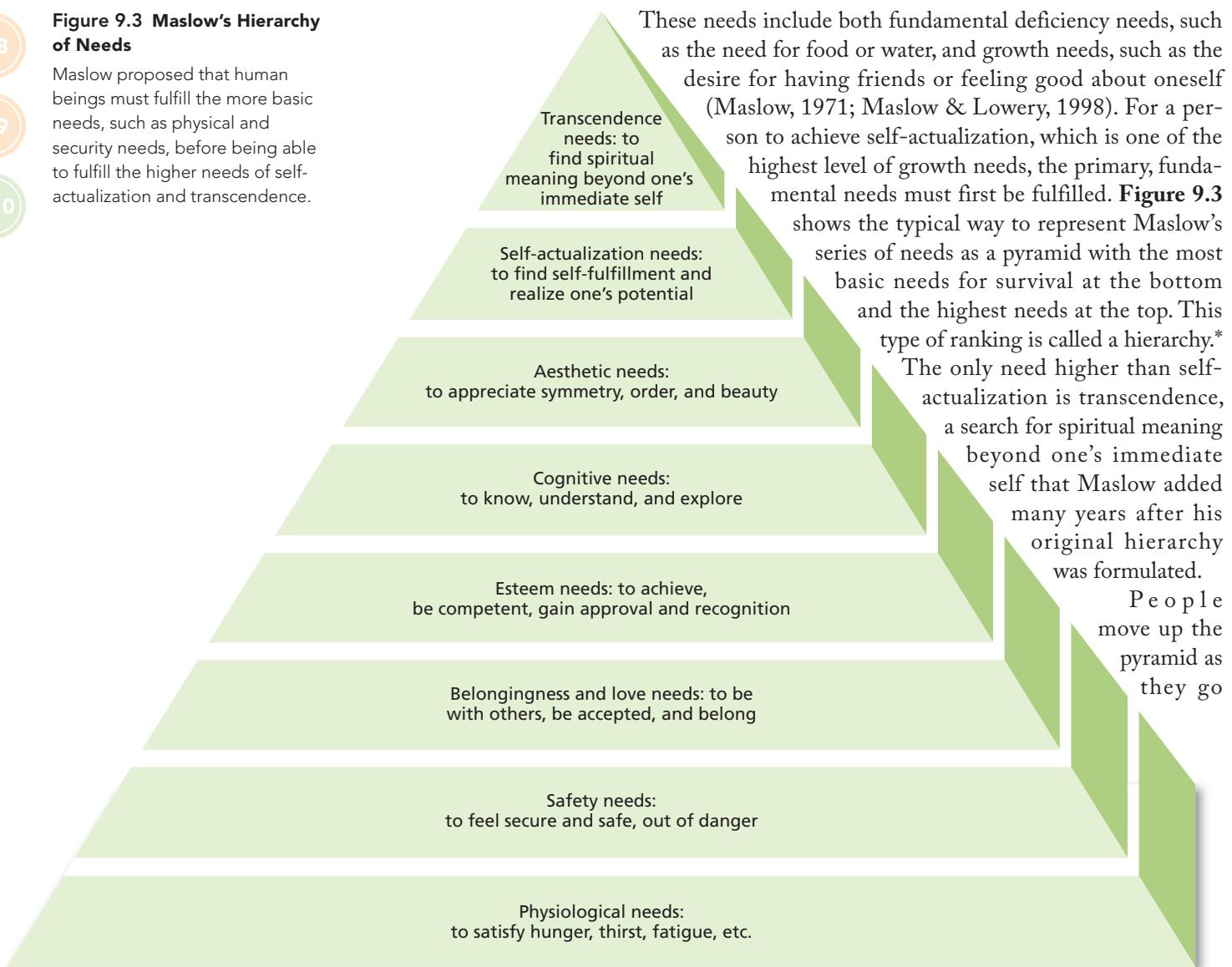
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[Watch the Video](#), What's In It For Me?: Meeting Our Needs: Maslow's Hierarchy, at [MyPsychLab](#)

Figure 9.3 Maslow's Hierarchy of Needs

Maslow proposed that human beings must fulfill the more basic needs, such as physical and security needs, before being able to fulfill the higher needs of self-actualization and transcendence.



*hierarchy: a graded or ranked series.

through life, gaining wisdom and the knowledge of how to handle many different situations. But a shift in life's circumstances can result in a shift down to a lower need. Moving up and down and then back up can occur frequently—even from one hour to the next. Times in a person's life in which self-actualization is achieved, at least temporarily, are called **peak experiences**. For Maslow, the process of growth and self-actualization is the striving to make peak experiences happen again and again.



Does this theory apply universally?

Maslow's theory has had a powerful influence on the field of management (Heil et al., 1998) and has spawned new ideas and concepts of what might be an appropriate revised hierarchy. [LINK](#) to Learning Objective B.7. In spite of this influence, Maslow's theory is not without its critics. There are several problems that others have highlighted, and the most serious is that there is little scientific support (Drenth et al., 1984). Like Sigmund Freud, Maslow developed his theory based on his personal observations of people rather than any empirically gathered observations or research. Although many people report that while they were starving, they could think of nothing but food, there is anecdotal evidence in the lives of many people, some of them quite well known, that the lower needs do not have to be satisfied before moving on to a higher need (Drenth et al., 1984). For example, artists and scientists throughout history have been known to deny their own physical needs while producing great works (a self-actualization need).

Maslow's work was also based on his studies of Americans. Cross-cultural research suggests that the order of needs on the hierarchy does not always hold true for other cultures, particularly those cultures with a stronger tendency than the culture of the United States to avoid uncertainty, such as Greece and Japan. In those countries security needs are much stronger than self-actualization needs in determining motivation (Hofstede, 1980; Hofstede et al., 2002). This means that people in those cultures value job security more than they do job satisfaction (holding an interesting or challenging job). In countries such as Sweden and Norway, which stress the quality of life as being of greater importance than what a person produces, social needs may be more important than self-actualization needs (Hofstede et al., 2002). [LINK](#) to Learning Objective 13.7.

Other theorists (Alderfer, 1972; Kenrick et al., 2010) have developed and refined Maslow's hierarchy. Douglas Kenrick and colleagues have suggested a modification to Maslow's original hierarchy that encompasses aspects of evolutionary biology, anthropology, and psychology. Their modification incorporates dynamics between internal motives and environmental threats and opportunities (Kenrick et al., 2010). However, their revision has not been without critique and has spawned further contemplation. Some elements of Kenrick's theory have been challenged, including a questioning of its focus on evolutionary aspects instead of human cultural influences (Kesebir et al., 2010), and its removal of self-actualization from both the pinnacle of the pyramid and from the hierarchy altogether as a stand-alone motive (Peterson & Park, 2010). Just as there are many aspects to motivation, any revision or discussion of an appropriate hierarchy of needs will need to take into account a wide variety of opinions and viewpoints.

SELF-DETERMINATION THEORY (SDT) Another theory of motivation that is similar to Maslow's hierarchy of needs is the **self-determination theory (SDT)** of Richard Ryan and Edward Deci (2000). In this theory, there are three inborn and universal needs that help people gain a complete sense of self and whole, healthy relationships with others. The three needs are *autonomy*, or the need to be in control of one's own behavior and goals (i.e., self-determination); *competence*, or the need to be able to master the challenging tasks of one's life; and *relatedness*, or the need to feel a sense of belonging, intimacy, and security in relationships with others. These needs are common in several theories of personality; the relatedness need is, of course, similar to Maslow's belongingness and love needs, and both autonomy and competence are important aspects of Erikson's theory



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"That is the correct answer, Bill, but I'm afraid you don't win anything for it."

©The New Yorker Collection 1986 Lee Lorenz from cartoonbank.com. All Rights Reserved.

of psychosocial personality development (Erikson, 1950, 1980).  to Learning Objective 8.7.

Ryan, Deci, and their colleagues (Deci et al., 1994; Ryan & Deci, 2000) believe that satisfying these needs can best be accomplished if the person has a supportive environment in which to develop goals and relationships with others. Such satisfaction will not only foster healthy psychological growth but also increase the individual's intrinsic motivation (actions are performed because they are internally rewarding or satisfying). Evidence suggests that intrinsic motivation is increased or enhanced when a person not only feels competence (through experiencing positive feedback from others and succeeding at what are perceived to be challenging tasks) but also a sense of autonomy or the knowledge that his or her actions are self-determined rather than controlled by others (deCharms, 1968; Deci & Ryan, 1985).

Previous research has found a negative impact on intrinsic motivation when an external reward is given for the performance (Deci et al., 1999), but while other studies find negative effects only for tasks that are not interesting in and of themselves (Cameron et al., 2001). When the task itself is interesting to the person (as might be an assignment that an instructor or manager has explained in terms of its importance and future value), external rewards may increase intrinsic motivation, at least in the short term. Although this finding is intriguing, further research is needed to determine if the long-term effects of extrinsic rewards on intrinsic motivation are consistently negative, as the bulk of the research has shown up to now.

 But don't we sometimes do things for both kinds of motives?

There are usually elements of both intrinsic and extrinsic motives in many of the things people do. Most teachers, for example, work for money to pay bills (the extrinsic motive) but may also feel that they are helping young children to become better adults in the future, which makes the teachers feel good about themselves (the intrinsic motive).

How universal are these three needs? Some cultures, such as the United States and Great Britain, are *individualistic*, stressing the needs of the individual over the group, independence, and self-reliance. Other cultures are collectivistic, such as those in Japan and China, and stress strong social ties, interdependence, and cooperation. Cross-cultural research indicates that even across such different cultures, the needs for autonomy, mastery, and belongingness are of similar importance (Chirkov, 2009; Chirkov et al., 2011; Ryan et al., 1999; Sheldon, 2012).

 Explore the Concept at MyPsychLab

CONCEPT MAP

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 **arousal**
need for stimulation

- **arousal theory** suggests people have an optimal level of tension that they work to maintain
- a moderate level is most commonly sought, but that level can range from low to high (sensation seeking)

 **incentive**
things that attract or lure people into action, most often due to rewarding properties

- based in part on principles of learning

 **humanistic**
based primarily on Maslow's hierarchy of needs; primary, basic needs must be met before higher levels can be met (see Fig. 9.3)

- other modifications differ in number of levels and areas of focus
- **self-determination theory:** similar to Maslow's hierarchy, three universal needs are autonomy, competence, and relatedness

Approaches to Understanding Motivation (continued)

PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. According to arousal theory, people are motivated towards _____ level of arousal.
 - a. their highest
 - b. their lowest
 - c. their optimum
 - d. their minimal

2. In terms of arousal and task difficulty, easy tasks typically demand a _____ level for optimal performance, whereas difficult tasks require a _____ level.
 - a. high-moderate; low-moderate
 - b. low-moderate; high-moderate
 - c. either a high or low; medium
 - d. low; low

3. In the strictest sense, what is incentive theory based on?
 - a. sensation and perception
 - b. learning theory
 - c. social conformity
 - d. internal unconscious forces

4. In Maslow's theory, how often do people reach a point of self-actualization?
 - a. Most people reach a state of self-actualization before they reach adulthood.
 - b. Most people reach a state of self-actualization as they finish adolescence.
 - c. Seldom, although there are times in a person's life when they are self-actualized at least temporarily.
 - d. No one ever reaches the ultimate state. Our motivations express themselves in how we try to attain it.

5. In Ryan and Deci's self-determination theory, what is the key to achieving one's needs for autonomy, competence, and relatedness?
 - a. an instinctual motivation
 - b. support from others around you
 - c. a motivation often driven by heredity
 - d. a driving desire not to be a failure

THINKING CRITICALLY:

What motivates you while you are in this psychology course?

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What, Hungry Again? Why People Eat

Satisfying hunger is one of our most primary needs. The eating habits of people today have become a major concern and a frequent topic of news programs, talk shows, and scientific research. Countless pills, supplements, and treatments are available to “help” people eat less and others to eat more. Eating is not only a basic survival behavior that reduces a primary drive; it is also a form of entertainment for many, and the attractive presentations and social environment of many eating experiences are a powerful incentive.

PHYSIOLOGICAL COMPONENTS OF HUNGER

What happens in the body to cause hunger, and how do social factors influence a person's experience of hunger?

Why do we eat? What causes us to feel hungry in the first place?

There are actually several factors involved in the hunger drive. Walter Cannon (Cannon & Washburn, 1912) believed that stomach contractions, or “hunger pangs,” caused hunger and that the presence of food in the stomach would stop the contractions and appease the hunger drive. Oddly enough, having an empty stomach is not the deciding factor in many cases. Although the stomach does have sensory receptors that respond to the pressure of the stretching stomach muscles as food is piled in and that send signals to the brain indicating that the stomach is full (Geliebter, 1988), people who have had their stomachs removed still get hungry (Janowitz, 1967).

HORMONAL INFLUENCES One factor in hunger seems to be the insulin response that occurs after we begin to eat. **Insulin** and **glucagon** are hormones that are secreted by the pancreas to control the levels of fats, proteins, and carbohydrates in the whole body, including glucose (blood sugar). Insulin reduces the level of glucose in the bloodstream, for example, whereas glucagon increases the level. Insulin, normally released in greater amounts after eating has begun, causes a feeling of more hunger because of the drop in blood sugar levels. Carbohydrates, especially those that are simple or highly refined (such

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Figure 9.4 Obese Laboratory Rat

The rat on the left has reached a high level of obesity because its ventromedial hypothalamus has been deliberately damaged in the laboratory. The result is a rat that no longer receives signals of being satiated, and so the rat continues to eat and eat and eat.

as table sugar, fruit drinks, white flour, and white bread or pasta), cause the insulin level to spike even more than other foods do because there is such a large amount of glucose released by these foods at one time. High blood sugar leads to more insulin released, which leads to a low blood sugar level, increased appetite, and the tendency to overeat. That is the basic principle behind many of the diets that promote low-carbohydrate intake. The proponents of these diets argue that if people control the carbohydrates, they can control the insulin reaction and prevent hunger cravings later on.

In recent years, a hormone called **leptin** has been identified as one of the factors that controls appetite. When released into the bloodstream, leptin signals the hypothalamus that the body has had enough food, reducing appetite and increasing the feeling of being full, or sated.

THE ROLE OF THE HYPOTHALAMUS The stomach and the pancreas are only two of the body parts involved in hunger. In Chapter Two the role of the hypothalamus in controlling many kinds of motivational stimuli, including hunger, was seen as a result of its influence on the pituitary. But the hypothalamus itself has different areas, controlled by the levels of glucose and insulin in the body, which appear to control eating behavior. ☀

Explore the Concept: *The Effects of the Hypothalamus on Eating Behavior*, at [MyPsychLab](#)

The *ventromedial hypothalamus (VMH)* may be involved in stopping the eating response when glucose levels go up (Neary et al., 2004). In one study, rats whose VMH areas (located toward the bottom and center of the hypothalamus) were damaged would no longer stop eating—they ate and ate until they were quite overweight (Hetherington & Ranson, 1940). (See **Figure 9.4** for a picture of a rat with this kind of damage.) However, they did not eat everything in sight. They actually got rather picky, only overeating on food that appealed to them (Ferguson & Keesey, 1975; Parkinson & Weingarten, 1990). In fact, if all the food available to them was unappealing, they did not become obese and in some cases even lost weight.

Another part of the hypothalamus, located on the side and called the *lateral hypothalamus (LH)*, seems to influence the onset of eating when insulin levels go up (Neary et al., 2004). Damage to this area caused rats to stop eating to the point of starvation. They would eat only if force-fed and still lost weight under those conditions (Anand & Brobeck, 1951; Hoebel & Teitelbaum, 1966).

WEIGHT SET POINT AND BASAL METABOLIC RATE Obviously, the role of the hypothalamus in eating behavior is complex. Some researchers (Leibel et al., 1995; Nisbett, 1972) believe that the hypothalamus affects the particular level of weight that the body tries to maintain, called the **weight set point**. Injury to the hypothalamus does raise or lower the weight set point rather dramatically, causing either drastic weight loss or weight gain.

Metabolism, the speed at which the body burns available energy, and exercise also play a part in the weight set point. Some people are no doubt genetically wired to have faster metabolisms, and those people can eat large amounts of food without gaining weight. Others have slower metabolisms and may eat a normal or even less than normal amount of food and still gain weight or have difficulty losing it (Bouchard et al., 1990). (Some people swear they can gain weight just by *looking* at a piece of cake!) Regular, moderate exercise can help offset the slowing of metabolism and the increase in the weight set point that comes with it (Tremblay et al., 1999).

The rate at which the body burns energy when a person is resting is called the **basal metabolic rate (BMR)** and is directly tied to the set point. If a person's BMR decreases (as it does in adulthood and with decreased activity levels), that person's weight set point increases if the same number of calories is consumed. **Table 9.2** shows the changes in BMR of a typical woman and man as age increases from 10 years to 80 years. Notice that the BMR decreases more dramatically as the age of the person increases. Adolescents typically have a very high BMR and activity level and, therefore, a lower weight set point,

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Table 9.2**Average Basal Metabolic Rates for a Female and Male**

AGE RANGE	AGES 10–18	AGES 19–30	AGES 31–60	AGES 61–80
Female (5½ ft.)	1,770*	1,720	1,623	1,506
Male (6 ft.)	2,140	2,071	1,934	1,770

*Numbers in the table represent the number of calories a person needs to consume each day to maintain body weight (without exercise).

meaning they can eat far more than an adult of the same size and not gain weight. But when that adolescent becomes an adult, the BMR begins to decline. Adults should reduce the number of calories they consume and exercise most every day, but the tendency is to eat more and move less as income levels and job demands increase. Even if the eating habits of the teenage years are simply maintained, excessive weight gain is not far behind. (In some people, the excessive weight gain may be mostly “behind.”)

If you would like to calculate your own BMR, there are numerous Internet sites that allow a person to enter data such as height, age, weight, and activity level. The BMR is then automatically calculated according to a standard formula. Simply type “basal metabolic rate calculator” into your Web search engine to find these sites.

SOCIAL COMPONENTS OF HUNGER

People often eat when they are not really hungry. There are all sorts of social cues that tell people to eat, such as the convention of eating breakfast, lunch, and dinner at certain times. A large part of that “convention” is actually the result of classical conditioning.  [Learning Objective 5.2](#). The body becomes conditioned to respond with the hunger reflex at certain times of the day; through association with the act of eating, those times of the day have become conditioned stimuli for hunger. Sometimes a person who has just eaten a late breakfast will still “feel” hungry at noon, simply because the clock says it’s time to eat. People also respond to the appeal of food. How many times has someone finished a huge meal only to be tempted by that luscious-looking cheesecake on the dessert cart? To see whether you have any implicit preferences toward either healthy food or junk food, participate in the experiment *Implicit Association Test: Food*.

Simulation

Implicit Association Test: Food

This Implicit Association Test asks you to classify a set of words or images into groups. Your goal is to classify items as quickly and as accurately as you can.



[Go to the Experiment ►](#)

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(top) Cultural factors play an important part in why people eat. Women in Japan have been found to be motivated to eat by hunger and social demands, illustrated by the interaction during a meal at this family gathering.

(bottom) Women in the United States may eat because they are depressed or for other emotional reasons, rather than just to appease hunger or as part of a social situation. Obviously, this woman does not need the social trappings of a bowl, dining table, and the company of others to motivate her eating habits—unless you count the cat.

Food can also be used in times of stress as a comforting routine, an immediate escape from whatever is unpleasant (Dallman et al., 2003). Rodin (1981, 1985) found that the insulin levels that create hunger may actually increase *before* food is eaten (similar to the way Pavlov's dogs began salivating before they received their food). Like getting hungry at a certain time of day, this physiological phenomenon may also be due to classical conditioning: In the past, eating foods with certain visual and sensory characteristics led to an insulin spike, and this pairing occurred so frequently that now just looking at or smelling the food produces the spike before the food is consumed (Stockhorst, 1999). This may explain why some people (who are called “externals” because of their tendency to focus on the external features of food rather than internal hunger) are far more responsive to these external signals—they produce far more insulin in response to the *anticipation* of eating than do nonexternals, or people who are less affected by external cues (Rodin, 1985).

Cultural factors and gender also play a part in determining hunger and eating habits. In one study, a questionnaire about eating habits was given to both men and women from the United States and Japan. Although no significant differences in what initiates eating existed for men in either culture, women in the United States were found to be much more likely to start eating for emotional reasons, such as depression. Japanese women were more likely to eat because of hunger signals or social demands (Hawks et al., 2003). In this same study, both men and women from the United States were more likely to eat while watching television or movies than were Japanese men and women. Both culture and gender must be taken into account when studying why and under what circumstances people eat.

OBESITY

What are some biological, social, and cultural factors that contribute to obesity?

It would be nice if people all over the world ate just the amount of food that they needed and were able to maintain a healthy, normal weight. Unfortunately, that is not the case for many people. Some people weigh far more than they should, whereas others weigh far less.

Several maladaptive eating problems, including anorexia nervosa, bulimia nervosa, and binge-eating disorder, are classified as clinical (mental) disorders in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, or *DSM-5* (American Psychiatric Association, 2013), which is a listing of disorders and their symptoms used by psychological professionals to make a diagnosis. These disorders are discussed in a later chapter.  [LINK to Learning Objective 14.6](#).

In this chapter, we look at the problem of obesity. Why do some people get so fat? Is it just overeating?

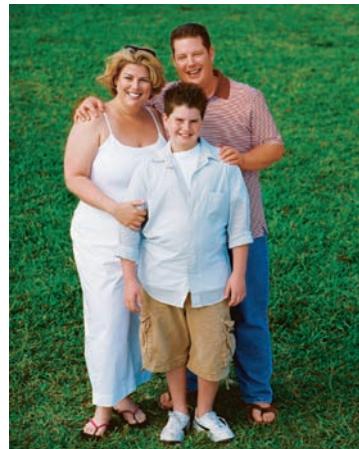
There are several factors that contribute to *obesity*, a condition in which the body weight of a person is 20 percent or more over the ideal body weight for that person's height. Actual definitions of obesity vary. Some definitions consider 20 to 30 percent to be overweight and limit obesity to 30 percent or more. Others state that men are obese at 20 percent over the ideal weight and women at 30 percent. However it is defined, a significant factor in obesity is heredity. There appear to be several sets of genes, some on different chromosomes, which influence a person's likelihood of becoming obese (Barsh et al., 2000). If there is a history of obesity in a particular family, each family member has a risk of becoming obese that is double or triple the risk of people who do not have a family history of obesity (Bouchard, 1997). Hormones also play a role, particularly leptin, which plays an important part in controlling appetite. Problems with leptin production or detection can lead to overeating (Friedman & Halaas, 1998).

Certainly, another obesity factor is overeating. Around the world, as developing countries build stronger economies and their food supplies become stable, the rates of obesity increase dramatically and quickly (Barsh et al., 2000). Foods become more varied and enticing* as well, and an increase in variety is associated with an increase in eating beyond the physiological need

*enticing: attractive; desirable.

to eat (Raynor & Epstein, 2001). In industrialized societies when workers spend more hours in the workplace, there is less time available for preparing meals at home and more incentive to dine out (Chou et al., 2004). When the “dining out” choices include fast food and soft drinks, as is so often the case, obesity rates increase. In sum, as cultures become more industrialized and follow Western-culture lifestyles, negative aspects of those lifestyles, such as obesity, also increase. Over the last 20 years, rates of obesity in developing countries have tripled. Specifically, this is a trend in countries that have adopted the Western lifestyle of lower exercise rates and overeating—especially those foods that are cheap but high in fat and calories. In China, as well as many countries in the Middle East, Southeast Asia, and the Pacific Islands, 10 to 25 percent of children have been found to be overweight and another 2 to 10 percent are obese (Hossain et al., 2007).

As mentioned earlier, metabolism slows down as people age. Aside from not changing the eating habits of their youth and lowering their intake, as they earn more income people also often increase the amount of food they consume, thereby assuring a weight gain that may lead to obesity. The United States has the highest rate of obesity in the world: a third of its population is now obese (Flegal et al., 2012; Friedman, 2000, 2003; Marik, 2000; Mokdad et al., 2001).



This family is becoming more typical in the United States as obesity rates continue to rise. How much of the excess weight on each of these family members is caused by poor choices in diet and lack of exercise, and how much might be caused by inherited biological factors?

psychology in the news

Cartoon Characters Influence Children’s Food and Taste Preferences



Since the 1970s, rates of obesity have doubled for American preschoolers and more than tripled for children ages 6 to 11; these alarming statistics, not surprisingly, are of concern to parents and health-care professionals alike. Each year, food and beverage companies spend more than \$1.6 billion targeting young consumers through television, the Internet, video games, and movie- or television-character licensing agreements (Roberto et al., 2010).

Many parents are all too familiar with the allure of cartoon and movie characters on a variety of food items. Whether it is the call of the character on the cereal box or the special toy in their child’s meal, many American children are seemingly motivated primarily by the cartoon or movie character on the product packaging or the enticing toy or gadget associated with the character. Getting the special prize or toy is one thing, but can the use of licensed characters also affect food preferences? According to researchers at Yale University and a study of forty 4- to 6-year-old children, the answer is “yes!”

The researchers paired stickers of Dora the Explorer®, Scooby Doo®, and Shrek® with three different snacks: graham crackers, gummy fruit snacks, and baby carrots. Overall children preferred the taste of food items that were presented with cartoon characters as compared to plain packaging; they especially preferred the taste of gummy snacks and graham crackers paired with the characters. Although character stickers were not enough to influence taste preferences, children were more likely to choose baby carrots with character stickers as compared to those in plain packaging.

Despite the relatively small sample size and a few other limitations noted by the researchers, the outcomes of this study provide preliminary support that the use of licensed

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It is possible that cartoon and movie characters on fast-food packaging can not only influence what children choose to eat, but affect their taste preferences as well.

characters can influence not only children's eating habits but their taste preferences as well. The researchers noted that recognition of the potential negative influences toward poorer nutritional choices should be acknowledged and has implications for the continued use of such characters in the marketing of lower nutritional food items (Roberto et al., 2010). Another study by different researchers yielded similar findings (Lapierre et al., 2011).

Questions for Further Discussion

1. Besides the influence of cartoon and movie characters, how might observational learning impact what a child chooses to eat?
2. This study focused on the eating habits of young children. What about teenagers and adults? Can you think of a food product or products that these age groups might be influenced to try or like as the result of influential figures (e.g., professional athletes)?

Explore the Concept at [MyPsychLab](#)

CONCEPT MAP

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hunger

- impacted by insulin response; insulin (normally released more after onset of eating) reduces level of glucose in bloodstream (resulting in lower blood sugar and increased hunger); glucagon increases level of glucose
- ventromedial area of the hypothalamus may be involved in stopping eating when glucose level goes up; lateral hypothalamus appears to influence onset of eating when insulin level goes up
- person's weight set point and basal metabolic rate are tied to hypothalamus, and the hormone leptin appears to affect appetite
- hunger and eating behaviors are influenced by social cues and convention (e.g., eating at certain times), culture, and gender

Why People Eat

maladaptive eating

- **obesity:** body weight 20% or more over ideal (based on height); significantly impacted by genetics, overeating, exercise, and changes in metabolism
 - **anorexia nervosa**
 - **bulimia nervosa**
 - **binge-eating disorder**

[LINK](#) to Chapter Fourteen, *Psychological Disorders*

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Damage to the _____ in rats can cause them to starve to death while damage to the _____ will cause them to eat and eat and eat.
 - a. pancreas; stomach
 - b. liver; kidneys
 - c. ventromedial hypothalamus; lateral hypothalamus
 - d. lateral hypothalamus; ventromedial hypothalamus
2. The rate at which the body burns energy while at rest is known as
 - a. weight set point.
 - b. basal metabolic rate.
 - c. leptin.
 - d. glucagon.
3. If calorie intake stays the same, as the basal metabolic rate decreases, the weight set point
 - a. decreases.
 - b. increases.
 - c. stays the same.
 - d. varies up and down.
4. Jermaine eats a late breakfast at 10:00 A.M. but finds he is hungry at 11:30 A.M. when he typically eats lunch. What best explains his hunger pains only 90 minutes after eating breakfast?
 - a. heredity
 - b. social pressure
 - c. classical conditioning
 - d. self-actualization
5. In cultures where Western lifestyles of eating and exercising have been adopted, obesity rates have _____ over the last 20 years.
 - a. remained relatively stable
 - b. decreased slightly
 - c. doubled
 - d. tripled
6. According to researchers at Yale, what might be one way to get children to eat more carrots?
 - a. Include the word "healthy" on the outside of the package.
 - b. Include a brief explanation of the amount of vitamins in carrots.
 - c. Put a prize in the package.
 - d. Put a cartoon character on the outside of the package.

Emotion

This chapter began with an overview of the motives that drive human behavior. But people do more than just behave—they experience feelings during every human action. Human beings are full of feelings, or emotions, and although emotions may be internal processes, there are outward physical signs of what people are feeling. This section of the chapter explores the world of human emotions and how those emotions are connected to both thinking and actions. Before we begin, take a moment to take the survey experiment *How Do You Deal With Your Emotions?* to learn more about how you identify, express, and manage your emotions.

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Simulation

How Do You Deal with Your Emotions?

This survey asks about your experiences with identifying, expressing, and managing your emotions. An emotion is a subjective reaction to an object, event, person, or memory.

Go to the Experiment ►

Think about the TYPES of EMOTIONS you tend to share with others. How often do you share the emotions listed below with other people?

Nervousness

- Never
- Very Rarely
- Rarely
- Occasionally
- Frequently
- Very Frequently
- Prefer Not to State

☞ Simulate the Experiment, *How Do You Deal With Your Emotions?*, on [MyPsychLab](#)



What part does the way we feel about things play in all of our daily activities—what exactly causes feelings?

THE THREE ELEMENTS OF EMOTION

9.7 What are the three elements of emotion?

The Latin root word *mot*, meaning “to move,” is the source of both of the words we use in this chapter over and over again—*motive* and *emotion*. **Emotion** can be defined as the “feeling” aspect of consciousness, characterized by three elements: a certain physical arousal, a certain behavior that reveals the feeling to the outside world, and an inner awareness of the feeling.

THE PHYSIOLOGY OF EMOTION Physically, when a person experiences an emotion, an arousal is created by the sympathetic nervous system. [LINK](#) to Learning Objective 2.4. The heart rate increases, breathing becomes more rapid, the pupils dilate, and the mouth may become dry. Think about the last time you were angry and then about the last time you were frightened. Weren’t the physical symptoms pretty similar? Although facial expressions do differ among various emotional responses (Ekman, 1980; Ekman et al., 1969; Ekman & Friesen, 1978), emotions are difficult to distinguish from one another on the basis of physiological reactions alone. However, in the laboratory using devices

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to measure the heart rate, blood pressure, and skin temperature, researchers have found that different emotions may be associated with different physiological reactions: Sadness, anger, and fear are associated with greater increases in heart rate than is disgust; higher increases in skin conductance occur during disgust as compared to happiness; and anger is more often associated with vascular measures, such as higher diastolic blood pressure, as compared to fear (Larsen et al., 2008; Levenson, 1992; Levenson et al., 1992).

Which parts of the brain are involved in various aspects of emotion? As discussed in Chapter Two, the *amygdala*, a small area located within the limbic system on each side of the brain, is associated with emotions such as fear and pleasure in both humans and animals (Breiter et al., 1997; Davis & Whalen, 2001; Fanselow & Gale, 2003; Hurlemann et al., 2010; Ritcley et al., 2011) and is also involved in the facial expressions of human emotions (Morris et al., 1998).

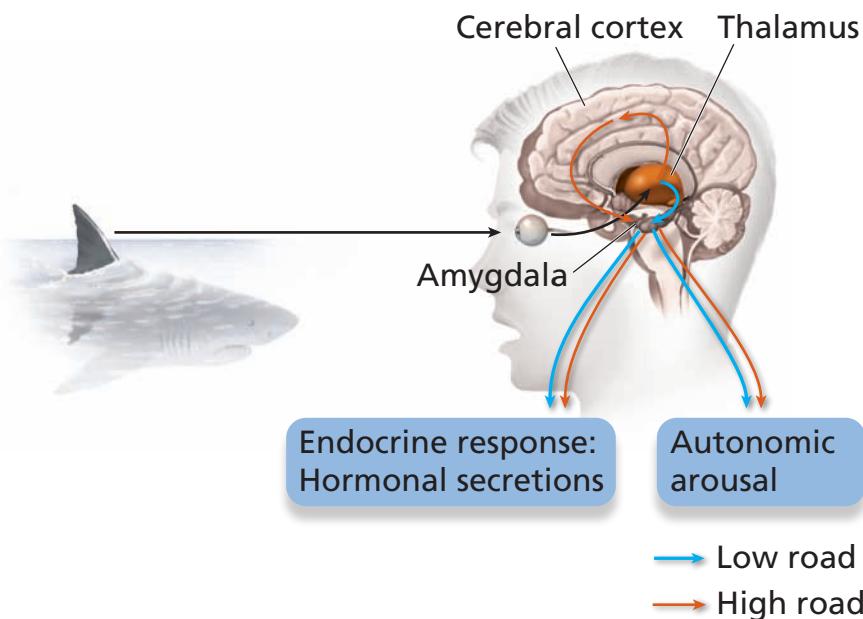
When portions of the amygdala are damaged in rats, the animals cannot be classically conditioned to fear new objects—they apparently cannot remember to be afraid (R. J. Davidson et al., 2000; Fanselow & Gale, 2003). In humans, damage to the amygdala has been associated with similar effects (LaBar et al., 1995) and with impairment of the ability to determine emotions from looking at the facial expressions of others (Adolphs & Tranel, 2003).

A lot of what we know about the amygdala's role in emotion comes from the work of Dr. Joseph LeDoux and his many colleagues and students. (Note for the curious: Dr. LeDoux's Ph.D. advisor was Dr. Michael Gazzaniga, whose work was discussed in Chapter Two.) The amygdala is a complex structure with many different nuclei and subdivisions, whose roles have been investigated primarily through studies of fear conditioning (LeDoux & Phelps, 2008). Fear conditioning has been very helpful in relating behaviors to brain function because it results in stereotypical autonomic and behavioral responses. It is basically a classical conditioning procedure where an auditory stimulus (conditioned stimulus) is paired with foot shock (unconditioned stimulus) to elicit autonomic and behavioral conditioned responses (LeDoux, 1996; LeDoux & Phelps, 2008).

LeDoux's work has provided many insights into the brain's processing of emotional information and the role of the amygdala. Emotional stimuli travel to the amygdala by both a fast, crude "low road" (subcortical) and a slower but more involved cortical "high road" (LeDoux, 1996, 2007; LeDoux & Phelps, 2008). (See **Figure 9.5**.) The direct route allows for quick responses to stimuli that are possibly dangerous, sometimes before we actually know what the stimuli are, but with the awareness provided by the indirect cortical route (specifically, processing by the prefrontal cortex), we can override the direct route and take control of our emotional responses (LeDoux, 1996; LeDoux & Phelps, 2008; Öhman, 2008).

Figure 9.5 The "Low Road" and "High Road"

When we are exposed to an emotion-provoking stimulus (such as a shark), the neural signals travel by two pathways to the amygdala. The "low road" is the pathway underneath the cortex and is a faster, simpler path, allowing for quick responses to the stimulus, sometimes before we are consciously aware of the nature of the stimulus. The "high road" uses cortical pathways and is slower and more complex, but it allows us to recognize the threat and, when needed, take more conscious control of our emotional responses. In this particular example, the low road shouts, "Danger!" and we react before the high road says, "It's a shark!"



LeDoux's work also provides a mechanism for understanding psychological disorders related to anxiety or fear. [LINK](#) to Learning Objective 14.4. It is possible that the direct route may be the primary processing pathway for individuals with anxiety disorders and the indirect, cortical pathway is not able to override the processing initiated by the direct route. This would result in difficulty or inability to control our anxieties, or the inability to extinguish fears we've already acquired (LeDoux, 1996; LeDoux & Phelps, 2008).

Besides the amygdala, other subcortical and cortical areas of the brain are involved in the processing of emotional information. Research suggests that emotions may work differently depending on which side of the brain is involved. One area of investigation has been the frontal lobes. Researchers have found that positive emotions are associated with the left frontal lobe of the brain whereas negative feelings such as sadness, anxiety, and depression seem to be a function of the right frontal lobe (R. J. Davidson, 2003; Geschwind & Iacoboni, 2007; Heilman, 2002). In studies where the electrical activity of the brain has been tracked using an electroencephalograph, [LINK](#) to Learning Objective 2.6, left frontal lobe activation has been associated with pleasant emotions while right frontal lobe activity has been associated with negative emotional states (R. J. Davidson, 2003). Furthermore, increased left frontal lobe activity has been found in individuals trained in meditation, and for the participants in this study, greater left frontal lobe activity was accompanied by a reduction in their anxiety as well as a boost in their immune system (R. J. Davidson et al., 2003).

The ability to interpret the facial expressions of others as a particular emotion also seems to be a function of one side of the brain more than the other. Researchers have found that when people are asked to identify the emotion on another person's face, the right hemisphere is more active than the left, particularly in women (Voyer & Rodgers, 2002). This difference begins weakly in childhood but increases in adulthood, with children being less able to identify negative emotions as well as they can positive emotions when compared to adults (Barth & Boles, 1999; Lane et al., 1995). This finding is consistent with early research that assigns the recognition of faces to the right hemisphere (Berent, 1977; Ellis, 1983).

Other types of emotional processing involve a variety of other brain areas. Have you ever been told to control your emotions? Different brain areas take primary roles based on the different ways you try to control your emotions, but there is a degree of overlap across several of the strategies. For example, some common strategies for regulating one's emotions include distraction, reappraisal, and controlling the influence of emotions on decision making. All three of these strategies take advantage of the lateral prefrontal cortex and anterior cingulate cortex and, as you might expect from the discussion before, the amygdala also comes into play (J. S. Beer, 2009).

However, distraction appears to be supported by activity in the anterior cingulate cortex, and reappraisal is supported by activity in the lateral orbitofrontal cortex; and both are accompanied by lower activity in the amygdala (J. S. Beer, 2009). Furthermore, distraction and reappraisal may engage more brain areas in general as compared to spontaneous control of emotions in decision making. Generally, brain areas associated with emotional control are the same brain areas responsible for control of nonemotional information (J. S. Beer, 2009).

THE BEHAVIOR OF EMOTION: EMOTIONAL EXPRESSION How do people behave when in the grip of an emotion? There are facial expressions, body movements, and actions that indicate to others how a person feels. Frowns, smiles, and sad expressions combine with hand gestures, the turning of one's body, and spoken words to produce an understanding of emotion. People fight, run, kiss, and yell, along with countless other actions stemming from the emotions they feel.

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**Figure 9.6 Facial Expressions of Emotion**

Facial expressions appear to be universal. For example, these faces are consistently interpreted as showing (a) anger, (b) fear, (c) disgust, (d) happiness, (e) surprise, and (f) sadness by people of various cultures from all over the world. Although the situations that cause these emotions may differ from culture to culture, the expression of particular emotions remains strikingly the same.

Facial expressions can vary across different cultures, although some aspects of facial expression seem to be universal. (See **Figure 9.6** for some examples of universal facial expressions.) Charles Darwin (1898) was one of the first to theorize that emotions were a product of evolution and, therefore, universal—all human beings, no matter what their culture, would show the same facial expression because the facial muscles evolved to communicate specific information to onlookers. For example, an angry face would signal to onlookers that they should act submissively or expect a fight. Although Darwin's ideas were not in line with the behaviorist movement of the early and middle twentieth century, which promoted environment rather than heredity as the cause of behavior, other researchers have since found evidence that there is a universal nature to at least seven basic emotions, giving more support to the evolutionary perspective within psychology (Ekman, 1973; Ekman & Friesen, 1969, 1971). [LINK](#) to Learning Objective 1.4. Even children who are blind from birth can produce the appropriate facial expressions for any given situation without ever having witnessed those expressions on others, which strongly supports the idea that emotional expressions have their basis in biology rather than in learning (Charlesworth & Kreutzer, 1973; Fulcher, 1942).

In their research, Ekman and Friesen found that people of many different cultures (including Japanese, European, American, and the Fore tribe of New Guinea) can consistently recognize at least seven facial expressions: anger, fear, disgust, happiness, surprise, sadness, and contempt (Ekman & Friesen, 1969, 1971). Although the emotions and the related facial expressions appear to be universal, exactly when, where, and how an emotion is expressed may be determined by the culture. **Display rules** that can vary from culture to culture (Ekman, 1973; Ekman & Friesen, 1969) are learned ways of controlling displays of emotion in social settings. For example, Japanese people have strict social rules about showing emotion in public situations—they simply do not show emotion, remaining cool, calm, and collected, at least on the *outside*. But if in a more private situation, as

a parent scolding a child within the home, the adult's facial expression would easily be recognized as "angry" by people of any culture. The emotion is universal and the way it is expressed on the face is universal, but whether it is expressed or displayed depends on the learned cultural rules for displaying emotion.

Display rules are different between cultures that are *individualistic* (placing the importance of the individual above the social group) and those that are *collectivistic* (placing the importance of the social group above that of the individual). Whereas the culture of the United States is individualistic, for example, the culture of Japan is collectivistic. At least part of the difference between the two types of display rules may be due to these cultural differences (Edelmann & Iwawaki, 1987; Hofstede, 1980; Hofstede et al., 2002).

 [Learning Objective 13.7.](#)

Display rules are also different for males and females. Researchers looking at the display rules of boys and girls found that boys are reluctant to talk about feelings in a social setting, whereas girls are expected and encouraged to do so (Polce-Lynch et al., 1998). With adults, researchers looking at the expression of anger in the workplace found that women are generally less willing than men to express negative emotions, although factors such as status complicate the findings somewhat (Domagalski & Steelman, 2007).

SUBJECTIVE EXPERIENCE: LABELING EMOTION The third element of emotion is interpreting the subjective feeling by giving it a label: anger, fear, disgust, happiness, sadness, shame, interest, and so on. Another way of labeling this element is to call it the "cognitive element," because the labeling process is a matter of retrieving memories of previous similar experiences, perceiving the context of the emotion, and coming up with a solution—a label.

The label a person applies to a subjective feeling is at least in part a learned response influenced by their language and culture. Such labels may differ in people of different cultural backgrounds. For example, researchers in one study (J. L. Tsai et al., 2004) found that Chinese Americans who were still firmly rooted in their original Chinese culture were far more likely to use labels to describe their emotions that referred to bodily sensations (such as "dizzy") or social relationships (such as "friendship") than were more "Americanized" Chinese Americans and European Americans, who tended to use more directly emotional words (such as "liking" or "love").

In another study, even the subjective feeling of happiness showed cultural differences (Kitayama & Markus, 1994). In this study, Japanese students and students from the United States were found to associate a general positive emotional state with entirely different circumstances. In the case of the Japanese students, the positive state was more associated with friendly or socially engaged feelings. The students from the United States associated their positive emotional state more with feelings that were socially disengaged, such as pride. This finding is a further reflection of the differences between collectivistic and individualistic cultures. A major goal for psychologists engaged in cross-cultural research in emotions is to attempt to understand the meaning of other people's mental and emotional states without interpreting them incorrectly, or misleadingly, in the language or mindset of the researchers (Shweder et al., 2008).

THEORIES OF EMOTION



 So which of the three elements is the most important?

In the early days of psychology, it was assumed that feeling a particular emotion led first to a physical reaction and then to a behavioral one. According to this viewpoint—we'll call it the common sense theory of emotion—seeing a snarling dog in one's path causes the feeling of fear, which stimulates the body to arousal, followed by the behavioral act of running; that is, people are aroused because they are afraid. (See **Figure 9.7** on the next page.)

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Figure 9.7 Common Sense Theory of Emotion

In the common sense theory of emotion, a stimulus (snarling dog) leads to an emotion of fear, which then leads to bodily arousal (in this case, indicated by shaking) through the autonomic nervous system (ANS).

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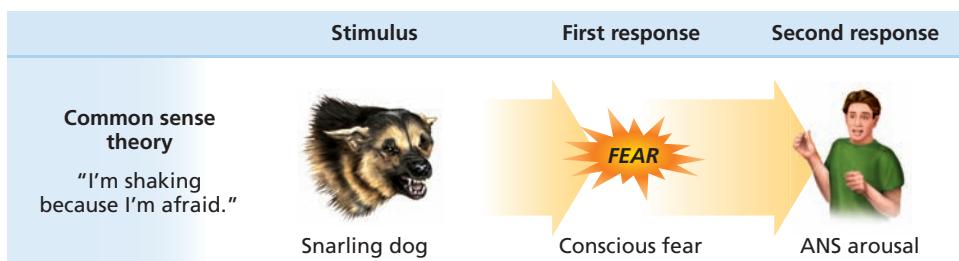
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**JAMES-LANGE THEORY OF EMOTION****9.8 How do the James-Lange and Cannon-Bard theories of emotion differ?**

William James (1884, 1890, 1894), who was also the founder of the functionalist perspective in the early history of psychology, to Learning Objective 1.2, disagreed with the common sense viewpoint. He believed that the order of the components of emotions was quite different. At nearly the same time, a physiologist and psychologist in Denmark, Carl Lange (1885), came up with an explanation of emotion so similar to that of James that the two names are used together to refer to the theory—the **James-Lange theory of emotion**. (See Figure 9.8.)



In this theory, a stimulus of some sort (for example, the large snarling dog) produces a physiological reaction. This reaction, which is the arousal of the “fight-or-flight” sympathetic nervous system (wanting to run), produces bodily sensations such as increased heart rate, dry mouth, and rapid breathing. James and Lange believed that the physical arousal led to the labeling of the emotion (fear). Simply put, “I am afraid because I am aroused,” “I am embarrassed because my face is red,” “I am nervous because my stomach is fluttering,” and “I am in love because my heart rate increases when I look at her (or him).”

What about people who have spinal cord injuries that prevent the sympathetic nervous system from functioning? Although James-Lange would predict that these people should show decreased emotion because the arousal that causes emotion is no longer there, this does not in fact happen. Several studies of people with spinal cord injuries report that these people are capable of experiencing the same emotions after their injury as before, sometimes even more intensely (Bermond et al., 1991; Chwalisz et al., 1988).

CANNON-BARD THEORY OF EMOTION Physiologists Walter Cannon (1927) and Philip Bard (1934) theorized that the emotion and the physiological arousal occur more or less at the same time. Cannon, an expert in sympathetic arousal mechanisms, did not feel that the physical changes caused by various emotions were distinct enough to allow them to be perceived as different emotions. Bard expanded on this idea by stating that the sensory information that comes into the brain is sent simultaneously (by the thalamus) to both the cortex and the organs of the sympathetic nervous system. The fear and the bodily reactions are, therefore, experienced at the same time—not one after the other. “I’m afraid and running and aroused!” (See Figure 9.9.)

This theory, known as the **Cannon-Bard theory of emotion**, also had its critics. Lashley (1938) stated that the thalamus would have to be pretty sophisticated to make sense of all the possible human emotions and relay them to the proper areas of the cortex and

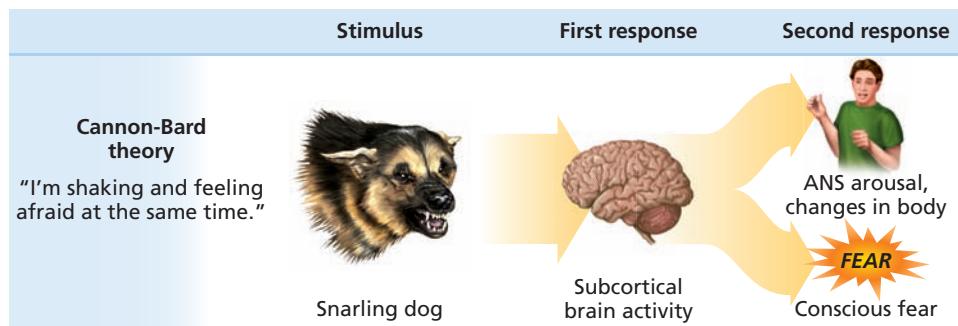


Figure 9.9 Cannon-Bard Theory of Emotion

In the Cannon-Bard theory of emotion, a stimulus leads to activity in the brain, which then sends signals to arouse the body and interpret the emotion at the same time.

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body. It would seem that other areas of the brain must be involved in processing emotional reactions. The studies of people with spinal cord injuries, which appear to suggest that emotions can be experienced without feedback from the sympathetic organs to the cortex and were cited as a criticism of the James-Lange theory, seem at first to support the Cannon-Bard version of emotions: People do not need feedback from those organs to experience emotion. However, there is an alternate pathway that does provide feedback from these organs to the cortex; this is the *vagus nerve*, one of the cranial nerves (LeDoux, 1994). The existence of this feedback pathway makes the case for Cannon-Bard a little less convincing.

SCHACHTER-SINGER AND COGNITIVE AROUSAL THEORY OF EMOTION

What are the key elements in cognitive arousal theory, the facial feedback hypothesis, and the cognitive-mediation theory of emotion?

The early theories talked about the emotion and the physical reaction, but what about the mental interpretation of those components? In their **cognitive arousal theory (two-factor theory)**, Schachter and Singer (1962) proposed that two things have to happen before emotion occurs: the physical arousal and a labeling of the arousal based on cues from the surrounding environment. These two things happen at the same time, resulting in the labeling of the emotion. (See **Figure 9.10**.)

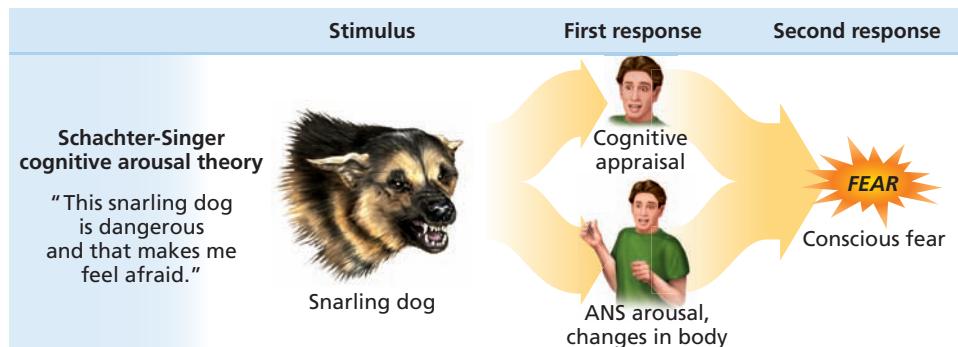


Figure 9.10 Schachter-Singer Cognitive Arousal Theory of Emotion

Schachter and Singer's cognitive arousal theory is similar to the James-Lange theory but adds the element of cognitive labeling of the arousal. In this theory, a stimulus leads to both bodily arousal and the labeling of that arousal (based on the surrounding context), which leads to the experience and labeling of the emotional reaction.

For example, if a person comes across a snarling dog while taking a walk, the physical arousal (heart racing, eyes opening wide) is accompanied by the thought (cognition) that this must be fear. Then and only then will the person experience the fear emotion. In other words, "I am aroused in the presence of a scary dog; therefore, I must be afraid." Evidence for this theory was found in what is now a classic experiment, described in the accompanying Classic Studies in Psychology. [Watch the Video](#), *The Basics: Theories of Emotion and Motivation: Three Theories of Emotion*, at [MyPsychLab](#)

THE FACIAL FEEDBACK HYPOTHESIS: SMILE, YOU'LL FEEL BETTER In his 1898 book *The Expression of the Emotions in Man and Animals*, Charles Darwin stated that facial expressions evolved as a way of communicating intentions, such as threat or fear, and that these expressions are universal within a species rather than specific to a culture. He also believed (as in the James-Lange theory) that when such emotions are expressed freely on the face, the emotion itself intensifies—meaning that the more one smiles, the happier one feels.

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classic studies in psychology



The Angry/Happy Man



In 1962, Stanley Schachter and Jerome Singer designed an experiment to test their theory that emotions are determined by an interaction between the physiological state of arousal and the label, or cognitive interpretation, that a person places on the arousal. Male student volunteers were told that they were going to answer a questionnaire about their reactions to a new vitamin called Suproxin. In reality, they were all injected with a drug called epinephrine, which causes physical arousal in the form of increased heart rate, rapid breathing, and a reddened face—all responses that happen during a strong emotional reaction.

Each student then participated in one of two conditions. In one condition, a confederate* posing as one of the participants started complaining about the experimenter, tearing up his questionnaire and storming out. In the other condition, there was one man who acted more like he was very happy, almost giddy and playing with some of the objects in the room. The “angry” man and the “happy” man in both conditions deliberately behaved in the two different ways as part of the experiment.

After both conditions had played out, participants in each of the two conditions were asked to describe their own emotions. The participants who had been exposed to the “angry” man interpreted their arousal symptoms as anger, whereas those exposed to the “happy” man interpreted their arousal as happiness. In all cases, the actual cause of arousal was the epinephrine and the physical symptoms of arousal were identical. The only difference between the two groups of participants was their exposure to the two different contexts. Schachter and Singer’s theory would have predicted exactly these results: Physiological arousal has to be interpreted cognitively before it is experienced as a specific emotion.

Although this classic experiment stimulated a lot of research, much of that research has failed to find much support for the cognitive arousal theory of emotion (Reisenzein, 1983, 1994). But this theory did serve to draw attention to the important role that cognition plays in determining emotions. The role of cognition in emotion has been revisited in some more modern theories of emotion, as you will see in the remainder of the chapter.

Questions for Further Discussion

1. How might observing the emotions of others under more normal circumstances (i.e., not in a drugged state) affect a person’s own emotional state?
2. According to Schachter and Singer’s theory, for your first date with a person, should you choose a happy movie or a sad one?
3. In this experiment, what was the independent variable manipulated by the experimenters? What was the dependent variable?
4. This experiment used deception, as the participants were not told the true nature of the injection they received. What kind of ethical problems might have arisen from this deception? What problems would the experimenters have had in getting this study approved by an ethics committee today?

Modern psychologists have proposed a theory of emotion that is consistent with much of Darwin’s original thinking. Called the **facial feedback hypothesis**, this explanation assumes that facial expressions provide feedback to the brain concerning the emotion being expressed, which in turn not only intensifies the emotion but also actually *causes* the emotion (Buck, 1980; Ekman, 1980; Ekman & Friesen, 1978; Keillor et al., 2002). (See **Figure 9.11**.)

*confederate: someone who is cooperating with another person on some task.

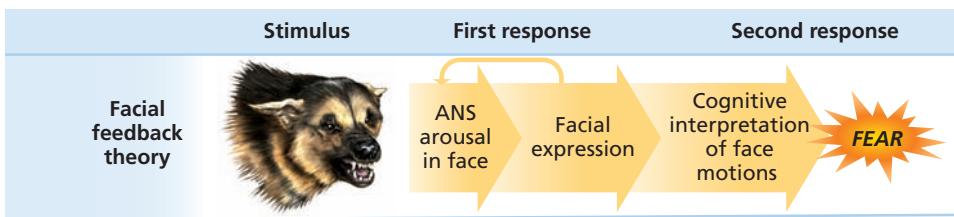


Figure 9.11 Facial Feedback Theory of Emotion

In the facial feedback theory of emotion, a stimulus such as this snarling dog causes arousal and a facial expression. The facial expression then provides feedback to the brain about the emotion. The brain then interprets the emotion and may also intensify it.



Does that mean that I don't smile because I'm happy—I'm happy because I smile?

As the old song goes, “put on a happy face” and yes, you’ll feel happier, according to the facial feedback hypothesis. One fairly recent study does cast some doubt on the validity of this hypothesis, however. If the facial feedback hypothesis is correct, then people who have facial paralysis on both sides of the face should be unable to experience emotions in a normal way. But a case study conducted on just such a person revealed that although she was unable to express emotions on her paralyzed face, she could respond emotionally to slides meant to stimulate emotional reactions, just as anyone else would (Keillor et al., 2002). Clearly, the question of how much the actual facial expression determines the emotional experience has yet to be fully answered.

LAZARUS AND THE COGNITIVE-MEDIATIONAL THEORY As mentioned in the Classic Studies in Psychology section, Schachter and Singer’s (1962) study stressed the importance of cognition, or thinking, in the determination of emotions. One of the more modern versions of cognitive emotion theories is Lazarus’s **cognitive-medational theory** of emotion (1991). In this theory, the most important aspect of any emotional experience is how the person interprets, or appraises, the stimulus that causes the emotional reaction. To *mediate* means to “come between” and in this theory the cognitive appraisal mediates by coming between the stimulus and the emotional response to that stimulus.

For example, remember the person who encountered a snarling dog while walking through the neighborhood? According to Lazarus, the appraisal of the situation would come *before* both the physical arousal and the experience of emotion. If the dog is behind a sturdy fence, the appraisal would be something like “no threat.” The most likely emotion would be annoyance, and the physical arousal would be minimal. But if the dog is not confined, the appraisal would more likely be “danger—threatening animal!” which would be followed by an increase in arousal and the emotional experience of fear. In other words, it’s the *interpretation* of the arousal that results in the emotion of fear, not the labeling as in the Schachter-Singer model, and the interpretation comes first. (See **Figure 9.12**.)

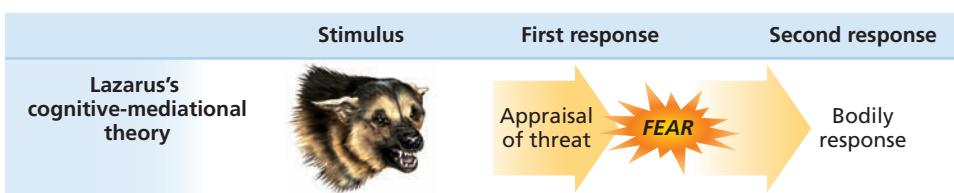


Figure 9.12 Lazarus's Cognitive-Medational Theory of Emotion

In Lazarus’s cognitive-medational theory of emotion, a stimulus causes an immediate appraisal (e.g., “The dog is snarling and not behind a fence, so this is dangerous”). The cognitive appraisal results in an emotional response, which is then followed by the appropriate bodily response.

Not everyone agrees with this theory, of course. Some researchers believe that emotional reactions to situations are so fast that they are almost instantaneous, which would leave little time for a cognitive appraisal to occur first (Zajonc, 1998). Others (Kihlstrom et al., 2000) have found that the human brain can respond to a physical threat before conscious thought enters the picture. And as addressed earlier, the amygdala can prompt emotional reactions before we are consciously aware of what we are responding to (LeDoux, 1996, 2007; LeDoux & Phelps, 2008).



The facial feedback hypothesis assumes that changing your own facial expression can change the way you feel. Smiling makes people feel happy, and frowning makes people feel sad. This effect seems to have an impact on the people around us as well. Is it hard for you to stay in a bad mood when the people around you are smiling and laughing?

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Which theory is right?

Human emotions are so incredibly complex that it might not be out of place to say that all of the theories are correct to at least some degree. In certain situations, the cognitive appraisal might have time to mediate the emotion that is experienced (such as falling in love), whereas in other situations, the need to act first and to think and feel later is more important. (See **Figure 9.13**.)

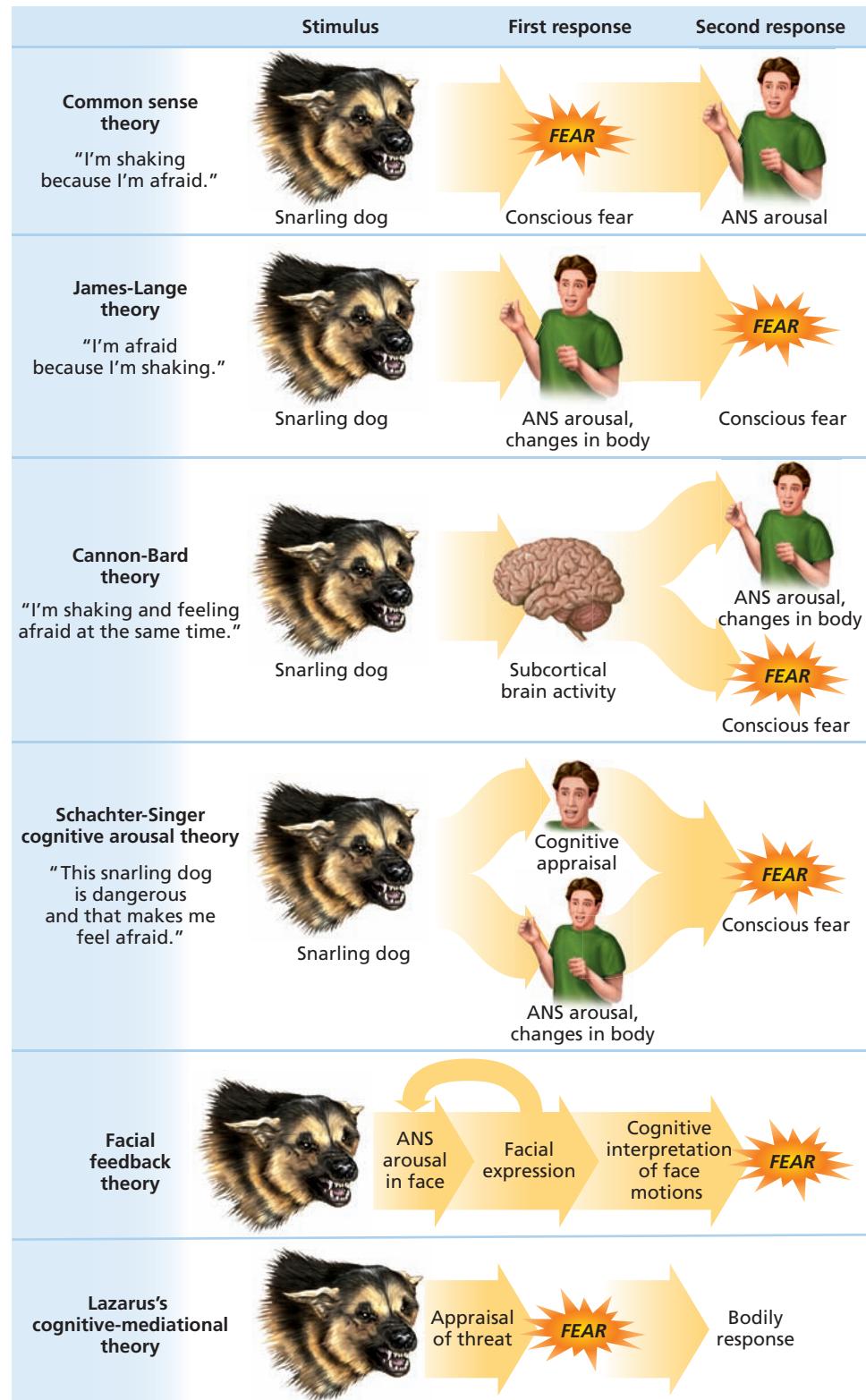


Figure 9.13 Comparison of Theories of Emotion

These figures represent the six different theories of emotion as discussed in the text.

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 Explore the Concept at [MyPsychLab](#)

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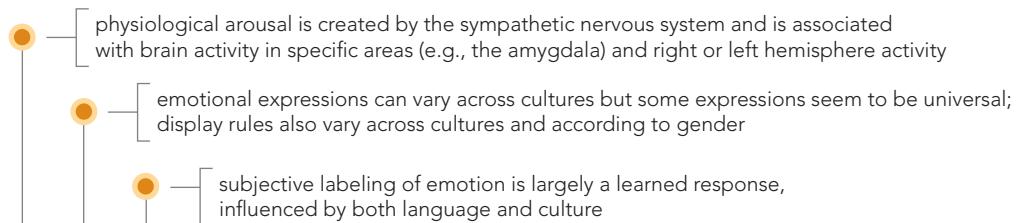
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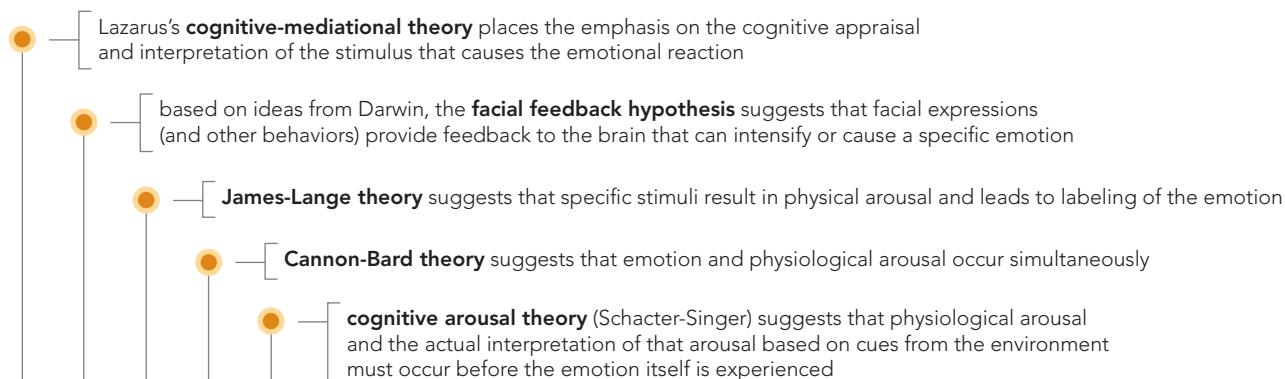
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CONCEPT MAP



Emotion

(is "feeling" aspect of consciousness, characterized by physiological arousal, specific expressive behavior, and inner awareness of feelings)



Various Theories of Emotion

have been suggested, each with a slightly different focus and interpretation (see Fig. 9.13)

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. The phrase, "I'm embarrassed because my face is red" is best explained by which theory of emotion?
 - a. Cannon-Bard
 - b. James-Lange
 - c. Schachter-Singer
 - d. traditional theory of emotion
2. "I believe that emotions and physiological arousal tend to happen simultaneously." Which theorist would be responsible for making such a statement?
 - a. Walter Cannon or Philip Bard
 - b. William James or Carl Lange
 - c. Stanley Schachter or Jerome Singer
 - d. Sigmund Freud or Erik Erikson
3. One day at school, someone collides with you in the hall and knocks you down, causing you to be angry. However, when playing football with friends, if you get knocked down, you do not express anger. What theory best explains how we label each situation and choose the appropriate emotion to show?

<ol style="list-style-type: none"> a. James-Lange b. Cannon-Bard 	<ol style="list-style-type: none"> c. Schachter-Singer d. facial feedback
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4. In Schachter and Singer's classic study, participants who received epinephrine and were in the company of the "angry" research confederate interpreted their physiological arousal as _____, whereas those who were exposed to the "happy" confederate interpreted their arousal as _____.
 - a. anger; happiness
 - b. happiness; anger
 - c. happiness; happiness
 - d. anger; anger
5. Eileen smiles wherever she goes. She smiles a lot in the classroom, which in turn prompts her fellow students to smile, making them feel happier too. This effect is best explained by which of the following theories of emotion?
 - a. James-Lange
 - b. cognitive-mediation
 - c. Schachter-Singer
 - d. facial feedback

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Applying Psychology to Everyday Life: When Motivation Is Not Enough

What are the stages of the GTD method?

Now that we have discussed a variety of ways in which behavior gets initiated or maintained, what can you do to make sure you complete the tasks you need to finish or address the commitments you've made? Many college students find it difficult to keep track of all of their class assignments and projects, and to remember all of the things they are supposed to do—and when to do them. Keeping on task can be especially challenging when you might not be exactly thrilled about doing some of them in the first place. As such, if motivation is not enough to help you get things accomplished, what else can you do to ensure that you do what needs to be done?

There have been a variety of time- and task-management systems developed over the years, each with a slightly different focus on various aspects of motivation. One system suggests you should first identify key principles or important areas in your life (such as family, education, career, etc.); the next step is to sort your to-do list using those key categories, ranking your tasks by priority or in the order you need to do them. Finally, keep track of each item by plotting it on your calendar. This works for some people. For others it may sound like more steps than you want to do, or feel you need to do.

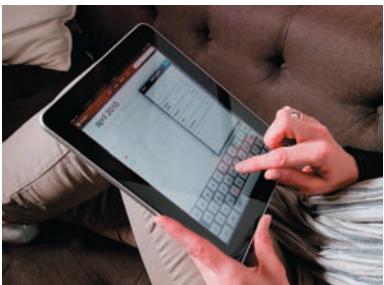
The book *Getting Things Done: The Art of Stress-Free Productivity* by David Allen and his “Getting Things Done” (or “GTD”) methodology can provide a useful structure for a wide range of people who need help, well, in getting things done (Allen, 2001, 2008). Think back to Jennifer, the college student who ran into difficulties after starting college. With a system like GTD, she may have improved her chances of being more successful her first year.

The GTD method consists of five stages of processing your “stuff” into actual outcomes, identifying “next actions” you can actually take to gain and maintain control of your tasks and commitments. The five stages of the GTD method are:

1. Capture anything and everything that has your attention, getting it out of your head and physically collected in one place. This place can be a folder, notebook, computer program, spreadsheet, a set of index cards, or the like.
2. Process and define what you can take action on and identify the next steps. For example, instead of “do my research paper,” identify actionable next steps such as “pinpoint topic, collect articles, schedule meeting to discuss ideas with classmates,” for example.
3. Organize information and reminders into categories or contexts, based on how and when you need them. For example, if you need to send an email or text message to your group partners, you probably need to have your phone or computer to do so; “phone” or “computer” might be a context that you use.
4. Complete weekly reviews of your projects, next actions, and new items. To get things done, you need to review what you need to do.
5. Do your next actions, in the appropriate context or time frame for doing so.

Adapted from David Allen's *Getting Things Done: The Art of Stress-Free Productivity* (2001) and *Making It All Work* (2008).

In this discussion we've only highlighted aspects of one specific approach for organizing and keeping on top of all those things you need to get done. There are a variety of time- and task-management systems and tools available, many more than we can cover in this textbook,  to Learning Objective PIA.2. Finding an approach or strategy that works best for you will likely pay off, not only now while you are in school but also in areas



How do you keep track of all of your class assignments, appointments, and deadlines?

of your personal and future professional lives as well. Take some time now and investigate available strategies that will help you get organized and stay on track to meet your obligations in a timely manner. If you do, the next time you find that motivation and emotion are not enough to prompt you to get what you need done taken care of, you'll be glad you did.

Questions for Further Discussion:

1. Aside having a bunch of "lists" and possibly getting things done, what might be some specific personal benefits to keeping track of tasks and projects you have committed to?
2. What sort of personal barriers or roadblocks might you have to not using a time- or task-management system?

Writing Prompt

▼ Imagine you are walking alone late at night and hear footsteps behind you. Think about your emotional reaction to this situation. Consider the major theories of emotion: James-Lange theory, Cannon-Bard theory, and Schachter-Singer theory. From the perspective of these major theories of emotion, describe how each would predict the sequence of events that would occur as you experience a reaction to this situation.

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chapter summary

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Approaches to Understanding Motivation

9.1 How do psychologists define motivation, and what are the key elements of the early instinct and drive-reduction approaches to motivation?

- Motivation is the process by which activities are started, directed, and sustained so that physical and psychological needs are fulfilled.
- Instinct approaches proposed that some human actions may be motivated by instincts, which are innate patterns of behavior found in both people and animals.
- Drive-reduction approaches state that when an organism has a need (such as hunger), the need leads to psychological tension that motivates the organism to act, fulfilling the need and reducing the tension.
- Primary drives involve needs of the body whereas acquired (secondary) drives are those learned through experience. Homeostasis is the tendency of the body to maintain a steady state.

9.2 What are the characteristics of the three types of needs?

- The need for affiliation is the desire to have friendly social interactions and relationships with others as well as the desire to be held in high regard by others.

- The need for power concerns having control over others, influencing them, and having an impact on them. Status and prestige are important to people high in this need.
- The need for achievement is a strong desire to succeed in achieving one's goals, both realistic and challenging.
- The self-theory of emotion links the need for achievement to the concept of locus of control. A belief in control over one's life leads to more attempts to achieve, even in the face of failure. Those who believe that they have little control over what happens to them are more likely to develop learned helplessness.

9.3 What are the key elements of the arousal and incentive approaches to motivation?

- In arousal theory, a person has an optimal level of arousal to maintain. People who need more arousal than others are called sensation seekers.
- In the incentive approach, an external stimulus may be so rewarding that it motivates a person to act toward that stimulus even in the absence of a drive.

9.4 How do Maslow's hierarchy of needs and self-determination theories explain motivation?

- Maslow proposed a hierarchy of needs, beginning with basic physiological needs and ending with transcendence needs. The more basic needs must be met before the higher needs can be fulfilled.

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- Self-determination theory (SDT) is a model of motivation in which three basic needs are seen as necessary to an individual's successful development: autonomy, competence, and relatedness.
- Intrinsic motivation occurs when people act because the act itself is satisfying or rewarding, whereas extrinsic motivation occurs when people receive an external reward (such as money) for the act.

What, Hungry Again? Why People Eat

9.5 What happens in the body to cause hunger, and how do social factors influence a person's experience of hunger?

- The physiological components of hunger include signals from the stomach and the hypothalamus, and the increased secretion of insulin.
- When the basal metabolic rate slows down, the weight set point increases and makes weight gain more likely.
- The social components of hunger include social cues for when meals are to be eaten, cultural customs and food preferences, and the use of food as a comfort device or as an escape from unpleasantness.
- Some people may be externals who respond to the anticipation of eating by producing an insulin response, increasing the risk of obesity.

9.6 What are some biological, social, and cultural factors that contribute to obesity?

- Maladaptive eating may lead to obesity.
- A third of the population of the United States is obese.

Emotion

9.7 What are the three elements of emotion?

- Emotion is the "feeling" aspect of consciousness and includes physical, behavioral, and subjective (cognitive) elements.
- Physical arousal is tied to activation of the sympathetic nervous system.
- The amygdala plays a key role in emotional processing.

test YOURSELF

ANSWERS AVAILABLE IN ANSWER KEY.

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Pick the best answer.

- Eli enjoys woodcarving. Although none of his teenage friends are interested, he often spends hours creating several different pieces. His enjoyment of the task is all his own, and he rarely shows others his work. Many would call his motivation _____ in nature.

a. instinctual	c. extrinsic
b. arousal	d. intrinsic
- Jasmine often requires her friends' approval when she buys new outfits. Her need is an example of a(n) _____ drive.

a. primary
b. acquired (secondary)
c. innate
d. instinctive

9.8 How do the James-Lange and Cannon-Bard theories of emotion differ?

- The James-Lange theory states that a stimulus creates a physiological response that then leads to the labeling of the emotion.
- The Cannon-Bard theory asserts that the physiological reaction and the emotion are simultaneous, as the thalamus sends sensory information to both the cortex of the brain and the organs of the sympathetic nervous system.

9.9 What are the key elements in cognitive arousal theory, the facial feedback hypothesis, and the cognitive-mediation theory of emotion?

- In Schachter and Singer's cognitive arousal theory, both the physiological arousal and the actual interpretation of that arousal must occur before the emotion itself is experienced. This interpretation is based on cues from the environment.
- In the facial feedback hypothesis, facial expressions provide feedback to the brain about the emotion being expressed on the face, intensifying the emotion.
- In the cognitive-mediation theory of emotion, the cognitive component of emotion (the interpretation) precedes both the physiological reaction and the emotion itself.

Applying Psychology to Everyday Life: When Motivation Is Not Enough

9.10 What are the stages of the GTD method?

- Time- or task-management systems can help you keep track of commitments and accomplish specific tasks and general goals.
- The stages of the Getting Things Done (GTD) method involve capturing, processing, organizing, reviewing, and doing the tasks you have committed to.
- Motivation and emotion are sometimes not enough to prompt human behavior.

5. Dodi is always looking for new hobbies. He prefers exciting hobbies that will get him noticed. In his company, Dodi constantly asks for feedback from customers so he can know what he needs to do to be the best. Dodi is high in the need for _____.
a. achievement
b. affiliation
c. power
d. attention
6. An important component to Carol Dweck's theory of motivation is
a. one's view of self.
b. an understanding of classical conditioning and its impact on motivation.
c. the importance of heredity on biological motivations.
d. an understanding of emotions.
7. According to the arousal theory, people are typically motivated towards _____ point of arousal.
a. the highest
b. the optimal
c. the easiest
d. the quickest
8. According to Maslow, what is meant by a peak experience?
a. that point, even for a moment, when someone reaches a state of self-actualization
b. the point at which someone reaches transcendence
c. the point at which someone begins to work through the hierarchy
d. the point at which someone must descend back down the hierarchy to address a previous need which is no longer secure
9. Jacob believes he is in control of his own destiny. He feels he is secure in the friendships he has with others. However, he still feels the need to master many of the challenges in his own life and career. According to self-determination theory, which stage is Jacob still working to complete?
a. autonomy
b. competence
c. relatedness
d. affiliation
10. Leptin is a hormone involved in
a. appetite control.
b. metabolism control.
c. digestion of fatty foods.
d. neurotransmissions.
11. The structure in the brain that, when damaged, causes rats to eat and eat and eat is called the
a. ventromedial pituitary.
b. lateral hippocampus.
c. ventromedial hypothalamus.
d. lateral hypothalamus.
12. The level of weight the body tries to maintain is called the
a. basal metabolic rate.
b. weight set point.
c. basal set point.
d. weight metabolic rate.
13. Studies indicate that women from _____ are more likely to eat because their body tells them they are hungry.
a. Hungary
b. the United States
c. Italy
d. Japan
14. Since Dillon's family has a history of obesity, he has _____ of becoming obese compared to people without such a family history.
a. the same risk
b. double or triple the risk
c. five times the risk
d. less risk
15. LeDoux's work on the physiology involving emotions has focused on what part of the brain?
a. thalamus
b. hippocampus
c. prefrontal cortex
d. amygdala
16. Research on facial expressions has taught us that facial expressions are
a. inherent to a region and therefore mean different things in different countries.
b. inherent to a culture and therefore mean different things to different cultures.
c. learned.
d. universal.
17. What is meant by a display rule?
a. an understanding of when and under what conditions emotions and feelings may be displayed within a culture
b. an understanding of what behaviors can be expressed when someone is new to a situation
c. an understanding of how children are to act in the presence of adults
d. an understanding of how to hide emotions from others
18. What theory of emotion states that the emotion typically occurs before arousal and behavior?
a. the original, or common-sense, theory
b. Schachter and Singer's theory
c. Cannon and Bard's theory
d. James and Lange's theory
19. Which theory of emotion relies heavily on cognition and labeling?
a. the original, or common-sense, theory
b. Schachter and Singer's theory
c. Cannon and Bard's theory
d. James and Lange's theory
20. The first stage of David Allen's Getting Things Done (GTD) method is _____ anything and everything that has your attention.
a. reviewing
b. doing
c. capturing
d. organizing

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sexuality and gender

Couvade syndrome is a gender-defying condition in which a man whose partner is pregnant may experience a kind of “sympathy pregnancy.” For instance, he may feel physical pain while his wife is in labor. Men in Western cultures, as their roles as participating fathers have changed, have actually shown an increase in couvade experiences.

There are several possible explanations for couvade syndrome. Some view it as a psychiatric disorder—perhaps out of jealousy of the attention given to the pregnant wife. Others note that it involves real biological changes. One study showed these men produce female hormones normally associated with the production of breast milk (Storey et al., 2000). It may be a way for some men to work through their feelings about impending fatherhood. Or it may be related to how emotionally sensitive they are, or prone to personal distress (Kazmierczak et al., 2013). Whatever the cause or causes, couvade syndrome remains a fascinating condition which seems to defy ordinary gender roles.

What are some cultural expectations for your gender? In what ways do you adhere to these gender roles and in what ways do you defy them?

A video player interface featuring a woman with long brown hair, wearing a black graduation gown and cap, standing against a white background. She is smiling slightly. The video player includes a play button, volume control, and closed captioning (CC) icons. The video is set against a background with floating blue circles and a graduation cap icon. Below the video is a call-to-action button labeled "Watch the Video at MyPsychLab.com".

Why study sexuality and gender?

Human sexual behavior is responsible for the reproduction of the human race, but it is also one of the most important motivators of human behavior. Gender, the psychological identification of a person as masculine or feminine, affects not only how people think of themselves but also their relationships with others as friends, lovers, and coworkers, and how those others think of them as well.

Learning objectives

10.1

What are the physical differences between females and males?

10.2

What is gender, and how can biology and learning influence gender-role development?

10.3

How do gender roles develop, and how can they be influenced by stereotypes or an emphasis on androgyny?

10.4

How do men and women differ in thinking, social behavior, and personality?

10.5

What happens in the bodies of women and men during sexual intercourse?

10.6

What did the early and most recent surveys of human sexual behavior reveal?

10.7

How do different sexual orientations develop?

10.8

How do physical and psychological sexual problems differ?

10.9

What are sexually transmitted infections, and what can be done to prevent the spread of these disorders?



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The Physical Side of Human Sexuality

What are the physical differences between females and males?

Before discussing gender and gender identity, it may help to understand the physical structures of the human sexual system and the function of those structures. These structures differ for females and males and develop at different times in an individual's life. As you read this next section, keep in mind that physical sex characteristics are not the same as the experience of *gender*, the psychological aspects of identifying oneself as male or female.

THE PRIMARY SEX CHARACTERISTICS

The sexual organs include structures that are present at birth and those that develop during *puberty*, the period of physiological change that takes place in the sexual organs and reproductive system during late middle childhood and adolescence. to Learning Objective 8.8.

Primary sex characteristics are directly involved in human reproduction. While not fully developed until puberty, these physical characteristics are present in the infant at birth. In the female, these characteristics include the **vagina** (the tube leading from the outside of the body to the opening of the womb), **uterus** (the womb), and **ovaries** (the female sex glands). In males, the primary sex characteristics include the **penis** (the organ through which males urinate and which delivers the male sex cells or sperm), the **testes** or **testicles** (the male sex glands), the **scrotum** (an external pouch that holds the testes), and the **prostate gland** (a gland that secretes most of the fluid that carries the sperm). (See **Figure 10.1**.)

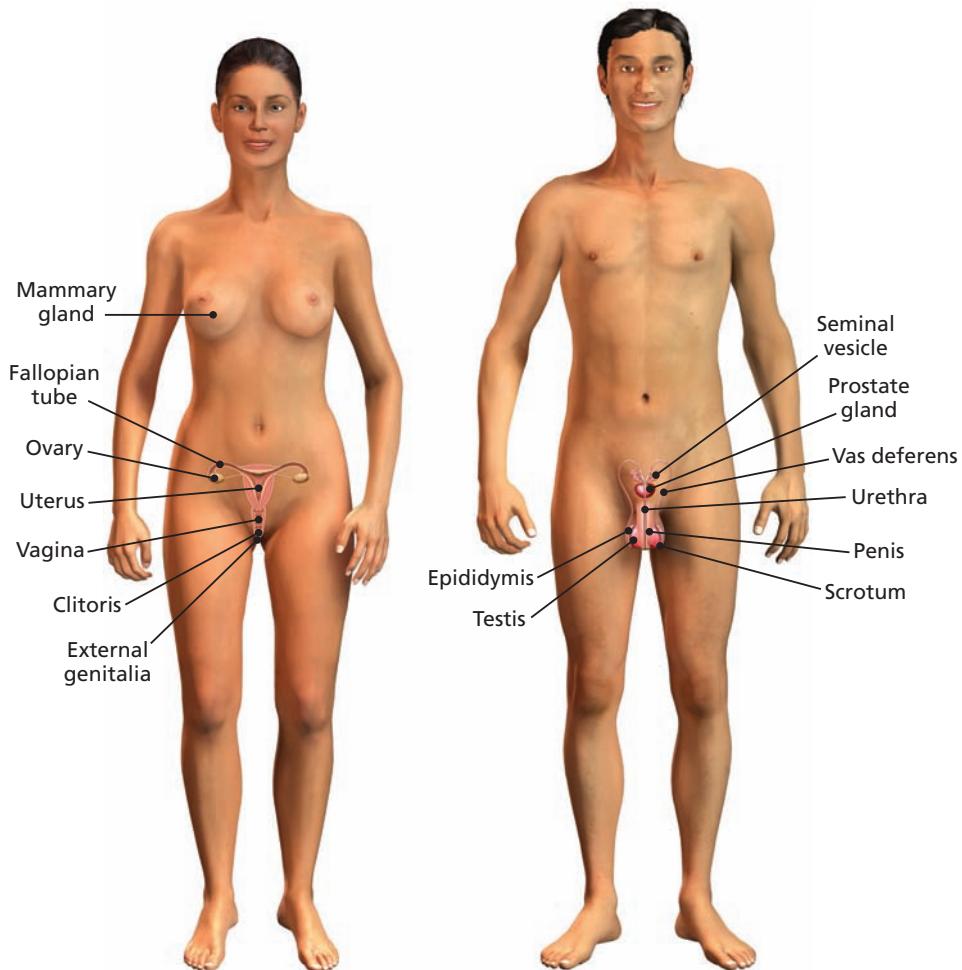


Figure 10.1 Male and Female Sexual Organs

These figures show the sexual organs of men and women. With the exception of breast-tissue development in the female, which occurs during puberty, all of these structures develop during the prenatal period.

THE SECONDARY SEX CHARACTERISTICS

Secondary sex characteristics develop during puberty and are only indirectly involved in human reproduction. These characteristics serve to distinguish the male from the female and may act as attractants to members of the opposite sex, ensuring that sexual activity and reproduction will occur. They are also, in many cases, a physical necessity for reproduction.

FEMALE SECONDARY SEX CHARACTERISTICS In females, secondary sex characteristics include a growth spurt that begins at about ages 10 to 12 and finishes about 1 year following the first *menstrual cycle*, in which the blood and tissue lining of the uterus exit the body through the vagina if there is no pregnancy to support. This first cycle is known as **menarche** and occurs at an average age of about 12 in more developed countries such as the United States.

The earlier onset of menarche in more developed countries is associated with the availability of better health care and nutrition, and, along with an increase in height and weight compared to previous generations, is an example of a *secular trend*, a change or series of changes that takes place over a long period of time (Bellis et al., 2006; Roche, 1979). But better physical health is not the only factor in the decrease in age of menarche. Stress, in the form of marital strife, absentee fathers, and increasing rates of divorce also plays a part in speeding up the changes of puberty (Gluckman & Hansom, 2006; Parent et al., 2003). Some of the consequences of an earlier menarche (and an earlier production of sperm in boys, as well) include the possibility of pregnancy in children at a far younger age than previously thought possible (Wellings et al., 2001). Pregnancy in adolescence is not only hard on the young mothers physically but has negative social impact—poverty, child abuse and neglect, and a failure to continue in school, to name a few (Kirchengast, 2009).

Other changes include enlarged breasts about 2 years after the growth spurt, wider hips to allow the passage of the fetus through the pelvic bones, pubic hair, and fat deposits on the buttocks and thighs. Some secondary sex characteristics also involve the growth and development of the primary sexual organs. In females, this occurs when the **mammary glands** in the breasts become capable of producing milk for an infant and when the menstrual cycle begins (Kreipe, 1992; Lee, 1995).

MALE SECONDARY SEX

CHARACTERISTICS The secondary sex characteristics of males include a deepening voice; emergence of facial, chest, and pubic hair; and the development of coarser skin texture. These changes are also accompanied by a large increase in height that continues beyond the growth spurt of the female. The male growth spurt occurs about 2 years later than the female growth spurt, but males continue to gain height until the late teens. Although the larynx (voice box) increases in size in both sexes, it increases so much in males that part of the tissue forming it becomes visible under the skin of the neck in a structure known as the Adam's apple. Primary sex characteristics also undergo changes during puberty, including the onset of the production of sperm (*spermarche*, occurring at a little over 14 years of age) and the growth of the penis and



Puberty changes come about 2 years earlier for girls than for boys, including the growth spurt. This dancing couple are both 13 years old, but the physical difference in height is quite obvious.

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testes, which will eventually allow the male to function sexually and to reproduce (Kreipe, 1992; Lee, 1995).



How does the person's body know which sexual characteristics to develop? Aren't some babies born with sex organs belonging to both sexes?

DEVELOPMENT OF SEX CHARACTERISTICS The primary sex characteristics develop as the embryo is growing in the womb as a result of the chromosomes contained within the embryonic cells as well as hormonal influences. At about 5 weeks of pregnancy, two organs called the *gonads* form in the embryo. Two sets of ducts (tubes) also develop next to the gonads, the Wolffian ducts (which can become the male sex organs) and the Müllerian ducts (which can become the female sex organs). At this point, the gonads are undifferentiated—neither fully male nor fully female—and the embryo could potentially become either male or female. The deciding factor is controlled by the chromosomes: If the chromosomes of the 23rd pair contain a Y chromosome, a gene on that Y chromosome causes the gonads to release *testosterone*, a male hormone or **androgen**. (Female hormones are called **estrogens**.) Testosterone causes the Wolffian ducts to develop into the male sex organs, while the Müllerian ducts deteriorate. If the 23rd pair of chromosomes contains two female or X chromosomes, the Y gene is absent so no testosterone is released, and the gonads will develop into the estrogen-secreting ovaries. The Müllerian ducts become the female sex organs while the Wolffian ducts deteriorate. Watch the [Video](#), *The Basics: Sex and Gender Differences: Development of Sex Characteristics*, at [MyPsychLab](#)

On rare occasions, an infant is born with sexual organs that are ambiguous—not clearly male or female. People with this condition are referred to as **intersexed** or **intersexual**, meaning “between the sexes” (the term *hermaphroditism* was previously used). It is very rare to find a person who truly has both ovary and testicle material in their body. More commonly, the development of the external genitals is affected by either chromosome defects or the presence of the wrong hormones at a critical time in the development of the fetus in the womb (Hutcheson & Snyder, 2004). In this case, a female clitoris might look more like a penis, or a penis might be so small as to resemble a clitoris. Approximately 1 out of 1,500 children are born with this condition (Blackless et al., 2000; Dreger, 1998, 1999).

The Psychological Side of Human Sexuality: Gender

What is gender, and how can biology and learning influence gender-role development?

Whereas sex can be defined as the physical characteristics of being male or female, **gender** is defined as the psychological aspects of being male or female. The expectations of one's culture, the development of one's personality, and one's sense of identity are all affected by the concept of gender. Watch the [Video](#), *The Basics: Sex and Gender Differences: Distinguishing Sex and Gender*, at [MyPsychLab](#)

GENDER ROLES AND GENDER TYPING

Gender roles are the culture's expectations for behavior of a person who is perceived as male or female, including attitudes, actions, and personality traits associated with a particular gender within that culture (Tobach, 2001; Unger, 1979). **Gender typing** is the process by which people learn their culture's preferences and expectations for male and female behavior. The process of developing a person's **gender identity** (a sense of being male or female) is influenced by both biological and environmental factors (in the form of parenting and other child-rearing behaviors), although which type of factor has greater influence is still controversial.

Most researchers today would agree that biology has an important role in gender identity, at least in certain aspects of gender identity and behavior (Diamond & Sigmundson, 1997; Money, 1994; Reiner, 1999, 2000). In one study, 25 genetically male children who were born with ambiguous genitalia were surgically altered and raised as girls. Now, as older children and teenagers, they prefer male play activities such as sports. Fourteen of these children have openly declared themselves to be boys (Reiner, 2000).

Gender identity, like physical sex, is also not always as straightforward as males who are masculine and females who are feminine. People's sense of gender identity does not always match their external appearance or even the sex chromosomes that determine whether they are male or female (Califia, 1997; Crawford & Unger, 2004; White, 2000). Such people are typically termed *transgendered*. Biology and environment both have an influence on the concept of a person's gender identity. In a syndrome called *gender dysphoria*, a person experiences gender incongruence, feeling that he or she is occupying the body of the other gender, or some alternative gender that is not the same as their assigned gender, and has significant distress about the incongruence (American Psychiatric Association, 2013). Although the causes of gender dysphoria are not fully understood, there is some evidence for both prenatal influences and early childhood experiences as causes (Stein, 1984; Ward, 1992; Zhou et al., 1995). While some people with this condition feel so strongly that they are the wrong gender that they have surgery to have primary and/or secondary sexual sex characteristics of the gender they feel they were always meant to be, many others prefer to receive hormone treatment only or to embrace their identity as it is. People who choose to alter themselves physically through surgery or hormonal treatments are generally termed *transsexuals*.

Many Native American tribes have long recognized the role of the male *winkte* (a contraction of the Lakota word *winyanktehca*, meaning "to be as a woman or two-souls person") in their societies. These tribes traditionally were not only tolerant of such different individuals but also had important places for them in the social structure as caretakers of children, as cooks, and as menders and creators of clothing. The *winkte* also performed certain rituals for bestowing luck upon a hunt (Medicine, 2002). Although some *winkte* (now often referred to as people with two spirits) may have been homosexuals, many were not and would now be recognized as having an alternate gender identity or gender dysphoria. Unfortunately, as tribes have modernized and become more integrated into the larger European-dominated culture of the United States, the tolerant attitudes of other Native Americans toward the *winkte* have begun to be replaced with homophobic attitudes and aggressive behavior toward those who are different in this way (Medicine, 2002).

BIOLOGICAL INFLUENCES What are the biological influences on gender? Aside from the obvious external sexual characteristics of the genitals, there are also hormonal differences between men and women. Some researchers believe that exposure to these hormones during fetal development not only causes the formation of the sexual organs but also predisposes the infant to behavior that is typically associated with one gender or the other. There have been several studies of infant girls who were exposed to androgens before birth (for example, some drugs to prevent miscarriages are male hormones). In these studies, the girls were found to be tomboys during early childhood—preferring to play with typically "boy" toys, wrestling and playing rough, and playing with boys rather than with other girls (Berenbaum & Snyder, 1995; Money & Mathews, 1982; Money & Norman, 1987). However, when these girls grew up, they became more typically "female" in their desire for marriage and motherhood, which many of these same researchers took as evidence that upbringing won out over the hormonal influences.



Was their early tomboy nature due to the influence of the male hormones?

This is difficult to prove, as the parents of these girls were told about their infants' exposure to male hormones during the pregnancy and may have formed assumptions

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This is We-Wa, a Zuni berdache (the Zuni version of *winkte*). This photograph was taken near the end of the 19th century.

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about the effects of such masculinizing hormones on their children. It is entirely possible that these girls were simply allowed, or even encouraged, to be more “masculine” as small children because the parents were expecting them to be masculine. As these same girls grew older, they were exposed to the gender-role expectations of teachers, friends, and the media, which may have influenced them to become more like the feminine gender stereotype in contrast to their earlier “masculine” style of behavior. Some studies have attempted to investigate gender socialization factors by researching the behavior of non-human animals. For instance, as the video *The Basics: Sex and Gender Differences: Gender Socialization* explains, male and female rhesus monkeys, appear to prefer typically “boy” and “girl” toys, such as trucks and dolls respectively, indicating a possible biological influence.



Watch the Video, *The Basics: Sex and Gender Differences: Gender Socialization*, at [MyPsychLab](#)

Another study examined the way in which men and women respond to visual sexual stimuli and found that although men and women may report being equally aroused by erotic pictures, what happens in their brains is quite different (Hamann et al., 2004). Using a brain-scanning technique called **functional magnetic resonance imaging (fMRI)**, the researchers found that the amygdala and hypothalamus areas of the limbic system (areas involved in emotional and sexual responses) were more strongly active in men than in women who viewed the pictures. [Learning Objective 2.8](#). The researchers concluded that the male brain's enhanced reaction might be a product of natural selection, as early human males who could quickly recognize a sexually receptive female would have had a greater opportunity to mate and pass on their genes to their offspring.

ENVIRONMENTAL INFLUENCES Even if the girls who were exposed to androgens prenatally were initially influenced by these hormones, it seems fairly clear that their later “reversion” to more feminine ways was at least somewhat influenced by the pressures of society. In most cultures, there are certain roles that males and females are expected to play (gender roles, in other words), and the pressure that can be brought to bear on a person who does not conform to these expectations can be tremendous. In most Western cultures, the pressure to be masculine is even greater for males than the pressure to be feminine is for girls. The term *tomboy* is not generally viewed as an insult, but there are



"We don't believe in pressuring the children. When the time is right, they'll choose the appropriate gender."

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Robert Mankoff from cartoonbank.com.
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no terms for a boy who acts in a feminine manner that are not insulting—*sissy*, for example, is not a nice term at all. And although studies of parents' influence on their children's gender typing show that both parents have an impact, they also show that the fathers are almost always more concerned about their sons showing male gender behavior than they are about their daughters showing female gender behavior (Lyton & Romney, 1991).

CULTURE AND GENDER A person's culture is also an environmental influence. Although initial cross-cultural studies suggested that cultural differences had little effect on gender roles (Best & Williams, 2001), more recent research suggests that in the past few decades a change has occurred in cultures that are of different "personalities." Cultures that are more individualistic (those stressing independence and with loose ties among individuals) and have fairly high standards of living are becoming more nontraditional, especially for women in those cultures. Research has shown that more traditional views of gender seem to be held by collectivistic cultures (those stressing interdependence and with strong ties among individuals, especially familial ties) that have less wealth, although even in these cultures, women were more likely to be less traditional than men (Forbes et al., 2009; Gibbons et al., 1991; Shafiro et al., 2003). Other studies have found that the most nontraditional ideas about gender roles and gender behavior are found in countries such as the Netherlands, Germany, Italy, and England, whereas the most traditional ideas predominate in African and Asian countries such as Nigeria, Pakistan, and Japan (Best & Williams, 2001). The United States, often seen as very nontraditional by researchers, actually was somewhere in the middle in these studies, perhaps due to the large variation in subcultures that exists within this multicultural country. Environment, even in the form of culture, seems to play at least a partial and perhaps dominant role in gender behavior.

The experiment *Gender and Sexuality Survey* asks you about your own views on gender and what factors influence gender roles. We've seen how biology, environment, and culture may all have an influence on differences in gender behavior. What about differences that originate within the brain itself? Are male and female brains really all that different? The following special section has a few possible answers.



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Although Asian cultures are often more traditional in the roles that men and women play within society, even in these cultures gender roles are becoming more flexible, as this male preschool teacher in a Chinese classroom demonstrates. Why might gender roles in these traditional countries be changing?

Simulation

Gender and Sexuality Survey

This survey asks you about your attitudes toward gender, your gender-based experiences, and how gender-typing may affect you and your life.

Please indicate the extent of your agreement with the following statement:

The types of toys a child plays with affects his/her gender.

- Strongly Disagree
- Moderately Disagree
- Neither Agree nor Disagree
- Moderately Agree
- Strongly Agree
- Prefer not to State

Go to the Experiment ➔

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issues in psychology



Sex Differences in Science and Math: A Game Changer?



You've probably heard it at some point in your life: Men have better spatial ability than women. Because fields like science, technology, engineering, and math (often referred to as STEM) are heavily dependent upon having a good spatial ability, men tend to dominate these fields. Arguments have gone back and forth on whether this difference is caused by biological differences or by environmental influences (Linn & Petersen, 1985; Moffat et al., 1998; Voyer et al., 1995).

Gender roles, the cultural expectations for being male or female, would be an example of the latter, an influence of environment—upbringing and social experiences. In a recent study, researchers David Reilly and David Neumann (2013) analyzed 12 studies of a particular aspect of spatial ability (mental rotation) in males and females from high school age through young adulthood. Their findings strongly suggest that gender roles may play a very large part in the sex differences in spatial abilities.

In their findings, the researchers found that there are much larger differences in spatial ability *within* one gender than can be found *between* genders. If spatial ability is tied to biological factors associated with being male or female (genetic variations or hormonal influences, for example), we would expect to see the opposite: larger differences between males and females, not within males or females. This led the researchers to look closely at the data represented by the 12 studies.

They found that men with a strong male gender identity and both men and women with an androgynous gender identity (one in which people see themselves as people first and male or female second) were superior in spatial ability to those who possessed a strong female gender identity. Through play and recreational activities such as football, baseball, soccer, and so on, boys and androgynous girls (who don't let being a girl keep them from playing the games typically associated with boys) develop the spatial abilities that will help them excel in STEM careers. If we want to see more women going into STEM fields, the answer may lie in encouraging girls to engage in play activities that have been traditionally considered "for the boys."

Questions for Further Discussion

1. What kinds of opportunities should parents give their children to promote the development of spatial abilities?
2. Are there drawbacks to encouraging girls to play stereotypically male games?

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 Explore the Concept at [MyPsychLab](#)

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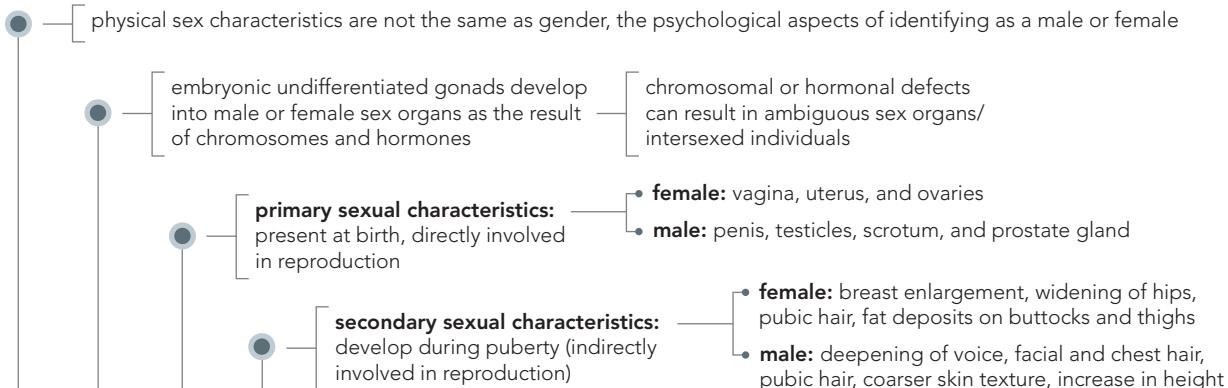
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CONCEPT MAP**The Physical Side of Human Sexuality**

-  key concepts
- **gender roles:** cultural behavioral expectations for males or females
 - **gender typing:** process by which people learn gender roles
 - **gender identity:** sense of being male or female (influenced by both biology and environment)

The Psychological Side of Human Sexuality: Gender

-  gender
- is defined as the psychological aspects of being masculine or feminine and is influenced by culture, individual personality, and self-identity
- **biological influences:** sexual characteristics of the genitals, hormonal differences, and possible differences in brain structure and processing
 - **environmental influences:** parental influences and cultural expectations to adhere to gender roles
 - **culture:** individualistic/nontraditional versus collectivistic/traditional role adoption

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. The sex structures that develop during puberty are categorized as
 - a. primary sex characteristics.
 - b. secondary sex characteristics.
 - c. either primary or secondary sex characteristics.
 - d. primary or secondary sex characteristics based on the culture.
2. Which of the following is a secondary sex characteristic?

a. uterus	c. enlarging breasts
b. penis	d. ovaries
3. People who are intersexual
 - a. commonly have both ovaries and testes.
 - b. are extremely rare—1 in a million births.
 - c. have a mixture of male and female sexual characteristics.
 - d. are people who suffer from gender dysphoria but are physically normal.
4. The process by which people learn their culture's preferences and expectations for male and female behavior is called
 - a. gender role.
 - b. gender identity.
 - c. gender typing.
 - d. gender stereotyping.
5. People whose sense of gender identity does not match their external appearance are known as
 - a. intersexed.
 - b. homosexual.
 - c. hermaphrodites.
 - d. transgendered.
6. In terms of the view of gender-role development in the United States, most scientists agree that our culture is _____, especially where women are concerned.
 - a. individualistic
 - b. collectivistic
 - c. traditional
 - d. somewhere in the middle

THINKING CRITICALLY:

How do you believe men and women are portrayed in today's media? Strong? Weak? Inept and unable to take care of themselves? Is it different for television, commercials, or movies?

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THEORIES OF GENDER-ROLE DEVELOPMENT

How do gender roles develop, and how can they be influenced by stereotypes or an emphasis on androgyny?

How do children acquire the knowledge of their society or culture's gender-role expectations? How does that knowledge lead to the development of a gender identity? Although early psychodynamic theorists such as Freud ([LINK](#) to Learning Objective 13.2) believed that children would learn their gender identities as a natural consequence of resolving the sexual conflicts of early childhood, many modern theorists focus on learning and cognitive processes for the development of gender identity and behavior.

SOCIAL LEARNING THEORY Social learning theory, which emphasizes learning through observation and imitation of models, attributes* gender-role development to those processes. Children observe their same-sex parents behaving in certain ways and imitate that behavior. When the children imitate the appropriate gender behavior, they are reinforced

with positive attention. Inappropriate gender behavior is either ignored or actively discouraged (Fagot & Hagan, 1991; Mischel, 1966).

Of course, parents are not the only gender-role models available to children. In addition to older brothers and sisters, family friends, teachers, and peers, children are exposed to male and female behavior on television and in other media. In fact, television, movies, and children's books are often filled with very traditional male and female roles. In these books, doctors are males and nurses are female far more often than the other way around, for example. Although some children's books and television programs make a genuine effort to present males and females in nontypical occupations, there are far more that maintain traditional roles for men and women.



As children develop the concept of gender, they begin to imitate the behavior of those they see as similar to themselves. This young girl is learning that women wear cosmetics while she plays at helping her mother put on her makeup. As she grows, she will incorporate more of her mother's behavior and ideas about what it is to be female into her own personality.

GENDER SCHEMA THEORY A theory of gender-role development that combines social learning theory with cognitive development is called **gender schema theory** (Bem, 1987, 1993). In this theory based on the Piagetian concept of schemes ([LINK](#) to Learning Objective 8.6), children develop a schema, or mental pattern, for being male or female in much the same way that they develop schemas for other concepts such as "dog," "bird," and "big." As their brains mature, they become capable of distinguishing among various concepts. For example, a "dog" might at first be anything with four legs and a tail, but as a child encounters dogs and other kinds of animals and is given instruction, "dog" becomes more specific and the schema for "dog" becomes well defined.

In a similar manner, children develop a concept for "boy" and "girl." Once that schema is in place, children can identify themselves as "boy" or "girl" and will notice other members of that schema. They notice the behavior of other "boys" or "girls" and imitate that behavior. They play with their parents and pick up on differences in the behavior of fathers and mothers (Lindsey et al., 2010). Rather than being simple imitation and reinforcement, as in

*attributes: explains as a cause.

social learning theory, children acquire their gender-role behavior by organizing that behavior around the schema of “boy” or “girl.” Evidence for this theory includes the finding that infants can discriminate between male and female faces and voices before age 1 (Martin, 2000), a sign that infants are already organizing the world into those two concepts.

GENDER STEREOTYPING

A **stereotype** is a concept that can be held about a person or group of people that is based on very superficial characteristics. A **gender stereotype** is a concept about males or females that assigns various characteristics to them on the basis of nothing more than being male or female.

MALE AND FEMALE GENDER STEREOTYPES The male gender stereotype generally includes the following characteristics: aggressive, logical, decisive, unemotional, insensitive, nonnurturing, impatient, and mechanically talented. The female stereotype typically includes these characteristics: illogical, changeable, emotional, sensitive, naturally nurturing, patient, and all-thumbs when it comes to understanding machines. Notice that each of these stereotypes has both positive and negative characteristics.

Some researchers believe that accepting stereotyping of any kind, even positive stereotyping, can lead to **sexism**, or prejudice about males and females. In fact, some researchers (Glick & Fiske, 2001) claim that acceptance of positive stereotypes can lead to **benevolent sexism**, prejudice that is more socially acceptable but still leads to men and women being treated unequally. Not all men are mechanically talented, nor are all women naturally nurturing, for example. A positive stereotype for men is that they are strong and protective of women, implying that women are weak and need protection, just as the positive female stereotype of natural nurturance of children implies that males cannot be nurturing. Such stereotypes, although somewhat “flattering” for the sex about whom they are held, can be harmful to the other sex.

ANDROGYNY Psychologist Sandra Bem (1975, 1981) has developed the concept of **androgyny** to describe a characteristic of people whose personalities reflect the characteristics of both males and females, regardless of gender. This allows them to be more flexible in everyday behavior and career choices. People who fall into the gender-role stereotypes, according to Bem, often find themselves limited in their choices for problem solving because of the stereotype’s constraints on “proper” male or female behavior. An androgynous person, on the other hand, can make a decision based on the situation rather than on being masculine or feminine.

For example, let’s say that a man, through an unhappy circumstance, is left to raise his three small children. If he is a male who has “bought into” the male stereotype, he has no confidence in his ability to bring up these children by himself. He may rush into another relationship with a woman just to provide his children with a “mother.” Similarly, a “traditional” female who is left without a husband might have difficulty in dealing with raising sons and with a task as simple as mowing the lawn. Researchers have found that when traditional males, traditional females, and androgynous people are compared in terms of the degree of depression they experience when their lives are filled with many negative events, the androgynous people report less than half the depression exhibited by traditional men and only a third of the depression felt by traditional women (Roos & Cohen, 1987). **Figure 10.2** shows the results of this study.

GENDER DIFFERENCES

How do men and women differ in thinking, social behavior, and personality?

Although there are clear biological differences in males and females, even to the point of affecting the size of certain structures in the brain (Swaab et al., 2012; Zilles & Amunts, 2012), what sort of differences exist in the behavior of males and females?



What are some of the ways in which this father may influence his sons' gender identities as they grow up?

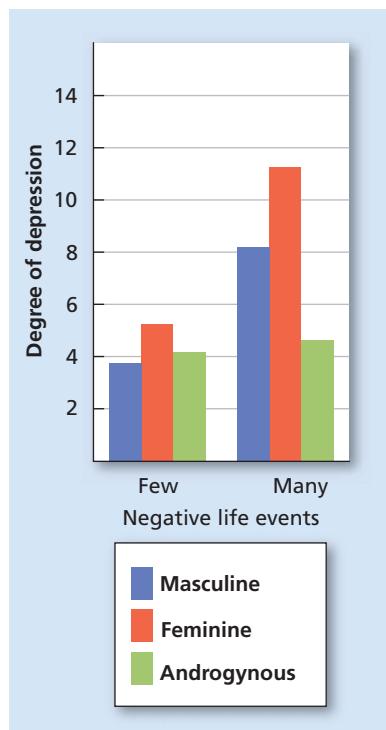


Figure 10.2 Depression as Influenced by Negative Life Events

The bar graph shows that men who are masculine and women who are feminine in their gender roles experience a significant increase in depression when they are exposed to an increased number of negative life events. The same is not true for people with an androgynous gender role. How might being androgynous allow a person to be more adaptable?

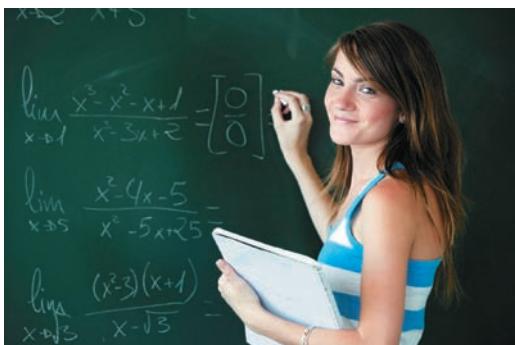
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"It's a guy thing."

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It was long believed that the difference between girls and boys in math skills was a function of biology, but research now shows that psychological and social issues are the more likely causes.

Are those differences due to biology, socialization, or a combination of the two influences?

COGNITIVE DIFFERENCES Researchers have long held that females score higher on tests of verbal abilities than do males, but that males score higher on tests of mathematical skills and spatial skills (Diamond, 1991; Voyer et al., 1995). Early explanations of these differences in cognitive functioning involved physical differences in the way each sex used the two hemispheres of the brain as well as hormonal differences (Witelson, 1991). Other research, however, strongly suggests that psychological and social issues may be more responsible for these differences, as these differences have become less and less obvious (Hyde & Plant, 1995; Kimura, 1999; Voyer et al., 1995; Watt, 2000). In particular, the supposed differences in math abilities between boys and girls have now been shown to be more the effect of girls' lack of confidence rather than any biological difference in the working of the brain (American Association of University Women, 1992, 1998; Else-Quest et al., 2010; Sadker & Sadker, 1994). That the disparities (which are actually quite small) seem to be disappearing as society has begun to view the two genders as more equal in ability is taken as a sign that more equal treatment in society has reduced the gender difference.

SOCIAL AND PERSONALITY DIFFERENCES The differences normally cited between men and women in the ways they interact with others and in their personality traits are often the result of stereotyped thinking about the sexes. It is difficult to demonstrate differences that are not caused by the way boys and girls are socialized as they grow up. Boys are taught to hold in their emotions, not to cry, to be "strong" and "manly." Girls are encouraged to form emotional attachments, be emotional, and be open about their feelings with others.

In communication, research suggests that when men talk to each other, they tend to talk about current events, sports, and other events. This has been called a "report" style of communication and seems to involve switching topics frequently, with attempts to dominate the conversation by certain members of the group. In contrast, women tend to use a "relate" style of communication with each other, revealing a lot about their private lives and showing concern and sympathy. They tend to interrupt each other less and let everyone participate in the conversation (Argamon et al., 2003; Coates, 1986; Pilkington, 1998; Swann, 1998). Another study, using fMRI technology, found that men listen with the left hemisphere only, whereas women listen with both hemispheres, suggesting that women pay attention to the tone and emotion of statements as well as the content (Lurito et al., 2000).

 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP

10.3 10.4

theories of gender-role development

- **social learning theory:** gender roles learned through observation and imitation of models
- **gender schema theory** (Bem): Piaget-like schemas and concepts for male and female develop and influence gender roles
- **gender stereotyping:** positive or negative characteristics assigned on basis of being male or female; can lead to sexism (prejudice)
- **androgyny** (based on Bem's work): positive aspects of both males and females, regardless of gender

The Psychological Side of Human Sexuality: Gender

gender differences

- **cognitive differences** (e.g., listening skills) may be present but are possibly due to psychological and social issues rather than biology
- **social and personality differences** are often the result of stereotyped thinking about the sexes

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Alex sees his mother mixing ingredients for a cake. Later, Alex takes a bowl and spoon out of the cabinet and pretends to mix some imaginary ingredients. Of which theory of gender development would this be a good example?
 - a. gender schema theory
 - b. gender-role theory
 - c. psychoanalytic theory
 - d. social learning theory

2. Which theory of gender-role development places a heavy emphasis on the use of mental patterns?
 - a. gender schema theory
 - b. psychoanalytic theory
 - c. social learning theory
 - d. behavioral theory

3. Karl is often perceived as strong and tough, but he also has been known to be sincere and loving. Karla is warm and kind but is also independent and assertive when necessary. Bem would classify such behavior as examples of
 - a. androgyny
 - b. schema error
 - c. benevolent sexism
 - d. negative stereotyping

4. Studies show that women tend to use a _____ style to their conversation while men use a _____ style.
 - a. relate; report
 - b. masculine; feminine
 - c. report; relate
 - d. androgynous; stereotypical

THINKING CRITICALLY:

Can you think of examples of benevolent sexism in your own life?

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Human Sexual Behavior

What happens in the bodies of women and men during sexual intercourse?



I've heard that men and women experience sex differently—is that true? What is different?

In 1957, gynecologist Dr. William Masters and psychologist Dr. Virginia Johnson began what would become a controversial* study of the human sexual response in 700 men and women volunteers (Masters & Johnson, 1966). At that time in history, human sexuality was still a relatively forbidden topic to all but young adults, who were exploring the concepts of “free love” and engaging in premarital sex far more openly than in the past. Masters and Johnson devised equipment that would measure the physical responses that occur during sexual activity. They used this equipment to measure physiological activity in both men and women volunteers who either were engaging in actual intercourse or masturbation. Although many conservative and religious people were outraged by this research, it remains as one of the most important studies of the human sexual response.

SEXUAL RESPONSE

Masters and Johnson (1966) identified four stages of a sexual-response cycle in their groundbreaking research. Although these stages are similar in both men and women, there are some differences. Also, the transition between the stages is not necessarily as well defined as the descriptions of the stages might seem to describe, and the length of time spent in any one phase can vary from experience to experience and person to person.

PHASE 1: EXCITEMENT This first phase is the beginning of sexual arousal and can last anywhere from 1 minute to several hours. Pulse rate increases, blood pressure rises, breathing quickens, and the skin may show a rosy flush, especially on the chest or breast areas. In women, the clitoris swells, the lips of the vagina open, and the inside of the vagina moistens in preparation for intercourse. In men, the penis becomes erect, the testes pull up, and the skin of the scrotum tightens. Nipples will harden and become more erect in both sexes, but especially in the female.

PHASE 2: PLATEAU In the second phase of the sexual response, the physical changes that began in the first phase are continued. In women, the outer part of the vagina swells with

*controversial: leading to arguments or opposing viewpoints.

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increased amounts of blood to that area, while the clitoris retracts under the clitoral hood but remains highly sensitive. The outer lips of the vagina become redder in color. In men, the penis becomes more erect and may release a few drops of fluid. This phase may last only a few seconds to several minutes.

PHASE 3: ORGASM The third phase is the shortest of the three stages and involves a series of rhythmic muscular contractions known as the **orgasm**. In women, this involves the muscles of the vaginal walls and can happen multiple times, lasting slightly longer than the orgasm experience of the male. The uterus also contracts, creating a pleasurable sensation. In men, the orgasmic contractions of the muscles in and around the penis trigger the release of **semen**, the fluid that contains the male sex cells, or sperm. Men typically have only one intense orgasm. Timing is also different for women and men, with women taking longer to reach orgasm than men, and women requiring more stimulation to achieve orgasm.

PHASE 4: RESOLUTION The final phase of the sexual response is **resolution**, the return of the body to its normal state before arousal began. The blood that congested the blood vessels in the various areas of the genitals recedes; the heart rate, blood pressure, and breathing all reduce to normal levels during this phase. In women, the clitoris retracts, the color of the vaginal lips returns to normal, and the lips close once more. In men, the erection is lost, the testes descend, and the scrotal sac thins again. Also, men have a **refractory period** during which they cannot achieve another erection, lasting anywhere from several minutes to several hours for different individuals. The older the man gets, the longer the refractory period tends to extend. Women do not have a refractory period and in fact may achieve another series of orgasms if stimulation continues.

Read the Classic Studies in Psychology section that follows for a more detailed look at the historic Masters and Johnson study and to learn how this landmark research was accomplished. (See also **Figures 10.3** and **10.4**.)

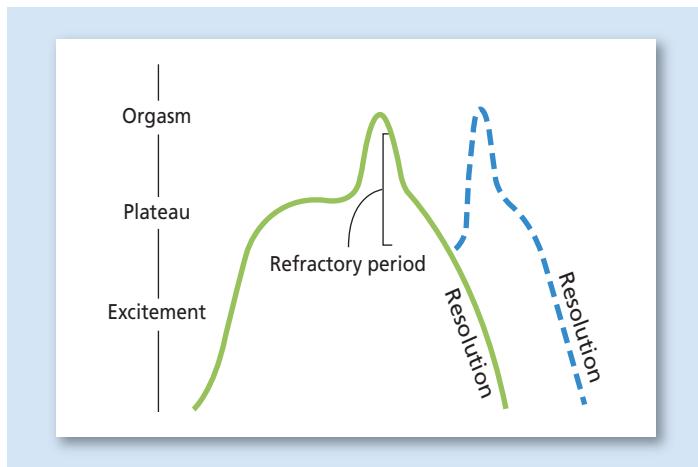


Figure 10.3 The Male Sexual-Response Cycle

A male experiences sexual arousal (excitement), a plateau lasting a few seconds to a few minutes, orgasm, and then experiences a refractory period during which another erection is not yet possible. This refractory period can last for several minutes to several hours and tends to increase in length with age. Resolution, in which the body returns to its prearousal state, is last.

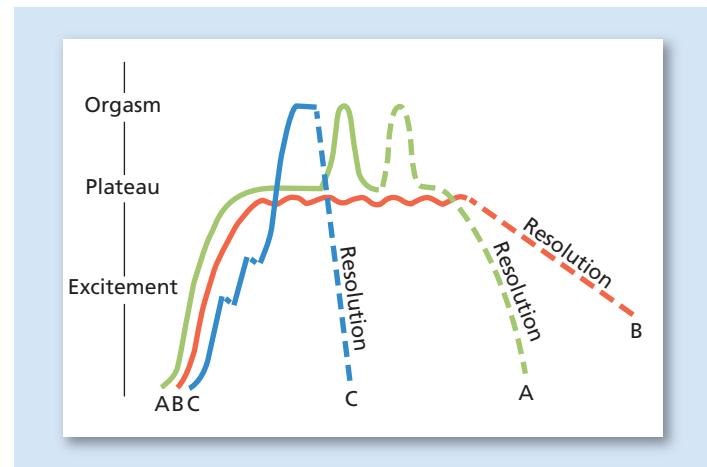


Figure 10.4 The Female Sexual-Response Cycle

Women can experience several different patterns of sexual response. In Pattern A, a woman experiences excitement, a plateau, and orgasm in a manner similar to a man. Unlike a man, the woman does not have a refractory period and can experience several orgasms before entering resolution. In Pattern B, there is a longer plateau period but no orgasm, and in Pattern C, the woman goes from excitement to orgasm to a quick resolution without experiencing a plateau period.

classic studies in psychology

Masters and Johnson's Observational Study of the Human Sexual Response

William Masters and Virginia Johnson pioneered the first direct observational study of human sexual behavior. Their study stirred up tremendous controversy in an era that feared that the study of human sexuality would undermine the structure of the family and society. Masters obtained permission from his department chair at the Washington University School of Medicine in St. Louis, Missouri, in 1954. He then assembled an advisory board composed of the police commissioner, a newspaper publisher, and several prominent religious leaders, in addition to the university's chancellor. Together, they accomplished a feat that seems incredible in today's media-driven world: They convinced the press to keep completely quiet about this research into human sexuality for the next 12 years (Kolodny, 2001).

Such research had to be conducted discreetly, as even Masters's choice of subjects was controversial. His initial studies in 1955 and 1956 were done entirely with prostitutes. He conducted interviews with them and observed them at work. Although this research was never published, he used the opportunity to think about what kind of instrumentation he would need to properly measure the sexual responses in a more controlled setting. Together with psychologist Virginia Johnson, Masters devised equipment that would allow them to measure sexual responses in humans in a laboratory setting. These machines were similar to a polygraph machine (a lie detector) but much more complex in their design and the particular physiological responses (for example, heart rate, body temperature) they measured. Masters and Johnson also used photography and direct observation in the laboratory settings, using prostitutes and other volunteers as subjects.

The publication of *Human Sexual Response* in 1966 was the end result of the 12 years of research. Masters and Johnson became instant celebrities and the book itself became a best-seller. This was the beginning of a partnership that lasted over 30 years. That partnership not only changed many people's attitudes about what was sexually normal but also challenged many sexual myths and created the field of sex therapy. Although direct observational studies can have the disadvantage of affecting the participant's behavior, the work of Masters and Johnson has remained some of the most important work in the field of human sexuality and is still used in sex therapy and sex education and by infertility and conception experts (Kolodny, 2001; Masters, Johnson, & Kolodny, 1995).

Questions for Further Discussion

1. Would researchers today be able to convince the press (newspapers, magazines, and television) to keep research into human sexuality secret, as Masters did?
2. What problems with their research might have come from the fact that many of their participants were prostitutes?
3. In what ways might this kind of research be easier to conduct today?
4. In what ways might this kind of research be more difficult to conduct today?



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Dr. William Masters and Dr. Virginia Johnson examined human sexuality by measuring physiological responses in a laboratory. Their subjects were volunteers, many of whom were prostitutes, a fact that caused an uproar when their research became public.

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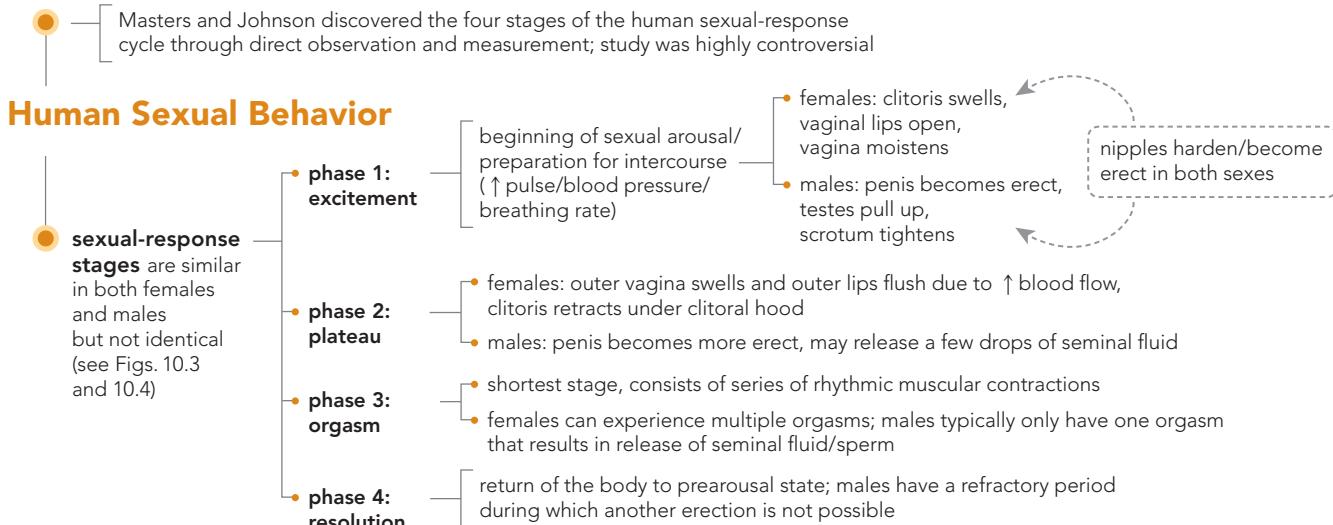
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 Explore the Concept at [MyPsychLab](#)
CONCEPT MAP**PRACTICE quiz** How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Which of the following is the first phase of the human sexual response cycle?
 - a. excitement
 - b. plateau
 - c. orgasm
 - d. resolution
2. In which of the phases of sexual response do the testes pull up?
 - a. excitement
 - b. plateau
 - c. orgasm
 - d. resolution
3. Which phase of the sexual response is typically the shortest, lasting a few seconds to several minutes?
 - a. excitement
 - b. plateau
 - c. orgasm
 - d. resolution
4. Which of the following phases does not occur in women?
 - a. excitement
 - b. plateau
 - c. orgasm
 - d. refractory period

DIFFERENT TYPES OF SEXUAL BEHAVIOR**What did the early and most recent surveys of human sexual behavior reveal?**

While Masters and Johnson focused their research on the physiological responses that occur during the sexual act, other researchers had already been studying the different forms of sexual behavior. The study of sexual behavior is not the study of the sex act, but rather when, with whom, and under what circumstances sexual acts take place. Although there were other attempts to study human sexual behavior before the mid-twentieth-century studies of Alfred Kinsey (Kinsey et al., 1948; Kinsey et al., 1953), his original work remains an important source of information concerning the different ways in which people engage in the sex act. A movie based on Kinsey's life and work was released in the United States in 2004. Even more than half a century later, Kinsey's work is still so controversial that many movie theaters in the United States refused to show the film.

 [Watch the Video](#), Special Topics: Cultural Norms and Sexual Behavior, at [MyPsychLab](#)



What were the findings of the report?

THE KINSEY STUDY In 1948, Alfred Kinsey published a controversial report on the results of a massive survey of sexual behavior collected from 1938 forward (Kinsey et al.,

1948). His findings concerning the frequency of behavior such as masturbation, anal sex, and premarital sex rocked many people, who were apparently not ready to believe that so many people had tried alternative sexual behaviors. Kinsey believed that sexual orientation was not an either/or situation in which one is either completely heterosexual or completely homosexual but instead that sexual orientation is on a continuum,* with some people falling at either extreme and some falling closer to the middle. The idea that there were many people who fit into that middle range of sexual orientation was shocking and, for many at that time, unbelievable.

Kinsey used highly trained interviewers who conducted face-to-face interviews with the participants, who were all male in the original study. A later survey was published in 1953 that dealt exclusively with females (Kinsey et al., 1953). The participants were volunteers supposedly from both rural and urban areas and from different socioeconomic, religious, and educational backgrounds. In reality, a large portion of the participants were well-educated, urban, young Protestants. In Kinsey's survey results, nearly half of the men but less than twenty percent of the women reported having bisexual experiences. More than three times as many men as women had intercourse by age 16 (twenty-one percent versus six percent). Men were also more likely to report engaging in premarital sex, extramarital sex, and masturbation than were women. Ten percent of the men and two to six percent of the women answering the survey identified themselves as predominantly homosexual (Gebhard & Johnson, 1979/1998).

Although Kinsey's data are still quoted in many discussions of sexual behavior, his original surveys were far from perfect. As stated earlier, the participants were almost exclusively white, middle class, and college educated. Older people, those who lived in rural regions, and less educated people were not well represented. Some critics claimed that Kinsey gave far more attention to sexual behavior that was considered unusual or abnormal than he did to "normal" sexual behavior (Geddes, 1954). Also, Kinsey's surveys were no less susceptible to the exaggerations, falsifications, and errors of any method using self-report techniques. Finally, a face-to-face interview might cause some people being interviewed to be inhibited about admitting to certain kinds of sexual behavior, or others might exaggerate wildly, increasing the likelihood of inaccurate data.

THE JANUS REPORT In 1993, Dr. Samuel S. Janus and Dr. Cynthia L. Janus published the results of the first large-scale study of human sexual behavior since those of Kinsey and colleagues (1948) and Masters and Johnson (1966). This national survey, begun in 1983, sampled 3,000 people from all 48 mainland states. Survey respondents ranged in age from 18 to over 65 years old from all levels of marital status, educational backgrounds, and geographical regions in the United States.

Findings from the Janus Report (Janus & Janus, 1993) differed from Kinsey's findings, but not extremely so. For example, fewer men reported masturbating in the Janus Report than did in Kinsey's study (eighty percent versus ninety-two percent), but the percentage of women reporting increased from sixty-two percent in Kinsey's survey to seventy percent in the Janus survey. Rates of premarital sex were about the same as in Kinsey's survey, but men in the Janus survey reported less extramarital sex than men in the Kinsey survey, while women's reporting of extramarital sex was the same in the two surveys. Percentages of both men and women in the Janus survey



Alfred Kinsey conducted many of his interviews face to face, as seen here. How might having to answer questions about one's sexual behavior be affected by Kinsey's presence?

*continuum: a sequence of values, elements, or behavior that varies by small degrees.

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reporting as predominantly homosexual were also very similar to the earlier Kinsey study.

EXPLAINING THE SURVEY FINDINGS Why are men so much more sexually active than women, both before and during marriage? It may be in their genes. Evolutionary theory emphasizes that organisms will do what they must to maximize their chances of passing on their genetic material in their offspring, and that process is different for men and women. Robert Trivers proposed a theory of *parental investment* to explain the different sexual behavior of men and women (Trivers, 1972). Males of many species, including humans, do not have to invest a lot of time or effort into impregnating a female, so they are better off—genetically speaking—when they seek many sexual encounters with many sexual partners. Females, on the other hand, invest much more time and effort in reproducing: the pregnancy, feeding the infants, and so on. So females are better off being more selective about the males they choose for sex.  [Watch the Video, What's In It For Me?: The Dating Game, at MyPsychLab](#)

In real life terms, this translates into men preferring women who are younger, prettier (immediate sexual attraction being the big draw), and therefore are likely to produce healthy, attractive offspring. Women are more likely to prefer men who are older (which means they will likely have more income and resources), hard workers, and loyal (Buss, 1989, 2007; Buss & Schmitt, 1993, 2011). Men are much more likely than women to have multiple sexual partners, even well into middle age, while women are more likely to have fewer partners over their lifetime (McBurney et al., 2005; Schutzwohl et al., 2009). This is true for both heterosexual and homosexual men and women (Peplau & Fingerhut, 2007). Men even think about sex differently, having more sexual fantasies than women and of a greater variety (Okami & Shackelford, 2001) as well as simply thinking about sex more often than women (Laumann et al., 1994).

One survey highlights the fact that age is not necessarily a barrier to being sexually active. The survey of over 3,000 people aged 57 to 85 found that many people are sexually active well into their 80s (Lindau et al., 2007). The most common barriers to sexual activity were health problems or lack of a partner rather than a lack of desire.

Of course, surveys have their problems, as stated earlier. One possible problem might occur when asking the question, “At what age did you first have sex?” A study (Sanders et al., 2010) reports that not everyone means the same thing by the words, “have sex” or “had sex.” In a sample of people 18 to 96 years old, 30 percent did not consider oral sex to be sex. Many older men—nearly a fourth of those surveyed—did not consider penile–vaginal intercourse to be sex! Some thought it wasn’t sex if there was no orgasm. There was simply little agreement among survey participants as to what “having sex” really means, and researchers examining sexual behavior through the survey method should be very aware of this possible confusion.  [Watch the Video, The Big Picture: The Power of Sex, at MyPsychLab](#)

SEXUAL ORIENTATION

How do different sexual orientations develop?

The term **sexual orientation** refers to a person’s sexual attraction and affection for members of either the opposite or the same sex. One of the more important questions that researchers are trying to answer is whether sexual orientation is the product of learning and experience or if it is biological in origin. As the video *Thinking Like a Psychologist: Sexual Orientation: Categories* shows, there are a variety of sexual orientation categories that individuals may identify with and getting reliable data can be challenging.



 Watch the Video, Thinking Like a Psychologist: Sexual Orientation: Categories, at [MyPsychLab](#)

HETEROSEXUAL The most common sexual orientation is **heterosexual**, in which people are sexually attracted to members of the opposite physical sex, as in a man being attracted to a woman or vice versa. (The Greek word *hetero* means “other,” so *heterosexual* means “other sexual” or attraction for the other sex.) Heterosexuality is a socially acceptable form of sexual behavior in all cultures.

HOMOSEXUAL It is difficult to get an accurate percentage for **homosexual** orientation, or sexual attraction to members of one’s own sex. (The Greek word *homo* means “same.”) The problem concerns the discrimination, prejudice, and mistreatment that homosexual people face in most cultures, making it more likely that a homosexual person will lie about his or her sexual orientation to avoid such negative treatment. A national survey estimates that about 2.3 percent of men and 1.3 percent of women aged 15 to 44 years consider themselves to be homosexuals, meaning that their sexual orientations are exclusively or predominantly homosexual (Mosher et al., 2005).

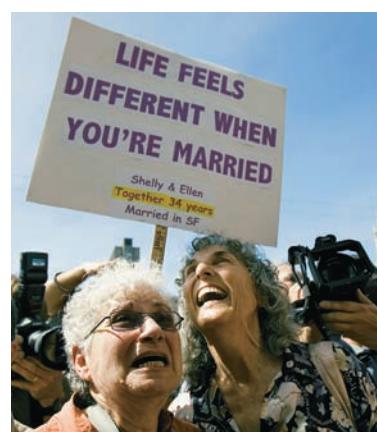


 If people have had a homosexual experience as well as heterosexual ones, does that make them bisexuals?

BISEXUAL A person who is **bisexual** may be either male or female and is attracted to both sexes. In the same national survey, only 1.8 percent of the men and 2.8 percent of the women considered themselves to be bisexual (Mosher et al., 2005). (It should be noted that many people experiment with alternative sexual behavior before deciding upon their true sexual identity; one bisexual experience does not make a person bisexual any more than one homosexual experience makes a person homosexual.)

Bisexual people do not necessarily have relationships with both men and women during the same period of time and may vary in the degree of attraction to one sex or the other over time. Many bisexuals may not act on their desires but instead have a long-term monogamous relationship with only one partner.

The survey also found that a nearly equal percentage of men and women—just fewer than 4 percent—considered themselves to be “something else.” Obviously, sexual orientation is not as clearly defined as many people have assumed.



Homosexuality is a sexual orientation that has faced discrimination and prejudice in many cultures. Shelly Bailes and Ellen Pontac, partners for 34 years, highlight the fact that their “couplingness” and a sense of commitment are not limited to heterosexual pairs alone.

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DEVELOPMENT OF SEXUAL ORIENTATION Although heterosexuality may be socially acceptable across cultures, there are various cultures in which homosexuality and bisexuality are not considered acceptable and in which people of those orientations have faced prejudice, discrimination, harassment, and much worse. Although attitudes in some of these cultures are beginning to change to more positive ones (Loftus, 2001; Tucker & Potocky-Tripodi, 2006), full acceptance of alternatives to heterosexuality is still a long way off. Try the experiment, *Implicit Association Test: Sexuality*, to learn what implicit preferences and prejudices you may hold toward both heterosexuals and homosexuals.

Simulation

Implicit Association Test: Sexuality

This Implicit Association Test asks you to classify a set of words or images into groups. Your goal is to classify items as quickly and as accurately as you can.



[Go to the Experiment ►](#)

© Simulate the Experiment, *Implicit Association Test: Sexuality*, on [MyPsychLab](#)

Young people who are coming to terms with their identities and sexual orientation seem to have great difficulty when faced with being homosexual, bisexual, or transgender. These adolescents are at higher risk than their heterosexual peers for substance abuse, sexually risky behavior, eating disorders, suicidal thinking, and victimization by others (Coker et al., 2009; Zhao et al., 2010). When identification of one's sense of self as homosexual is paired with being another type of social minority (such as Asian American or Pacific Islander living in the United States), the stresses and pressures are compounded (Hahm & Adkins, 2009). In the cultures from which these young people's families originate, traditional values make homosexuality a dishonor and shame to the family.



Is sexual orientation a product of the environment, biology, or both?

This is a very controversial issue for both heterosexuals and homosexuals (Diamond, 1995). If homosexuality is a product of upbringing and environmental experiences, it can be assumed to be a behavior that can be changed, placing a burden of choice to be "normal" or "abnormal" squarely on the shoulders of homosexual people. If it is biological, either through genetic influences or hormonal influences during pregnancy, then it can be seen as a behavior that is no more a choice than whether the infant is born a male or a female. The implications of homosexuality as biological lead to some

volatile* issues: If it is not a choice or a learned behavior pattern, then society will no longer be able to expect or demand that homosexuals change their sexual behavior or orientation. Homosexuality becomes an issue of diversity rather than socially unacceptable behavior. In a survey of college students (Elliott & Brantley, 1997), the majority of women reported knowing they were gay or bisexual by their high school/college years, while the majority of men reported knowing they were gay or bisexual by junior high/high school.

In the past several decades, a large body of research in the areas of biological differences in the brains of heterosexual and homosexual males, genetic influences on sexual orientation, and even prenatal influences on sexual orientation has been amassed by various scientists. One of the earliest studies, for example, found that severe stress experienced by pregnant women during the second trimester of pregnancy (the time during which the sexual differences in genitalia are formed) results in a significantly higher chance of any male children becoming homosexual in orientation (Ellis et al., 1988). Another study found that homosexual men and heterosexual women respond similarly (and quite differently than heterosexual men) to a testosterone-based pheromone (glandular chemical) that is secreted in perspiration (Savic et al., 2005). In a recent study, researchers have found that while there has yet to be any actual gene found for the transmission of homosexuality, there are genetic "switches" that can be passed on and which may be the reason that homosexuality tends to run in families (Rice et al., 2012). These switches, called *epi-marks*, control when, where, and how much of the information contained in our genes is expressed. There are sex-specific epi-marks that control the sexual characteristics of the fetus during prenatal development. These sexual characteristics include not only physical sex organ development but also sexual identity and sexual partner preference. Normally epi-marks are created anew with each generation, but occasionally remain to be passed on to the next generation. When that happens, they may cause the reverse of their intended effect, including a reverse of sexual orientation.

Birth order has also been the subject of research in this area, with studies suggesting that the more older brothers a man has, the more likely the younger man is to be homosexual in orientation (Blanchard, 2001; McConaghy et al., 2006). The hypothesis is that with each male birth, the mother of these males develops a kind of "antibody" effect against the Y chromosome and these antibodies pass through the placenta and affect the sexual orientation of the later-born males.

Finally, a neuroimaging study with heterosexual men and women and homosexual men and women found that the heterosexual men and homosexual women seemed neurologically similar when compared to homosexual men and heterosexual women, who were in turn neurologically similar to each other (Savic & Lindström, 2008).

The evidence for genetic influences on sexual orientation is increasingly convincing. In studies of male and female homosexuals who have identical twins, fraternal twins, or adopted siblings, researchers found that 52 percent of the identical twin siblings were also gay, compared to 22 percent of the fraternal twins and only 11 percent of the adopted brothers and sisters (Bailey & Pillard, 1991). In a similar study with lesbian women only, 48 percent of identical twins were also gay compared to 16 percent of the fraternal twins and 6 percent of the adopted siblings (Bailey et al., 1993). Other research along similar lines has supported these findings (Bailey et al., 2000; Dawood et al., 2000). However, these findings should be interpreted cautiously. Twin studies are difficult to conduct without the influence of environment on behavior. Even twins who are raised apart tend to be reared in similar environments, so that the influence of learning and experience on sexual orientation cannot be entirely ruled out.

*volatile: explosive.

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Some research suggests that homosexuality may be transmitted by genes carried on the X chromosome, which is passed from mother to son but not from father to son. In 33 out of 40 homosexual brothers, Dean Hamer and colleagues (Hamer et al., 1993) found an area on the X chromosome (in a location called Xq28) that contains several hundred genes that the homosexual brothers had in common in every case, even though other genes on that chromosome were different. This was taken as evidence that the brothers had both inherited a set of genes, donated on the mother's X chromosome, that might be responsible for their sexual orientation. These findings have been supported in other research as well (Hu et al., 1994; Turner, 1995).

One of the most common behavioral findings about male homosexuals is that they are consistently "feminine" as children, according to developmental psychologist J. Michael Bailey (Bailey & Zucker, 1995). Bailey has determined that about three fourths of homosexual male adults were "feminine" boys (defined as boys who were uninterested in sports or rough play, desired to be girls, or had a reputation as a "sissy"), a far greater rate than in the general population of males. Bailey and colleague Ken Zucker interpret these findings as further support for the biological foundations of sexual orientation. Of course, those differences in childhood behavior could also have been the result of attention and other forms of reinforcement from the social environment. It is simply a very difficult task to separate the environmental influences on any aspect of behavior from the biological ones. One thing is certain: The issue of what causes sexual orientation will continue to generate research and controversy for a long time to come.  Watch the Video, Thinking Like a Psychologist: Sexual Orientation: Possible Origins at [MyPsychLab](#)

Some scientists have wondered why homosexuality still exists, because from an evolutionary point of view—if it is genetic—the genes for homosexuality should have been removed from the gene pool long ago. The following special section takes a look at this issue.

issues in psychology



What Is the Evolutionary Purpose of Homosexuality?



Homosexuals do not often reproduce, so why hasn't the trait gone away? One recent theory has to do with something called the "kin selection hypothesis." Even though a homosexual member of a family may not reproduce himself or herself, by nurturing other family members such as nieces and nephews, they would be helping to continue many of their own genes through those kin (Iemmola & Camperio Ciani, 2008; Rahman & Hull, 2005). In Samoa, researchers Paul Vasey and Doug VanderLaan (Vasey & VanderLaan, 2010) studied the fa'afafine, men who prefer men as sexual partners and are accepted within that culture as neither man nor woman, much as the winkte in Lakota culture. The researchers wanted to see if the kin selection hypothesis was a valid hypothesis in this society, so they gave fa'afafine, women, and heterosexual men in this culture a survey to measure their willingness to help nieces and nephews in various ways, as well as their willingness to do these same things for unrelated children. The survey results strongly support the kin selection hypothesis, with the fa'afafine far more likely than the women or heterosexual men to help their own kin rather than children in general.

Questions for Further Discussion

1. Samoan culture is not like Western culture. Would the kin selection hypothesis work in the United States to explain homosexuality's continued existence?
2. How do Western homosexual men and women transmit or protect their own genetic material?

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 Explore the Concept at [MyPsychLab](#)

differences in sexual behavior

- Kinsey pioneered the study of different types of sexual behavior through face-to-face surveys; study was highly controversial; sampling/representativeness questioned
- the Janus Report (first large-scale survey since Kinsey) examined both normal and deviant sexual behavior

CONCEPT MAP

suggested sexual orientation occurred on a continuum, not an either/or basis

Human Sexual Behavior

sexual orientation

person's sexual attraction and affection for members of the opposite or same sex

- key concepts
- sexual orientation is likely the product of both biology (i.e., brain structure, genetics) and environment; presence of biological foundations has implications for societal definitions of diversity versus deviance

- **heterosexuality:** attraction to members of the opposite sex; most common and socially acceptable
- **homosexuality:** attraction to members of one's own sex
- **bisexuality:** attraction to members of both sexes

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. According to researcher Alfred Kinsey, sexual orientation is best described as
 - a. typically an "either/or" state where most people are found to be either heterosexual or homosexual.
 - b. typically on a "continuum" with some people falling at either extreme and some falling closer to the middle.
 - c. typically bisexual in nature though many were unaware of it.
 - d. an unknown because people were busy exploring their sexuality.
2. In Kinsey's original data, approximately _____ of women reported being predominantly homosexual while as many as _____ of men reported the same.
 - a. 6 percent; 21 percent
 - b. 6 to 14 percent; 46 percent
 - c. 2 percent; 22 percent
 - d. 2-6 percent; 10 percent
3. Which of the following was a criticism of Kinsey's research?
 - a. The study was incomplete.
 - b. The study asked poorly worded questions.
 - c. The study was rushed.
 - d. The study had a restricted sample.
4. Robert Trivers's theory of parental investment states that a _____ desire to engage in sex at an early age results from _____.
 - a. man's; social pressure
 - b. man's; evolution
 - c. woman's; biological concerns
 - d. woman's; psychological pressure
5. One study found that the major reason for decrease in sexual activity in later adulthood was primarily due to
 - a. a loss of interest in sex.
 - b. fewer opportunities to find an available partner.
 - c. a belief that sex and sexual fantasies in late adulthood was unhealthy.
 - d. a desire to channel energy into other tasks.
6. The Savic et al. 2005 study found that homosexual men responded to a pheromone in the same way as
 - a. heterosexual men.
 - b. transsexual men.
 - c. heterosexual women.
 - d. homosexual women.

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Sexual Dysfunctions and Problems

How do physical and psychological sexual problems differ?

 What about when people have problems with sex, like impotence?

A **sexual dysfunction** is a problem with sexual functioning, or with the actual physical workings of the sex act. Sexual dysfunctions involve problems in three possible areas of sexual activity: sexual interest, arousal, and response. Broadly speaking, sexual

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dysfunctions may be *organic*, stemming from physical sources or disorders, or *psychogenic*, related to psychological factors such as worry and anxiety. However, body and mind influence each other's functioning and these categories are not mutually exclusive (Lewis et al., 2010).

Although we will not focus on them, the other major category of sexual problems is behavioral in nature. A *paraphilia* (also called *atypical sexual behavior*) is a condition in which the person either prefers to, or must, achieve sexual arousal and fulfillment through sexual behavior that is unusual or not socially acceptable. *Paraphilic disorders* arise when individuals have a paraphilia that is causing distress or impairment to the individual, or poses a risk or harm to others (American Psychiatric Association, 2013).

CAUSES AND INFLUENCES

Sexual dysfunctions and problems can be caused by purely *organic factors* (e.g., illness or side effects from drugs), *sociocultural factors* (such as negative attitudes toward sexual behavior), or *psychological factors* stemming from either personality problems, traumatic events, or relationship problems. More commonly, such problems can stem from a combination of these influences.

Organic factors include physical problems such as illnesses, side effects from medication, the effects of surgeries, physical disabilities, and even the use of illegal and legal drugs, such as cocaine, alcohol, and nicotine. Chronic illnesses such as diabetes, cancer, or strokes also belong in this category of factors.

Sociocultural influences on sexual attitudes and behavior also exist and may be a source of psychological stress leading to sexual dysfunction. In the United States and some other Western cultures, people may have experienced instruction from their parents (both direct and indirect teaching) that actually influenced them to form negative attitudes toward sex and sexual activities, such as masturbation. Some religious upbringing may also foster a sense of guilt about sex or an interest in sex. In one study, a relationship between conservative, religious traditionalism and sexual attitudes was found for married members of Jewish, Protestant, and Catholic faiths (Purcell, 1985). The research showed that the more conservative and traditional the married couples were, the less interest and pleasure they took in sexual activity and the more they experienced guilt, shame, and sexual inhibitions. In non-Western cultures, such as that of India, sex may be seen as not only a duty of married couples but also a joy to be celebrated within the context of producing children (Gupta, 1994). In particular, women in India may have an entirely different attitude toward sex because a woman's status in Indian culture depends greatly on her ability to bear children.

Psychological stressors also include individual psychological problems, such as low self-esteem, anxiety over performance of the sex act, depression, self-consciousness about one's body image, anxiety disorders, or a history of previous sexual abuse or assault. Another source of psychological stress leading to sexual dysfunctions is the relationship between the two sexual partners. The sexual dysfunction may be only an outward symptom of an underlying problem with the relationship. Examples of such problems might be unresolved arguments, resentment of the partner who feels he or she has less power and influence over the relationship, lack of trust, infidelities, lack of physical attractiveness to the partner, or even lack of sexual skills on the part of one or both partners (Alperstein, 2001).

There are a variety of physical sexual dysfunctions included in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (*DSM-5*; American Psychiatric Association, 2013) that may be caused by psychological stressors. Although not directly related to the sequence or timing of the sexual response cycle, some are related to desire and arousal, others to the mechanics or physical aspects of sexual intercourse, and some to the timing or inability to reach orgasm. Sexual desire or arousal disorders include *female sexual interest/arousal disorder* and *male hypoactive sexual desire disorder*. Disorders related to the physical act of intercourse include *erectile disorder* and *genito-pelvic pain/penetration disorder*.

disorder. And lastly, disorders related to the timing or inability to reach orgasm include *premature (early) ejaculation*, *female orgasmic disorder*, and *delayed ejaculation* (American Psychiatric Association, 2013).

PREVALENCE

How common are problems like these—aren't they pretty rare?

Results of surveys from around the globe suggest that about 40 to 45 percent of women and 20 to 30 percent of men have at least one sexual dysfunction, and the rate increases as we age (Lewis et al., 2010). In the stress-filled world that many people live in today, it isn't all that surprising to find such a high degree of dysfunction. In fact, the figures may actually be higher than those reported in the survey. As stated in Chapter One, one of the hazards of doing survey research is that people don't always tell the truth ([LINK](#) to Learning Objective 1.8). If a person is going to lie about sexual problems, the most likely lie (or distorted truth) would probably be to deny or minimize such problems.

For all of the sexual dysfunctions, treatment can include medication, psychotherapy, hormone therapy, stress reduction, sex therapy, and behavioral training. For example, Masters and Johnson (1970) recommended a technique called *sensate focus* for treatment of premature ejaculation, in which each member of a couple engages in a series of exercises meant to focus attention on his or her own sensual experiences during various stages of sexual arousal and activity. Male erectile disorder is now commonly treated with drug therapy.  [Watch the Video](#), *In the Real World: Sexual Problems and Dysfunction*, at [MyPsychLab](#)



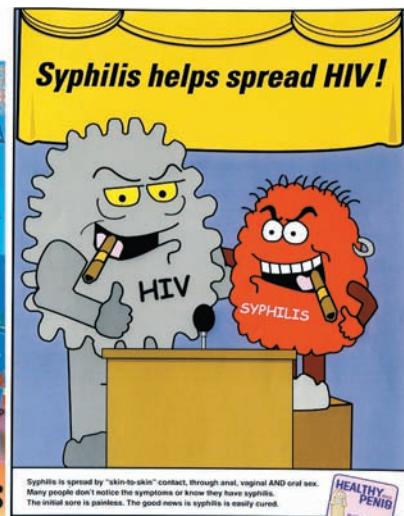
Erectile dysfunction is a major concern to many men who are unable to engage in sexual intercourse with their partners. Medications help some men function once again. Does this ad seem to promise more than just the revival of sexual functioning?

Sexually Transmitted Infections

What are sexually transmitted infections, and what can be done to prevent the spread of these disorders?

One of the consequences of unprotected sexual contact is the risk of contracting a **sexually transmitted infection (STI)**, an infection spread primarily through sexual contact. **Table 10.1** on the next page lists some of the more common sexually transmitted infections and their causes. Some STIs affect the sex organs themselves, whereas others have broader and more life-threatening effects. The bacterial infections are quite treatable with antibiotics, but those caused by viruses are more difficult to treat and are often incurable. Even curable bacterial infections can cause serious problems if left untreated, and some bacterial infections are difficult to detect because the symptoms in at least one sex are not all that noticeable. For example, *chlamydia*, listed in Table 10.1, is the most common STI and is easily treated but may go undetected in women because there are few symptoms or no symptoms noticed. If left untreated, chlamydia can cause *pelvic inflammatory disorder (PID)*, a condition that can damage the lining of the uterus and the fallopian tubes as well as the ovaries and other nearby structures. Ten percent of women in the United States will develop PID during their childbearing years (Miller & Graves, 2000).

Without a doubt, the one sexually transmitted infection that nearly everyone knows something about is **AIDS**, or **acquired immune deficiency syndrome**. AIDS is



These posters warning against sexually transmitted infections hang in a youth center in San Francisco, California. Adolescents often fail to take precautions against such infections and are becoming sexually active at younger ages, making them a high-risk group for STIs.

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Table 10.1**Common Sexually Transmitted Infections**

STI	CAUSE	SYMPTOMS
Chlamydia	Bacterial infection that grows within the body's cells	Swollen testicles, discharge, burning during urination; women may experience no symptoms
Syphilis	Bacterial infection	Sores that appear on or in the genital area and can spread to other body parts and the brain
Gonorrhea	Bacterial infection that grows rapidly in warm, moist areas of the body (mouth, anus, throat, genitalia)	In men, a foul-smelling, cloudy discharge from the penis, burning upon urination; in women, inflamed cervix, light vaginal discharge
Genital Herpes	Herpes simplex virus	Sores on the genital area; itching, burning, throbbing, "pins-and-needles" sensations where sores are about to appear
Genital Warts	Human papillomavirus (HPV)	Warty growths on the genitalia
AIDS	Human immunodeficiency virus (HIV)	Severe malfunction and eventual breakdown of the immune system

caused by a viral infection, specifically the *human immunodeficiency virus*, or *HIV*. A person who has HIV does not necessarily have AIDS but is at risk for developing AIDS in the future. HIV wears down the body's immune system, making the body vulnerable to "opportunistic" infections—*infections caused by bacteria or viruses that, while harmless in a healthy immune system, will take hold when the immune system is weakened*. When a person with HIV develops one of these types of infections or when their immune system's T-cell count goes below a certain level, the person is said to have AIDS (Folkman & Chesney, 1995).



I've heard a lot of stories about how people can get AIDS. What's the real story?

HIV can be transmitted to a person from anyone who has the infection, even if that person doesn't look sick. According to the Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO), HIV may possibly be transmitted through:

- Having unprotected vaginal, oral, or anal sexual contact.
- Sharing a contaminated needle, syringe, or drug solution.
- Pregnancy, childbirth, and breastfeeding.
- Occupational exposure (accidental needle stick injuries or exposure to contaminated blood or other body fluids).
- Blood transfusion or organ transplant (this is extremely rare in the United States).

Blood, vaginal fluid, semen, breast milk, and other bodily fluids containing blood are ways in which HIV is passed from the infected person to an uninfected person. However, unprotected vaginal or anal sex or sharing needles with an infected person are the most common ways HIV is transmitted in the United States (Centers for Disease Control and Prevention, 2010, 2013). And while it is possible for a mother to transmit the virus to the baby during childbirth or breastfeeding, this is less common. Context is very important. In parts of Africa and other parts of the world, HIV-infected mothers are encouraged to breastfeed, especially if the mother is on antiretroviral (ARV) medications and the baby receives ARVs after birth, as the risk of the infant dying from unclean water or malnutrition is much greater than the risk of acquiring HIV through breastfeeding (World Health Organization, 2010, 2012).



These young men are attending a counseling session at a community-based AIDS clinic. They do not necessarily have AIDS; the purpose of this particular group is to help educate these men and others like them in ways to prevent HIV infections. With no cure as yet, prevention is the best defense against AIDS. Remember, AIDS can affect women and men of all sexual orientations.

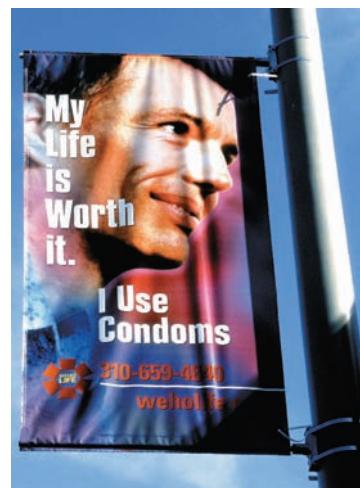
Contrary to a lot of myths about HIV, there is no scientific proof or documented cases of HIV being passed through tears or ordinary saliva. Kissing an infected person will not result in transmission, although it is possible to transmit the virus through oral sex or, rarely, through deep kissing when there are open sores or bleeding gums in the mouth of either party. More troubling is the finding that HIV can be transmitted to children who are fed by mothers who have “prechewed” food (a practice that occurs in several countries and cultures, including that of the United States). This is not common, though, and HIV cannot normally be transmitted through saliva; the women studied in this report all had sores or inflammations in their mouths, or the infants had cuts associated with teething in their mouths (Guar, 2008).

By the end of the year 2007, the number of estimated cases of AIDS in the United States had reached nearly half a million people, with the highest estimates by state existing in California, Florida, New York, and Texas (Centers for Disease Control and Prevention, 2009a). Over a quarter of a million people in the United States are living with HIV but not AIDS. However, this number is probably a vast underestimate, as many HIV infections remain undiagnosed or unreported. The CDC estimates that about 1.1 million adults and adolescents in total are currently living with HIV in the United States (Centers for Disease Control, 2013, February).

Treatments have improved greatly over the past decade, increasing the life expectancy of people with HIV or AIDS (Centers for Disease Control, 2013). Highly active antiretroviral therapy, or HAART for short, is a powerful “cocktail” of at least three and sometimes more medications aimed at reducing the virus in the blood so that it is no longer detectable. While it is not a cure, this treatment can delay progression from HIV to AIDS and improve immune system health (Cohen et al., 2011; Dieffenbach & Fauci, 2011).

In other cultures, AIDS is also taking a devastating toll. The most heavily hit areas in the world right now are the countries of sub-Saharan Africa, where an estimated 22.4 million people were living with HIV at the end of 2007—nearly two-thirds of the total HIV infections in the world (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2009b). In 2008, 1.4 million people died from AIDS in these countries, and more than 14 million children were orphaned by AIDS (UNAIDS, 2007, 2009b). The Applying Psychology in Everyday Life section at the end of this chapter examines the course of AIDS in Russia—a region that is quickly becoming another AIDS “hot spot.”

 **Explore the Concept**, AIDS Timeline, at [MyPsychLab](#)



Not too many years ago, no one would have dared to advertise condoms in such a public manner. The only consequences of unsafe sex were unwanted pregnancies and serious, but not necessarily life-threatening, sexually transmitted infections. With the onslaught of the AIDS virus, safe sex has taken on a whole new meaning.

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sexual dysfunctions and problems

- sexual dysfunctions are problems with sexual functioning or physical aspects of the sex act
- paraphilic disorders are characterized by unusual or socially unacceptable sexual behaviors

 **Explore the Concept** at [MyPsychLab](#)

CONCEPT MAP

Sexual Dysfunctions, Problems, and Infections

sexually transmitted infections (STIs)

- infections spread through unprotected sexual contact (see Table 10.1)
- acquired immune deficiency syndrome (AIDS)
- affect sex organs or have broader, life-threatening effects
- bacterial infections may be treatable with antibiotics if caught early; viruses are difficult to treat and may be incurable
- caused by a viral infection, the human immunodeficiency virus (HIV)
- onset often associated with opportunistic infections
- has no known cure, can affect females and males of all sexual orientations, and continues to impact cultures world-wide

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PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. What is a major cause of organic sexual dysfunction?
 - a. stress
 - b. paraphilias
 - c. heredity
 - d. economic status
2. Surveys suggest that about _____ percent of women and _____ percent of men have at least one sexual dysfunction.
 - a. 10; 25
 - b. 40–45; 20–30
 - c. 80; 50
 - d. 10–20; 30–40
3. The human papillomavirus or HPV is the cause of _____ in both men and women.
 - a. chlamydia
 - b. syphilis
 - c. genital warts
 - d. AIDS
4. Which of the following ways can the human immunodeficiency virus be passed along to another person?
 - a. kissing
 - b. exposure to an infected person's tears
 - c. exposure to an infected person's saliva
 - d. exposure to an infected person's blood

Applying Psychology to Everyday Life: The AIDS Epidemic in Russia

While sub-Saharan Africa is still the focal point of AIDS and HIV infections for now, Russia and several surrounding countries in Eastern Europe and Central Asia are quickly becoming the center for a new and rapidly expanding epidemic of AIDS. Within the last decade, the prevalence of HIV in Russia and these other areas has nearly doubled (UNAIDS, 2009).

What accounts for this horrific rise in AIDS cases? Drug users who often share needles are one cause. With the heavy opium-producing Afghanistan nearby, drug use is an ever-increasing problem in Russia and the surrounding region, with reports of over half a million registered drug users and nearly 30,000 drug-related deaths each year (Hamers & Downs, 2003; RIA Novosti, 2010). Then there are the sex workers: prostitutes who are not only at risk because of the nature of their work but also because of their lack of education about the transmission of HIV and their own drug use (UNAIDS, 2008b). Of course, the partners of these drug users and sex workers are also at risk. Nearly two-thirds of the infections in women are caused by heterosexual contact with husbands or male lovers (Federal Service for Surveillance of Consumer Rights Protection and Human Well-Being of the Russian Federation and UNAIDS, 2008).

Another group at risk are prisoners (Dolan et al., 2007). The majority of the inmates were infected before entering the prison. Of note—one of the smallest groups responsible for the increase in AIDS and HIV infections are homosexuals (UNAIDS, 2008a). Homosexuality in Russia and the surrounding areas was once punishable by death, so it is not so surprising that there are either fewer homosexuals in those countries or, at the very least, few who are willing to reveal themselves as homosexuals.

Some researchers believe that between 2009 and 2015, Russia will experience its greatest number of AIDS-related deaths (Feshbach, 2008). Clearly, education about HIV and AIDS as well as a concerted effort to reduce the drug-using population, or, at the very least, giving them the tools necessary to reduce the risk of infection, must be a priority in the future—if there is to be one.

Questions for Further Discussion

1. Are there other countries around the world that you think might be the next site of an HIV/AIDS epidemic?
2. How would you go about trying to educate people who do not understand how HIV is spread?

Writing Prompt

- ▼ Compare and contrast the concepts of gender, gender role, and gender typing.

Words: 0

Print

Feedback

 Write the Response on **MyPsychLab**

chapter summary

 Listen to the **Audio File** of your chapter **MyPsychLab**

The Physical Side of Human Sexuality

10.1 What are the physical differences between females and males?

- The female sexual organs present at birth are the primary sex characteristics consisting of vagina, uterus, and ovaries.
- The female sexual organs that develop during puberty are secondary sex characteristics consisting of the growth spurt, onset of the menstrual cycle, breast development, widening hips, pubic hair, fat deposits, and further growth and development of the uterus, vagina, and ovaries.
- The primary male sex characteristics are the penis, scrotum, testicles, and prostate gland.
- The secondary male sex characteristics are an enlarged larynx (Adam's apple), deepening voice, facial and chest hair, pubic hair, coarser skin texture, and a large increase in height.

The Psychological Side of Human Sexuality:

Gender

10.2 What is gender, and how can biology and learning influence gender-role development?

- Gender is the psychological aspect of being male or female.
- Gender roles are the culture's expectations for male and female behavior and personality.
- Gender typing is the process by which people in a culture learn the appropriate gender-role behavior.
- Gender identity is a person's sense of being male or female.
- Gender identities are formed by biological influences, in the form of hormones and chromosomes, as well as environmental influences, in the form of parenting, surroundings, and culture, on the formation of gender identity.

10.3 How do gender roles develop, and how can they be influenced by stereotypes or an emphasis on androgyny?

- Social learning theorists believe that gender identity is formed through reinforcement of appropriate gender behavior as well as imitation of gender models.

- Gender schema theorists believe that gender identity is a mental schema that develops gradually, influenced by the growth of the brain and organization of observed male or female behavior around the schema.
- Gender stereotyping occurs when people assign characteristics to a person based on the person's male or female status rather than actual characteristics.
- Androgyny describes people who do not limit themselves to the male or female stereotyped characteristics, instead possessing characteristics associated with both traditional masculine and feminine roles.

10.4 How do men and women differ in thinking, social behavior, and personality?

- Cognitive differences between men and women include a male advantage in mathematical and spatial skills and a female superiority in verbal skills. These differences are now less than they were previously.
- Males and females are socially taught to interact differently and express emotions differently. Men tend to talk with each other in a "report" style, whereas women tend to talk to each other in a "relate" style.

Human Sexual Behavior

10.5 What happens in the bodies of women and men during sexual intercourse?

- Masters and Johnson found four phases of human sexual response: arousal, plateau, orgasm, and resolution.

10.6 What did the early and most recent surveys of human sexual behavior reveal?

- Alfred Kinsey conducted a series of sexual-behavior surveys in the late 1940s and early 1950s, revealing some highly controversial findings about the kinds of sexual behavior common among people in the United States, including homosexuality, premarital sex, and extramarital sex.
- In the mid-1990s, Janus and Janus published the results of a large-scale survey of sexual behavior in the United States. Their survey results did not differ widely from those of Kinsey but they looked at many more types of sexual behavior and factors related to sexual behavior than did Kinsey's surveys.

10.7 How do different sexual orientations develop?

- Research suggests that there are biological differences between heterosexuals and homosexuals, and that there may be genetic influences as well.

Sexual Dysfunctions and Problems**10.8 How do physical and psychological sexual problems differ?**

- Sexual dysfunctions are problems with sexual functioning. They may be caused by physical problems, interpersonal or sociocultural issues, or psychological problems, and can affect sexual interest, arousal, and response.
- These dysfunctions include female sexual interest/arousal disorder, male hypoactive sexual desire disorder, erectile disorder, genito-pelvic pain/penetration disorder, premature (early) ejaculation, female orgasmic disorder, and delayed ejaculation.

Sexually Transmitted Infections**10.9 What are sexually transmitted infections, and what can be done to prevent the spread of these disorders?**

- Sexually transmitted infections can affect the sexual organs and the ability to reproduce and may result in pain, disfigurement, and even death.

test YOURSELF

ANSWERS AVAILABLE IN ANSWER KEY.

 **Study** and **Review** with more quizzes and a customized study plan at [MyPsychLab](#)

Pick the best answer.

- Primary sex characteristics
 - include the development of pubic and ancillary hair.
 - always begin their development during puberty.
 - are typically the same for males and females.
 - are directly involved in human reproduction.
- What is the average age in the United States that menarche typically begins?
 - 10
 - 12
 - 13
 - 14
- If the gonads within an embryo produce testosterone because of the presence of a Y gene on the sex chromosome, then the _____ will develop and the _____ will deteriorate.
 - Müllerian ducts; Wolffian ducts
 - Wolffian ducts; Müllerian ducts
 - ovaries; testes
 - testes; ovaries
- An intersexed person is
 - a person who has sex with both men and women.
 - another name for a homosexual.
 - a person born with ambiguous sexual organs.
 - another name for a heterosexual.
- Annika's mother wants her daughter to grow up to become a mother of a large family. Such an expectation for Annika might be seen as an example of her
 - gender role.
 - gender typing.
 - gender identity.
 - gender constancy.

- Some common bacterial sexually transmitted infections are chlamydia, syphilis, and gonorrhea. These infections are treatable with antibiotics.
- Viral sexually transmitted infections include genital herpes (caused by the herpes simplex virus that also causes cold sores) and genital warts (caused by the human papillomavirus). Neither can be cured and both can lead to complications such as increased risk of cancer.
- Acquired immune deficiency syndrome (AIDS) is caused by a viral infection called human immunodeficiency virus (HIV) that is transmitted through an exchange of blood, vaginal fluid, semen, or breast milk. Having unprotected sex or sharing a needle with an infected person are the most common routes of transmission. HIV may also be transmitted through pregnancy, childbirth, or breastfeeding a baby while infected, occupational exposure, or receiving contaminated blood or organ transplant.
- AIDS wears down the immune system, opening the body up to infections that, over time, will result in death.

- Darla shares with a close friend that she often feels a strong desire to be another gender and that it bothers her so much that she is having problems at work and in her social life. What is the term used to describe this?
 - a hermaphrodite
 - transsexual
 - intersexed
 - gender dysphoria
- In social learning theory, gender identity results
 - when a child learns that they are either a "girl" or "boy."
 - from observation and imitation.
 - from biological changes that occurred before birth.
 - from unconscious forces.
- Jennifer's aunt tries to explain that running around with boys on the playground isn't "ladylike." Such a statement could be an example of
 - androgyny.
 - gender typing.
 - role development.
 - gender stereotyping.
- Plateau occurs in
 - Phase 1.
 - Phase 2.
 - Phase 3.
 - Phase 4.
- The refractory period is a time during which
 - a woman cannot have another orgasm.
 - a man cannot have another erection.
 - a man can be erect but not have an orgasm.
 - a woman cannot be aroused.

11. Which of the following studies was the most controversial for its method of gathering information?
- the Kinsey report
 - the Janus report
 - Masters and Johnson's study
 - Savic's research on sexual orientation
12. The Kinsey report indicates that more than _____ as many men had intercourse by age 16 than did women.
- twice
 - four times
 - ten times
 - three times
13. Parental Investment theory seeks to explain
- why men have sex more often than women.
 - why women are sexually attracted to men.
 - why couples meet and remain together.
 - why sexual activity diminishes in seniors.
14. Research on the epi-mark offers a _____ explanation to the existence of homosexuality.
- genetic
 - psychological
 - social
 - behavioral
15. The idea that homosexuality evolved as a way to aid the continuation of the homosexual person's genes through the nurturance of other family members, such as nieces and nephews, is called the _____ hypothesis.
- family support
 - kin selection
 - sexual support
 - kin evolutionary
16. Sexual dysfunctions and problems can be caused by
- organic factors.
 - organic and sociocultural factors.
 - organic, psychological, and sociocultural factors.
 - hereditary factors primarily.
17. Which of the following sexually transmitted infections can ultimately affect the brain?
- genital herpes
 - chlamydia
 - syphilis
 - gonorrhea
18. Brandon has a couple of painful sores on his penis and experiences severe itching and burning in the surrounding area. Brandon probably has
- genital herpes.
 - chlamydia.
 - syphilis.
 - gonorrhea.
19. Which of the following is a way in which HIV can be transmitted?
- through exposure to contaminated blood or other body fluids containing contaminated blood
 - by sharing beverages with someone who is HIV positive
 - by making contact with the tears of an HIV patient
 - through hand holding, especially if the person with HIV is perspiring
20. Alicia is horrified to hear that her date from last night carries the human immunodeficiency virus. While they did not engage in sex, they did share a quick kiss at the end of the evening, hastened by her phone ringing in her apartment. Besides discussing her concerns with her date should they go out again, what precautions should Alicia take?
- She should see her doctor immediately, since kissing can cause the spread of HIV.
 - She should see her doctor only if she begins to have symptoms.
 - She should try to calm down, since stress helps transmit HIV.
 - She should try not to worry, since kissing has not been proven to be a successful way to transmit HIV, and follow-up with her doctor or other health-care provider if she has concerns or questions.

11

stress and health

Secretary to psychologist: "Doctor, there is a patient here who thinks he is invisible."

Psychologist: "Tell him I can't see him right now."

Why begin a chapter on stress and health with a joke? Researchers have long known that humor is a great stress reliever and have recently found two possible reasons for the stress-reducing benefits of laughter. In one study, researchers found that laughing can not only significantly *increase* levels of health-protecting hormones, but also just *looking forward* to a positive and humorous laughing experience can significantly *decrease* levels of potentially damaging hormones (Berk et al., 2008). Another study found that repetitive, joyous laughter causes the body to respond as if receiving moderate exercise, which enhances mood and immune system activity, lowers both bad cholesterol and blood pressure, raises good cholesterol, and decreases stress hormones (Berk et al., 2009). The moral of the story: Laugh it up! **What are some common sources of stress in your life? How do you cope with or relieve stress?**

A young man with dark hair and a light beard, wearing a light blue button-down shirt, stands with his arms crossed. He is positioned in the center of a white rectangular frame. The background behind him is white. Surrounding him are various blue fitness-related icons: two blue dumbbells to the left, a blue jump rope to the right, several blue circles of different sizes, and a small grey star above his shoulder. Below the image is a dark grey video player bar. From left to right, it contains: a white circular progress bar with a small white dot; a white play button icon; a volume icon with a sound wave symbol; a closed captioning icon labeled "CC"; and a share icon with two arrows. At the bottom left of the frame, there is a small grey button with a video camera icon and the text "Watch the Video at MyPsychLab.com".

Why study stress and health?

How are they related? Stress is not a rare experience but something that all people experience in varying degrees every day. This chapter will explore the sources of stress in daily life, the factors that can make the experience of stress easier or more difficult, and the ways that stress influences our physical and mental health. We'll finish by discussing various ways to cope with the stresses of everyday life as well as with the extraordinary experiences that arise in life that have the potential to induce stress.

Learning objectives

- | | |
|--|---|
| 11.1
How do psychologists define stress? | 11.6
What social factors influence stress reactions? |
| 11.2
What kinds of external events can cause stress? | 11.7
What are some ways in which people cope with stress reactions? |
| 11.3
What are some psychological factors in stress? | 11.8
How is coping with stress affected by culture and religion? |
| 11.4
How does stress affect the physical functioning of the body and its immune system? | 11.9
What are some ways to become a more optimistic thinker? |
| 11.5
How do cognitive factors and personality differences affect the experience of stress? | |



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Stress and Stressors

Life is really about change. Every day, each person faces some kind of challenge, big or small. Just deciding what to wear to work or school can be a challenge for some people, whereas others find the drive to the workplace or school the most challenging part of the day. There are decisions to be made and changes that will require that you adapt already-made plans. Sometimes there are actual threats to well-being—an accident, a fight with the boss, a failed exam, or the loss of a job, to name a few. All of these challenges, threats, and changes require people to respond in some way.

DEFINITION OF STRESS

How do psychologists define stress?

Stress is the term used to describe the physical, emotional, cognitive, and behavioral responses to events that are appraised* as threatening or challenging.

Stress can show itself in many ways. Physical problems can include unusual fatigue, sleeping problems, frequent colds, and even chest pains and nausea. People under stress may behave differently, too: pacing, eating too much, crying a lot, smoking and drinking more than usual, or physically striking out at others by hitting or throwing things. Emotionally, people under stress experience anxiety, depression, fear, and irritability, as well as anger and frustration. Mental symptoms of stress include problems in concentration, memory, and decision making, and people under stress often lose their sense of humor.



I feel like that most of the time!

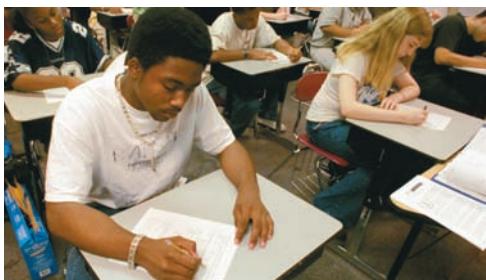
Most people experience some degree of stress on a daily basis, and college students are even more likely to face situations and events that require them to make changes and adapt their behavior: Assigned readings, papers, studying for tests, juggling jobs, car problems, relationships, and dealing with deadlines are all examples of things that can cause a person to experience stress. Some people feel the effects of stress more than others because what is appraised as a threat by one person might be appraised as an opportunity by another. (For example, think of how you and your friends might respond differently to the opportunity to write a 10-page paper for extra credit in the last 3 weeks of the semester.) Stress-causing events are called **stressors**; they can come from within a person or from an external source and range from relatively mild to severe.

WHAT ARE STRESSORS?

Events that can become stressors range from being stuck behind a person in the 10-items-or-less lane of the grocery store who has twice that amount, to dealing with the rubble left after a tornado or a hurricane destroys one's home. Stressors can range from the deadly serious (hurricanes, fires, crashes, combat) to the merely irritating and annoying (delays, rude people, losing one's car keys). Stressors can even be imaginary, as when a couple puts off doing their income tax return, imagining that they will have to pay a huge tax bill, or when a parent imagines the worst happening to a teenage child who isn't yet home from an evening out.

Actually, there are two kinds of stressors: those that cause **distress**, which occurs when people experience unpleasant stressors, and those that cause **eustress**, which results from positive events that still make demands on a person to adapt or change. Marriage, a job promotion, and having a baby may all be positive events for most people, but they all require a great deal of change in people's habits, duties, and often lifestyle, thereby

*appraised: in this sense, evaluated or judged in terms of importance or significance.



Taking a test is just one of many possible stressors in a college student's life. What aspects of college life have you found to be stressful? Do other students experience the same degree of stress in response to the same stressors?

creating stress. Hans Selye (1936) originally coined the term eustress to describe the stress experienced when positive events require the body to adapt.

In an update of Selye's original definition, researchers now define **eustress** as the optimal amount of stress that people need to promote health and well-being. The arousal theory, discussed in Chapter Nine, is based on the idea that a certain level of stress, or arousal, is actually necessary for people to feel content and function well (Zuckerman, 1994). [LINK](#) to Learning Objective 9.3. That arousal can be viewed in terms of eustress. Many students are aware that experiencing a little anxiety or stress is helpful to them because it motivates them to study, for example. Without the arousal created by the impending exam, many students might not study very much or at all. In fact, as the video *The Basics: Stress and Your Health: Stress and Memory* describes, studies have shown that small amounts of stress may actually improve our memory. What about the student who is so stressed out that everything he's studied just flies right out of his head? Obviously, a high level of anxiety concerning an impending exam that actually interferes with the ability to study or to retrieve the information at exam time is distress. The difference is not only in the degree of anxiety but also in how the person interprets the exam situation. A number of events, great and small, good and bad, can cause us to feel "stressed out." The next section looks at how life's big deals and little hassles contribute to our overall stress experience.



[Watch the Video](#), *The Basics: Stress and Your Health: Stress and Memory*, at [MyPsychLab](#)

ENVIRONMENTAL STRESSORS: LIFE'S UPS AND DOWNS

What kinds of external events can cause stress?

From the annoyingly loud next-door neighbor to major life changes, good or bad, stress is a fact of life. Let's take a look at the various causes of stress in everyday life.

CATASTROPHES Losing one's home in a tornado is an example of a stressor called a **catastrophe**, an unpredictable event that happens on a large scale and creates tremendous amounts of stress and feelings of threat. Wars, hurricanes, floods, fires, airplane crashes, and other disasters are catastrophes. The terrorist-driven destruction of the World Trade Center in New York City on September 11, 2001, is a prime example of a catastrophe.

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In one study, nearly 8 percent of the people living in the area near the attacks developed a severe stress disorder, and nearly 10 percent reported symptoms of depression even as late as 2 months after the attack (Galea et al., 2002). A study done 4 years later found a nearly 14 percent increase in stress disorders as well as continued persistence of previously diagnosed stress disorders (Pollack et al., 2006).  [LINK](#) to Learning Objective 14.4. Other examples of catastrophes are the devastation caused by Hurricane Katrina on August 29, 2005, and Hurricane (“Superstorm”) Sandy on October 22–29, 2012 (Kessler et al., 2006; Stewart, 2012; Swenson & Marshall, 2005).

MAJOR LIFE CHANGES Thankfully, most people do not have to face the extreme stress of a catastrophe. But stress is present even in relatively ordinary life experiences and does not have to come from only negative events, such as job loss. Sometimes there are big events, such as marriage or going to college, that also require a person to make adjustments and changes—and adjustments and changes are really the core of stress, according to early researchers in the field (Holmes & Rahe, 1967).

The Social Readjustment Rating Scale (SRRS) Thomas Holmes and Richard Rahe (1967) believed that any life event that required people to change, adapt, or adjust their lifestyles would result in stress. Like Selye, they assumed that both negative events (such as getting fired) and positive events (such as getting a promotion) demand that a person adjust in some way, and so both kinds of events are associated with stress. Using a sample of nearly 400 people, Holmes and Rahe devised a scale to measure the amount of stress in a person’s life by having that person add up the total “life change units” associated with each major event in their **Social Readjustment Rating Scale (SRRS)** (see **Table 11.1**).

When an individual adds up the points for each event that has happened to him or her within the past 12 months (and counting points for repeat events as well), the resulting score can provide a good estimate of the degree of stress being experienced by that person. The researchers found that certain ranges of scores on the SRRS could be associated with increased risk of illness or accidents. (Note: Table 11.1 is not a complete listing of the original 43 events and associated life change units and should not be used to calculate a stress “score”! If you would like to calculate your SRRS score, try this free Web site: <http://www.stresstips.com/lifeevents.htm>.)

The risk of illness or accidents increases as the score increases. If a person’s score is 300 or above, that person has a very high chance of becoming ill or having an accident in the near future (Holmes & Masuda, 1973). Illness includes not only physical conditions such as high blood pressure, ulcers, or migraine headaches but mental illness as well. In one study, researchers found that stressful life events of the kind listed in the SRRS were excellent predictors of the onset of episodes of major depression (Kendler & Prescott, 1999).

The SRRS was later revised (Miller & Rahe, 1997) to reflect changes in the ratings of the events in the 30 intervening years. Miller and Rahe found that overall stress associated with many of the items on the original list had increased by about 45 percent from the original 1967 ratings, citing changes in such issues as gender roles, economics, and social norms as possible reasons.

How can stress cause a person to have an accident? Many studies conducted on the relationship between stress and accidents in the workplace have shown that people under a lot of stress tend to be more distracted and less cautious and, therefore, place themselves at a greater risk for having an accident (Hansen, 1988; Sherry et al., 2003).

THE COLLEGE UNDERGRADUATE STRESS SCALE (CUSS) The SRRS, as it was originally designed, seems more appropriate for adults who are already established in their careers. There are versions of the SRRS that use as life events some of those things more likely to be experienced by college students. One of these more recent versions is the **College Undergraduate Stress Scale (CUSS)** (Renner & Mackin, 1998). This scale is quite different from Holmes and Rahe’s original scale because the stressful events listed and rated include those that would be more common or more likely to happen to a college student.

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Table 11.1**Sample Items From the Social Readjustment Rating Scale (SRRS)**

MAJOR LIFE EVENT	LIFE CHANGE UNITS
Death of spouse	100
Divorce	75
Marital separation	65
Jail term	63
Death of a close family member	63
Personal injury or illness	53
Marriage	50
Dismissal from work	47
Marital reconciliation	45
Pregnancy	40
Death of close friend	37
Change to different line of work	36
Change in number of arguments with spouse	36
Major mortgage	31
Foreclosure of mortgage or loan	30
Begin or end school	26
Change in living conditions	25
Change in work hours or conditions	20
Change in residence/schools/recreation	19
Change in social activities	18
Small mortgage or loan	17
Vacation	13
Christmas	12
Minor violations of the law	11

Sources: Adapted and abridged from Holmes & Rahe (1967).

Some of the higher stress items on the CUSS include rape, a close friend's death, contracting a sexually transmitted disease also final exam week and flunking a class. Some of the lower stress items include peer pressure, homesickness, falling asleep in class, pressure to make high grades, and dating concerns.



You mention that the CUSS has "falling asleep in class" as one of its items. How can falling asleep in class be stressful? It's what happens when the professor catches you that's stressful, isn't it?

Ah, but if you fall asleep in class, even if the professor doesn't catch on, you'll miss the lecture notes. You might then have to get the notes from a friend, find enough money

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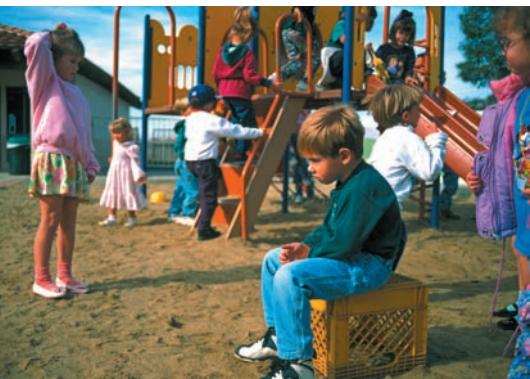
to pay for the copy machine, try to read your friend's handwriting, and so on—all stressful situations. Actually, all the events listed on both the SRSS and the CUSS are stressful not just because some of them are emotionally intense but also because there are so many little details, changes, adjustments, adaptations, frustrations, and delays that are caused by the events themselves. The death of a spouse, for example, rates 100 life change units because it requires the greatest amount of adjustment in a person's life. A lot of those adjustments are going to be the little details: planning the funeral, deciding what to do with the spouse's clothes and belongings, getting the notice in the obituaries, answering all of the condolence cards with a thank-you card, dealing with insurance and changing names on policies, and on and on and on. In other words, major life events create a whole host of hassles.

HASSLES Although it's easy to think about big disasters and major changes in life as sources of stress, the bulk of the stress we experience daily actually comes from little frustrations, delays, irritations, minor disagreements, and similar small aggravations. These daily annoyances are called **hassles** (Lazarus, 1993; Lazarus & Folkman, 1984). Experiencing major changes in one's life is like throwing a rock into a pond: There will be a big splash, but the rock itself is gone. What is left behind are all the ripples in the water that came from the impact of the rock. Those "ripples" are the hassles that arise from the big event.

Lazarus and Folkman (1984) developed a *hassles scale* that has items such as "misplacing or losing things" and "troublesome neighbors." A person taking the test for hassles would rate each item in the scale in terms of how much of a hassle that particular item was for the person. The ratings range between 0 (no hassle or didn't occur) to 3 (extremely severe hassle). Whereas the major life events of Holmes and Rahe's scale (1967) may have a long-term effect on a person's chronic physical and mental health, the day-to-day minor annoyances, delays, and irritations that affect immediate health and well-being are far better predictors of short-term illnesses such as headaches, colds, backaches, and similar symptoms (Burks & Martin, 1985; DeLongis et al., 1988; Dunn et al., 2006). In one study, researchers found that among 261 participants who experienced headaches, scores on a scale measuring the number and severity of daily hassles were significantly better predictors of headaches than were scores on a life-events scale (Fernandez & Sheffield, 1996). The researchers also found that it was not so much the number of daily hassles that predicted headaches but rather the perceived severity of the hassles.

Research has indicated that hassles may also come from quite different sources depending on a person's developmental stage (Ellis et al., 2001). In this study, researchers surveyed 270 randomly selected people from ages 3 to 75. The participants were asked to check off a list of daily hassles and pleasures associated with having "bad days" and "good days," respectively, as well as ranking the hassles in terms of frequency and severity of impact. For children ages 3 to 5, getting teased was the biggest daily hassle. For children in the 6 to 10 age group, the biggest hassle was getting bad grades. Children 11 to 15 years old reported feeling pressured to use drugs, whereas older adolescents (ages 16 to 22) cited trouble at school or work. Adults found fighting among family members the greatest source of stress, whereas the elderly people in the study cited a lack of money.

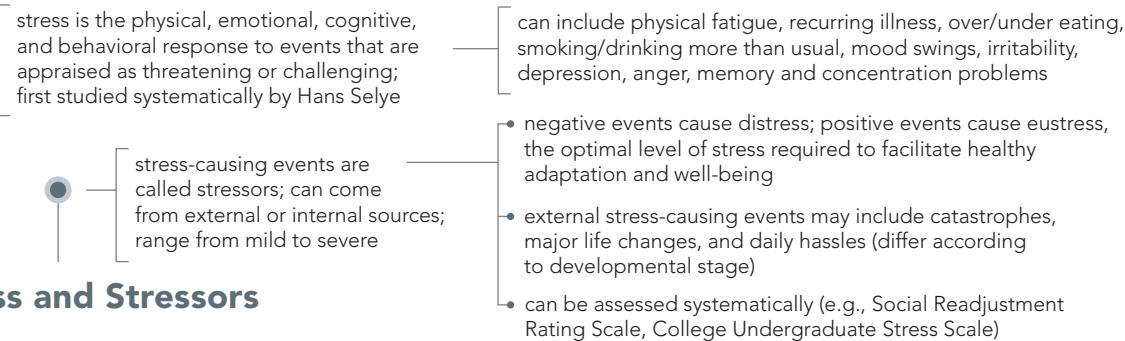
In that same study, the researchers were somewhat surprised to find that elderly people were much more strongly affected by such hassles as going shopping, doctor's appointments, and bad weather than the children and younger adults were. It may be that while a young person may view going shopping as an opportunity to socialize, older adults find it threatening: Physically, they are less able to get to a place to shop and may have to rely on others to drive them and help them get around and, thus, may take much more time for shopping and doing errands than a younger person would. Mentally, shopping could be seen as threatening because of a lack of financial resources to pay for needed items. Even the need to make decisions might be seen as unpleasant to an older person.



Children in the preschool-age range find teasing by their peers to be the biggest daily hassle they experience. This boy may be upset because he has been teased by the other children. What other hassles might a child in this age range experience?

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 Explore the Concept at [MyPsychLab](#)
CONCEPT MAP**Stress and Stressors****PRACTICE quiz How Much Do You Remember?**

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Studies show that _____ is the optimal amount of stress that people need to positively promote their health and sense of well-being, which coincides with _____ theory.
 - a. intensity; cognitive consistency
 - b. distress; biological instinct
 - c. eustress; arousal
 - d. eustress; Maslow's
2. What is a primary application of the Social Readjustment Rating Scale (SRRS) developed by Holmes and Rahe?
 - a. to estimate your potential level of stress for the next 36 months
 - b. to estimate your risk of illness or having an accident in the near future
 - c. to estimate how long you will live based on your current lifestyle
 - d. to estimate your risk of cancer
3. What does the Social Readjustment Rating Scale (SRRS) use to determine its results?
 - a. The SRRS asks users to subjectively rate their stress level.
 - b. The SRRS examines diet and family history to determine one's overall health risks.
 - c. The SRRS records specific positive and negative life events to determine an individual's current level of stress.
 - d. The SRRS looks exclusively at any catastrophes that a person has experienced.
4. Who, if anyone, would consider going shopping as a daily hassle and therefore stressful?
 - a. adolescents
 - b. those in their 20s and 30s
 - c. senior citizens
 - d. Hassles are stressful at any age, and studies do not find shopping to be a stressor or hassle at any age.

THINKING CRITICALLY:

What aspects of college life do you find most stressful? What makes these particular ones more stressful than others?

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PSYCHOLOGICAL STRESSORS: WHAT, ME WORRY?**What are some psychological factors in stress?**

Although several specific stressors (such as marriage, car problems, etc.) have already been mentioned, the psychological reasons why people find these events stressful fall into several categories.

PRESSURE When there are urgent demands or expectations for a person's behavior coming from an outside source, that person is experiencing **pressure**. Pressure occurs when people feel that they must work harder, faster, or do more, as when meeting a deadline or studying for final exams.

Time pressure is one of the most common forms of pressure. Although some people claim to "work well under pressure," the truth is that pressure can have a negative impact on a person's ability to be creative. Psychologist Teresa Amabile has

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gathered research within actual work settings strongly indicating that when time pressure is applied to workers who are trying to come up with creative, innovative ideas, creativity levels decrease dramatically—even though the workers may think they have been quite productive because of the effort they have made (Amabile et al., 2002).



Residents in retirement homes and nursing homes benefit both physically and psychologically when they can choose for themselves the activities in which they wish to participate, such as this exercise class. What are some other means of control residents might experience?

participants, researchers Rodin and Langer (Langer & Rodin, 1976; Rodin & Langer, 1977) found that those residents who were given more control over their lives (e.g., being able to choose activities and their timing) were more vigorous, active, and sociable than those in the control group. Employees at mental health clinics who have more input into and control over policy changes experience less stress than those who believe themselves to have little control (Johnson et al., 2006). A more recent study found that retirees experience more happiness and less stress when retirement is by their choice and not forced upon them, regardless of whether the retirement was rapid or gradual (Calvo et al., 2009).

The stress-increasing effects of lack of control explain the relationship between unpredictability and stress as well. When potentially stressful situations are unpredictable, as in police work, the degree of stress experienced is increased. An unpredictable situation is one that is not controllable, which may at least partially explain the increase in stress (Zucchi et al., 2009). In one study, rats were either given an electric shock after a warning tone or given a shock with no warning. The rats receiving the unpredictable shocks developed severe stomach ulcers (Weiss, 1972).

FRUSTRATION **Frustration** occurs when people are blocked or prevented from achieving a desired goal or fulfilling a perceived need. As a stressor, frustration can be *external*, such as when a car breaks down, a desired job offer doesn't come through after all, or a theft results in the loss of one's belongings. Losses, rejections, failures, and delays are all sources of external frustration.

Obviously, some frustrations are minor and others are more serious. The seriousness of a frustration is affected by how important the goal or need actually is. A person who is delayed in traffic while driving to the mall to do some shopping just for fun will be less frustrated than a person who is trying to get to the mall before it closes to get that last-minute forgotten and important anniversary gift.

Internal frustrations, also known as *personal frustrations*, occur when the goal or need cannot be attained because of internal or personal characteristics. For example, someone who wants to be an astronaut might find that severe motion sickness prevents him or her from such a goal. If a man wants to be a professional basketball player but is only 5 feet

UNCONTROLLABILITY Another factor that increases a person's experience of stress is the degree of control that the person has over a particular event or situation. The less control a person has, the greater the degree of stress. Researchers in both clinical interviews and experimental studies have found that lack of control in a situation actually increases stress disorder symptoms (Breier et al., 1987; Henderson et al., 2012).

In studies carried out in a nursing home with the elderly residents as the participants, researchers Rodin and Langer (Langer & Rodin, 1976; Rodin & Langer, 1977)

tall and weighs only 85 pounds, he may find that he cannot achieve that goal because of his physical characteristics. A person wanting to be an engineer but who has no math skills would find it difficult to attain that goal.

When frustrated, people may use several typical responses. The first is *persistence*, or the continuation of efforts to get around whatever is causing the frustration. Persistence may involve making more intense efforts or changing the style of response. For example, anyone who has ever put coins into a vending machine only to find that the drink does not come out has probably (1) pushed the button again, more forcefully, and (2) pushed several other buttons in an effort to get some kind of response from the machine. If neither of these strategies works, many people may hit or kick the machine itself in an act of aggression.

Aggression, or actions meant to harm or destroy, is unfortunately another typical reaction to frustration. Early psychologists in the field of behaviorism proposed a connection between frustration and aggression, calling it the *frustration-aggression hypothesis* (Dollard et al., 1939; Miller et al., 1941). [LINK](#) to Learning Objective 12.11. Although they believed that some form of frustration nearly always precedes aggression, that does not mean that frustration *always* leads to aggression. In fact, aggression is a frequent and persistent response to frustration, but it is seldom the first response. In a reformulation of the frustration-aggression hypothesis, Berkowitz (1993) stated that frustration creates an internal “readiness to aggress” but that aggression will not follow unless certain external cues are also present. For example, if the human source of a person’s frustration is far larger and stronger in appearance than the frustrated person, aggression is an unlikely outcome!



Okay, so if the person who ticked you off is bigger than you—if aggression isn’t possible—what can you do?

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One could try to reason with the person who is the source of frustration. Reasoning with someone is a form of persistence. Trying to “get around” the problem is another way in which people can deal with frustration. Another possibility is to take out one’s frustrations on less threatening, more available targets, in a process called **displaced aggression**. Anyone who has ever been frustrated by things that occurred at work or school and then later yelled at another person (such as a spouse, parent, child, etc.) has experienced displaced aggression. The person one really wants to strike out at is one’s boss, the teacher, or whoever or whatever caused the frustration in the first place. That could be dangerous, so the aggression is reserved for another less threatening or weaker target. For example, unemployment and financial difficulties are extremely frustrating, as they block a person’s ability to maintain a certain standard of living and acquire desired possessions. In one study, male unemployment and single parenthood were the two factors most highly correlated to rates of child abuse (Gillham et al., 1998). Unemployment is also one of the factors correlated most highly with the murder of abused women, creating four times the risk of murder for women in abusive relationships (Campbell & Wolf, 2003). Both studies are examples of displaced aggression toward the weaker targets of children and women. Such targets often become *scapegoats*, or habitual targets of displaced aggression. Scapegoats are often pets, children, spouses, and even minority groups (who are seen as having less power). [LINK](#) to Learning Objective 12.8.

Another possible reaction to frustration is **escape** or **withdrawal**. Escape or withdrawal can take the form of leaving, dropping out of school, quitting a job, or ending a relationship. Some people manage a psychological escape or withdrawal into apathy (ceasing to care about or act upon the situation), fantasy (which is only a temporary escape), or the use of drugs. Obviously the latter reaction can lead to even more problems. Others resort to what they see as the final escape: suicide.



These parents are fighting in front of their obviously distressed daughter. In some instances, a child who experiences this kind of frustration might act out aggressively toward a sibling or a pet in a form of displaced aggression.

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This couple has just purchased their first house, a rite of passage for many young couples. The decision to become a homeowner, with the "pulls" of privacy and earning equity and the "pushes" of mortgage payments and upkeep, is often an approach-avoidance conflict.

CONFLICT Whenever you find yourself torn between two or more competing and incompatible desires, goals, or actions, you are in conflict. There are different forms of conflict, depending upon the nature of the incompatible desires, goals, or actions.

Approach-Approach Conflict. In an **approach-approach conflict**, a person experiences desire for two goals, each of which is attractive. Typically, this type of conflict, often called a "win-win situation," is relatively easy to resolve and does not involve a great deal of stress. Because both goals are desirable, the only stress involved is having to choose between them, acquiring one and losing the other. An example of this might be the need to choose between the chocolate cake or key lime pie for dessert or from among several good choices for a date to the prom. "Six on one hand, half a dozen on the other" is a phrase that sums up this conflict nicely.

Avoidance-Avoidance Conflict. **Avoidance-avoidance conflicts** are much more stressful. In this conflict, the choice is between two or more goals or events that are unpleasant. This type of conflict is so common that there are numerous phrases to symbolize it, for example, "caught between a rock and a hard place," "between the devil and the deep blue sea," "out of the frying pan into the fire," and "lose-lose situation." People who are fearful of dental procedures might face the conflict of suffering the pain of a toothache or going to the dentist. Because neither alternative is pleasant, many people avoid making a choice by delaying decisions (Tversky & Shafir, 1992). For example, given the choice of risky back surgery or living with the pain, some people would wait, hoping that the pain would go away on its own and relieve them of the need to make a choice.

Approach-Avoidance Conflict. **Approach-avoidance conflicts** are a bit different in that they only involve one goal or event. That goal or event may have both positive and negative aspects that make the goal appealing and yet unappealing at the same time. For example, marriage is a big decision to make for anyone and usually has both its attractive features, such as togetherness, sharing good times, and companionship, and also its negative aspects, such as disagreements, money issues, and mortgages. This is perhaps the most stressful of all of the types of conflict, causing many people to vacillate* or be unable to decide for or against the goal or event. The author of this text experienced a very stressful approach-avoidance conflict when deciding to write the book: On the one hand, there would be money, prestige, and the challenge of doing something new. On the other hand, a tremendous amount of effort and time would be required to write the text, which would take time and energy away from other areas of life. Another example is the offer of a promotion that would require a person to move to a city he or she doesn't like—more money and higher status but all the hassles of moving and living in a less-than-perfect place.

What if I have to choose between two things, and each of them has good points and bad points?

Multiple Approach-Avoidance Conflicts. When the choice is between two goals that have both positive and negative elements to each goal, it is called a **double approach-avoidance conflict**. For example, what if a person had the choice of buying a house out in the country or in the city? The house in the country has its attractions: privacy, fresh air, and quiet. But there would be a long commute to one's job in the city. A house in the city would make getting to work a lot easier, but then there are the negative aspects of pollution, noise, and crowded city streets. Each choice has both good and bad points. This type of conflict also tends to lead to vacillation. Other examples of this type of conflict might be trying to decide which of two people one wants to date or which of two majors one should choose.

*vacillate: to go back and forth between one decision and another.

It is fairly common to face **multiple approach-avoidance conflicts** in daily life. In a multiple approach-avoidance conflict, one would have more than two goals or options to consider, making the decision even more difficult and stressful. For many college students, deciding on a specific school or a career major is actually this type of conflict.

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 Explore the Concept at [MyPsychLab](#)
CONCEPT MAP**pressure**

urgent demands or expectations

uncontrollability

lower sense of control associated with greater stress

frustration

due to external (losses, rejections, failures, delays) or internal (personal characteristics) factors; can result in several typical responses

- persistence
- aggression
- escape/withdrawal (suicide is a drastic form of escape)

conflict

- **approach-approach conflict** does not involve a great deal of stress; person experiences attraction to two or more desires or goals
- **avoidance-avoidance conflict** is more stressful; choice between two or more undesirable situations
- **approach-avoidance conflict** can be most stressful; single goal or event has both positive and negative aspects
- **multiple approach-avoidance conflicts** are fairly common in daily life (e.g., **double approach-avoidance**) due to life decisions affecting two or more goals

Stress and Stressors (continued)

(psychological stressors are often related to external events)

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Jorgé has deadlines and expectations placed on him both at school and at work, making him feel like he always has to do more and to work harder and faster. Jorgé is experiencing
 - a. frustration.
 - b. uncontrollability.
 - c. pressure.
 - d. conflict.
2. A retail store has announced to its employees that half of them will be laid off after a two-week, random review of their personnel records. No current performance appraisals or individual interviews are being held. Over the next two weeks, many of the employees are arguing, fighting, and doing a poor job of taking care of their customers. What aspects of stress most likely started these behaviors?
 - a. pressure and conflict
 - b. uncontrollability and frustration
 - c. pressure and frustration
 - d. uncontrollability and conflict
3. Lisa wants the lead singing part in the next school musical but by all accounts, she is not musically gifted in any way and has a rather unpleasant singing voice. Lisa may eventually realize her lack of singing ability is an _____ frustration.
 - a. internal
 - b. external
 - c. unacceptable
 - d. extrinsic
4. The first response that people typically make when frustrated is to
 - a. try again.
 - b. get angry.
 - c. get creative.
 - d. give up.
5. Marriage is sometimes perceived as a unique stressor. On one hand, you have many good aspects such as finding that special someone, long-term commitment, and sometimes even combined incomes. On the other hand, there is a perceived loss of independence, a sense of finality, and the fear of "what if this isn't the right one?" Therefore marriage may be seen as an example of a _____ conflict.
 - a. approach-approach
 - b. avoidance-avoidance
 - c. approach-avoidance
 - d. double approach-avoidance

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Physiological Factors: Stress and Health

How does stress affect the physical functioning of the body and its immune system?

Chapter Two discussed in detail the function of the *autonomic nervous system* (ANS) the part of the human nervous system that is responsible for automatic, involuntary, and life-sustaining activities. The ANS consists of two divisions, the *parasympathetic* and the *sympathetic*. It is the sympathetic nervous system (the “fight-or-flight” system,  [LINK](#) to Learning Objective 2.4) that reacts when the human body is subjected to stress: Heart rate increases, digestion slows or shuts down, and energy is sent to the muscles to help deal with whatever action the stressful situation requires. The parasympathetic system returns the body to normal, day-to-day functioning after the stress is ended. Both systems figure prominently in a classic theory of the body’s physiological reactions to stress, the general adaptation syndrome.

 [Watch the Video](#), *The Basics: Stress and Your Health: Physiological Responses to Stress*, at [MyPsychLab](#)

THE GENERAL ADAPTATION SYNDROME

Endocrinologist Hans Selye was the founder of the field of research concerning stress and its effects on the human body. He studied the sequence of physiological reactions that the body goes through when adapting to a stressor. This sequence (see **Figure 11.1**) is called the **general adaptation syndrome (GAS)** and consists of three stages (Selye, 1956)

 [Explore the Concept](#), Selye’s General Adaptation Syndrome, at [MyPsychLab](#):

- **Alarm:** When the body first reacts to a stressor, the sympathetic nervous system is activated. The adrenal glands release hormones that increase heart rate, blood pressure, and the supply of blood sugar, resulting in a burst of energy. Reactions such as fever, nausea, and headache are common.
- **Resistance:** As the stress continues, the body settles into sympathetic division activity, continuing to release the stress hormones that help the body fight off, or resist, the stressor. The early symptoms of alarm lessen and the person or animal may actually feel better. This stage will continue until the stressor ends or the organism has used up all of its resources. Researchers have found that one of the hormones released under stress, noradrenaline (norepinephrine), actually seems to affect the brain’s processing of pain, so that when under stress a person may experience a kind of analgesia (insensitivity to pain) if, for example, the person hits an arm or a shin (Delaney et al., 2007).
- **Exhaustion:** When the body’s resources are gone, exhaustion occurs. Exhaustion can lead to the formation of stress-related diseases (e.g., high blood pressure or a weakened immune system) or the death of the organism if outside help is unavailable (Stein-Behrens et al., 1994). When the stressor ends, the parasympathetic division activates and the body attempts to replenish its resources.

Alarm and resistance are stages that people experience many times throughout life, allowing people to adapt to life’s demands (Selye, 1976). It is the prolonged secretion of the stress hormones during the exhaustion stage that can lead to the most harmful effects of stress. It was this aspect of Selye’s work that convinced other researchers of the connection between stress and certain *diseases of adaptation* as Selye termed them. The most common of these diseases are ulcers and high blood pressure.

IMMUNE SYSTEM AND STRESS

As Selye first discovered, the **immune system** (the system of cells, organs, and chemicals in the body that responds to attacks on the body from diseases and injuries) is affected by stress. The field of **psychoneuroimmunology** concerns the study of the effects

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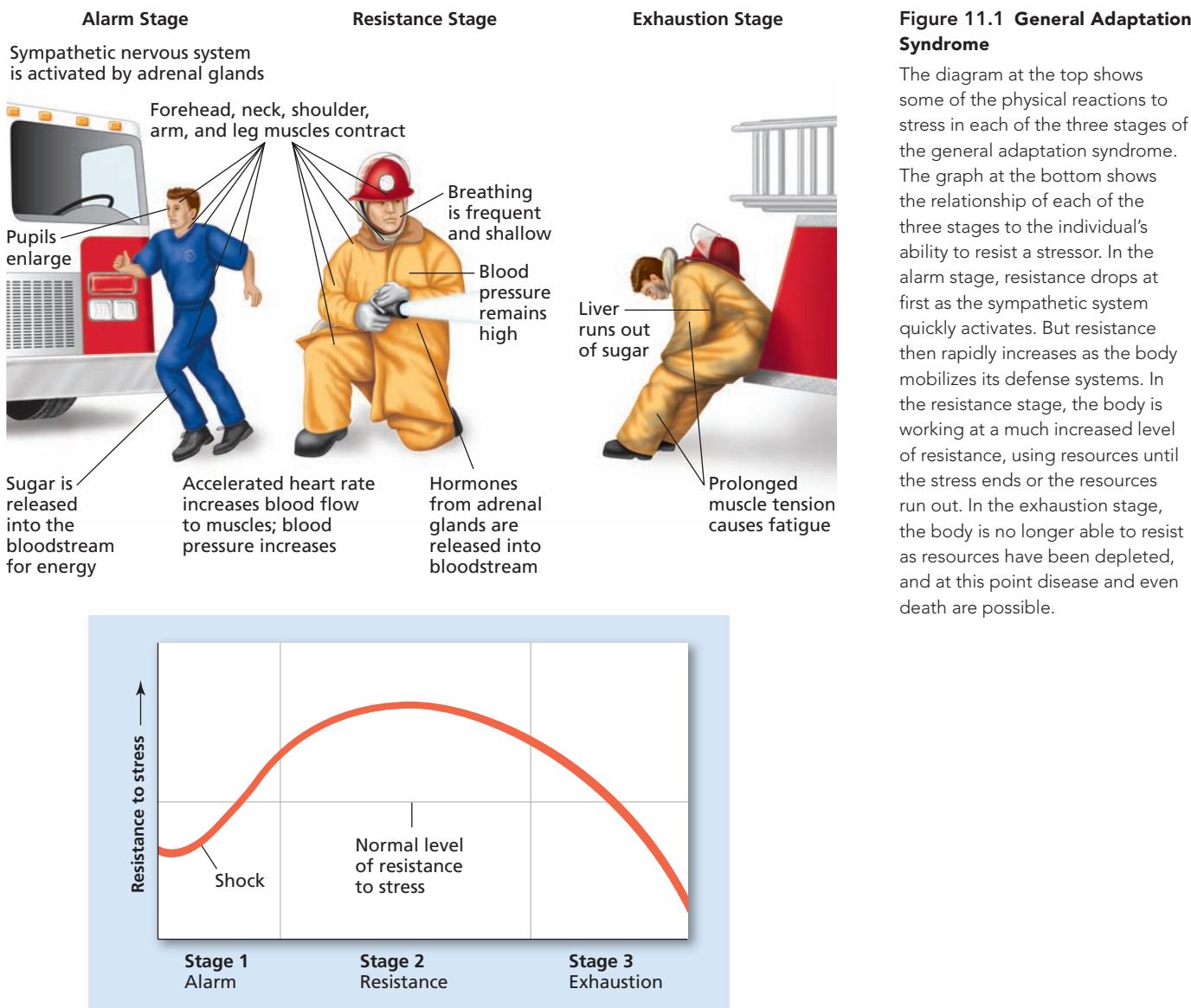
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of psychological factors such as stress, emotions, thinking, learning, and behavior on the immune system (Ader, 2003; Cohen & Herbert, 1996; Kiecolt-Glaser, 2009; Kiecolt-Glaser et al., 1995, 1996, 2002). Researchers in this field have found that stress triggers the same response in the immune system that infection triggers (Maier & Watkins, 1998). Certain enzymes and other chemicals (including antibodies) are created by immune cells when the immune cells, or white blood cells, encounter an infection in the body. The white blood cells surround the bacteria or other infectious material and release the chemicals and enzymes into the bloodstream. From there, these chemicals activate receptor sites on the *vagus nerve*, the longest nerve that connects the body to the brain. It is the activation of these receptor sites that signals the brain that the body is sick, causing the brain to respond by further activation of the immune system.

Stress activates this same system but starts in the brain rather than in the bloodstream. The same chemical changes that occur in the brain when it has been alerted by the *vagus nerve* to infection in the body occurred in laboratory animals when they were kept isolated from other animals or given electric shocks (Maier & Watkins, 1998). This has the effect of “priming” the immune system, allowing it to more successfully resist the effects of the stress, as in Selye’s resistance stage of the GAS.

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Hormones also play a part in helping the immune system fight the effects of stress. Researchers (Morgan et al., 2009) have found that a hormone called dehydroepiandrosterone (DHEA), known to provide antistress benefits in animals, also aids humans in stress toleration—perhaps by regulating the effects of stress on the hippocampus (part of the limbic system). [LINK](#) to Learning Objective 2.8.



So stress actually increases the activity of the immune system? But then how does stress end up causing those diseases, like high blood pressure?

The positive effects of stress on the immune system only seem to work when the stress is not a continual, chronic condition. As stress continues, the body's resources begin to fail in the exhaustion phase of the general adaptation to stress (Kiecolt-Glaser et al., 1987, 1995, 1996; Prigerson et al., 1997). In one study, college students who were undergoing a stressful series of exams were compared to a group of similar students relaxing during a time of no classes and no exams (Deinzer et al., 2000). The exam group tested significantly lower for immune system chemicals that help fight off disease than did the relaxing control group, even as long as 14 days after the exams were over. The suppression of immune system functioning by stress apparently can continue even after the stress itself is over.

One reason that the early stress reaction is helpful but prolonged stress is not might be that the stress reaction, in evolutionary terms, is really only “designed” for a short-term response, such as running from a predator (Sapolsky, 2004). That level of intense bodily and hormonal activity isn’t really meant to go on and on, as it does for human beings in the modern, stress-filled life we now know. Humans experience the stress reaction over prolonged periods of times and in situations that are not necessarily life-threatening, leading to a breakdown in the immune system. (See **Figure 11.2**.)

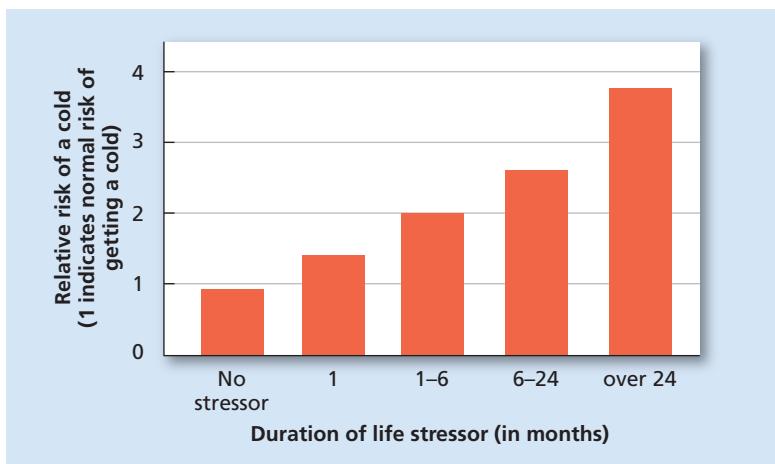
HEART DISEASE Of course, anything that can weaken the immune system can have a negative effect on other bodily systems. Stress has been shown to put people at a higher risk of **coronary heart disease (CHD)**, the buildup of a waxy substance called plaque in the arteries of the heart. This relationship is at least in part because the liver, which is not activated while the sympathetic nervous system is aroused, does not have a chance to clear the fat and cholesterol from the bloodstream, leading to clogged arteries and eventually the possibility of heart attacks or strokes. In one study, middle-aged men were questioned about stress, diet, and lifestyle factors and were examined for biological risk factors for heart disease: obesity, high blood sugar, high triglycerides (a type of fatty acid found in the blood), and low levels of HDL or “good” cholesterol. (See **Figure 11.3**.) Stress and the production of stress hormones were found to be strongly linked to all four biological risk factors: The more stress the men were exposed to in their work environment and home life, the more likely they were to exhibit these risk factors (Brunner et al., 2002).

Other studies have produced similar findings. One study looked at the heart health of people who suffered acute stress reactions after the 9/11 terrorist attacks and found a 53 percent increase in heart ailments over the 3 years following the attacks (Holman et al., 2008), whereas another large-scale study found that work stress is highly associated with an increased risk of coronary heart disease due to negative effects of stress on the autonomic nervous system and glandular activity (Chandola et al., 2008). Recent studies have shown a clear relationship between stress in the workplace and an increased risk of coronary heart

Figure 11.2 Stress Duration and Illness

In this graph, the risk of getting a cold virus increases greatly as the months of exposure to a stressor increase. Although a stress reaction can be useful in its early phase, prolonged stress has a negative impact on the immune system, leaving the body vulnerable to illnesses such as a cold.

Source: Cohen et al. (1998).



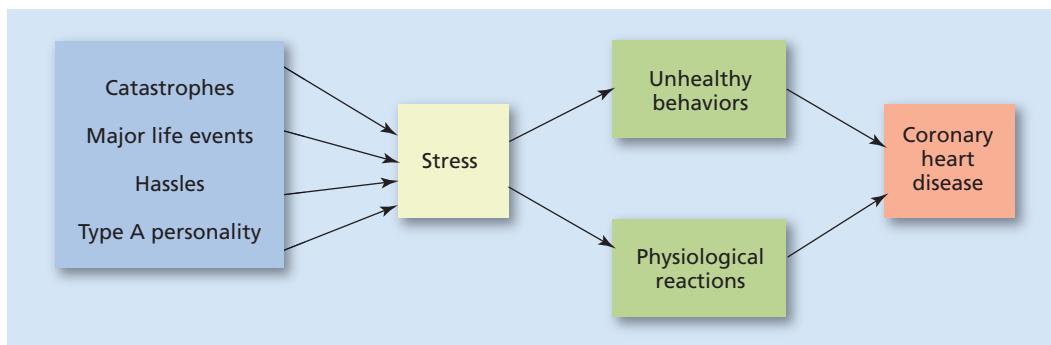


Figure 11.3 Stress and Coronary Heart Disease

The blue box on the left represents various sources of stress (Type A personality refers to someone who is ambitious, always working, and usually hostile). In addition to the physical reactions that accompany the stress reaction, an individual under stress may be more likely to engage in unhealthy behavior such as overeating, drinking alcohol or taking other kinds of drugs, avoiding exercise, and acting out in anger or frustration. This kind of behavior also contributes to an increased risk of coronary heart disease.

disease as well as depression, sleep disturbances, and unhealthy habits such as a lack of physical activity—none of which are good for coronary health (Emeny et al., 2012, 2013). Prolonged stress is simply not good for the heart.

DIABETES Review the last paragraph, and it becomes obvious that weight problems may also become associated with stress. One chronic illness sometimes associated with excessive weight gain is *diabetes*, specifically **Type 2 diabetes** (Type 1 diabetes is associated with failure of the pancreas to secrete enough insulin, necessitating medication, and is usually diagnosed before the age of 40). Type 2 diabetes is associated with excessive weight gain and occurs when pancreas insulin levels become less efficient as the body size increases. Type 2 diabetes can respond favorably to proper diet, exercise, and weight loss, but may also require medication. Typically, it is associated with older adults, but with the rise in obesity among children, more cases of Type 2 diabetes in children are now occurring.

While controllable, diabetes is a serious disorder that has now been associated with an increased risk of Alzheimer's disease, although memory loss appears to be slower for diabetic Alzheimer patients than for nondiabetic Alzheimer's patients (Sanz et al., 2010). Several ongoing longitudinal studies strongly suggest that Type 2 diabetes not only is associated with mental decline in middle-aged individuals (Nooyens et al., 2010), but there is also indication that stress can compound the risk of that mental decline (Reynolds et al., 2010).

Research has continued to link high levels of stress with increased risk of diabetes. A 35-year study in Sweden monitored the health and stress factors of 7,500 men who began the study with no history of diabetes or coronary heart disease (Novak et al., 2013). Those men who reported experiencing permanent stress, related to home life and/or work life, had a 45 percent higher chance of developing diabetes compared to men who reported no stress or only periodic stress. Another study found that high levels of stress in the workplace can accurately predict who will develop diabetes, particularly in those people who had low levels of social support (Toker et al., 2012).

CANCER Cancer is not one disease but rather a collection of diseases that can affect any part of the body. Unlike normal cells, which divide and reproduce according to genetic instructions and stop dividing according to those same instructions, cancer cells divide without stopping. The resulting tumors affect the normal functioning of the organs and systems they invade, causing them to fail, eventually killing the organism.

Although stress itself cannot directly give a person cancer, stress can have a suppressing effect on the immune system, making the unchecked growth of cancer more

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likely. In particular, an immune-system cell called a **natural killer (NK) cell** has as its main functions the suppression of viruses and the destruction of tumor cells (Herberman & Ortaldo, 1981). Stress has been shown to depress the release of natural killer cells, making it more difficult for the body's systems to fight cancerous growths (Zorilla et al., 2001). The hormone adrenaline is released under stress and has been found to interfere with a protein that normally would suppress the growth of cancer cells (Sastry et al., 2007). In other research, stress has been linked to the release of hormones such as adrenaline and noradrenaline that, over time, can cause mistakes (such as damage to the telomeres, structures at the ends of chromosomes that control the number of times a cell can reproduce) in the instructions given by the genes to the cells of the body. As these mistakes "pile up" over the years, cells can begin to grow out of control, causing the growth of tumors and possibly cancer (Kiecolt-Glaser et al., 2002).

Stress may impact the effectiveness of cancer treatments as well. In one study of mice implanted with human prostate cancer cells, treatment with a drug to destroy the cancer cells and prevent growth of tumors was effective when the mice were kept calm and stress-free, but failed miserably when the mice were stressed (Hassan et al., 2013).

One possible bit of positive news: Unlike the research linking stress at work to heart disease and diabetes, one study has found that work-related stress does not appear to be linked to developing cancer of the colon, lungs, breasts, or prostate (Heikkila et al., 2013). While 5 percent of over 100,000 participants in the 12 years over which the study took place developed some form of cancer, there was no association between job-related stress and risk of cancer.

OTHER HEALTH ISSUES Heart disease and cancer are not the only diseases affected by stress. Studies have shown that children in families experiencing ongoing stress are more likely to develop fevers with illness than are other children (Wyman et al., 2007). (Oddly enough, this same study showed that in children, stress actually seems to improve the function of their natural killer cells, just the opposite effect that is seen in adults.) A review of research and scientific literature (Cohen et al., 2007) found stress to be a contributing factor in a variety of human diseases and disorders, including heart disease, depression, and HIV/AIDS. Another longitudinal study's findings suggest that experiencing work-related stress in middle age may increase an individual's chances of developing both physical and mental disabilities in old age (Kulmala et al., 2013).

issues in psychology



Health Psychology and Stress



In the last three decades, people have become more aware of health issues and their relationship to what we do, what we eat, who we see, and how we think. A relatively new branch of psychology has begun to explore these relationships.

Health psychology focuses on how our physical activities, psychological traits, and social relationships affect our overall health and rate of illnesses. Psychologists who specialize in this field are typically clinical or counseling psychologists and may work with medical doctors in a hospital or clinic setting, although there are health psychologists who are primarily engaged in teaching and research. Some health psychologists focus on health and wellness issues in the workplace or public health issues such as disease prevention through immunizations or nutrition education. Others are more concerned with health-care programs that service all levels of the socioeconomic layers of society (Marks et al., 2005). **Watch the Video**, *The Big Picture: Health Psychology*, at **MyPsychLab**

Health psychologists seek to understand how behavior (such as use of drugs, optimism, personality, or the type of food one eats) can affect a person's ability to fight off illnesses—or

increase the likelihood of getting sick. They want to know how to prevent illness, and how factors like poverty, wealth, religion, social support, personality, and even one's ethnicity can affect health. In this age of a new focus on health care, health psychology is destined to become a more important force in future research.  [Watch the Video](#), *Special Topics: Health Disparities*, at [MyPsychLab](#)

Questions for Further Discussion

1. How have some of the factors studied by health psychologists affected you in recent months?
2. What health issues might arise in the college or university setting that could have a positive or negative impact on your psychological and physical well-being?

THE INFLUENCE OF COGNITION AND PERSONALITY ON STRESS

How do cognitive factors and personality differences affect the experience of stress?

The physical effects of stress on the body and the immune system are only part of the picture of the influence of stress in daily life. Cognitive factors, such as how an individual interprets a stressful event, and psychological factors, such as personality type, can affect the impact of stress.  [Watch the Video](#), *The Basics: Stress and Your Health: Positive Cognitions*, at [MyPsychLab](#)

COGNITIVE FACTORS IN STRESS: LAZARUS'S COGNITIVE APPRAISAL APPROACH Cognitive psychologist Richard Lazarus developed a cognitive view of stress called the *cognitive-mediation theory* of emotions, in which the way people think about and appraise a stressor is a major factor in how stressful that particular stressor becomes (Lazarus, 1991, 1999; Lazarus & Folkman, 1984).  [LINK](#) to [Learning Objective 9.9](#). According to Lazarus, there is a two-step process in assessing the degree of threat or harm of a stressor and how one should react to that stressor. (See **Figure 11.4** on the next page.)

Primary Appraisal The first step in appraising a stressor is called **primary appraisal**, which involves estimating the severity of the stressor and classifying it as a threat (something that could be harmful in the future), a challenge (something to be met and defeated), or a harm or loss that has already occurred. If the stressor is appraised as a threat, negative emotions may arise that inhibit the person's ability to cope with the threat. For example, a student who has not read the text or taken good notes will certainly appraise an upcoming exam as threatening. If the stressor is seen as a challenge, however, it is possible to plan to meet that challenge, which is a more positive and less stressful approach. For example, the student who has studied, read, and feels prepared is much more likely to appraise the upcoming exam as an opportunity to do well.

Perceiving a stressor as a challenge instead of a threat makes coping with the stressor (or the harm it may already have caused) more likely to be successful. Whereas perceiving the stressor as an embarrassment, or imagining future failure or rejection, is more likely to lead to increased stress reactions, negative emotions, and an inability to cope well (Folkman, 1997; Lazarus, 1993). Think positive!

Secondary Appraisal In **secondary appraisal**, people who have identified a threat or harmful effect must estimate the resources that they have available for coping with the stressor. Resources might include social support, money, time, energy, ability, or any number of potential resources, depending on the threat. If resources are perceived as adequate or abundant, the degree of stress will be considerably less than if resources are missing or lacking. Using the example of the student and the upcoming exam, a

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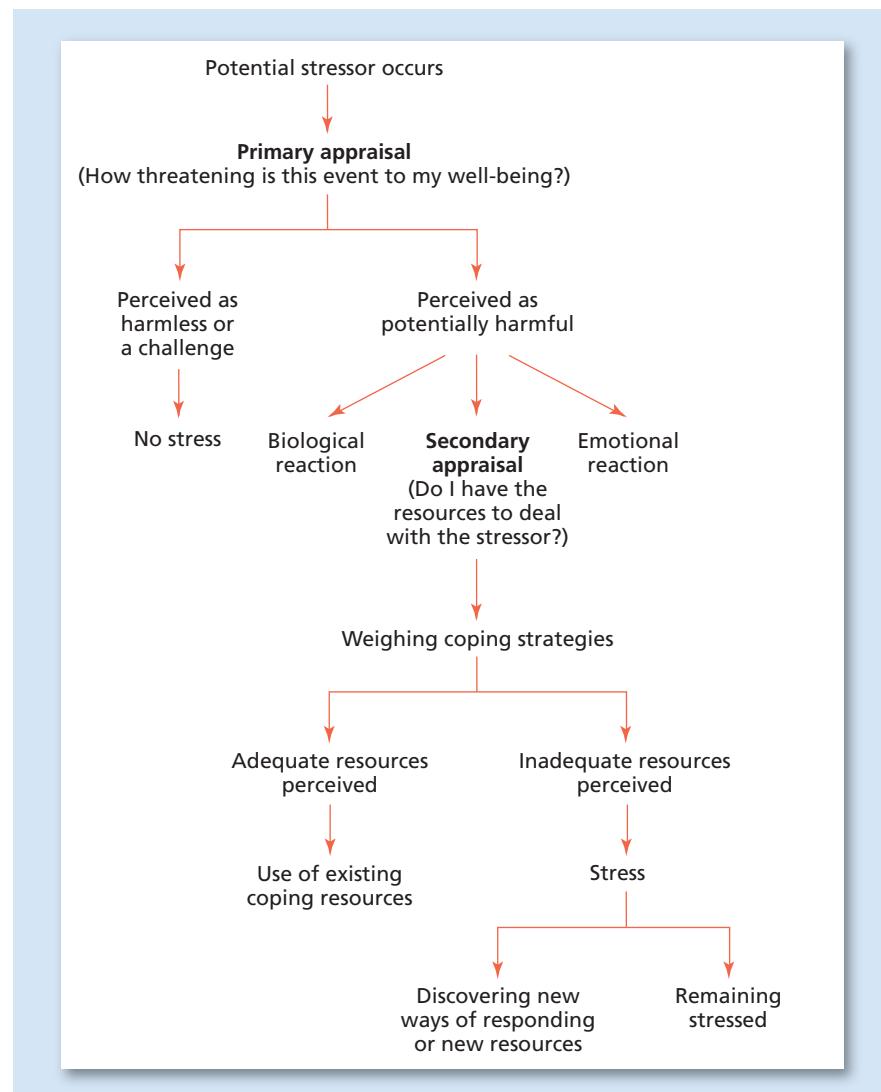
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Figure 11.4 Responses to a Stressor

Lazarus's Cognitive Appraisal Approach. According to this approach, there are two steps in cognitively determining the degree of stress created by a potential stressor. Primary appraisal involves determining if the potential stressor is a threat. If it is perceived as a threat, secondary appraisal occurs in addition to the bodily and emotional reactions. Secondary appraisal involves determining the resources one has to deal with the stress, such as time, money, physical ability, and so on. Inadequate resources lead to increased feelings of stress and the possibility of developing new resources to deal with the stress.



student who feels that she has the time to study and the ability to understand the material in that time will feel much less distress than the student who has little time to study and doesn't feel that she understood all the content of the lectures covered on the exam.

PERSONALITY FACTORS IN STRESS Of course, how one cognitively assesses a stressor has a lot to do with one's personality. People with certain kinds of personality traits—such as aggressiveness or a naturally high level of anxiety, for example—seem to create more stress for themselves than may exist in the actual stressor. Even as long ago as the early 1930s, psychologists have had evidence that personality characteristics are a major factor in predicting health. A longitudinal study begun in 1932 (Lehr & Thomae, 1987) found that personality was almost as important to longevity* as were genetic, physical, or lifestyle factors. Other researchers have found that people who live to be very old—into their 90s and even over 100 years—tend to be relaxed, easygoing, cheerful, and active. People who have the opposite personality traits, such as aggressiveness, stubbornness,

*longevity: how long people live

inflexibility, and tenseness, typically do not live as long as the *average* life expectancy (Levy et al., 2002).

Those positive and negative personality traits are some of the factors associated with two personality types that have been related to how people deal with stress and the influence of certain personality characteristics on coronary heart disease.

Type A and Type B In 1974, medical doctors Meyer Freidman and Ray Rosenman published a book titled *Type A Behavior and Your Heart*. The book was the result of studies spanning three decades of research into the influence of certain personality characteristics on coronary heart disease (Friedman & Kasanin, 1943; Friedman & Rosenman, 1959; Rosenman et al., 1975). Since then, numerous researchers have explored the link between what Friedman called Type A and Type B personalities.

Type A people are workaholics—they are very competitive, ambitious, hate to waste time, and are easily annoyed. They feel a constant sense of pressure and have a strong tendency to try to do several things at once. Often successful but frequently unsatisfied, they always seem to want to go faster and do more, and they get easily upset over small things. A typical Type A finds it difficult to relax and do nothing—Type A people take work with them on vacation, a laptop to the beach, and do business over the phone in the car.

In contrast, Type B people are not that competitive or driven, tend to be easygoing and slow to anger, and seem relaxed and at peace. Type B people are more likely to take a book to the beach to cover up their face than to actually read the book.

In 1961, the Western Collaborative Group Study (Rosenman et al., 1975) assessed 3,500 men and followed them for 8 years. For example, participants were asked to agree or disagree with statements such as “I can relax without guilt,” in which strong agreement indicates a Type B personality. The results were that Type A men were 3 times more likely to develop heart disease than were Type B men. (See **Figure 11.5**.)

The Framingham Heart Study found that the risk of coronary heart disease for women who work and are also Type A is four times that of Type B working women (Eaker & Castelli, 1988). Other research has narrowed the key factors in Type A personality and heart disease to one characteristic: hostility* (Frederickson et al., 1999; Matthews et al., 2004; Williams, 1999; Williams et al., 1980). Williams and his colleagues used the Minnesota Multiphasic Personality Inventory, a personality test that looks for certain characteristics that include the level of hostility. [LINK](#) to Learning Objective 13.8. In this study, 424 patients who had undergone exploratory surgery for coronary heart disease were examined, and the presence of heart disease was related both to being Type A and to being hostile, with hostility being the more significant factor in the hardening of the arteries to the heart (Williams, 2001; Williams et al., 1980).

Numerous studies support the link between hostility and increased risk of coronary heart disease. A study of hostility levels and risk factors for heart disease in over 4,000 young adults found that increases in hostility over a 5-year follow-up study were associated with a rise in high blood pressure, one of the major risk factors of heart disease (Markovitz et al., 1997). Another study of anger in young men and their risk for premature heart disease found that over a period of slightly more than three decades, the young men who had exhibited high levels of hostility in their youth were far more likely to develop premature cardiovascular disease, particularly heart attacks, than were those men who had lower levels of anger and hostility (Chang et al., 2002). Similar studies found that hostility in college-aged males and females was significantly related to increased risk of heart disease, particularly if levels of hostility rose in middle age (Brondolo et al., 2003; Siegler et al., 2003).



"He always times 60 Minutes."

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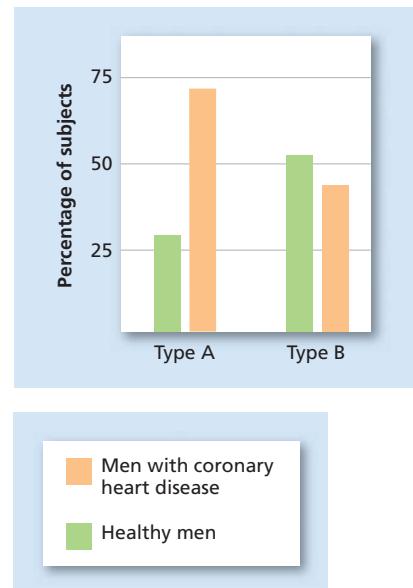


Figure 11.5 Personality and Coronary Heart Disease

The two bars on the left represent men with Type A personalities. Notice that within the Type A men, there are more than twice as many who suffer from coronary heart disease as those who are healthy. The two bars on the right represent men with Type B personalities. Far more Type B personalities are healthier than are Type A personalities, and there are far fewer Type B personalities with coronary heart disease when compared to Type A personalities.

Source: Miller et al. (1991, 1996).

*hostility: feelings of conflict, anger, and ill will that are long lasting.

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Even children may not escape the hostility–heart disease link. One study found that children and adolescents who scored high on assessments of hostility were more likely to show physical changes such as obesity, resistance to insulin, high blood pressure, and elevated levels of triglycerides 3 years after the initial measurements of hostility had been made (Raikkonen et al., 2003).



What about people who don't blow their top but try to keep everything "in" instead? Wouldn't that be bad for a person's health?

Type C A third personality type was identified by researchers Temoshok and Dreher (1992) as being associated with a higher incidence of cancer. **Type C** people tend to be very pleasant and try to keep the peace but find it difficult to express emotions, especially negative ones. They tend to internalize their anger and often experience a sense of despair over the loss of a loved one or a loss of hope. They are often lonely. These personality characteristics are strongly associated with cancer, and people who have cancer and this personality type often have thicker cancerous tumors as well (Eysenck, 1994; Temoshok & Dreher, 1992). Just as the stress of hostility puts the cardiovascular systems of Type A people at greater risk, the internalized negative emotions of the Type C personality may increase the levels of harmful stress hormones, weaken the immune system, and slow recovery.

A word of caution here: "personality type" theories have come under criticism in recent years. Many consider them to be too simplistic—many people would not fall easily into one type or another. Nevertheless, many of the personality traits associated with these types do seem to be associated with stress and longevity. Many of the characteristics of the Type A personality, for example, fit the description of a major personality trait called *neuroticism*, the tendency to worry, be moody, and be emotionally intense.  to Learning Objective 13.6. One recent longitudinal study's findings indicate that these characteristics are associated with an increased risk of an earlier death because people with these traits engage in poor health habits—poor diet, excessive drinking, smoking, and lack of exercise, to name a few (Mroczek et al., 2009).

The Hardy Personality Not all Type A people are prone to heart disease. Some people actually seem to thrive on stress instead of letting stress wear them down. These people have what is called the **hardy personality**, a term first coined by psychologist Suzanne Kobasa (1979). Hardy people (call them "Type H") differ from ordinary, hostile Type A people and others who suffer more ill effects due to stress in three ways:

- Hardy people have a deep sense of *commitment* to their values, beliefs, sense of identity, work, and family life.
- Hardy people also feel that they are in *control* of their lives and what happens to them.
- Hardy people tend to interpret events in primary appraisal differently than people who are not hardy. When things go wrong, they do not see a frightening problem to be avoided but instead a *challenge* to be met and answered.

Why would those three characteristics (often known as the three "Cs" of hardiness) lessen the negative impact of stress? Commitment makes a person more willing to make sacrifices and to deal with hardships than if commitment were lacking. Think about it: Have you ever had a job that you hated? Every little frustration and every snag was very stressful, right? Now think about doing something you love to do. The frustrations and snags that

inevitably come with any endeavor just don't seem quite as bad when you are doing something you really want to do, do they?

As for control, uncontrollability is one of the major factors cited as increasing stress, as was discussed earlier in this chapter. Seeing events as challenges rather than problems also changes the level of stress experienced, a difference similar to that felt when riding a roller coaster: If riding the coaster is your own idea, it's fun; if someone makes you ride it, it's not fun.

The tendency for hardness may even have genetic roots. Researchers have recently found that there seems to be a biochemical link between feeling miserable and an increased risk of death, and that there may be a genetic variation in some individuals that actually severs that link, making that individual more biologically resilient or hardy (Cole et al., 2010).

The four personality types discussed so far could be summed up this way: If life gives you lemons,

- Type A people get enraged and throw the lemons back, having a minor heart attack while doing so.
- Type B people gather all the lemons and make lemonade.
- Type C people don't say anything but fume inside where no one can see.
- Type H people gather the lemons, make lemonade, sell it, turn it into a franchise business, and make millions. (Remember, laughing is good for you!)

EXPLANATORY STYLE: OPTIMISTS AND PESSIMISTS In addition to personality type, there are other personal factors that have an influence on people's reactions to stressors. One of these factors is the attitude that people have toward the things that happen to them in life.

Optimists are people who always tend to look for positive outcomes. *Pessimists* seem to expect the worst to happen. For an optimist, a glass is half full, whereas for a pessimist, the glass is half empty. Researchers have found that optimism is associated with longer life and increased immune-system functioning. Mayo Clinic researchers conducted a longitudinal study of optimists and pessimists (as assessed by a scale) over a period of 30 years (Maruta et al., 2002). The results for pessimists were not good: They had a much higher death rate than did the optimists, more problems with physical and emotional health, more pain, less ability to take part in social activities, and less energy than optimists. The optimists had a 50 percent lower risk of premature death and were more calm, peaceful, and happy than the pessimists (Maruta et al., 2002). Other studies link being optimistic to higher levels of helper T cells (immune system cells that direct and increase the functioning of the immune system) and higher levels of natural killer cells, the body's antivirus, and anticancer cells (Segerstrom et al., 1998; Segerstrom & Sephton, 2010). Martin Seligman is a social learning psychologist who developed the concept of *learned helplessness*, [LINK](#) to Learning Objective 5.11, and began the positive psychology movement. Seligman (2002) has outlined four ways in which optimism may affect how long a person lives:

1. Optimists are less likely to develop learned helplessness, the tendency to stop trying to achieve a goal that has been blocked in the past.
2. Optimists are more likely than pessimists to take care of their health by preventive measures (such as going to the doctor regularly, eating right, and exercising) because they believe that their actions make a difference in what happens to them. (Remember, this is a characteristic of hardy people as well.)



Type Z behavior

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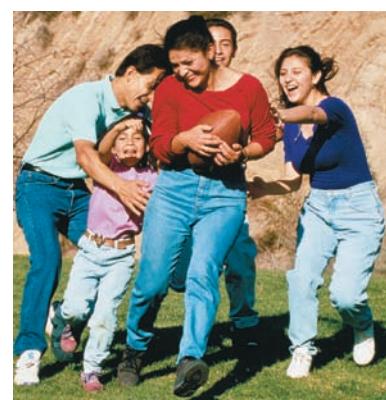
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Regular exercise—whether alone or in the company of family and friends—increases the functioning of the immune system and helps give people a sense of control over their health. Having a sense of control decreases feelings of stress, which also helps the immune system to function well.

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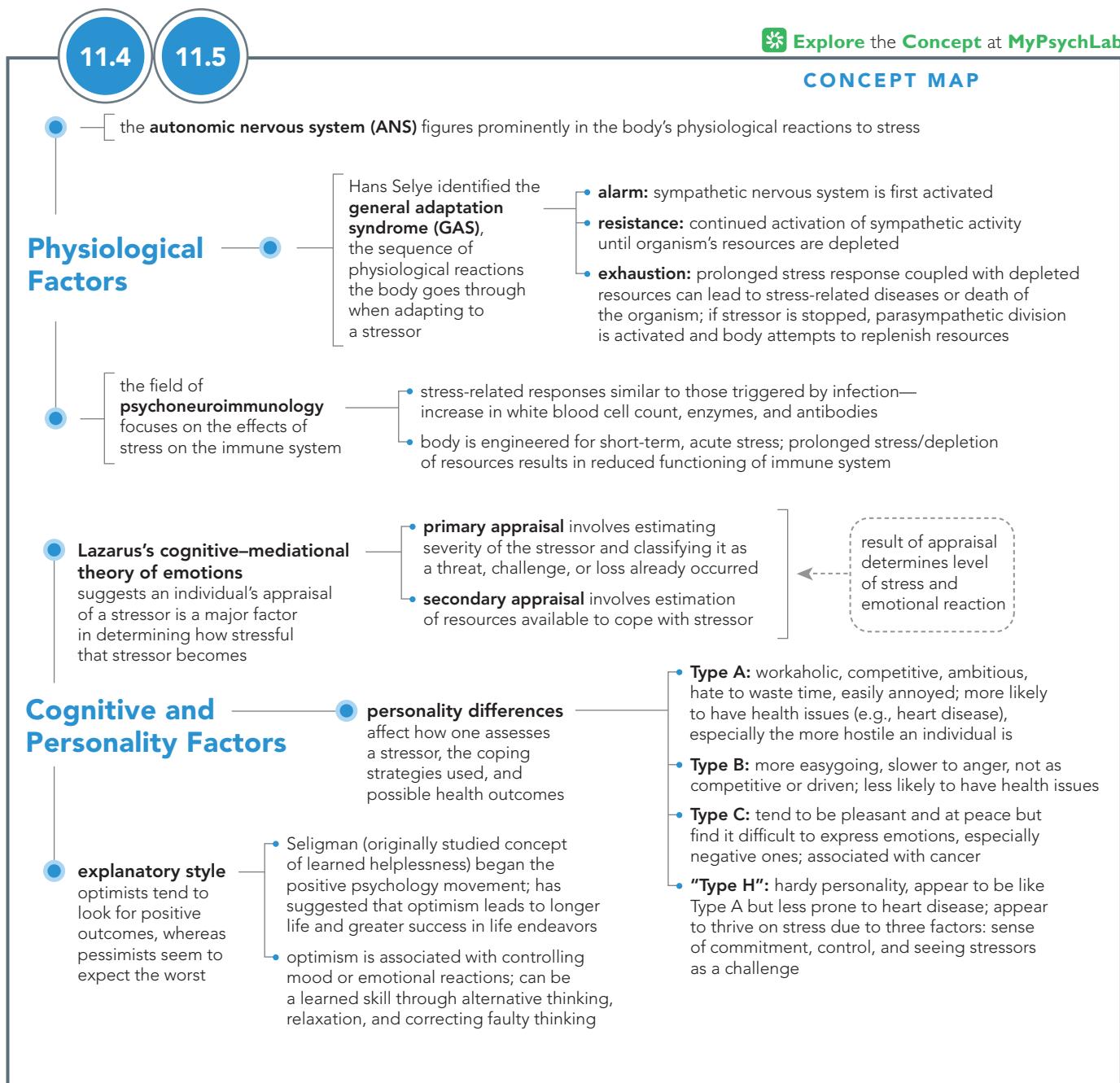
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3. Optimists are far less likely than pessimists to become depressed, and depression is associated with mortality because of the effect of depression on the immune system.
4. Optimists have more effectively functioning immune systems than pessimists do, perhaps because they experience less psychological stress.

Seligman (1998) has also found that optimists are more successful in their life endeavors than pessimists are. Optimistic politicians win more elections, optimistic students get better grades, and optimistic athletes win more contests. For some advice on how to become more optimistic, see the Applying Psychology feature at the end of this chapter.



PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. This stage of the general adaptation syndrome is accompanied by activation of the sympathetic nervous system.
 - a. alarm
 - b. resistance
 - c. exhaustion
 - d. termination
2. Typically, the immune-system response to stress is effective as long as
 - a. the stressor is eustress.
 - b. the stressor is not continuous or chronic.
 - c. the stressor is not a virus.
 - d. the stressor is not a bacteria.
3. According to Richard Lazarus, when someone asks themselves, "How can I deal with this potentially harmful stressor?" the individual is focused on a _____ appraisal.
 - a. primary
 - b. secondary
 - c. tertiary
 - d. minimal
4. Greg rushes to an appointment, arriving 20 minutes early, while Aaron arrives with only minutes to spare. Slightly annoyed when Greg points this out, Aaron replies very casually, "Hey, I'm here." We might assume Greg has more of a _____ personality while Aaron is more _____.

a. Type A; Type B	c. Type B; Type C
b. Type A; Type C	d. Type C; Type A
5. The key Type A personality component related to heart disease is
 - a. hostility.
 - b. frustration.
 - c. learned helplessness.
 - d. apathy.
6. Olivia feels as if she is in control of her life and is committed to her goals. What final aspect of hardiness does she need to possess to be considered a hardy personality?
 - a. being concerned when faced with problems
 - b. exhibiting callousness in the face of threat
 - c. being able to contain her anger
 - d. seeing an event as a challenge rather than a problem

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SOCIAL FACTORS IN STRESS: PEOPLE WHO NEED PEOPLE

What social factors influence stress reactions?

As stated earlier, much of the stress in everyday life comes from having to deal with other people and with the rules of social interaction. Overcrowding, for example, is a common source of stress. Overcrowding on our roadways, or traffic congestion, is one factor in aggressive driving behavior, which may escalate, or trigger in someone else, a disproportionate response or even *road rage* (AAA Foundation, 2009). Road rage is a criminal act of assault by drivers against other drivers, which can result in serious injuries or even death. Two of the more prominent social factors in creating stressful living conditions are both economically based: poverty and job stress.

POVERTY Living in poverty is stressful for many reasons. Lack of sufficient money to provide the basic necessities of life can lead to many stressors for both adults and children: overcrowding, lack of medical care, increased rates of disabilities due to poor prenatal care, noisy environments, increased rates of illness (such as asthma in childhood) and violence, and substance abuse (Aline et al., 2000; Bracey, 1997; Leroy & Symes, 2001; Park et al., 2002; Renchler, 1993; Rouse, 1998; Schmitz et al., 2001).

JOB STRESS Even if a person has a job and is making an adequate salary, there are stresses associated with the workplace that add to daily stressors. Some of the typical sources of stress in the workplace include the workload, a lack of variety or meaningfulness in work, lack of control over decisions, long hours, poor physical work conditions, racism, sexism, and lack of job security (Murphy, 1995).

Stress at work can result in the same symptoms as stress from any other source: headaches, high blood pressure, indigestion, and other physical symptoms; anxiety, irritability, anger, depression, and other psychological symptoms; and behavioral symptoms



Poverty can lead to many conditions that increase the degree of stress experienced by both adults and children. These children, for example, may face an increased risk of malnutrition, illness, and exposure to violence because of the conditions under which they must live.

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such as overeating, drug use, poor job performance, or changes in family relationships (Anschuetz, 1999).

 There are times when I feel like I've just had it with school and all the work the teachers pile on—is that something like workplace stress?

One of the more serious effects of workplace stress is a condition called burnout. **Burnout** can be defined as negative changes in thoughts, emotions, and behavior as a result of prolonged stress or frustration, resulting in both mental and physical exhaustion (Miller & Smith, 1993). In addition to exhaustion, symptoms of burnout are extreme dissatisfaction, pessimism, lowered job satisfaction, and a desire to quit. Although burnout is most commonly associated with job stress, college students can also suffer from burnout when the stresses of college life—term papers, exams, assignments, and the like—become overwhelming.

The emotional exhaustion associated with burnout can be lessened when a person at risk of burnout is a member, within the work environment, of a social group that provides support and also the motivation to continue to perform despite being exhausted (Halbesleben & Bowler, 2007).



This Buddhist group is celebrating Songkran, the New Year, by performing their cultural ritual of pouring water over their elder's palms. Although they are wearing clothing typical of people living in Los Angeles, California, where the ceremony is taking place, they still maintain some of their former cultural traditions. This is a good example of integration.

dress like the majority culture and adopt some of those characteristics as well. For people who choose integration, acculturative stress is usually low (Ward & Rana-Deuba, 1999).

In *assimilation*, the minority person gives up the old cultural identity and completely adopts the majority culture's ways. In the early days of the United States, many immigrants were assimilated into the mainstream American culture, even changing their names to sound more "American." Assimilation leads to moderate levels of stress, most likely due to the loss of cultural patterns and rejection by other members of the minority culture who have not chosen assimilation (LaFromboise et al., 1993; Lay & Nguyen, 1998).

Separation is a pattern in which the minority person rejects the majority culture's ways and tries to maintain the original cultural identity. Members of the minority culture

refuse to learn the language of the dominant culture, and they live where others from their culture live, socializing only with others from their original culture. An example of this might be seen in many “Chinatown” areas across the United States, in which there are some residents who do not speak any English and who rarely go outside their neighborhood. Separation results in a fairly high degree of stress, and that stress will be even higher if the separation is forced (by discrimination from the majority group) rather than voluntary (self-imposed withdrawal from the majority culture).

The greatest acculturative stress will most likely be experienced by people who have chosen to be *marginalized*, neither maintaining contact with their original culture nor joining the majority culture. They essentially live on the “margins” of both cultures without feeling or becoming part of either culture. Many Native Americans may feel marginalized, neither belonging to their original tribe of origin nor to the majority culture. Marginalized individuals do not have the security of the familiar culture of origin or the acceptance of the majority culture and may suffer a loss of identity and feel alienated from others (Roysircar-Sodowsky & Maestas, 2000). Obviously, marginalized people have little in the way of a social-support system to help them deal with both everyday stresses and major life changes.



I hear the term “social-support system” all the time now. Exactly what is it?

THE POSITIVE BENEFITS OF SOCIAL SUPPORT A **social-support system** is the network of friends, family members, neighbors, coworkers, and others who can offer help to a person in need. That help can take the form of advice, physical or monetary support, information, emotional support, love and affection, or companionship. Research has consistently shown that having a good social-support system is of critical importance in a person’s ability to cope with stressors: People with good social-support systems are less likely to die from illnesses or injuries than those without such support (Kulik & Mahler, 1989, 1993). Breast cancer patients who have good social support tend to be better able to deal with pain and other symptoms of their disease (Kroenke et al., 2012).

Marriage, itself a form of social support, is a good predictor of healthy aging and longevity (Gardner & Oswald, 2004; Vaillant, 2002). Social support has been found to have a positive effect on the immune system (Holt-Lunstad et al., 2003); for example, it has been shown to improve the mental health and physical functioning of people who have *lupus*, a chronic inflammatory disease that can affect nearly any part of the body (Sutcliffe et al., 1999; M. M. Ward et al., 1999), as well as those with cancer and HIV (Carver & Antoni, 2004; Gonzalez et al., 2004). Thinking positively impacts health as well: In one recent study, people who experience warmer, more pleasant and upbeat emotions tend to have better health, and the researchers conclude that this connection is likely due to these people being able to make more social connections (Kok et al., 2013). The increased social-support network then has a positive effect on the health of these individuals.

Social support can make a stressor seem less threatening because people with such support know that there is help available. Having people to talk to about one’s problems reduces the physical symptoms of stress—talking about frightening or frustrating events with others can help people think more realistically about the threat, for example, and talking with people who have had similar experiences can help put the event into perspective.  to Learning Objective 15.6. The negative emotions of loneliness and depression, which are less likely to occur with someone who has social support, can adversely affect one’s ability to cope (Beehr et al., 2000; Weisse, 1992). Positive emotions, on the other hand, have a decidedly beneficial effect on health, helping people recover from stressful experiences more quickly and effectively (Tugade & Fredrickson, 2004). Positive emotions are more likely to occur in the presence of friends and family.

How people think about a stressor is also a powerful influence on their ability to cope, as the next section will discuss.

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Coping with illness is always made easier when one has social support. Here, a man recovering in the hospital is visited by a volunteer and her dog. Animals are also a good source of social support, and people who have animals have been shown to recover from illnesses and stressors more quickly (Allen et al., 2002).

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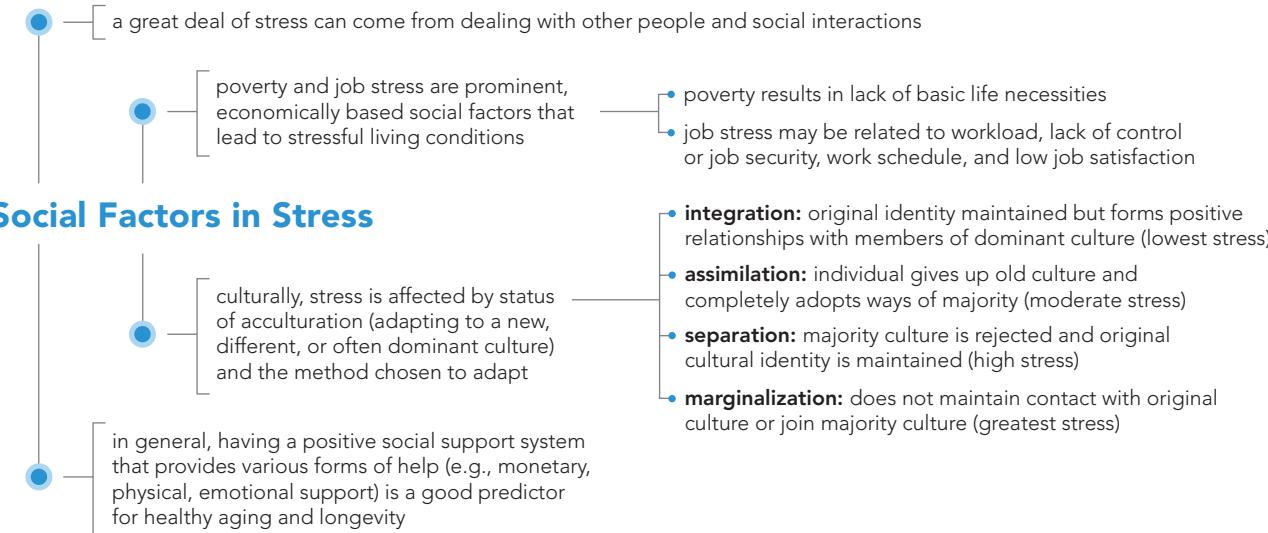
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 Explore the Concept at [MyPsychLab](#)
CONCEPT MAP**PRACTICE quiz** How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

- What are considered the two most prominent social factors in creating stressful living conditions?
 - poverty and job stress
 - income level and marital status
 - overall health and personality
 - motivation level and heredity
- Devon is a full-time college student who has not taken a semester off in three years. He increasingly finds himself fatigued and stressed by the seemingly never-ending stream of papers, exams, and group projects. It has gotten to the point where he lacks the energy to work on his projects and put little effort into his studying, figuring "What's the point?" What might Devon be experiencing?
 - Devon is simply stressed. Nothing more.
 - Devon is suffering from acculturative stress.
 - Devon is suffering from burnout.
 - Devon is suffering from eustress.
- Joaquin moved from Nicaragua to the United States. He learned to speak and write English, changed his last name so that it would sound more "American," and no longer maintains any of his old culture's styles of dress or customs. Joaquin has used which method of entering the majority culture?
 - integration
 - assimilation
 - separation
 - marginalization
- What does the greatest acculturative stress typically come from?
 - integration
 - assimilation
 - separation
 - marginalization

THINKING CRITICALLY:

In general, studies show that people who have social support are better able to deal with the effects of stress, but this does not mean that all social relationships have a positive effect on one's ability to cope. How can the people in your life interfere with your ability to handle stress, and what are some positive ways in which you can reduce that interference?

Coping With Stress

 I have exams and my job and my relationship to worry about, so I feel pretty stressed out—how do people deal with all the stress they face every day?

So far, this chapter has talked about what stress is and the factors that can magnify the effects of stress, as well as the effects of stress on a person's physical health. Effectively dealing with stress involves increased awareness so changes can be made in factors that are actually controllable. Participate in the experiment *Will This Survey Stress You Out?* to evaluate the level of stress in your life and what methods you use to cope with it.

Simulation

Will This Survey Stress You Out?

This survey asks about your experiences with stress and the things that stress you out (also called “stressors”), and about the techniques you use for managing stress.

[Go to the Experiment ►](#)

To what extent is the following statement TRUE about you: When faced with a potentially stressful situation, I try to predict what might happen, think about how I've handled this stressor before, and try to minimize the stress that this thing/event/person might cause me.

- Almost Always True
- Usually True
- Often True
- Occasionally True
- Sometimes But Infrequently True
- Usually Not True
- Almost Never True

☞ Simulate the Experiment, Will This Survey Stress You Out?, on [MyPsychLab](#)

COPING STRATEGIES

What are some ways in which people cope with stress reactions?

Coping strategies are actions that people can take to master, tolerate, reduce, or minimize the effects of stressors, and they can include both behavioral strategies and psychological strategies.

PROBLEM-FOCUSED COPING One type of coping strategy is to work on eliminating or changing the stressor itself. When people try to eliminate the source of a stress or reduce its impact through their own actions, it is called **problem-focused coping** (Folkman & Lazarus, 1980; Lazarus, 1993). For example, a student might have a problem understanding a particular professor. The professor is knowledgeable but has trouble explaining the concepts of the course in a way that this student can understand. Problem-focused coping might include talking to the professor after class, asking fellow students to clarify the concepts, getting a tutor, or forming a study group with other students who are also having difficulty to pool the group's resources.

EMOTION-FOCUSED COPING Problem-focused coping can work quite well but is not the only method people can use. Most people use both problem-focused coping and **emotion-focused coping** to successfully deal with controllable stressful events (Eschenbeck et al., 2008; Folkman & Lazarus, 1980; Lazarus, 1993; Stowell et al., 2001). Emotion-focused coping is a strategy that involves changing the way a person feels or emotionally reacts to a stressor. This reduces the emotional impact of the stressor and makes it possible to deal with the problem more effectively. For example, the student who is faced with a professor who isn't easy to understand might share his concerns with a friend, talking it through until calm enough to tackle the problem in a more direct manner. Emotion-focused coping also works for stressors that are uncontrollable and for which problem-focused coping is not possible. Someone using emotion-focused coping may decide to view the stressor as a challenge rather than a threat, decide that the problem is a minor one, write down concerns in a journal, or even ignore the problem altogether.



Ignore it? But won't that just make matters worse?

True, ignoring a problem is not a good strategy when there is something a person can actively do about solving the problem. But when it is not possible to change or

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An audience watches what is obviously a funny movie, one of the more popular choices for film-goers. A large part of the success of such comedies can be attributed to the human need to laugh—laughter helps us cope with many of life's stresses.



This man is practicing Zen yoga meditation. Meditation increases relaxation and helps to lower blood pressure and muscle tension.

eliminate the stressor, or when worrying about the stressor can be a problem itself, ignoring the problem is not a bad idea. Researchers working with people who had suffered heart attacks found that those people who worried about a future attack were more likely to suffer from symptoms of severe stress, such as nightmares and poor sleep (both factors that increase the risk of a future heart attack), than were the people who tried to ignore their worries (Ginzburg et al., 2003). [LINK](#) to Learning Objective 14.4.

Using humor can also be a form of emotion-focused coping, as the opening story to this chapter suggests. A study on the effects of laughter found that laughter actually boosted the action of the immune system by increasing the work of natural killer cells (cells that attack viruses in the body). In this study, participants were shown a humor video for 1 hour. Blood samples were taken 10 minutes before the viewing, 30 minutes into the viewing, 30 minutes after viewing, and 12 hours after viewing the humor video. There were significant increases in natural killer cell activity and nearly half a dozen other immune-system cells and systems, with some effects lasting the full 12 hours after the video ended (Berk et al., 2001).

MEDITATION AND RELAXATION AS A COPING MECHANISM **Meditation** is a series of mental exercises meant to refocus attention and achieve a trancelike state of consciousness. [LINK](#) to Learning Objective 4.1. Meditation can produce a state of relaxation that can aid in coping with the physiological reactions to a stressful situation. When properly meditating, brain waves change to include more theta and alpha waves (indicating deep relaxation), but little to no delta waves, which would indicate deep sleep (Lagopoulos et al., 2009).

Have you ever found yourself staring out into space, or at some little spot on the wall or table, only to realize that your mind has been a complete blank for the last several minutes?

The state just described is really nothing more than **concentrative meditation**, the form of meditation best known to the general public. In concentrative meditation, the goal is to focus the mind on some repetitive or unchanging stimulus (such as a spot or the sound of one's own heart beating) so that the mind can forget daily hassles and problems and the body can relax. In fact, Herbert Benson (Benson, 1975; Benson et al., 1974a, 1974b) found that meditation produces a state of relaxation in which blood pressure is lowered, alpha waves (brain waves associated with relaxation) are increased, and the amounts of melatonin secreted at night (the hormone that helps induce sleep) are increased.

Research shows that meditation is a good way to relax and lower blood pressure in adolescents and adults, men and women, and both Whites and African Americans (Barnes et al., 1997; Rainforth et al., 2007; Schneider et al., 1995; Wenneberg et al., 1997). It isn't the only way, as reading a good book or taking a warm bath also produces relaxation. Even simply resting for the same amount of time as one might meditate can be just as relaxing. The advantage of meditation is that people can do it almost anywhere, even in the classroom just before a big test. (It would be a little difficult to take a warm bath then.)

Other research has suggested that meditation can reduce the levels of chronic pain (Brown & Jones, 2010; Kabat-Zinn et al., 1986), reduce the symptoms of anxiety, depression, and hostility (Kabat-Zinn et al., 1985), reduce the risk of heart disease (Schneider et al., 2010), and reduce stress levels in cancer patients (Speca et al., 2000). Reducing stress levels in cancer patients through meditation will increase the likelihood of recovery and reduce the incidence of recurrence.

Meditation for only 20 minutes can produce lowered blood pressure in people with hypertension (high blood pressure). It can calm anxiety, help people get to sleep, and help people deal with stress.

As mentioned above, meditation is only one way to relax. In addition to warm baths and reading a good book, there are a few techniques recommended by experts to promote stress relief. One method is *progressive muscle relaxation*, in which you focus on tensing and then relaxing each of your muscle groups, usually beginning with the feet and working your way up the body. The purpose of this exercise is to help people recognize the

difference between tense muscles and relaxed ones—we are often tensed up without realizing it. Another method is *visualization*, in which you use your imagination to “go” to a calm, peaceful place or situation, using as many of your senses as you can.

HOW CULTURE AFFECTS COPING

How is coping with stress affected by culture and religion?

Imagine this scene: You are driving out in the country when you come upon an elderly man working on a large wooden box, polishing it with great care. You stop to talk to the man and find out that the box is his own coffin, and he spends his days getting it ready, tending to it with great care. He isn’t frightened of dying and doesn’t feel strange about polishing his own coffin. How would you react?

If you were from the same rural area of Vietnam as the elderly man, you would probably think nothing strange is going on. For elderly people in the Vietnamese culture, thoughts of death and the things that go along with dying, such as a coffin, are not as stressful as they are to people from Western cultures. In fact, *stress* isn’t all that common a term in Vietnamese society compared to Western societies (Phan & Silove, 1999).

Coping with stress in Vietnamese culture may include rituals, consulting a fortune-teller, or eating certain foods (Phan & Silove, 1999). In many Asian cultures, meditation is a common stress-relief tool, including the art of tai chi, a form of meditational exercise (Yip, 2002).

Other examples of cultural differences in coping: Thai children are twice as likely to use emotion-focused coping methods when facing powerful adults (doctors giving shots, angry teachers, etc.) than are children in the United States (McCarty et al., 1999). Adolescents in Northern Ireland, when compared to those in Colombia and Australia, tend to blame themselves when experiencing stress over social issues (e.g., fear of war, community violence) but also use more social/emotional support (Frydenberg et al., 2001). The Colombian youth used more problem-focused coping, as well as spiritual support and taking social action. Even within subcultures, there are different forms of coping: In interviews with Asian American, African American, and Hispanic American people living in New York after the September 11 terrorist attacks, researchers found that while both African American and Hispanic American people reported using church attendance and other forms of religious coping, Asian Americans reported using acceptance of the event as something out of their control (Constantine et al., 2005; Kuo, 2011). Cultures also vary in how much they engage their social network to help them cope.  Watch the Video, Thinking Like a Psychologist: Personality and Health: How Culture Affects Coping, at [MyPsychLab](#)

Obviously, culture is an important factor in the kinds of coping strategies an individual may adopt and even in determining the degree of stress that is experienced. Mental health professionals should make an effort to include an assessment of a person’s cultural background as well as immediate circumstances when dealing with adjustment problems due to stress.

HOW RELIGION AFFECTS COPING

A belief in a higher power can also be a source of great comfort in times of stress. There are several ways that religious beliefs can affect the degree of stress people experience and the ability to cope with that stress (Hill & Butter, 1995; Pargament, 1997).

First, most people who hold strong religious beliefs belong to a religious organization and attend regular religious functions, such as services at a synagogue, mosque, temple, or church. This membership can be a vital part of a person’s social-support system. People do not feel alone in their struggle, both literally because of the people who surround them in their religious community and spiritually because of the intangible presence of their deity (Koenig et al., 1999).



These Peruvian villagers in a cemetery are honoring their loved ones who have passed away. The Day of the Dead is not only a celebration of the lives of those who have passed on but also a celebration for the living, who use this holiday to gain a sense of control over one of life’s most uncontrollable events—death itself. What rituals or ceremonies do people of other cultures use to cope with death?

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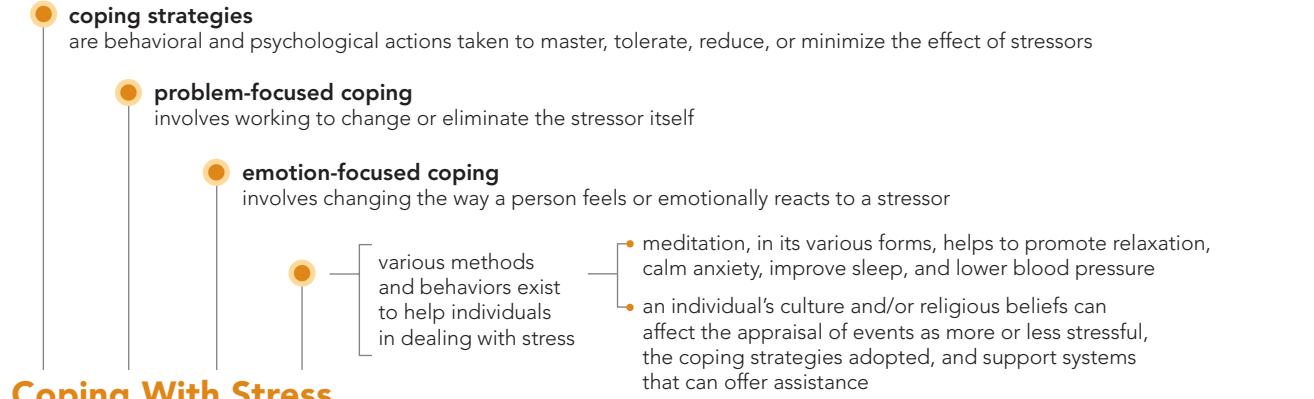
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Another way that religion helps people cope involves the rituals and rites that help people feel better about personal weaknesses, failures, or feelings of inadequacy (Koenig et al., 2001). These include rituals such as confession of sins or prayer services during times of stress. Religion can also increase the likelihood that a person will volunteer to help others, and feel stronger and better in many ways. Finally, religious beliefs can give meaning to things that otherwise seem to have no meaning or purpose, such as viewing death as a pathway to a paradise, or the destruction of one's home in a natural disaster as a reminder to place less attachment on material things.

Many religions also encourage healthy behavior and eating habits—eating wisely; limiting or forgoing the use of alcohol, tobacco, and other drugs; and sanctioning monogamous relationships. Some research even suggests that people with religious commitments live longer than those who have no such beliefs, although this is correlational research ([LINK](#) to [Learning Objective 1.9](#)) and should not be interpreted as concluding that religious belief causes longer life expectancies (Hummer et al., 1999; Koenig et al., 1999; Lambert et al., 2013; Strawbridge et al., 1997; Thoresen & Harris, 2002).

11.7

11.8

 Explore the Concept at [MyPsychLab](#)
CONCEPT MAP**PRACTICE quiz How Much Do You Remember?**

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Wanda explains that she ignores her problems when she feels she cannot control them or when she worries about them to the point of causing problems elsewhere in her life. What does the research say about using such an approach?
 - a. This method can be somewhat harmful, even if only used occasionally.
 - b. This method is helpful only if you are a Type B personality.
 - c. This method is fine when the stressor cannot be eliminated or worrying about the stressor causes problems.
 - d. This method is dangerous, since a stressor really must be dealt with so as to feel better.
2. What does the research tell us about the effects of laughter on alleviating stress?
 - a. Laughter can alleviate immediate stress but the effects last only a few minutes.
 - b. Laughter has been shown to help the immune system.
 - c. Laughter in reality has little to no effect on one's overall stress level.
 - d. Laughter can actually have a negative effect on the body.
3. Simply put, what type of stress reduction is tai chi, the focusing of the mind on specific movements of the body?
 - a. optimism
 - b. meditation
 - c. personality type
 - d. progressive muscle relaxation
4. Meditation, progressive muscle relaxation, and guided visualization are _____ coping strategies for stress.

<ol style="list-style-type: none"> a. very effective b. basically ineffective 	<ol style="list-style-type: none"> c. emotion-focused d. problem-focused
---	--
5. What effect, if any, does religion have on one's stress?
 - a. Religion has not been shown to effect one's stress.
 - b. Religion can actually increase one's stress.
 - c. Religion can help to alleviate stress in young people, but not in senior citizens.
 - d. Religion can help people effectively cope with stress in multiple ways.

THINKING CRITICALLY:

What methods of stress reduction do you typically rely on? How effective do you believe them to be? Why?

Applying Psychology to Everyday Life: Becoming More Optimistic

What are some ways to become a more optimistic thinker?

As the work of Martin Seligman and others has shown, optimistic thinking is a good thing. How can you become more optimistic? Optimism is mostly a matter of controlling mood or emotional reactions to situations. The way to become an optimist is to monitor one's own thinking. Recognition of negative thoughts is the first step, followed by disputing those same negative thoughts (Seligman, 2002). The problem is that most people don't really think about their thoughts or characterize them as negative or pessimistic, which means that the damaging effects of such thinking are left uncontrolled. Here's a plan to follow to become an optimistic thinker:

1. When a bad mood strikes, stop and think about what just went through your head.
2. When you've recognized the negative statements, treat them as if they came from someone else—someone who is trying to make your life miserable. Think about the damage the statement is doing to you.
3. Argue with those thoughts. Challenge each negative statement and replace it with a more positive statement.

Example: "I'll never get this term paper finished, it's too hard and there's so much going on that it's impossible!"

1. What words in this statement make it pessimistic? "Never" is a long time. Why is it too hard? Is it really impossible, or just difficult? Is it just one part of the paper that seems so hard, or is it the whole thing?
2. That statement isn't going to help me at all; it just makes me feel worse and that makes me unmotivated to work on the paper.
3. I can finish the term paper. I'm just going to have to devote more time to working on it. I can make a timetable for finishing the different parts of the paper and stop spending so much time watching television and escaping into other activities that can wait until the paper is finished. I've been in situations like this before and managed, so I can manage now, too.

Notice that the third way of thinking is much more positive and hopeful. It includes ways to get around what seemed too hard or impossible in the negative statement. Essentially, the last step in becoming a more optimistic thinker is to learn to argue with yourself and correct distorted or faulty thinking. Recognizing faulty thinking can be difficult at first. The following questions may help people to home in on* negative thinking:

1. In thinking about the thoughts you have had in the last few hours, how many of them were negative thoughts? How could you change those thoughts to be more positive?
2. When thinking about people you know who make a lot of negative self-statements or who are always minimizing their efforts or putting themselves down, how does their behavior make you feel? How do you think their behavior makes them feel?

 **Watch** the [Video](#), *What's In It For Me?: The Challenge Of Quitting Bad Health Habits*, at [MyPsychLab](#)

Questions for Further Discussion

1. Do you think you are an optimist, a pessimist, or somewhere in between?
2. What are some things you can do in your own life to become more optimistic?

*home in on: in this instance, to move toward a target or goal.

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Writing Prompt

- ▼ Imagine a friend has just lost his job which helped him cover tuition costs. Apply Lazarus and Folkman's cognitive theory of stress and describe his potential reactions to this job loss. In your answer, be sure to describe the following: stressful event; primary appraisal; secondary appraisal; stress response.

Words: 0

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 Write the Response on **MyPsychLab**

chapter summary

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Stress and Stressors

11.1 How do psychologists define stress?

- Stress is the physical, emotional, and behavioral responses that occur when events are identified as threatening or challenging.
- Stress that has a negative impact is called "distress." Eustress is the optimal amount of stress that people need to function well.

11.2 What kinds of external events can cause stress?

- Catastrophes are events such as floods or crashes that can result in high levels of stress.
- Major life changes create stress by requiring adjustments. Major life changes have an impact on chronic health problems and risk of accidents.
- Hassles are the daily frustrations and irritations that have an impact on day-to-day health.

11.3 What are some psychological factors in stress?

- Four sources of stress are pressure, uncontrollability, frustration, and conflict.
- Frustration, which can be internal or external, may result in persistence, aggression, displaced aggression, or withdrawal.

Physiological Factors: Stress and Health

11.4 How does stress affect the physical functioning of the body and its immune system?

- The autonomic nervous system consists of the sympathetic system, which responds to stressful events, and the parasympathetic system, which restores the body to normal functioning after the stress has ceased.
- The general adaptation syndrome is the body's reaction to stress and includes three stages of reaction: alarm, resistance, and exhaustion.
- Stress causes the immune system to react as though an illness or invading organism has been detected, increasing the functioning of the immune system.
- As the stress continues or increases, the immune system can begin to fail.

11.5 How do cognitive factors and personality differences affect the experience of stress?

- The cognitive appraisal approach states that how people think about a stressor determines, at least in part, how stressful that stressor will become.
- The first step in appraising a stressor is called primary appraisal, in which the person determines whether an event is threatening, challenging, or of no consequence. Threatening events are more stressful than those seen as challenging.

- The second step is secondary appraisal, in which the person assesses the resources available to deal with the stressor, such as time, money, and social support.
- Type A personalities are ambitious, time conscious, hostile, and angry workaholics who are at increased risk of coronary heart disease, primarily due to their anger and hostility.
- Type B personalities are relaxed and easygoing and have one-third the risk of coronary heart disease as do Type A personalities if male, and one-fourth the risk if female and working outside the home.
- Type C personalities are pleasant but repressed, internalizing their negative emotions.
- Hardy people are hard workers who lack the anger and hostility of the Type A personality, instead seeming to thrive on stress.
- Optimists look for positive outcomes and experience far less stress than pessimists, who take a more negative view.

11.6 What social factors influence stress reactions?

- Several social factors can be a source of stress or increase the effects of stress: poverty, stresses on the job or in the workplace, and entering a majority culture that is different from one's culture of origin.
- Burnout is a condition that occurs when job stress is so great that the person develops negative thoughts, emotions, and behavior as well as an extreme dissatisfaction with the job and a desire to quit.
- The four methods of acculturation are integration, assimilation, separation, and marginalization.
- Social-support systems are important in helping people cope with stress.

Coping With Stress

11.7 What are some ways in which people cope with stress reactions?

- Problem-focused coping is used when the problem can be eliminated or changed so that it is no longer stressful or so that the impact of the stressor is reduced.
- Emotion-focused coping is often used with problem-focused coping and involves changing one's emotional reactions to a stressor.
- Meditation can produce a state of relaxation and reduce the physical reactions common to stressful situations.
- Concentrative meditation involves focusing inward on some repetitive stimulus, such as one's breathing.

11.8 How is coping with stress affected by culture and religion?

- Different cultures perceive stressors differently, and coping strategies will also vary from culture to culture.
 - People with religious beliefs also have been found to cope better with stressful events.

test YOURSELF

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Pick the best answer.

1. Dean has a comprehensive final exam in three weeks that he is concerned about. His concerns prompt him to go ahead and start studying and in doing so, he feels less worried as the exam approaches. In this example, the exam, Dean's concerns, and his behavior may be seen as an example of _____.

 - burnout
 - depression
 - distress
 - eustress

2. Researchers today believe that eustress is based off of _____ of motivation.

 - Maslow's theory
 - the arousal theory
 - the biological theory
 - the need for affiliation theory

3. Unpredictable, large-scale events that create a great deal of stress and feelings of threat are called

 - major life events.
 - catastrophes.
 - hassles.
 - major hassles.

4. A score above 300 on the SRRS would indicate a person has a _____ of becoming ill or having an accident.

 - very high risk
 - average
 - low risk
 - no risk

5. In addition to being emotionally intense, many items on both the SRRS and CUSS are stressful because they

 - involve the most hassles.
 - cause heart disease.
 - turn into catastrophes.
 - lead to mild stress disorder.

6. Research suggests the number and perceived severity of daily hassles are strong predictors of

 - diabetes.
 - headaches.
 - depression.
 - heart attacks.

7. Based on previous research, who is more likely to experience lack of money as the biggest daily hassle in their life?

 - children
 - adolescents
 - young adults
 - elderly people

8. Time pressure is often found to have a negative impact on

 - creativity.
 - depression.
 - predictability.
 - frustration.

9. Michael was cut from his high school basketball team. He told his friends that he was cut because the coach did not like him, but his close friends know Michael was cut because he hardly ever practiced. In this situation, Michael's excuse is an example of a(n) _____ frustration, while the fact he despises practicing is an example of a(n) _____ frustration.

 - personal; external
 - external; personal
 - internal; external
 - personal; internal

10. Kina's husband comes home from work angry because of an argument he had with his boss. Subsequently, Kina's husband begins yelling at her for no apparent reason. Ultimately, Kina finds herself yelling at their youngest child for apparently no good reason other than being frustrated. Kina is displaying

 - escape.
 - withdrawal.
 - displaced aggression.
 - projection.

11. Erica was very frustrated with her job and ultimately decided to quit. What do we call this method of handling frustration?

Applying Psychology to Everyday Life: Becoming More Optimistic

11.9 What are some ways to become a more optimistic thinker?

- The best way to become more optimistic is to recognize negative thoughts and change them to more helpful positive thoughts.

ANSWERS AVAILABLE IN ANSWER KEY.

- a. This approach is called using a scapegoat.
b. This is an example of an emotion-focused method.
c. This approach is called escape or withdrawal.
d. This approach is called ignoring.

12. Keenan is trying to decide if he should go on spring break with his friends to Las Vegas or with his other friends to Miami Beach, both of which he has enjoyed going to in the past. Keenan's situation is an example of a(n) _____ conflict.
a. approach–approach c. approach–avoidance
b. avoidance–avoidance d. multiple approach–avoidance

13. In which of Selye's stages is death a possible outcome?
a. alarm c. reaction
b. resistance d. exhaustion

14. According to Richard Lazarus, determining what can be done to deal with one's stress is an example of a _____ appraisal.
a. primary c. formal
b. secondary d. tertiary

15. Jolene rarely takes any work home, preferring to leave her work worries at the office. She is a bit carefree and not as ambitious as some of the other women in her office. Instead, Jolene likes to have a lot of leisure time whenever possible. She is also easygoing and doesn't lose her temper often, preferring to avoid conflict. Which of the following statements about Jolene is most likely TRUE?
a. She is a Type A personality. c. She is a Type C personality.
b. She is a Type B personality. d. Jolene's risk of coronary heart disease is high.

16. Azriel seems to thrive on stress and feels very much in control of his life. He would probably be labeled a _____ personality.
a. Type A c. Type C
b. Type B d. hardy

17. Huong has moved from China to the United States. While she dresses and acts like her American friends, she still has retained much of her cultural heritage and attends traditional Chinese dance classes on the weekends. This is an example of
a. assimilation. c. separation.
b. integration. d. marginalization.

18. Gary is having trouble with psychology and statistics. He goes to the school's academic help center for tutoring and spends extra time working on problems at home. Gary's method of coping is
a. problem focused. c. defensive focused.
b. emotion focused. d. internal.

19. To alleviate her stress, Jenny often closes her eyes and envisions herself on a quiet beach during sunset. This vision often helps her to relax, especially before talking in front of a crowd. Such an approach is known as
a. relaxation. c. progressive muscle relaxation.
b. concentrative meditation. d. visualization.

20. Which of the following people may have the greatest ability to cope with stress?
a. Mary, a very religious person who is involved in her community
b. Carrie, who works hard but doesn't have any apparent hobbies or other interests
c. Jeri, who has few friends and whose family lives far away from her
d. Larry, who is highly driven to succeed

12

social psychology

Early in May of 2013, a man helped three young woman escape from a decade of captivity. Amanda Berry, Gina DeJesus, and Michelle Knight had been kidnapped as young girls and held captive in a house in Cleveland, Ohio. Charles Ramsey, who lived next door, had been eating dinner one night when he heard Amanda's cries for help. Instead of turning back to his dinner, he went to the aid of the young woman, helping her and the other victims escape. Ramsey's actions may not seem heroic at first—it's what anyone should, and would, do, right? But psychologists have long known that just the opposite is often true. A well-known principle in social psychology is the *bystander effect*: The likelihood of someone who is in trouble being helped decreases as the number of witnesses or bystanders increases. As we'll learn, there are many aspects of how people influence the actions and even the thinking of others.

How are your actions influenced by others? Are there certain actions or personal beliefs that you feel are consistent regardless of your social surroundings?

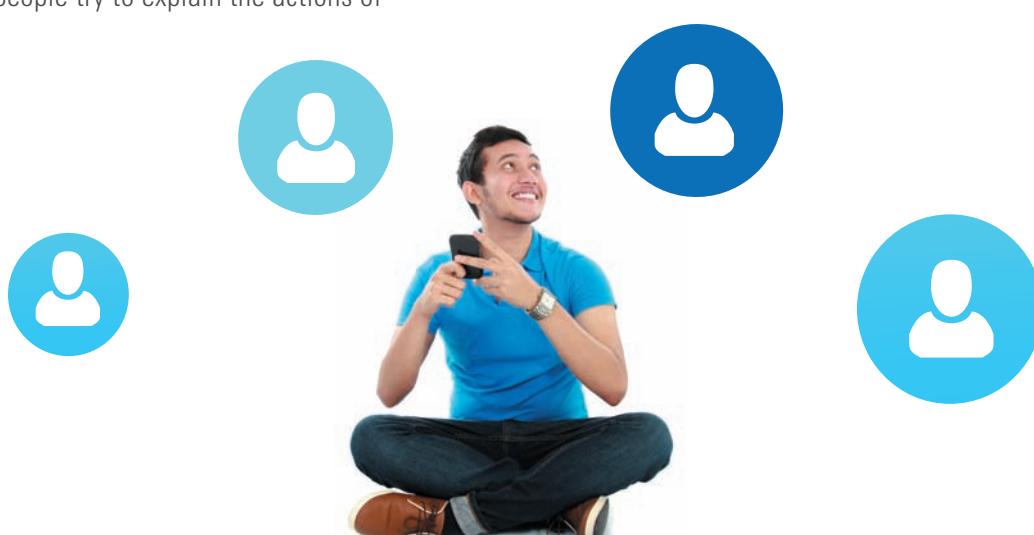
The image shows a video player interface. In the center is a portrait of a woman with dark hair and glasses, wearing an orange blouse. Behind her are two stylized birds composed of numerous small, colorful shapes. The video player has a dark grey control bar at the bottom. From left to right, it contains: a play/pause button, a volume icon, a captioning icon labeled 'CC', and a sharing icon. Below the video player is a call-to-action button with the text 'Watch the Video at MyPsychLab.com' and an eye icon.

Why study social psychology?

If people lived in total isolation from other people, there would be no reason to study the effect that other people have on the behavior of individuals and groups. But human beings are social creatures—we live with others, work with others, and play with others. The people who surround us all of our lives have an impact on our beliefs and values, decisions and assumptions, and the way we think about ourselves and about other people in general. Why are some people prejudiced toward certain other people? Why do we obey some people but not others? What causes us to like, to love, or to hate others? The answers to all these questions and many more can be found in the study of social psychology.

Learning objectives

- | | |
|---|--|
| 12.1
What factors influence people or groups to conform to the actions of others, and how does the presence of others affect individual task performance? | 12.8
How are prejudice and discrimination different? |
| 12.2
How is compliance defined, and what are some ways to gain the compliance of another? | 12.9
Why are people prejudiced, and how can prejudice be stopped? |
| 12.3
What factors make obedience more likely? | 12.10
What factors govern attraction and love, and what are some different kinds of love? |
| 12.4
What are the three components of an attitude, how are attitudes formed, and how can attitudes be changed? | 12.11
How is aggressive behavior determined by biology and learning? |
| 12.5
How do people react when attitudes and behavior are not the same? | 12.12
What is altruism, and how is deciding to help someone related to the presence of others? |
| 12.6
How are social categorization and implicit personality theories used in impression formation? | 12.13
What is social neuroscience? |
| 12.7
How do people try to explain the actions of others? | |



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Social Influence: Conformity, Group Behavior, Compliance, and Obedience

Chapter One defined psychology as the scientific study of behavior and mental processes, including how people think and feel. The field of **social psychology** also looks at behavior and mental processes but includes as well the social world in which we exist, as we are surrounded by others to whom we are connected and by whom we are influenced in so many ways. It is the scientific study of how a person's behavior, thoughts, and feelings influence and are influenced by social groups  Watch the Video, *The Big Picture: The Social World*, at [MyPsychLab](#).

Each of us lives in a world filled with other people. An infant is born into a world with adults who have an impact on the infant's actions, personality, and growth. Adults must interact with others on a daily basis. Such interactions provide ample opportunity for the presence of other people to directly or indirectly influence the behavior, feelings, and thoughts of each individual in a process called **social influence**. There are many forms of social influence. People can influence others to follow along with their own actions or thoughts, to agree to do things even when the person might prefer to do otherwise, and to be obedient to authorities. The mere presence of others, whether real or merely implied, can even influence the way people perform tasks successfully or unsuccessfully.

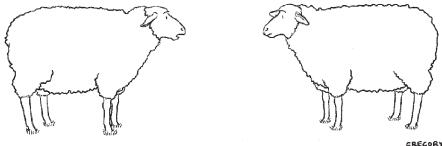
CONFORMITY

What factors influence people or groups to conform to the actions of others, and how does the presence of others affect individual task performance?

Have you ever noticed someone looking up at something? Did the urge to look up to see what that person was looking at become so strong that you actually found yourself looking up? This common practical joke always works, even when people suspect that it's a joke. It clearly demonstrates the power of **conformity**: changing one's own behavior to more closely match the actions of others.

In 1936, social psychologist Muzafer Sherif conducted a study in which participants were shown into a darkened room and exposed to a single point of light. Under those conditions, a point of light will seem to move because of tiny, involuntary movements of the eye.  to Learning Objective 3.11. The participants were not told of this effect and reported the light moved anywhere from a few inches to several feet. When a confederate (a person chosen by the experimenter to deliberately manipulate the situation) also gave estimates, the original participants began to make estimates of motion that were more and more similar to those of the confederate (Sherif, 1936). This early experiment on conformity has been criticized because the judgments being made were ambiguous* (i.e., the light wasn't really moving so any estimate within reason would sound good). Would participants be so easily swayed if the judgments were more specifically measurable and certain?

ASCH'S CLASSIC STUDY ON CONFORMITY Solomon Asch (1951) conducted the first of his classic studies on conformity by having seven participants gather in a room. They were told that they were participating in an experiment on visual judgment. They were then shown a white card with only one line on it followed by another white card with three lines of varying lengths. The task was to determine which line on the second card was most similar to the line on the first card (see Figure 12.1).



"Sure, I follow the herd—not out of brainless obedience, mind you, but out of a deep and abiding respect for the concept of community."

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*ambiguous: having no clear interpretation or able to be interpreted in many ways rather than just one way.

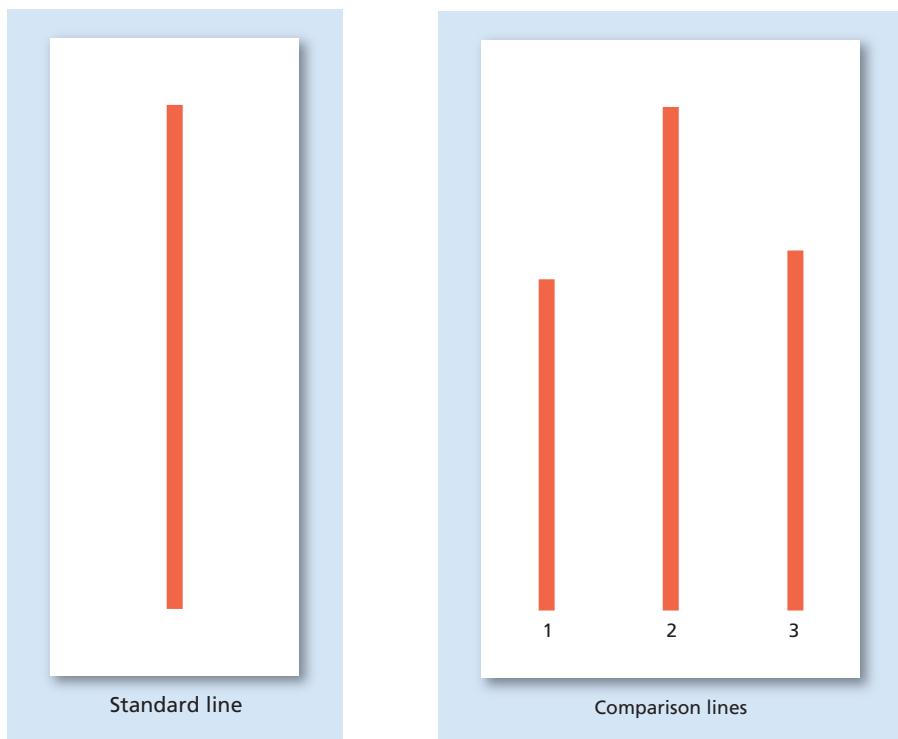


Figure 12.1 Stimuli Used in Asch's Study

Participants in Asch's famous study on conformity were first shown the standard line. They were then shown the three comparison lines and asked to determine to which of the three was the standard line most similar. Which line would you pick? What if you were one of several people, and everyone who answered ahead of you chose line 3? How would that affect your answer?

Source: Adapted from Asch (1956).

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In reality, only the next-to-the-last person in the group was a real participant. The others were all confederates who were instructed by the experimenter to pick the same *incorrect* line from the comparison lines. Would the real participant, having heard the others pick what seemed to be the wrong answer, change to conform to the group's opinion? Surprisingly, the participants conformed to the group answer a little over one-third of the time. Asch also found that the number of confederates mattered: Conformity increased with each new confederate until there were four confederates; more than that did not increase the participants' tendency to conform (Asch, 1951). In a later experiment, Asch (1956) found that conformity greatly decreased if there was just one confederate who gave the correct answer—apparently, if participants knew that there was at least one other person whose answer agreed with their own, the evidence of their own eyes won out over the pressure to conform to the group.

Subsequent research in the United States has found less conformity among participants, perhaps suggesting that the Asch conformity effect was due to the more conforming nature of people in the era and culture of the United States in the 1950s (Lalancette & Standing, 1990; Nicholson et al., 1985; Perrin & Spencer, 1980, 1981). In other cultures, however, studies have found conformity effects similar to those in Asch's study (Neto, 1995). Still others have found even greater effects of conformity in collectivist cultures, such as Hong Kong, Japan, and Zimbabwe (Bond & Smith, 1996; Kim & Markus, 1999). This cultural difference may exist only when face-to-face contact is a part of the task, however. One study found that when the Asch judgment task is presented in an online format (participants were in communication but not able to see each other), the cultural difference disappears (Cinnirella & Green, 2007).



What about gender—are men or women more conforming?

Research shows that gender differences are practically nonexistent unless the situation involves behavior that is not private. If it is possible to give responses in

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private, conformity is no greater for women than for men, but if a public response is required, women do tend to show more conformity than men (Eagly, 1987; Eagly et al., 2000; Eagly & Carly, 2007). This effect may be due to the socialization that women receive in being agreeable and supportive; however, the difference in conformity is quite small.

Why do people feel the need to conform at all? One factor at work is *normative social influence*, the need to act in ways that we feel will let us be liked and accepted by others (Hewlin, 2009; Kaplan & Miller, 1987). We use the behavior and attitudes of other people as our “measuring stick” of what is “normal.” We then judge how we are doing against that “norm.” Have you ever laughed at a joke you really didn’t get because everyone else was laughing? That’s an example of normative social influence. Another factor at work is *informational social influence*, in which we take our cues for how to behave from other people when we are in a situation that is not clear or is ambiguous (Isenberg, 1986). In this case, the behavior of the people around us provides us with information about how we should act, and so we conform to their actions.

THE HAZARDS OF GROUPTHINK Shortly after the terrorist attack on the World Trade Center in New York, President George W. Bush and his administration made the decision to invade Iraq, find Saddam Hussein, and stop him before he could use his “weapons of mass destruction” that the administration and its advisors believed were hidden in Iraq. This decision to invade a country that had not committed an open act of war against the United States was made and executed *without* building any broad-based support from allies. Although there were advisors who thought the action to be a mistake, no one person was willing to stand up to the rest of the group and challenge the group’s decision and assumptions. Many now see this decision (a costly decision in terms of lost lives and casualties, huge monetary expenditures, and—according to many—the tarnishing of the diplomatic status of the United States in the eyes of the rest of the world) as a prime example of **groupphink**. Groupphink occurs when people within a group feel it is more important to maintain the group’s cohesiveness than to consider the facts realistically (Hogg & Hains, 1998; Janis, 1972, 1982; Kamau & Harorimana, 2008; Schafer & Crichlow, 1996). Other examples include the sinking of the *Titanic* in 1912 (the group responsible for designing and building the ship assumed she was unsinkable and did not even bother to include enough lifeboats on board for all the passengers), the *Challenger* disaster of 1986 in which a part on the shuttle was known by a few to be unacceptable (but no one spoke up to delay the launch), and the disastrous Bay of Pigs invasion of Cuba during the Kennedy administration.

Why does groupphink happen? Social psychologist Irving Janis (1972, 1982), who originally gave this phenomenon its name, lists several “symptoms” of groupphink. For example, group members may come to feel that the group can do no wrong, is morally correct, and will always succeed, creating the illusion of invulnerability.* Group members also tend to hold stereotyped views of those who disagree with the group’s opinions, causing members to think that those who oppose the group have no worthwhile opinions. They exert pressure on individual members to conform to group opinion, prevent those who might disagree from speaking up, and even censor themselves so that the group’s mindset will not be disturbed in a “don’t rock the boat” mentality. Self-appointed “mind guards” work to protect the leader of the group from contrary viewpoints. (See **Table 12.1**.)

Several things can be done to minimize the possibility of groupphink (Hart, 1998; McCauley, 1998; Moorhead et al., 1998). For example, leaders should remain

*invulnerability: quality of being unable to be attacked or harmed.



On April 20, 2010, an explosion occurred on the Deepwater Horizon oil drilling rig in the Gulf of Mexico. Oil flowed into the Gulf for three months, but the environmental impact will no doubt be felt for years. How might groupphink apply in this situation?

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Table 12.1**Characteristics of Groupthink**

CHARACTERISTIC	DESCRIPTION
Invulnerability	Members feel they cannot fail.
Rationalization	Members explain away warning signs and help each other rationalize their decision.
Lack of introspection	Members do not examine the ethical implications of their decision because they believe that they cannot make immoral choices.
Stereotyping	Members stereotype their enemies as weak, stupid, or unreasonable.
Pressure	Members pressure each other not to question the prevailing opinion.
Lack of disagreement	Members do not express opinions that differ from the group consensus.
Self-deception	Members share in the illusion that they all agree with the decision.
Insularity	Members prevent the group from hearing disruptive but potentially useful information from people who are outside the group.

Source: Janis (1972, 1982).

impartial and the entire group should seek the opinions of people outside the group. Any voting should be done by secret ballots rather than by a show of hands, and it should be made clear that group members will be held responsible for decisions made by the group.

GROUP BEHAVIOR

Social influence is clearly seen in the behavior of people within a group, as Asch's classic study and the discussion of groupthink illustrated. But conformity and groupthink are only two ways in which a group can influence the behavior of an individual. Here are just a few others.

GROUP POLARIZATION Once called the "risky shift" phenomenon, **group polarization** is the tendency for members involved in a group discussion to take somewhat more extreme positions and suggest riskier actions when compared to individuals who have not participated in a group discussion (Bossert & Schworm, 2008; Moscovici & Zavalloni, 1969). A good example of group polarization can occur when a jury tries to decide on punitive damages during a civil trial: Studies have found that if members of a jury individually favored a relatively low amount of punitive damages before deliberation, after deliberation the amount usually lessened further. Similarly, if the individual jurors favored stiffer penalties, the deliberation process resulted in even higher penalties (MacCoun & Kerr, 1988). Group polarization is thought to be due to both normative social influence and informational social influence.

SOCIAL FACILITATION AND SOCIAL LOAFING Social influence can affect the success or failure of an individual's task performance within a group. The perceived difficulty of the task seems to determine the particular effect of the presence of others as well: If a task is perceived as easy, the presence of other people seems to improve performance. If the task is perceived as difficult, the presence of others actually has a negative effect on performance. The positive influence of others on performance is called **social facilitation**, whereas the negative influence is called **social impairment** (Aiello & Douthitt, 2001; Michaels et al., 1982; Zajonc, 1965).

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In both social facilitation and social impairment, the presence of other people acts to increase arousal (Rosenblom et al., 2007; Zajonc, 1965, 1968; Zajonc et al., 1970). Social facilitation occurs because the presence of others creates just enough increased arousal to improve performance. But the presence of others when the task is difficult produces too high a level of arousal, resulting in impaired performance.  to Learning Objective 9.3.

Interestingly, people who are lazy tend not to do as well when other people are also working on the same task, but they can do quite well when working on their own. This phenomenon is called **social loafing** (Karau & Williams, 1993, 1997; Latané et al., 1979; Suleiman & Watson, 2008). The reason for this is that it is easier for a lazy person (a “loafer”) to hide laziness when working in a group of people, because it is less likely that the individual will be evaluated alone. But when the social loafer is working alone, the focus of evaluation will be on that person only. In that case, the loafer works harder because there is no one else to whom the work can be shifted.

Social loafing depends heavily on the assumption that personal responsibility for a task is severely lessened when working with a group of other people. One study suggests that although Americans may readily make that assumption, Chinese people, who come from a more interdependent cultural viewpoint, tend to assume that each individual within the group is still nearly as responsible for the group’s outcome as the group at large (Menon et al., 1999). Chinese people may, therefore, be less likely to exhibit social loafing than are people in the United States.

DEINDIVIDUATION Finally, when people are gathered in a group there is often a tendency for each individual in the group to experience **deindividuation**, the lessening of their sense of personal identity and personal responsibility (Diener et al., 1980). This can result in a lack of self-control when in the group that would not be as likely to occur if the individual were acting alone. People in a crowd feel a degree of anonymity—being unknown and unidentified—and are more likely to act impulsively as a result. One only has to think about behavior of people in a riot or even the actions of groups like the Klu Klux Klan to see examples of deindividuation. The Stanford prison experiment, discussed later in this chapter, is an excellent study of deindividuation in action (Zimbardo, 1970, 1971; Zimbardo et al., 2000).

COMPLIANCE

How is compliance defined, and what are some ways to gain the compliance of another?

 I have a friend who watches all those infomercials on the shopping channels and buys stuff that isn’t worth the money or that doesn’t work like it’s supposed to work. Why do people fall for pitches like that?

Marketing products is really very much a psychological process. In fact, the whole area of **consumer psychology** is devoted to figuring out how to get people to buy things that someone is selling.  to Learning Objective B.7. But infomercials are not the only means by which people try to get others to do what they want them to do. **Compliance** occurs when people change their behavior as a result of another person or group asking or directing them to change. The person or group asking for the change in behavior typically doesn’t have any real authority or power to command a change; when that authority does exist and behavior is changed as a result, it is called *obedience*, which is the topic of the next major section of this chapter.



At first the man in the foreground seems to be paying attention to the woman making the presentation. But if you look carefully at his computer screen, you’ll see he’s actually engaging in some serious social loafing. How do you think his colleagues around the room might feel about his behavior?

A number of techniques that people use to get the compliance of others clearly show the relationship of compliance to the world of marketing, as they refer to techniques that salespersons would commonly use.

FOOT-IN-THE-DOOR TECHNIQUE A neighbor asks you to keep an eye on his house while he is on vacation. It's a small request, so you agree. Later that day the neighbor asks if you would kindly water his plants while he's gone. This is a little bit more involved and requires more of your time and energy—will you do it? If you are like most people, you probably will comply with this second, larger request.

When compliance with a smaller request is followed by a larger request, people are quite likely to comply because they have already agreed to the smaller one and they want to behave consistently with their previous response (Cialdini et al., 1995; Dillard, 1990, 1991; Freedman & Fraser, 1966; Meineri & Guéguen, 2008). This is called the **foot-in-the-door technique** because the first small request acts as an opener. (Door-to-door salespeople once literally stuck a foot in the door to prevent the occupant from shutting it so they could continue their sales pitch, hence, the name.)

DOOR-IN-THE-FACE TECHNIQUE Closely related to the foot-in-the-door technique is its opposite: the **door-in-the-face technique** (Cialdini et al., 1975). In this method, the larger request comes first, which is usually refused. This is followed by a second smaller and more reasonable request that often gets compliance. An example of this would be if the neighbor first asked you to take care of his dog and cat in your home. After you refused to do so, the neighbor might ask if you would at least water his plants, which you would now be more likely to do.

LOWBALL TECHNIQUE Another compliance technique, also common in the world of sales, is called the **lowball technique** (Bator & Cialdini, 2006; Burger & Petty, 1981; Weyant, 1996). In this technique, once a commitment is made, the cost of that commitment is increased. (In the sense used here, *cost* does not necessarily mean money; *cost* can also mean time, effort, or other kinds of sacrifices.) For example, let's say that a professor agrees to write a textbook for a publishing company. Once committed to that process, the professor discovers that the task involves not only writing but also traveling to meet with editors, working nights and weekends to meet deadlines, and making the commitment to take time off from her teaching job to finish the text on time for publication. (This example is purely hypothetical, of course.)

A more common example will occur to anyone who has ever bought a car. The commitment to buy the car at one low price is quickly followed by the addition of other costs: extended warranties, additional options, taxes and fees, and so on, causing the buyer to spend more money than originally intended.  [Watch the Video](#), *What's in It for Me?*: *Persuasion: Three Methods*, at [MyPsychLab](#).

Cultural differences exist in people's susceptibility to these techniques. For the foot-in-the-door technique in particular, research has shown that people in individualist cultures (such as the United States) are more likely to comply with the second request than are people in collectivist cultures (such as Japan). The research suggests that people in collectivist cultures are not as concerned with being consistent with previous behavior because they are less focused on their inner motivation than are people in individualist cultures, who are more concerned with their inner motives and consistency (Cialdini et al., 1999; Petrova et al., 2003).  [LINK](#) to [Learning Objective 13.7](#).

The concept of compliance, along with conformity, also figures heavily in cult behavior, as the following Psychology in the News section explains.

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psychology in the news



Anatomy of a Cult



On September 3, 2012, the Reverend Sun Myung Moon, leader of the Unification Church and self-proclaimed messiah, died at the age of 92 (Brown, 2012). The Unification Church, founded by Moon in 1954, has expanded throughout the world and is a prime example of a cult. The term **cult** literally refers to any group of people with a particular religious or philosophical set of beliefs and identity. In the strictest sense of the word, the Roman Catholic Church and Protestantism are cults within the larger religion of Christianity. But most people associate the term *cult* with a negative connotation*: A group of people whose religious or philosophical beliefs and behavior are so different from that of mainstream organizations that they are viewed with suspicion and seen as existing on the fringes of socially acceptable behavior. Although many cults exist without much notice from more mainstream groups, at times members of cults have horrified the public with their actions, as was the case with the Reverend Jim Jones and the People's Temple.

In 1997, the followers of the Heaven's Gate cult, who believed that aliens in a spaceship were coming in the tail of the Hale-Bopp comet, committed suicide under the leadership of Marshall Applewhite. They believed that their souls would be taken up by the comet aliens.

Why would any person get so caught up in cult beliefs that suicide, and in some cases murder, becomes a desired behavior? It seems that people who are under a lot of stress, dissatisfied with their lives, unassertive, gullible, dependent, who feel a desire to belong to a group, and who are unrealistically idealistic ("We can solve all the world's problems if everyone will just love each other") are the most likely targets of cult recruitment (Langone, 1996). Young people rebelling against parental authority or trying to become independent of families are prime targets.

Cult leaders have certain techniques for gaining compliance that are common to most cult organizations. The first step is usually something called "love-bombing" by current cult members, who shower the recruits with affection and attention and claim to understand just how the potential cult members feel. Then efforts are made to isolate the recruits from family and friends who might talk them out of joining. This is accomplished in part by keeping the recruits so busy with rigid rituals, ways of dress, meditations, and other activities that they do not allow the recruits time to think about what is happening. Cults also teach their members how to stop questioning thoughts or criticisms, which are typically seen as sins or extremely undesirable behavior. In other words, cults promote a high degree of conformity and compliance (Singer & Lalich, 1995; Zimbardo & Hartley, 1985).

Commitments to the cult are small at first, such as attending a music concert or some other cult function. (Notice that this is the foot-in-the-door technique.) Eventually, a major step is requested by the cult, such as quitting one's job, turning over money or property to the cult, or similar commitments. Leaving a cult is quite difficult, as members of the cult in good standing will often track down a "deserter."

Parents, friends, and other family members have been known to hire special "deprogrammers" to help their loved one recover from cult membership, willingly or unwillingly. Sometimes people actually have to "kidnap" their loved one out of the cult environment. Nevertheless, as difficult as it is to leave, 90 percent or more of cult members do eventually get out (Barker, 1983, 2007; Galanter, 1983).

*connotation: the meaning of a word or concept that is more suggestive than directly stated.

Cults have existed all through recorded history and will probably continue to exist in the future. Most cults do not pose a physical threat to their members or others, but the examples of the followers of Jim Jones, Marshall Applewhite, and David Koresh (the Waco, Texas disaster in 1993) clearly demonstrate that cults, like any group of people, can become deadly.

Questions for Further Discussion

1. In what ways are the methods used by cults on new recruits similar to the methods used by the military when training new soldiers?
 2. Is it ethical for the family members of an adult to "kidnap" and deprogram a cult member?
 3. Which methods of compliance do cults seem to use to recruit new members?
 4. Do you think that the followers of the late Osama bin Laden constitute a cult? Why or why not?
-

OBEDIENCE

What factors make obedience more likely?

There is a difference between the concepts of compliance, which is agreeing to change one's behavior because someone else asks for the change, and **obedience**, which is changing one's behavior at the direct order of an authority figure. A salesperson who wants a person to buy a car has no real power to force that person to buy, but an authority figure is a person with social power—such as a police officer, a teacher, or a work supervisor—who has the right to demand certain behavior from the people under the authority figure's command or supervision.

How far will people go in obeying the commands of an authority figure? What factors make obedience more or less likely? These are some of the questions that researchers have been investigating for many years. The answers to these questions became very important not only to researchers but also to people everywhere after the atrocities committed by the soldiers in Nazi Germany—soldiers who were "just following orders."

MILGRAM'S SHOCKING RESEARCH In what is now a classic study, social psychologist Stanley Milgram set out to find answers to these questions. He was aware of Asch's studies of conformity and wondered how much impact social influence could have on a behavior that was more meaningful than judging the length of lines on cards. He designed what has become one of the most famous (even notorious*) experiments in the history of psychology.

Through ads placed in the local newspaper, Milgram recruited people who were told that they would be participating in an experiment to test the effects of punishment on learning behavior (Milgram, 1963, 1974). Although there were several different forms of this experiment with different participants, the basic premise was the same: The participants believed that they had randomly been assigned to either the "teacher" role or the "learner" role, when in fact the learner was a confederate already aware of the situation. The task for the learner was a simple memory test for paired words.

*notorious: widely and unfavorably known.

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Figure 12.2 Control Panel in Milgram's Experiment

In Stanley Milgram's classic study on obedience, the participants were presented with a control panel like this one. Each participant ("teacher") was instructed to give electric shocks to another person (the "learner," who only pretended to be shocked by pounding on the wall and playing a pre-recorded audio tape of grunts, protests, and screams). At what point do you think you would have refused to continue the experiment?

The teacher was seated in front of a machine through which the shocks would be administered and the level of the shocks changed. (See **Figure 12.2**.) For each mistake made by the learner, the teacher was instructed to increase the level of shock by 15 volts. The learner (who was not actually shocked) followed a carefully arranged script by pounding on the wall and playing a series of pre-recorded audio responses (sounds of discomfort, asking for the experiment to end, screaming) or remained silent as if unconscious—or dead. (See **Table 12.2** for samples similar to the scripted responses of the learner.) As the teachers became reluctant to continue administering the shocks, the experimenter in his authoritative white lab coat said, for example, "The experiment requires you to continue" or "You must continue," and reminded the teacher that the experimenter would take full responsibility for the safety of the learner.

How many of the participants continued to administer what they believed were real shocks? Milgram surveyed psychiatrists, college students, and other adults prior to the experiments for their opinions on how far the participants would go in administering shocks. Everyone predicted that the participants would all refuse to go on at some point, with most believing that the majority of the participants would start refusing as soon as the learner protested—150 volts. None of those he surveyed believed that any participant would go all the way to the highest voltage.

So were they right? Far from it—in the first set of experiments, 65 percent of the teachers went all the way through the experiment's final 450-volt shock level, although many were obviously uncomfortable and begged to be allowed to stop. Of those teachers who did protest and finally stopped, not one of them quit before reaching 300 volts!



So what happened? Were those people sadists? Why would they keep shocking someone like that?

No one was more stunned than Milgram himself. He had not believed that his experiments would show such a huge effect of obedience to authority. These results do not appear to be some random "fluke" resulting from a large population of cruel people residing in the area. These experiments have been repeated at various times, in the United States and in other countries, and the percentage of participants who

Table 12.2

Sample Script Items Similar to Those in Milgram's Classic Experiment

VOLTAGE OF "SHOCK"	STATEMENTS SIMILAR TO THE LEARNER'S SCRIPT
120	"Ouch! Experimenter, let me out of here, I'm through! Please, I have heart trouble, I don't want to go on."
150	"That's it, enough! I will not be part of this experiment, let me out now!"
300	(Scream of pain heard in the background) "I am not doing this anymore, you can't make me stay here. Get me out, get me out!"
330	(Louder and longer scream of pain) "Get me out, get me out, my heart, my heart! My chest hurts, get me out of here, let me out of here, you have no right to do this! Let me out of here!"

Adapted from: Milgram (1963, 1974).

went all the way consistently remained between 61 and 66 percent (Blass, 1999; Slater et al., 2006).



That's incredible—I just don't believe that I could do something like that to someone else.

EVALUATION OF MILGRAM'S RESEARCH Researchers have looked for particular personality traits that might be associated with high levels of obedience but have not found any one trait or group of traits that consistently predicts who will obey and who will not in experiments similar to Milgram's original studies (Blass, 1991). The people who "went all the way" were not necessarily more dependent or susceptible to being controlled by others; they were simply people like most other people, caught in a situation of "obey or disobey" the authority. Some have suggested that Milgram's results may have been due to the same kind of foot-in-the-door technique of compliance as discussed earlier, with participants more likely to go on with each next demanding step of the experiment because they had already agreed to the smaller increments of shock (Gilbert, 1981). Gradually increasing the size of follow-up requests is helpful in changing behavior or attitudes, and participants may have actually come to see themselves as the type of person that follows the experimenter's instructions (Burger, 1999, 2009; Cialdini & Goldstein, 2004).

Milgram's research also raised a serious ethical question: How far should researchers be willing to go to answer a question of interest? Some have argued that the participants in Milgram's studies may have suffered damaged self-esteem and serious psychological stress from the realization that they were willing to administer shocks great enough to kill another person, just on the say-so of an experimenter (Baumrind, 1964). Milgram (1964b) responded to the criticism by citing his follow-up study of the participants, in which he found that 84 percent of the participants were glad to have been a part of the experiment and only 1.3 percent said that they were sorry they had been in the experiment. A follow-up psychiatric exam 1 year later also found no signs of harm or trauma in the participants. Even so, most psychologists do agree that under the current ethical rules that exist for such research, this exact study would never be allowed to happen today.

 to Learning Objective 1.13.

There has been at least one attempt to replicate Milgram's study in recent years, although the shock was limited to only 150 volts (Burger, 2009). In that study, the confederates asked to end the study at 150 volts and the participants were asked whether they should continue or not. Regardless of their answer, the study was ended at that point. The results showed that the participants were only slightly less likely to obey than those in Milgram's study.

Some research has suggested that these studies may not actually examine "obedience" as most often portrayed. A follow-up study to the 2009 replication (Burger et al., 2011) found none of the participants continued with the experiment when the highest of the four prompts the experimenter used was reached. This was the only prompt readily seen as an actual order, "You have no other choice, you must go on." The more the prompts came across as an order, the less likely the teachers "obeyed" (Burger et al., 2011). Furthermore, it has been suggested that instead of obedience, the outcomes of the Milgram paradigm may be more about social identity. The participants identified themselves more in line with the experimenter than the learner, and acted in a way that demonstrated their commitment to the larger scientific process, rather than to the ordinary community (Reicher et al., 2012). Instead of blindly following orders, the participants were actively working to reach a goal established by the leader, or in this case, the experimenter. These possible reformulations will certainly offer social psychologists additional ways to further investigate the complex topic of obedience in the future.

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 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP

conformity changing one's own behavior to more closely match the actions of others

- several classic studies (i.e., Sherif, Asch) suggest that individuals will change their behaviors to conform to those of a group
- may be influenced by private vs. face-to-face contact, gender, or culture
- groupthink:** occurs when people within a group feel it is more important to maintain group cohesiveness rather than critically evaluate facts when making decisions often with dire consequences

compliance persons changing their behavior due to another person or group asking or directing them to change, often in the absence of any real authority or power

- foot-in-the-door technique**
- door-in-the-face technique**
- lowball technique**

Social Influence

(the ways in which a person's behavior can be affected by other people)

obedience changing one's behavior at the direct order of an authority figure

a classic study by Milgram (i.e., teacher/learner electrical shock study) indicated that 65% of "teachers" went all the way through shock levels, despite protest from "learners"

group behavior

group polarization risky shift phenomenon

presence of others increases extreme positions

task performance

can be affected by social influence

social facilitation = positive influence

social impairment = negative influence

presence of others increases arousal

social loafing occurs when people do not work hard when others are also working; easy to "hide" in a group

deindividuation group members may feel anonymous and experience less personal responsibility

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

- In Asch's study, conformity decreased when
 - at least four confederates were present.
 - at least one confederate agreed with the participant.
 - the participant was a male.
 - the participant had high self-esteem.
- Which of the following would not be effective in minimizing groupthink?
 - Caroline wants her team to openly vote by a show of hands either for or against her business plan.
 - Karen openly invites input from all team members and even those outside her team.
 - Annina reminds her team that everyone will be held responsible for the ultimate decision of her group.
 - Juanita works hard to remain impartial to all ideas no matter what they are.
- One of the keys to deindividuation is
 - group polarization.
 - group protection.
 - conformity.
 - anonymity.
- Conner needs just \$20 more to go out with his friends. He asks his mother for \$50 but she tells him he can have \$30 instead. In the end, Conner ended up with \$10 more than he originally planned. What technique did Connor use?
 - foot-in-the-door technique
 - door-in-the-face technique
 - lowball technique
 - planned obedience
- Follow-up research to Stanley Milgram's original study has found that _____ of "teachers" will deliver shocks up to the point of being lethal.
 - less than 30 percent
 - 40 percent
 - over 60 percent
 - over 80 percent

THINKING CRITICALLY:

Can you think of a time when you conformed with a group of friends? Did you believe their decision to do something was a poor decision? Did you conform with the group and go along with the behavior anyways? Why? Based on Asch's studies and studies on groupthink, what might have kept you from objecting?

Social Cognition: Attitudes, Impression Formation, and Attribution

Social cognition focuses on the ways in which people think about other people and how those cognitions influence behavior toward those other people. In this section, we'll concentrate on how we perceive others and form our first impressions of them, as well as how we explain the behavior of others and ourselves.

ATTITUDES

What are the three components of an attitude, how are attitudes formed, and how can attitudes be changed?

One area of social cognition concerns the formation and influence of attitudes on the behavior and perceptions of others. An **attitude** can be defined as a tendency to respond positively or negatively toward a certain idea, person, object, or situation (Triandis, 1971). This tendency, developed through peoples' experiences as they live and work with others, can affect the way they behave toward those ideas, people, objects, and situations and can include opinions, beliefs, and biases. In fact, attitudes influence the way people view these things *before* they've actually been exposed to them (Petty et al., 2003).

What do you mean—how can an attitude have an effect on something that hasn't happened yet?

Attitudes are not something people have when they are born. They are learned through experiences and contact with others and even through direct instruction from parents, teachers, and other important people in a person's life. Because attitudes involve a positive or negative evaluation of things, it's possible to go into a new situation, meet a new person, or be exposed to a new idea with one's "mind already made up" to like or dislike, agree or disagree, and so on (Eagly & Chaiken, 1993; Petty et al., 2003). For example, children are known for making up their minds about certain foods before ever tasting them, simply because the foods are "green." Those children may have tried a green food in the past and disliked it and now are predisposed* to dislike any green food whether they've tasted it or not.

THE ABC MODEL OF ATTITUDES Attitudes are actually made up of three different parts, or components, as shown in **Figure 12.3** on the next page. These components should not come as a surprise to anyone who has been reading the other chapters in this text because, throughout the text, references have been made to personality and traits being composed of the ways people think, feel, and act. By using certain terms to describe these three things, psychologists have come up with a handy way to describe the three components of attitudes (Eagly & Chaiken, 1993, 1998; Fazio & Olson, 2003).

Affective Component The *affective component* of an attitude is the way a person feels toward the object, person, or situation. *Affect* is used in psychology to mean "emotions" or "feelings," so the affective component is the emotional component. For example, some people might feel that country music is fun and uplifting.

Behavior Component The *behavior component* of an attitude is the action that a person takes in regard to the person, object, or situation. For example, a person who feels that country music is fun is likely to listen to a country music station, buy country music MP3s, or go to a country music concert.

*predisposed: referring to a tendency to respond in a particular way based on previous experience.

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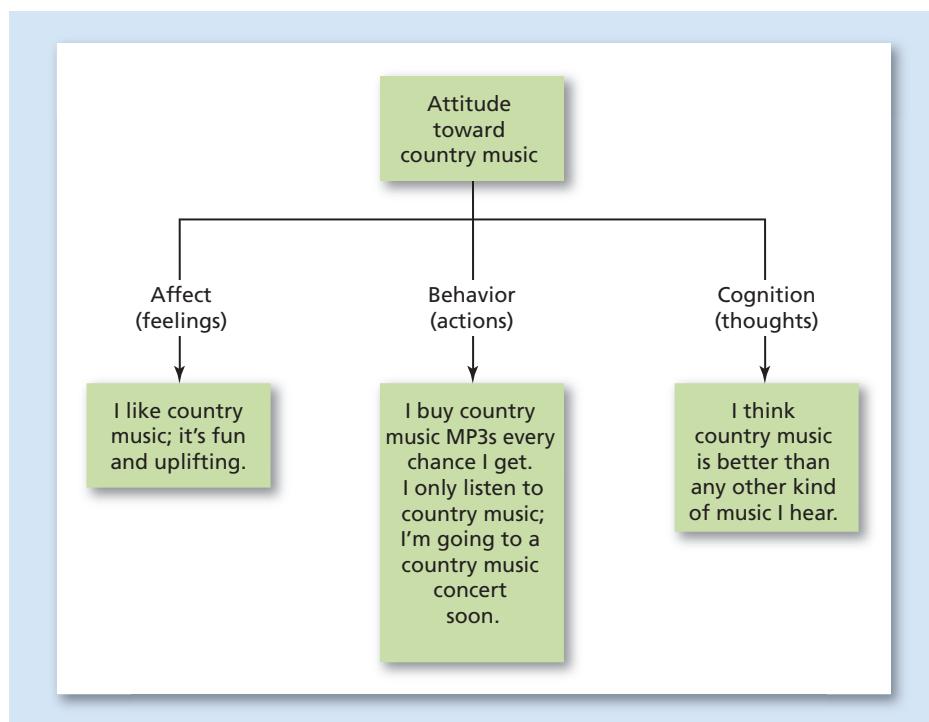
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Figure 12.3 Three Components of an Attitude

Attitudes consist of the way a person feels and thinks about something, as well as the way the person chooses to behave. If you like country music, you are also likely to think that country music is good music. You are also more likely to listen to this style of music, buy this type of music, and even go to a performance. Each of the three components influences the other two.



Cognitive Component Finally, the *cognitive component* of an attitude is the way a person thinks about him or herself, an object, or a situation. These thoughts, or cognitions, include beliefs and ideas about the focus of the attitude. For example, the country music lover might believe that country music is superior to other forms of music.

So if you know what someone thinks or feels about something, you can predict what that person will do, right?

Oddly enough, attitudes turn out to be pretty poor predictors of actual behavior in a number of controlled research studies. The results of several decades of research indicate that what people say and what people do are often two very different things (van de Garde-Perik et al., 2008; Wicker, 1971). Studies have found that attitudes predict behavior only under certain conditions. For example, in one study researchers found that a randomly chosen sample of people indicated in a survey that they believed in protecting the environment and would be willing to pay more for fruits and vegetables raised under environmentally friendly conditions. When the people of that same sample were studied for their actual buying habits, the only sample members who bought the ecofriendly fruit did so in grocery stores in areas of higher income levels. These consumers actually had the financial means to “put their money where their mouth was” (A. Clarke et al., 1999). Those members of the sample who did not live in a higher income area gave what they probably saw as a socially desirable answer on the survey, but in practice, their lower income influenced their actual behavior—they did NOT buy the more expensive ecofriendly fruit.

Another factor in matching attitudes and behavior concerns how specific the attitude itself is. People may hold a general attitude about something without reflecting that attitude in their actual behavior. For example, doctors generally hold the attitude that people should do everything they can to protect their health and promote wellness, yet many doctors still smoke tobacco, fail to exercise, and often get too little sleep. But a very specific attitude, such as “exercise is important to my immediate health,” will more likely be associated with the behavior of exercising (Ajzen, 2001; Ajzen & Fishbein, 2000).

Some attitudes are stronger than others, and strong attitudes are more likely to predict behavior than weak ones. A person who quit smoking because of failing health



While many people may believe in helping the environment by using organically grown products, one study found that only those with the money to buy these more expensive products did so.

might have a stronger attitude toward secondhand smoke than someone who quit smoking on a dare, for example. The importance, or salience*, of a particular attitude in a given situation also has an impact on behavior—the more important the attitude appears, the more likely the behavior will match the attitude. Someone who is antismoking might be more likely to confront a smoker breaking the rules in a hospital, for example, than they would a smoker outside the building (Eagly & Chaiken, 1998).

ATTITUDE FORMATION Attitude formation is the result of a number of different influences with only one thing in common: They are all forms of learning.

Direct Contact One way in which attitudes are formed is by direct contact with the person, idea, situation, or object that is the focus of the attitude. For example, a child who tries and dislikes brussels sprouts will form a negative attitude about brussels sprouts.

Direct Instruction Another way attitudes are formed is through direct instruction, either by parents or some other individual. Parents may tell their children that smoking cigarettes is dangerous and unhealthy, for example.

Interaction With Others Sometimes attitudes are formed because the person is around other people with that attitude. If a person's friends, for example, all hold the attitude that smoking is cool, that person is more likely to think that smoking is cool as well (Brenner, 2007; Eddy et al., 2000; Hill, 1990; Shean et al., 1994).

Vicarious Conditioning (Observational Learning) Many attitudes are learned through the observation of other people's actions and reactions to various objects, people, or situations. Just as a child whose mother shows a fear of dogs may develop a similar fear,  to Learning Objective 5.3, a child whose mother or father shows a positive attitude toward classical music may grow into an adult with a similarly positive attitude.

Attitudes are not only influenced by other people in a person's immediate world but also by the larger world of the educational system (many attitudes may be learned in school or through reading books) and the mass media of magazines, television, and the movies—a fact of which advertisers and marketing experts are well aware (Gresham & Shimp, 1985; MacKenzie et al., 1986).

ATTITUDE CHANGE: THE ART OF PERSUASION



Sometimes people learn attitudes that aren't necessarily good ones, right? So can attitudes change?

Because attitudes are learned, they are also subject to change with new learning. The world is full of people, companies, and other organizations that want to change peoples' attitudes. It's all about the art of **persuasion**, the process by which one person tries to change the belief, opinion, position, or course of action of another person through argument, pleading, or explanation.

Persuasion is not a simple matter. There are several factors that become important in predicting how successful any persuasive effort at attitude change might be. These factors include the following:

- **Source:** The *communicator* is the person delivering the message. There is a strong tendency to give more weight to people who are perceived as experts, as well as those who seem trustworthy, attractive, and similar to the person receiving the message (Eagly & Chaiken, 1975; O'Keefe, 2009; Petty & Cacioppo, 1986, 1996; Priester & Petty, 1995).

*salience: importance or having the quality of being obvious or easily seen.

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How the jurors in this courtroom interpret and process the information they are given will determine the outcome of the trial. Those who listen carefully to what is said by persons involved in the trial are using central-route processing. There may be some jurors, however, who are more affected by the appearance, dress, attractiveness, or tone of voice of the lawyers, defendant, and witnesses. When people are persuaded by factors other than the message itself, it is called peripheral-route processing.

- **Message:** The actual message should be clear and well organized (Booth-Butterfield, 1996). It is usually more effective to present both sides of an argument to an audience that has not yet committed to one side or the other (Crowley & Hoyer, 1994; O'Keefe, 2009; Petty & Cacioppo, 1996; Petty et al., 2003). Messages that are directed at producing fear are more effective if they produce only a moderate amount of fear and also provide information about how to avoid the fear-provoking consequences (Kleinot & Rogers, 1982; Meyrick, 2001; Petty, 1995; Rogers & Mewborn, 1976).

- **Target Audience:** The characteristics of the people who are the intended target of the message of persuasion are also important in determining the effectiveness of the message. The age of the audience members can be a factor, for example. Researchers have found that people who are in the young adult stage of the late teens to the mid-20s are more susceptible to persuasion than are older people (O'Keefe, 2009; Visser & Krosnick, 1998).

- **Medium:** The form through which a person receives a message is also important. For example, seeing and hearing a politician's speech on television may have a very different effect than simply reading about it in the newspaper or online. The visual impact of the television coverage is particularly important because it provides an opportunity for the source of the message to be seen as attractive, for example.

How easily influenced a person is will also be related to the way people tend to process information. In the **elaboration likelihood model** of persuasion (Petty & Cacioppo, 1986), it is assumed that people either elaborate (add details and information) based on what they hear (the facts of the message) or they do not elaborate at all, preferring to pay attention to the surface characteristics of the message (length, who delivers it, how attractive the message deliverer is, etc.). Two types of processing are hypothesized in this model: **central-route processing**, in which people attend to the content of the message; and **peripheral-route processing**, a style of information processing that relies on peripheral cues (cues outside of the message content itself), such as the expertise of the message source, the length of the message, and other factors that have nothing to do with the message content. This style of processing causes people not to pay attention to the message itself but instead to base their decisions on those peripheral factors (Petty & Cacioppo, 1986; Stiff & Mongeau, 2002). For example, the author once participated on a jury panel in which one woman voted "guilty" because the defendant had "shifty eyes" and not because of any of the evidence presented. [Watch the Video, What's in It for Me? Persuasion: Elaboration Likelihood Model, at MyPsychLab](#)

COGNITIVE DISSONANCE: WHEN ATTITUDES AND BEHAVIOR CLASH

How do people react when attitudes and behavior are not the same?

As stated earlier, sometimes what people say and what they do are very different. I once pointed this out to a friend of mine who was behaving this way, and he got really upset over it. Why did he get so upset?

When people find themselves doing things or saying things that don't match their idea of themselves as smart, nice, or moral, for example, they experience an emotional discomfort (and physiological arousal) known as **cognitive dissonance** (Aranson, 1997; Festinger, 1957; Kelly et al., 1997). When people are confronted with the knowledge that something they have done or said was dumb, immoral, or illogical, they suffer an inconsistency in cognitions. For example, they may have a cognition that says "I'm pretty smart" but also the cognition "That was a dumb thing to do," which causes a dissonance. (*Dissonance* is a term referring to an inconsistency or lack of agreement.)

When people experience cognitive dissonance, the resulting tension and arousal are unpleasant, and their motivation is to change something so that the unpleasant feelings and tension are reduced or eliminated. There are three basic things that people can do to reduce cognitive dissonance:

1. Change their conflicting behavior to make it match their attitude.
2. Change their current conflicting cognition to justify their behavior.
3. Form new cognitions to justify their behavior.

Take the example of Larry, who is a college graduate and a cigarette smoker. On one hand, Larry is educated enough to know that cigarette smoking is extremely harmful, causing lung problems, cancer, and eventually death. On the other hand, Larry enjoys smoking, feeling that it calms him and helps him deal with stress—not to mention the fact that he's thoroughly addicted and finds it difficult to quit. His attitude (smoking is bad for you) doesn't match his behavior. Larry is experiencing cognitive dissonance and knows he needs to do something to resolve his dilemma.

If Larry chooses the first way of dealing with cognitive dissonance, he'll quit smoking, no matter how difficult it is (Option 1). As long as he is working at changing the conflicting behavior, his dissonance will be reduced. But what if he can't quit? He might decide that smoking isn't as bad as everyone says it is, which changes his original conflicting attitude (Option 2). He might also form a new attitude by deciding that if he smokes "light" cigarettes, he's reducing his risk enough to justify continuing smoking (Option 3).

 **Watch the Video**, Thinking Like a Psychologist: Changing Attitudes and Behaviors, at [MyPsychLab](#)

In a classic experiment conducted at Stanford University by psychologist Leon Festinger and colleague James Carlsmith (1959), each male student volunteer was given an hour-long, very boring task of sorting wooden spools and turning wooden pegs. After the hour, the experimenters asked the participant to tell the female volunteer in the waiting room that the task was enjoyable. While half of the participants were paid only \$1 to try to convince the waiting woman, the other participants were paid \$20. (In the late 1950s, \$20 was a considerable sum of money—the average income was \$5,000, the average car cost \$3,000, and gas was only 25 cents a gallon.)

At the time of this study, many researchers would have predicted that the more the participants were paid to lie, the more they would come to like the task, because they were getting more reinforcement (\$20) for doing so. But what actually happened was that those participants who were paid only \$1 for lying actually convinced themselves that the task was interesting and fun. The reason is cognitive dissonance: Participants who were paid only \$1 experienced discomfort at thinking that they would lie to someone for only a dollar. Therefore, they must not be lying—the task really was pretty interesting, after all, and fun, too! Those who were paid more experienced no dissonance, because they knew exactly why they were lying—for lots of money—and the money was a sufficient amount to explain their behavior to their satisfaction. Although most people don't want to be thought of as liars, back then, getting paid enough money to fill the gas tank of one's car three or four times over was incentive enough to tell what probably seemed to be a harmless fib. Those who were paid only \$1 had to change their attitude toward the task so that they would not really be lying and could maintain their self-image of honesty. (See **Figure 12.4**.)

Cognitive dissonance theory has been challenged over the last 50 years by other possible explanations. Daryl Bem's *self-perception theory* says that instead of experiencing negative tension, people look at their own actions and then infer their attitudes from those actions (Bem, 1972). New research on dissonance still occurs, much of it focusing on finding the areas of the brain that seem to be involved when people are experiencing dissonance. These studies have found that the left frontal cortex (where language and much of our decision making occurs) is particularly active when people have made a decision that reduces dissonance and then acted upon that decision (Harmon-Jones, 2000, 2004, 2006; Harmon-Jones et al., 2008). Since reducing cognitive dissonance is mainly a function of people "talking" themselves into or out of a particular course of



Inducement	Attitude
\$1	+1.35
\$20	-0.5
Control	-0.45

*Based on a -5 to +5 scale, where -5 means "extremely boring" and +5 means "extremely interesting"

Figure 12.4 Cognitive Dissonance: Attitude Toward a Task

After completing a boring task, some participants were paid \$1 and some \$20 to convince others waiting to do the same task that the task was interesting and fun. Surprisingly, the participants who were paid only \$1 seemed to change their own attitude toward the task, rating it as interesting, whereas those who were paid \$20 rated the task no differently than a control group did. Source: Adapted from Festinger and Carlsmith (1959).

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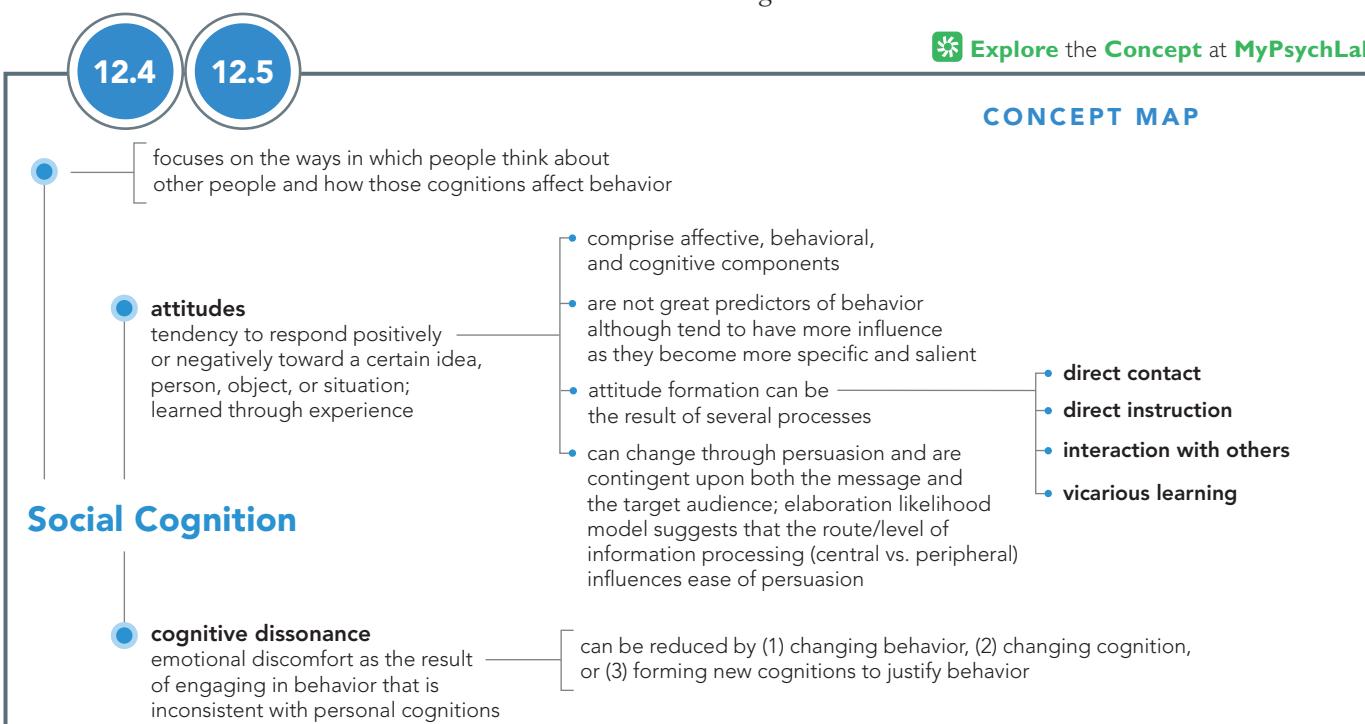
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action, this neurological finding is not surprising. But researchers at Yale University have found surprising evidence for cognitive dissonance in both 4-year-old humans and capuchin monkeys—two groups that are not normally associated with having the developed higher-level mental abilities thought to be in use during the resolution of dissonance (Egan et al., 2007; Egan et al., 2010). Are monkeys and pre-school humans more complex thinkers than we had assumed? Or are the cognitive processes used to resolve dissonance a lot simpler than previously indicated? Obviously, there are still questions to be answered with new research in cognitive dissonance.

 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP



PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

- Studies have found that attitudes are primarily the result of
 - heredity.
 - hormonal chemistry.
 - traumatic incidents.
 - learned behavior.
 - Which of the following represents the affective component of an attitude?
 - "I love to go to the clubs—it makes me so happy!"
 - "Tonight, we're going to that new club downtown."
 - "It is interesting to watch people when I'm out at a club."
 - "I'm going to wear a new outfit to the club tonight."
 - Erin hates snakes, even though she has never been bitten or been close to one. She developed her feelings by seeing how scared her mother was when she came across them in the garden, or even when watching a movie or television show where there was a snake. Erin's attitude toward snakes was most likely acquired through
 - direct contact.
 - direct instruction.
 - interaction with others.
 - vicarious conditioning.
 - As an attorney, you always recommend to your clients that they dress up in professional clothes for their day in court. What aspect of persuasion are you focusing upon?
 - the source
 - the message
 - the audience
 - the media
5. One of your friends tells you, "I didn't like the environmental-awareness presentation today. First of all it was too long, not to mention the person that gave it was drinking out of a polystyrene cup and drove away in a huge SUV." What kind of processing might your friend be using?
 - central-route processing
 - peripheral-route processing
 - cognitive-route processing
 - visual-route processing
6. In the famous Festinger experiment, participants were paid either \$1 or \$20 to lie to a woman in the waiting room about how interesting a task really was. The participants who convinced themselves that the task really was fun were the ones who were
 - paid immediately.
 - paid after one day.
 - paid only \$1.
 - paid \$20.

THINKING CRITICALLY:

Imagine that you are asked to create a television commercial to sell a new product. Given what you know of the factors that effectively influence persuasion, how might you persuade a customer?

IMPRESSION FORMATION

How are social categorization and implicit personality theories used in impression formation?

When one person meets another for the first time, it is the first opportunity either person will have to make initial evaluations and judgments about the other. That first opportunity is a very important one in **impression formation**, the forming of the first knowledge a person has about another person. Impression formation includes assigning the other person to a number of categories and drawing conclusions about what that person is likely to do—it's really all about prediction. In a sense, when first meeting another person, the observer goes through a process of concept formation similar to that discussed in Chapter Seven. Impression formation is another kind of social cognition.

There is a *primacy effect* in impression formation: The first time people meet someone, they form an impression of that person, often based on physical appearance alone, that persists even though they may later have other contradictory information about that person (DeCoster & Claypool, 2004; Lorenzo et al., 2010; Luchins, 1957; Macrae & Quadflieg, 2010). So the old saying is pretty much on target: First impressions do count.

SOCIAL CATEGORIZATION One of the processes that occur when people meet someone new is the assignment of that person to some kind of category or group. This assignment is usually based on characteristics the new person has in common with other people or groups with whom the perceiver has had prior experience. This **social categorization** is mostly automatic and occurs without conscious awareness of the process (Macrae & Bodenhausen, 2000). Although this is a natural process (human beings are just born categorizers, [LINK](#) to Learning Objective 7.1), sometimes it can cause problems. When the characteristics used to categorize the person are superficial* ones that have become improperly attached to certain ideas, such as “red hair equals a bad temper,” social categorization can result in a **stereotype**, a belief that a set of characteristics is shared by all members of a particular social category (Fiske, 1998). Stereotypes (although not always negative) are very limiting, causing people to misjudge what others are like and often to treat them differently as a result. Add the process of stereotyping to the primacy effect and it becomes easy to see how important first impressions really are. That first impression not only has more importance than any other information gathered about a person later on but may include a stereotype that is resistant to change as well (Hilton & von Hippel, 1996; Hugenberg & Bodenhausen, 2003).



It sounds as though we'd be better off if people didn't use social categorization.

Social categorization does have an important place in the perception of others. It allows people to access a great deal of information that can be useful about others, as well as helping people to remember and organize information about the characteristics of others (Macrae & Bodenhausen, 2000). The way to avoid falling into the trap of negatively stereotyping someone is to be aware of existing stereotypes and apply a little critical thinking: “Okay, so he’s a guy with a lot of piercings. That doesn’t mean that he’s overly aggressive—it just means he has a lot of piercings.”



At this job fair in Shanghai, China, thousands of applicants wait hopefully in line for an opportunity to get a job interview. Making a good first impression is important in any job interview situation, but when the competition numbers in the thousands, the people who will most likely get interviews are those who are neatly dressed and well-groomed.

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*superficial: on the surface.

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IMPLICIT PERSONALITY THEORIES The categories into which people place others are based on something called an **implicit personality theory**. Implicit personality theories are sets of assumptions that people have about how different types of people, personality traits, and actions are all related and form in childhood (Dweck et al., 1995; Erdley & Dweck, 1993). For example, many people have an implicit personality theory that includes the idea that happy people are also friendly people and people who are quiet are shy. Although these assumptions or beliefs are not necessarily true, they do serve the function of helping to organize *schemas*, or mental patterns that represent (in this case) what a person believes about certain “types” of people. (The concept of schema here is similar to the complex schemes proposed by Piaget.  to Learning Objective 8.6.) Of course, the schemas formed in this way can easily become stereotypes when people have limited experience with others who are different from them, especially in superficial ways such as skin color or other physical characteristics (Levy et al., 1998).

There is a test designed to measure the implicit attitudes that make up one’s implicit personality theory, called the Implicit Association Test, or IAT (Greenwald & Banaji, 1995; Greenwald et al., 1998). The test, taken by computer, measures the degree of association between certain pairs of concepts. For example, you might see the word “pleasant” on one side of the computer screen and the word “unpleasant” on the other side. In the middle would be another word that may be associated with one or the other of the two categories. You would be asked to sort the word into the appropriate category by pressing certain keys as quickly as you can. The computer measures reaction times, and it is the difference in reaction times over a series of similar comparisons that reveals implicit attitudes (Nosek et al., 2007). To try it out for yourself, participate in the experiment *Implicit Association Test: Prejudice*.

Simulation

Implicit Association Test: Prejudice

This Implicit Association Test asks you to classify a set of words or images into groups. Your goal is to classify items as quickly and as accurately as you can.



[Go to the Experiment ►](#)

 [Simulate the Experiment, Implicit Association Test: Prejudice, on MyPsychLab](#)

Some evidence suggests that implicit personality theories may differ from culture to culture as well as from individual to individual. For example, one study found that Americans and Hong Kong Chinese people have different implicit personality theories about how much the personality of an individual is able to change. Whereas Americans assume that personality is relatively fixed and unchanging, Chinese people native to Hong Kong assume that personalities are far more changeable (Chiu et al., 1997).

ATTRIBUTION

How do people try to explain the actions of others?

Another aspect of social cognition is the need people seem to have to explain the behavior of other people. Have you ever watched someone who was doing something you didn't understand? Chances are you were going through a number of possible explanations in your head: "Maybe he's sick, or maybe he sees something I can't see," and so on. It seems to be human nature to want to know why people do the things they do so that we know how to behave toward them and whom we might want to use as role models. If no obvious answer is available, people tend to come up with their own reasons. People also need an explanation for their own behavior. This need is so great that if an explanation isn't obvious, it causes the distress known as cognitive dissonance. The process of explaining both one's own behavior and the behavior of other people is called **attribution**.

CAUSES OF BEHAVIOR **Attribution theory** was originally developed by social psychologist Fritz Heider (1958) as a way of not only explaining why things happen but also why people choose the particular explanations of behavior that they do. There are basically two kinds of explanations—those that involve an external cause and those that assume that causes are internal.

When the cause of behavior is assumed to be from external sources, such as the weather, traffic, educational opportunities, and so on, it is said to be a **situational cause**. The observed behavior is assumed to be caused by whatever situation exists for the person at that time. For example, if John is late, his lateness might be explained by heavy traffic or car problems.

On the other hand, if the cause of behavior is assumed to come from within the individual, it is called a **dispositional cause**. In this case, it is the person's internal personality characteristics that are seen as the cause of the observed behavior. Someone attributing John's behavior to a dispositional cause, for example, might assume that John was late because his personality includes being careless of his and other people's time.

There's an emotional component to these kinds of attributions as well. When people are happy in a marriage, for example, researchers have found that when a spouse's behavior has a positive effect, the tendency is to attribute it to an internal cause ("He did it because he wanted me to feel good"). When the effect is negative, the behavior is attributed to an external cause ("She must have had a difficult day"). But if the marriage is an unhappy one, the opposite attributions occur: "He is only being nice because he wants something from me" or "She's being mean because it's her nature to be crabby" (Fincham et al., 2000; Karney & Bradbury, 2000).

FUNDAMENTAL ATTRIBUTION ERROR



But what else determines which type of cause a person will use?
For example, what determines how people explain the behavior of
someone they don't already know or like?

The best-known attributional bias is the **fundamental attribution error**, which is the tendency for people observing someone else's actions to overestimate the influence of that person's internal characteristics on behavior and underestimate the influence of the situation. In explaining our own behavior, the tendency to use situational

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attributions instead of personal is called the *actor–observer bias* because we are the actor, not the observer. In other words, people tend to explain the actions of others based on what “kind” of person they are rather than looking for outside causes, such as social influences or situations (Blanchard-Fields et al., 2007; Harman, 1999; Jones & Harris, 1967; Leclerc & Hess, 2007; Weiner, 1985). (For example, people hearing about Milgram’s “shock” study tend to assume that something is wrong with the “teachers” in the study rather than explaining their behavior within the circumstances of the situation.)



But why do we do that? Why not assume an external cause for everyone?

When people are the actors, they are very aware of the situational influences on their own behavior. For example, Tardy John was actually the one driving to work, and he knows that heavy traffic and a small accident made him late to work—he was *there*, after all. But an outside observer of John’s behavior doesn’t have the opportunity to see all of the possible situational influences and has only John himself in focus and, thus, assumes that John’s tardiness is caused by some internal personality flaw.

Other research has shown that when students are given an opportunity to make attributions about cheating, they make the fundamental attribution error and actor–observer bias: If others are cheating, it’s because they are not honest people, but if the students themselves are cheating it is because of the situation (Bogle, 2000).

Can the tendency to make these errors be reduced? There are several strategies for making errors in attribution less likely. One is to notice how many other people are doing the same thing. As a college professor, the author often has students who come in late. When it is only one student and it happens frequently, the assumption is that the student is not very careful about time (dispositional cause). But when a large number of students come straggling in late, the assumption becomes “there must be a wreck on the bridge,” which is a situational attribution. In other words, if a lot of people are doing it, it is probably caused by an outside factor.

Another trick is to think about what you would do in the same situation. If you think that you might behave in the same way, the cause of behavior is probably situational. People should also make the effort of looking for causes that might not be obvious. If John were to look particularly “stressed out,” for example, the assumption might be that something stressed him out, and that “something” might have been heavy traffic.

Although the fundamental attribution error has been found in American culture (Jones & Harris, 1967), would the same error occur in a culture very different from that of America’s, such as Japan’s? This is the question asked by researchers Masuda and Kitayama (2004), who had both American and Japanese participants ask a target person to read a prewritten attitudinal statement. The participants were then asked to give their opinion on the target’s real attitude. American participants made the classic error, assuming that the target’s attitude matched the reading. The Japanese participants, however, assumed that the person’s attitude might be different from the statement—the person might have been under social obligation to write the piece. Japanese society is a collectivistic culture, and a Japanese person might expect to write a paper to please a teacher or employer even though the paper’s contents do not necessarily express the writer’s attitudes. A summary of the research in cross-cultural differences in attribution provides further support for the idea that the fundamental attribution error is not a universal one (Peng et al., 2000). The work of Miller (1984) and many other researchers (Blanchard-Fields et al., 2007; Cha & Nam, 1985; Choi & Nisbett, 1998; Choi et al., 1999;

Lee et al., 1996; Morris & Peng, 1994; Morris et al., 1995; Norenzayan et al., 1999) strongly suggests that in more interdependent, collectivist cultures found in China, Hong Kong, Japan, and Korea, people tend to assume that external situational factors are more responsible for the behavior of other people than are internal dispositional factors—a finding that is exactly the reverse of the fundamental attribution error so common in the United States and other individualist Western cultures.

Even age is a factor in how likely someone is to fall prey to the fundamental attribution error. Several studies (Blanchard-Fields & Horhotka, 2005; Follett & Hess, 2002; Leclerc & Hess, 2007) have found that older adults show a stronger bias toward attributing the actions of another to internal causes than do younger people.

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 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP

- **stereotypes:** set of characteristics believed to be shared by all members of a particular category; can be useful (by limiting information processing)
- categories assigned are based on implicit personality theory, the set of assumptions formed in childhood about different types of people

Social Cognition: (continued) Impression Formation and Attribution

attribution is a process by which we explain both our own behavior and the behavior of others; based on attribution theory (Heider)

- **situational:** cause of behavior is assumed to come from external sources
- **dispositional:** cause of behavior is assumed to come from within the individual
- **fundamental attribution error** is the tendency to overestimate the influence of another person's internal characteristics on behavior and underestimate the external/situational factors; influenced by age and culture

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. If you were to describe impression formation in just one word, what would that be?
 - a. control
 - b. prediction
 - c. feelings
 - d. communication
2. According to the phenomenon known as social categorization, what is most influential in helping us form an attitude about someone or something?
 - a. Those things that happen first, also known as the primacy effect.
 - b. Those things that happen last, also known as the recency effect.
 - c. Those things that happen in the middle.
 - d. That which is repeated several times.
3. Kohanna thinks that everyone who smiles must always be happy and those people who are quiet must be naturally shy. Such assumptions are the bases for
 - a. stereotypes.
 - b. implicit personality theory.
 - c. attribution theory.
 - d. attitudes.
4. Caleb almost always shows up late for work. His friends attribute this to Caleb's laziness. This is an example of a _____ cause.
 - a. situational
 - b. dispositional
 - c. dispensational
 - d. superficial
5. How might someone who unknowingly is committing the fundamental attribution error explain Stanley Milgram's obedience study?
 - a. Subjects in that study were highly influenced by the power of Milgram and his team.
 - b. Subjects in that study desired a high degree of positive reinforcement.
 - c. Subjects in that study wanted to be part of Milgram's group.
 - d. Subjects in that study must have been the kind of people that like to hurt others.

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On September 6, 1957, this high school in Little Rock, Arkansas, became integrated, allowing African American students to attend school with White students. The desegregation laws were aimed at stopping discrimination but attitudes of prejudice persisted then, and to some degree still exist today. The courts can make laws against discrimination, but changing prejudicial attitudes is much more difficult.

Social Interaction: Prejudice and Discrimination

Social influence and social cognition are two of three main areas included in the field of social psychology. The third major area has to do with social interactions with others, or the relationships between people, both casual and intimate. Social interactions include prejudice and discrimination, liking and loving, and aggression and prosocial behavior.

DEFINING PREJUDICE AND DISCRIMINATION

How are prejudice and discrimination different?

We've seen how stereotypes, a set of characteristics that people believe is shared by all members of a particular social category or group, can be formed by using only superficial information about that person or group of people. When a person holds an unsupported and often negative stereotyped *attitude* about the members of a particular social group, it is called **prejudice**. The video *In the Real World: Are Stereotypes and Prejudices Inevitable?: Defining Prejudice* explains the connection between stereotypes and prejudice.

Watch the Video, *In the Real World: Are Stereotypes and Prejudices Inevitable?: Defining Prejudice*, at [MyPsychLab](#)

When prejudicial attitudes cause members of a particular social group to be treated differently than others in situations that call for equal treatment, it is called **discrimination**. Prejudice is the attitude and discrimination is the behavior that can result from that attitude. Although laws can be made to minimize discriminatory behavior, it is not possible to have laws against holding certain attitudes. In other words, discrimination can be controlled and in some cases eliminated, but the prejudicial attitude that is responsible for the discrimination cannot be so easily controlled or eliminated.

TYPES OF PREJUDICE AND DISCRIMINATION There are many kinds of prejudice. There are also many kinds of discrimination that occur as a result of prejudice. There's ageism, or prejudicial attitudes toward the elderly or teenagers (among others); sexism; racism, or prejudice toward those from different ethnic groups; prejudice toward those from different religions, those from different economic levels, those who are overweight, those

who are too thin, or who have a different sexual orientation. Prejudice can also vary in terms of what type of people or groups make the most likely targets. In any society, there will always be **in-groups** and **out-groups**, or “us” versus “them.” The in-group is all the people with whom a particular person identifies and the out-groups are everyone else (Brewer, 2001; Hewstone et al., 2002; Tajfel & Turner, 1986). The formation of in-groups and out-groups begins in childhood (Ruble et al., 2004) and continues as children become adults.

Once an in-group is established, prejudice toward and discriminatory treatment of the out-group or groups soon follow (Brewer, 2001). Members of the out-groups are usually going to become stereotyped according to some superficial characteristic, such as skin color or hair color, and getting rid of a stereotype once formed is difficult at best (Cameron et al., 2001; Hamilton & Gifford, 1976).

SCAPEGOATING Conflicts between groups are usually greater when there are other pressures or stresses going on, such as war, economic difficulties, or other misfortunes. When such pressures exist, the need to find a *scapegoat* becomes stronger. A scapegoat is a person or a group, typically a member or members of an out-group, who serves as the target for the frustrations and negative emotions of members of the in-group. (The term comes from the ancient Jewish tradition of sending a goat out into the wilderness with the symbolic sins of all the people on its head.)

Scapegoats are going to be the group of people with the least power, and the newest immigrants to any area are typically those who have the least power at that time. That is why many social psychologists believe that the rioting that took place in Los Angeles, California, in the spring of 1992 occurred in the areas it did. This was the time of the infamous Rodney King beating. Rodney King was an African American man who was dragged out of his car onto the street and severely beaten by four police officers. The beating was caught on tape by a bystander. At the trial, the officers were found not guilty of assault with a deadly weapon. This decision was followed by a series of violent riots (Knight, 1996).

The puzzling thing about these riots is that the greatest amount of rioting and violence did not take place in the neighborhoods of the mostly White police officers or in the African American neighborhoods. The rioting was greatest in the neighborhoods of the Asian Americans and Asians who were the most recent immigrants to the area. When a group has only recently moved into an area, as the Asians had, that group has the least social power and influence in that new area. So the rioters took out their frustrations *not* on the people seen as directly responsible for those frustrations but on the group of people with the least power to resist.

HOW PEOPLE LEARN PREJUDICE

Why are people prejudiced, and how can prejudice be stopped?

As we will see in the Classic Studies in Psychology section, even children are, under the right circumstances, prone to developing prejudiced attitudes. Is all prejudice simply a matter of learning, or are there other factors at work? Several theories have been proposed to explain the origins and the persistence of prejudice. In **social cognitive theory** (using cognitive processes in relation to understanding the social world), prejudice is seen as an attitude that is formed as other attitudes are formed, through direct instruction, modeling, and other social influences on learning.

REALISTIC CONFLICT THEORY The **realistic conflict theory** of prejudice states that increasing prejudice and discrimination are closely tied to an increasing degree of conflict between the in-group and the out-group when those groups are seeking a common resource, such as land or available jobs (Horowitz, 1985; Taylor & Moghaddam, 1994). Be-



"First, can we agree that it's a big backyard?"

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These Korean demonstrators were protesting the riots that followed the 1992 not guilty verdict in the beating of Rodney King. The riots lasted 6 days, killing 42 people and damaging 700 buildings in mainly Korean and other Asian American neighborhoods. The Asian American population of Los Angeles, California, became scapegoats for aggression.

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cause the examples of this from history and modern times are so numerous, it is possible to list only a few: the conflict between the early Crusaders and the Muslims, between the Jewish people and the Germans, the hatred between the Irish Catholics and the Irish Protestants, and the conflict between the native population of you-name-the-country and the colonists who want that land. The section that follows is a classic study that illustrates how easily in-groups and out-groups can be formed and how quickly prejudice and discrimination follow.

classic studies in psychology



Brown Eyes, Blue Eyes



In a small town in Iowa in 1968, a few days after the assassination of Dr. Martin Luther King, Jr., a second-grade teacher named Jane Elliot tried to teach her students a lesson in prejudice and discrimination. She divided her students into two groups, those with blue eyes and those with brown eyes.

On the first day of the lesson, the blue-eyed children were given special privileges, such as extra time at recess and getting to leave first for lunch. She also told the blue-eyed children that they were superior to the brown-eyed children, telling the brown-eyed children not to bother taking seconds at lunch because it would be wasted. She kept the blue-eyed children and the brown-eyed children apart (Peters, 1971).

Although Elliot tried to be critical of the brown-eyed out-group, she soon found that the blue-eyed children were also criticizing, belittling, and were quite vicious in their attacks on the brown-eyed children. By the end of the day, the blue-eyed children felt and acted superior, and the brown-eyed children were miserable. Even the lowered test scores of the brown-eyed children reflected their misery. Two days later, the brown-eyed children became the favored group and the effects from the first two days appeared again but in reverse this time: The blue-eyed children began to feel inferior and their test scores dropped.

The fact that test scores reflected the treatment received by the out-group is a stunning one, raising questions about the effects of prejudice and discrimination on the education of children who are members of stereotyped out-groups. That the children were so willing to discriminate against their own classmates, some of whom were their close friends before the experiment, is also telling. In his book about this classroom experiment, *A Class Divided*, Peters (1971) reported that the students who were part of the original experiment, when reunited 15 years later to talk about the experience, said that they believed that this early experience with prejudice and discrimination helped them to become less prejudiced as young adults.

Questions for Further Discussion

1. Is there anything about this experiment that you find disturbing?
2. How do you think adults might react in a similar experiment?
3. Are there any ethical concerns with what Elliot did in her classroom?
4. What kinds of changes might have occurred in the personalities and performances of the children if the experiment had continued for more than 2 days with each group?

SOCIAL IDENTITY THEORY In **social identity theory**, three processes are responsible for the formation of a person's identity within a particular social group and the attitudes, concepts, and behavior that go along with identification with that group (Tajfel & Turner, 1986). The first process is *social categorization*, as discussed earlier in this chapter. Just as people assign categories to others (such as Black, White, student, teacher, and so on) to help organize information about those others, people also assign themselves

to social categories to help determine how they should behave. The second element of social identity theory is *identification*, or the formation of one's **social identity**. A social identity is the part of the self-concept that includes the view of oneself as a member of a particular social group within the social category—typically, the in-group. The third aspect of social identity theory is **social comparison**, Festinger's (1954) concept in which people compare themselves favorably to others to improve their own self-esteem: "Well, at least I'm better off than that person." Members of the out-group make handy comparisons.

With respect to prejudice, social identity theory helps to explain why people feel the need to categorize or stereotype others, producing the in-group sense of "us versus them" that people adopt toward out-groups. Prejudice may result, at least in part, from the need to increase one's own self-esteem by looking down on others.

STEREOTYPE VULNERABILITY As discussed previously, stereotypes are the widespread beliefs a person has about members of another group. Not only do stereotypes affect the way people perceive other people, but also stereotypes can affect the way people see themselves and their performance (Snyder et al., 1977). **Stereotype vulnerability** refers to the effect that a person's knowledge of another's stereotyped opinions can have on that person's behavior (Osborne, 2007; Steele, 1992, 1997). Research has shown that when people are aware of stereotypes that are normally applied to their own group by others, they may feel anxious about behaving in ways that might support that stereotype. This fear results in anxiety and self-consciousness that have negative effects on their performance in a kind of **self-fulfilling prophecy**, or the effect that expectations can have on outcomes.

Stereotype vulnerability is highly related to *stereotype threat*, in which members of a stereotyped group are made anxious and wary of any situation in which their behavior might confirm a stereotype (Hyde & Kling, 2001; Steele, 1999).  [Learning Objective 7.8.](#)) In one study, researchers administered a difficult verbal test to both Caucasian and African American participants (Steele & Aronson, 1995). Half of the African American participants were asked to record their race on a demographic* question before the test, making them very aware of their minority status. Those participants showed a significant decrease in scores on the test when compared to the other participants, both African American and Caucasian, who did not answer such a demographic question. They had more incorrect answers, had slower response times, answered fewer questions, and demonstrated more anxiety when compared to the other participants (Steele & Aronson, 1995).

Similar effects of stereotype threat on performance have been found in women (Gonzales et al., 2002; Steele, 1997; Steele et al., 2002), and for athletes in academic settings (Yopyk & Prentice, 2005). A recent study did find that some people can overcome feelings of stereotype threat by identifying themselves with a different social identity, such as a woman who identifies herself with "college students" when taking a math exam rather than with "females," since the latter group is often stereotyped as being math deficient (Rydell & Boucher, 2010). This effect only held for those women with fairly high self-esteem, however.

OVERCOMING PREJUDICE

The best weapon against prejudice is education: learning about people who are different from you in many ways. The best way to learn about others is to have direct contact with them and to have the opportunity to see them as people rather than "as outsiders or strangers." *Intergroup contact* is very common in college settings, for example, where students and faculty from many different backgrounds live, work, and study together.



Social comparison involves comparing yourself to others so that your self-esteem is protected. What do you think each of these young girls might be thinking?

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*demographic: having to do with the statistical characteristics of a population.

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Because they go through many of the same experiences (midterms, finals, and so on), people from these diverse* backgrounds find common ground to start building friendships and knowledge of each other's cultural, ethnic, or religious differences.



Intergroup contact is one of the best ways to combat prejudice. When people have an opportunity to work together, as the students in this diverse classroom do, they get to know each other on common ground. Can you think of the first time you had direct contact with someone who was different from you? How did that contact change your viewpoint?

a series of crises (created deliberately by the experimenters) that the boys lost the hostility and formed friendships between the groups. When dealing with the crises, the boys were forced into a situation of **equal status contact**, in which they were all in the same situation with neither group holding power over the other. Equal status contact has been shown to reduce prejudice and discrimination, along with ongoing, positive cooperation. It appears that personal involvement with people from another group must be cooperative and occur when all groups are equal in terms of power or status to have a positive effect on reducing prejudice (Pettigrew & Tropp, 2000; Robinson & Preston, 1976).

THE "JIGSAW CLASSROOM" One possible way to help promote contact between people from different backgrounds to occur in a cooperative fashion is to make success at a task dependent on the cooperation of each person in a group of people of mixed abilities or statuses. If each member of the group has information that is needed to solve the problem at hand, a situation is created in which people must depend on one another to meet their shared goals (Aronson et al., 1978). Ordinarily, school classrooms are not organized along these lines but are instead more competitive and, therefore, more likely to create conflict between people of different abilities and backgrounds.

EQUAL STATUS CONTACT Contact between social groups can backfire under certain circumstances, however, as seen in a famous study (Sherif et al., 1961) called the "Robber's Cave." In this experiment conducted at a summer camp called Robber's Cave, 22 White, well-adjusted, 11- and 12-year-old boys were divided into two groups. The groups each lived in separate housing and were kept apart from each other for daily activities. During the second week, after in-group relationships had formed, the researchers scheduled highly competitive events pitting one group against the other. Intergroup conflict quickly occurred, with name-calling, fights, and hostility emerging between the two groups.

The third week involved making the two groups come together for pleasant, non-competitive activities, in the hope that cooperation would be the result. Instead, the groups used the activities of the third week as opportunities for more hostility. It was only after several weeks of being forced to work together to resolve

*diverse: different, varied.

In a “**jigsaw classroom**,” students have to work together to reach a specific goal. Each student is given a “piece of the puzzle,” or information that is necessary for solving the problem and reaching the goal (Aronson et al., 1978; Clarke, 1994). Students then share their information with other members of the group. Interaction between diverse students is increased, making it more likely that those students will come to see each other as partners and form friendly relationships rather than labeling others as members of an out-group and treating them differently. This technique works at the college level as well as in the lower school grades (Johnson et al., 1991; Lord, 2001).

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 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP

prejudice

unsupported and negative stereotypes (e.g., ageism, sexism, racism, etc.) about members of a particular social group

- **social cognitive theory** suggests that prejudice is an attitude formed as others are formed
- **realistic conflict theory** suggests that when resources are limited, prejudice and discrimination are closely tied to an increasing degree of conflict between groups that seek common resources
- **social identity theory** suggests three processes are responsible for the formation of a person’s identity within a social group—categorization, identification, and comparison
- **stereotype vulnerability** (knowledge of someone else’s stereotyped opinions) can result in self-fulfilling prophecy and is related to stereotype threat when situational anxiety occurs if a person’s behavior might confirm a stereotype
- **prejudice can be overcome** through education, equal status intergroup contact, and working together to achieve a specific goal (e.g., the “jigsaw classroom”)

Social Interaction: Prejudice and Discrimination

discrimination

occurs when prejudicial attitudes cause members of a social group to be treated differently than others in situations calling for equal treatment

scapegoating

can vary based on existence of in-groups and out-groups

(target for frustrations and negative emotions)
typically occurs for members of an out-group

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Prejudice is about _____ while discrimination is about _____.
 - a. beliefs; perceptions
 - b. perceptions; beliefs
 - c. behavior; attitudes
 - d. attitudes; behavior
2. Jewell and Amie became friends while taking an evening class at the local community college. Jewell was later horrified to find out that Amie was actually a teacher at the college. Subsequently, Jewell stopped talking with Amie, thus ending their friendship. What theory of prejudice and discrimination might this be an example of?
 - a. stereotype vulnerability theory
 - b. in-group/out-group theory
 - c. realistic conflict theory
 - d. social cognitive theory
3. In teacher Jane Elliot’s classic study, the most startling finding was that the
 - a. the in-group was kinder to the out-group.
 - b. the out-group was less prejudiced.
 - c. test scores dropped for each group during their respective turn as the out-group.
 - d. children were unwilling to discriminate with respect to the others.
4. Which of the following would be the most effective way to decrease prejudice?
 - a. Create an environment of equal status, where groups must rely upon each other to solve a common problem.
 - b. Bring groups together to talk about their feelings.
 - c. Bring groups together and allow them to work next to each other.
 - d. Bring groups together for a friendly competition.

THINKING CRITICALLY:

What was the first time you became aware that you had a prejudiced attitude toward something or someone? How did you confront that knowledge?

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Liking and Loving: Interpersonal Attraction

What factors govern attraction and love, and what are some different kinds of love?

Prejudice pretty much explains why people don't like each other. What does psychology say about why people like someone else? There are some "rules" for those whom people like and find attractive. Liking or having the desire for a relationship with someone else is called **interpersonal attraction**, and there's a great deal of research on the subject. (Who wouldn't want to know the rules?)

THE RULES OF ATTRACTION

Several factors are involved in the attraction of one person to another, including both superficial physical characteristics, such as physical beauty and proximity, as well as elements of personality.  [Watch the Video, What's in It for Me?:Attraction: Influences on Attraction, at MyPsychLab](#)

PHYSICAL ATTRACTIVENESS When people think about what attracts them to others, one of the topics that usually arises is the physical attractiveness of the other person. Some research suggests that physical beauty is one of the main factors that influence individuals' choices for selecting people they want to know better, although other factors may become more important in the later stages of relationships (Eagly et al., 1991; Feingold, 1992; White, 1980).

PROXIMITY—CLOSE TO YOU The closer together people are physically, such as working in the same office building or living in the same dorm, the more likely they are to form a relationship. **Proximity** refers to being physically near someone else. People choose friends and lovers from the pool of people available to them, and availability depends heavily on proximity.

One theory about why proximity is so important involves the idea of repeated exposure to new stimuli, sometimes called the *mere exposure effect*. The more people experience something, whether it is a song, a picture, or a person, the more they tend to like it. The phrase "it grew on me" refers to this reaction. When people are in physical proximity to each other, repeated exposure may increase their attraction to each other.

BIRDS OF A FEATHER—SIMILARITY Proximity does not guarantee attraction, just as physical attractiveness does not guarantee a long-term relationship. People tend to like being around others who are *similar* to them in some way. The more people find they have in common with others—such as attitudes, beliefs, and interests—the more they tend to be attracted to those others (Hartfield & Rapson, 1992; Moreland & Zajonc, 1982; Neimeyer & Mitchell, 1998). Similarity as a factor in relationships makes sense when seen in terms of validation of a person's beliefs and attitudes. When other people hold the same attitudes and beliefs and do the same kinds of actions, it makes a person's own concepts seem more correct or valid.



 Isn't there a saying about "opposites attract"? Aren't people sometimes attracted to people who are different instead of similar?

There is often a grain of truth in many old sayings, and "opposites attract" is no exception. Some people find that forming a relationship with another person who has *complementary* qualities (characteristics in the one person that fill a need in the other) can be very rewarding (Carson, 1969; Schmitt, 2002). Research does not support this view of attraction, however. It is similarity, not complementarity, that draws people together and helps them stay together (Berscheid & Reis, 1998; McPherson et al., 2001).

RECIPROCITY OF LIKING Finally, people have a very strong tendency to like people who like them, a simple but powerful concept referred to as **reciprocity of liking**. In one experiment, researchers paired college students with other students (Curtis & Miller, 1986). Neither student in any of the pairs knew the other member. One member of each pair was randomly chosen to receive some information from the experimenters about how the *other* student in the pair felt about the first member. In some cases, target students were led to believe that the other students liked them and, in other cases, that the targets disliked them.

When the pairs of students were allowed to meet and talk with each other again, they were friendlier, disclosed more information about themselves, agreed with the other person more, and behaved in a warmer manner *if they had been told* that the other student liked them. The other students came to like these students better as well, so liking produced more liking.

The only time that liking someone does not seem to make that person like the other in return is if a person suffers from feelings of low self-worth. In that case, finding out that someone likes you when you don't even like yourself makes you question his or her motives. This mistrust can cause you to act unfriendly to that person, which makes the person more likely to become unfriendly to you in a kind of self-fulfilling prophecy (Murray et al., 1998).  [Watch the Video, In the Real World: Speed Dating: Reciprocity, at MyPsychLab](#)

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psychology in the news



Facing Facebook—The Social Nature of Online Networking



There are some interesting research findings concerning the online networking phenomenon. For example, people using particular sites seem to have certain things in common. The findings of one study suggest that which social network sites a college student selects is related to racial identity, ethnic identity, and the education level of the student's parents (Hargittai, 2007). White students prefer Facebook, and Hispanic students prefer MySpace; and while Asian and Asian American students use Facebook more than MySpace, they use less popular sites like Xanga and Friendster more than any other ethnic group does. The more education the parents have, the more likely the student is to use Facebook and Xanga, and the less likely to use MySpace.

In China, the popular social networking site is Ozone, but Chinese users of this site spend less time on it, have fewer contacts, and seem to consider its use as less important when compared to users of Facebook in the United States (Jackson & Wang, 2013). When you consider the self-promotion focus of such social networking sites, it doesn't seem surprising that Chinese users, coming from a collectivistic cultural background that promotes connections with others over individual independence, would be less likely to use such a resource.

In another study, researchers found that young people who already experience positive social relationships use the online sites to enhance those same relationships, contrary to the stereotyped view that it would be the socially inept who would gravitate toward the anonymous nature of online networking (Mikami et al., 2010). In fact, those who are less well-adjusted either did not use social networking sites or used them in more negative ways: excessive bad language, hostile remarks, aggressive gestures, or posting of unflattering or suggestive photographs.

There may also be gender differences in how people organize their social networking. In a recent study, researchers found that females have more "friends," do more buying and selling, and are more likely to "friend" people who make the request than are males (Szell

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& Thurner, 2013). The study also found that females take fewer risks online than do males. Males talk to larger groups of contacts, and are less likely to "friend" other males than females. They respond very quickly to females requesting a friendship.

Finally, one study's findings suggest that users of social networking sites spend a lot more time on "social searching," which is defined as searching a site for specific information about a certain person, group, or event, than they do on "social browsing," defined as surveying the site without any specific target in mind (Wise et al., 2010). Users were also found to be more emotionally and positively engaged when searching rather than browsing. Again, this runs counter to the complaints of some who feel that such sites encourage time-wasting browsing. Instead, people are actively searching for information they desire.

Questions for Further Discussion

1. Why might certain networking sites be more attractive to one ethnicity over another?
2. How do you find yourself using networking sites, and how does that relate to the findings of these studies?

LOVE IS A TRIANGLE—ROBERT STERNBERG'S TRIANGULAR THEORY OF LOVE

Dictionary definitions of love refer to a strong affection for another person due to kinship, personal ties, sexual attraction, admiration, or common interests.

 But those aren't all the same kind of relationships. I love my family and I love my friends, but in different ways.

Psychologists generally agree that there are different kinds of love. One psychologist, Robert Sternberg, outlined a theory of what he determined were the three main components of love and the different types of love that combinations of these three components can produce (Sternberg, 1986, 1988b, 1997).

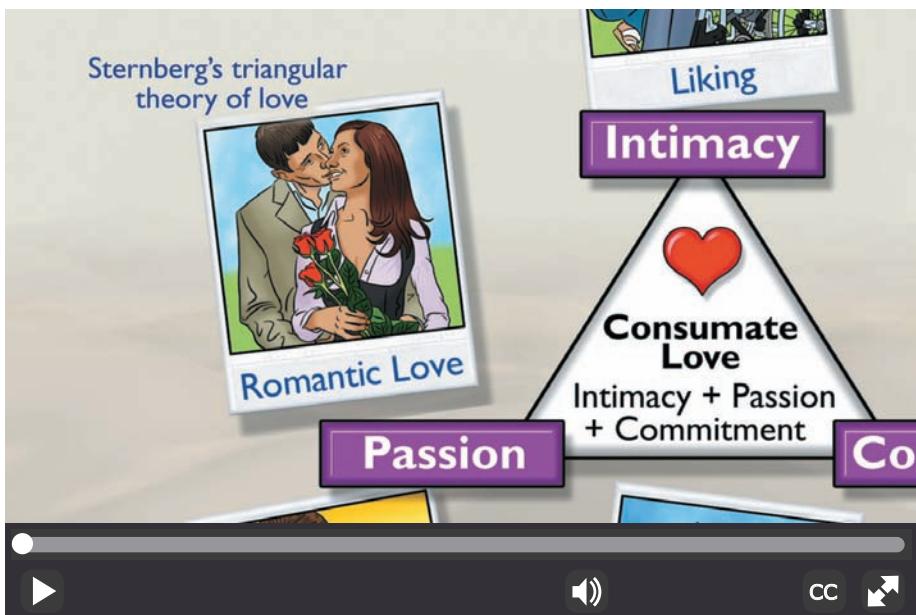
THE THREE COMPONENTS OF LOVE According to Sternberg, love consists of three basic components: intimacy, passion, and commitment.

Intimacy, in Sternberg's view, refers to the feelings of closeness that one has for another person or the sense of having close emotional ties to another. Intimacy in this sense is not physical but psychological. Friends have an intimate relationship because they disclose things to each other that most people might not know, they feel strong emotional ties to each other, and they enjoy the presence of the other person.

Passion is the physical aspect of love. Passion refers to the emotional and sexual arousal a person feels toward the other person. Passion is not simply sex; holding hands, loving looks, and hugs can all be forms of passion.

Commitment involves the decisions one makes about a relationship. A short-term decision might be, "I think I'm in love." An example of a more long-term decision is, "I want to be with this person for the rest of my life."

THE LOVE TRIANGLES A love relationship between two people can involve one, two, or all three of these components in various combinations. The combinations can produce seven different forms of love, as can be seen in the video *What's in It for Me?: Attraction: Sternberg's Triangular Theory* and in **Figure 12.5**.



[Watch the Video](#), *What's in It for Me?: Attraction: Sternberg's Triangular Theory* at [MyPsychLab](#)

Two of the more familiar and more heavily researched forms of love from Sternberg's theory are romantic love and companionate love. When intimacy and passion are combined, the result is the more familiar **romantic love**, which is sometimes called passionate love by other researchers (Bartels & Zeki, 2000; Diamond, 2003; Hartfield, 1987). Romantic love is often the basis for a more lasting relationship. In many Western cultures, the ideal relationship begins with liking, then becomes romantic love as passion is added to the mix, and finally becomes a more enduring form of love as a commitment is made.

When intimacy and commitment are the main components of a relationship, it is called **companionate love**. In companionate love, people who like each other, feel emotionally close to each other, and understand one another's motives have made a commitment to live together, usually in a marriage relationship. Companionate love is often the binding tie that holds a marriage together through the years of parenting, paying bills, and lessening physical passion (Gottman & Krookoff, 1989; Steinberg & Silverberg, 1987). In

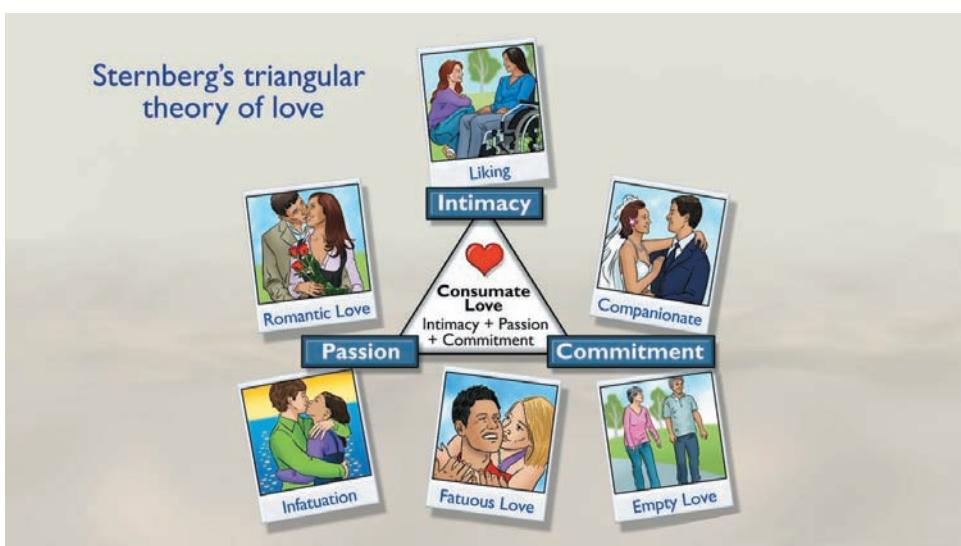


Figure 12.5 Sternberg's Triangular Theory of Love

This diagram represents the seven different kinds of love that can result from combining the three components of love: intimacy, passion, and commitment. Notice that some of these types of love sound less desirable or positive than others. What is the one key element missing from the less positive types of love?
Source: Adapted from Sternberg (1986).

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many non-Western cultures, companionate love is seen as more sensible. Choices for a mate on the basis of compatibility are often made by parents or matchmakers rather than the couple themselves (Duben & Behar, 1991; Hortaçsu, 1999; Jones, 1997; Thornton & HuiSheng, 1994).

Finally, when all three components of love are present, the couple has achieved *consummate love*, the ideal form of love that many people see as the ultimate goal. This is also the kind of love that may evolve into companionate love when the passion lessens during the middle years of a relationship's commitment.

12.10

 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP

liking or having the desire for a relationship with someone else; can be influenced by a variety of factors

- physical attractiveness
- proximity
- similarity
- complementary qualities
- reciprocity of liking

Social Interaction: (continued) Interpersonal Attraction

love

strong affection for another person due to kinship, personal ties, sexual attraction, admiration, or common interests

Sternberg's triangular theory suggests different components and types of love

- three components
 - intimacy
 - passion
 - commitment
- three types
 - romantic (intimacy and passion)
 - companionate (intimacy and commitment)
 - consummate (intimacy, passion, and commitment)

PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. The more you see someone, the more likely you are to like that person. Such a phenomenon is often due to
 - a. reciprocity of liking.
 - b. similarity.
 - c. mere exposure.
 - d. proximity.
2. What does the research say about the concept of opposites attract?
 - a. While it goes against the concept of similarity, it is real and research can prove it.
 - b. Opposites attract is really more an example of proximity although studies show that opposites can and often are attracted to one another.
 - c. Research notes that opposites attract but is unable to explain why this happens.
 - d. Studies do not support this idea but instead offer the explanation of complementary qualities.
3. In grade school, 12-year-old Chase does not know 12-year-old Corrine well, but starts to like her when he hears from her friends that she has a crush on him. This is an example of
 - a. reciprocity of liking.
 - b. similarity.
 - c. mere exposure.
 - d. proximity.
4. According to Robert Sternberg's three components of love, which component addresses the physical aspects?
 - a. intimacy
 - b. passion
 - c. commitment
 - d. concern
5. According to Sternberg, when all three components of love are present, a couple possesses _____ love.
 - a. romantic
 - b. passionate
 - c. companionate
 - d. consummate

Aggression and Prosocial Behavior

People have a tendency to either behave negatively or positively toward other people. When behavior is negative, it can become violent. But sometimes the choice is to act to help others rather than hurt them, and the next section discusses the differences between those two extremes.

AGGRESSION

How is aggressive behavior determined by biology and learning?

Unfortunately, violence toward others is another form of social interaction. When one person hurts or tries to destroy another person deliberately, either with words or with physical behavior, psychologists call it **aggression**. One common cause of aggressive behavior is frustration, which occurs when a person is prevented from reaching some desired goal. The concept of aggression as a reaction to frustration is known as the *frustration-aggression hypothesis* (Berkowitz, 1993; Miller et al., 1941). Many sources of frustration can lead to aggressive behavior. Pain, for example, produces negative sensations that are often intense and uncontrollable, leading to frustration and often aggressive acts against the nearest available target (Berkowitz, 1993). Loud noises, excessive heat, the irritation of someone else's cigarette smoke, and even awful smells can lead people to act out in an aggressive manner (Anderson, 1987; Rotton & Frey, 1985; Rotton et al., 1979; Zillmann et al., 1981).

Frustration is not the only source of aggressive behavior. Many early researchers, including Sigmund Freud (1930), believed that aggression was a basic human instinct, part of our death instinct. Famed sociobiologist Konrad Lorenz (1966) saw aggression as an instinct for fighting to promote the survival of our species. In evolutionary terms, those early humans who were most successful in protecting their territory, resources, and offspring were probably more aggressive, and so survived to pass on their genetic material (Buss, 2009; Cosmides & Tooby, 2013). But if aggression is an instinct present in all humans, it should occur in far more similar patterns across cultures than it does. Instinctual behavior, as often seen in animals, is not modifiable by environmental influences. Modern approaches include explanations of aggression as a biological phenomenon or a learned behavior.

AGGRESSION AND BIOLOGY There is some evidence that human aggression has, at least partially, a genetic basis. Studies of twins reared together and reared apart have shown that if one identical twin has a violent temper, the identical sibling will most likely also have a violent temper. This agreement between twins' personalities happens more often with identical twins than with fraternal twins (Miles & Carey, 1997; Rowe et al., 1999). It may be that some gene or complex of genes makes certain people more susceptible to aggressive responses under the right environmental conditions.

As discussed in Chapter Two, certain areas of the brain seem to control aggressive responses. The frontal lobes, amygdala, and other structures of the limbic system,  to Learning Objective 2.8, have been shown to trigger aggressive responses when stimulated in both animals and humans (Adams, 1968; Albert & Richmond, 1977; LaBar et al., 1995; Scott et al., 1997; Yang et al., 2010). Charles Whitman, the Texas Tower sniper, who in 1966 killed his mother and his wife and then shot and killed 12 more people before finally being killed by law enforcement officers, left a note asking for an examination of his brain. An autopsy did reveal a tumor that was pressing into his amygdala (Lavergne, 1997).

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There are also chemical influences on aggression. Testosterone, a male sex hormone, has been linked to higher levels of aggression in humans (Archer, 1991). This may help to explain why violent criminals tend to be young, male, and muscular. They typically have high levels of testosterone and low levels of serotonin, another important chemical found in the brain (Alexander et al., 1986; Brown & Linnoila, 1990; Coccaro & Kavoussi, 1996; Dabbs et al., 2001; Robins, 1996).



Don't some people get pretty violent after drinking too much?
Does alcohol do something to those brain chemicals?

Alcohol does have an impact on aggressive behavior. Psychologically, alcohol acts to release inhibitions, making people less likely to control their behavior even if they are not yet intoxicated. Biologically, alcohol affects the functioning of many neurotransmitters and in particular is associated with a decrease in serotonin (Virkkunen & Linnoila, 1996).  to [Learning Objective 2.2](#). In one study, volunteers were asked to administer electric shocks to an unseen “opponent” in a study reminiscent of Milgram’s shock experiment. The actual responses to the shock were simulated by a computer, although the volunteers believed that the responses were coming from a real person. The volunteers were told it was a test of reaction time and learning (Bushman, 1997). Volunteers participated both before consuming alcohol and after consuming alcohol. Participants were much more aggressive in administering stronger shocks after drinking.

THE POWER OF SOCIAL ROLES Although frustration, genetics, body chemicals, and even the effects of drugs can be blamed for aggressive behavior to some degree, much of human aggression is also influenced by learning. The social learning theory explanation for aggression states that aggressive behavior is learned (in a process called observational learning) by watching aggressive models get reinforced for their aggressive behavior (Bandura, 1980; Bandura et al., 1961).  to [Learning Objective 5.12](#). Aggressive models can be parents, siblings, friends, or people on television or in computerized games.

Some evidence suggests that even taking on a particular *social role*, such as that of a soldier, can lead to an increase in aggressive behavior. A **social role** is the pattern of behavior that is expected of a person who is in a particular social position. For example, “doctor” is a social role that implies wearing a white coat, asking certain types of questions, and writing prescriptions, among other things. A deeply disturbing experiment was conducted by famed social psychologist Philip Zimbardo at Stanford University in 1971. The experiment was recorded on film from the beginning to its rather abrupt end. About 70 young men, most of whom were college students, volunteered to participate for 2 weeks. They were told that they would be randomly assigned the social role of either a guard or a prisoner in the experiment. The “guards” were given uniforms and instructions not to use violence but to maintain control of the “prison.” The “prisoners” were booked at a real jail, blindfolded, and transported to the campus “prison,” actually the basement of one of the campus buildings. On Day 2, the prisoners staged a revolt (not planned as part of the experiment), which was quickly crushed by the guards. The guards then became increasingly more aggressive, using humiliation to control and punish the prisoners. For example, prisoners were forced to clean out toilet bowls with their bare hands. The staff observing the experiment had to release five of the prisoners who became so upset that they were physically ill. The entire experiment was canceled on the fifth day, after one of the prisoners reported to Zimbardo that what the experimenters were doing to the young men was terrible (Zimbardo, 1971).

The conclusions of Zimbardo and his colleagues highlighted the influence that a social role, such as that of “guard,” can have on perfectly ordinary people. Although

history is full of examples of people behaving horribly to others while filling a particular role; one need not travel very far into the past to find an example.

During the war in Iraq in 2003, an army reserve general was suspended from duty while an investigation into reported prisoner abuses was conducted. Between October and December 2003, investigators found numerous cases of cruel, humiliating, and other startling abuses of the Iraqi prisoners by the army military police stationed at the prison of Abu Ghraib (Hersh, 2004). Among the cruelties reported were pouring cold water on naked detainees, beating them with a broom handle or chair, threatening them with rape, and one case of actually carrying out the threat. How could any normal person have done such things? The “guards” in the Stanford prison study were normal people, but the effect of putting on the uniform and taking on the social role of guard changed their behavior radically. Is it possible that a similar factor was at work at Abu Ghraib? The behavior of the guards at Abu Ghraib was not part of a formal, controlled study, so further research will be needed to determine to what degree the social roles at work in situations like this influence the kind of behavior seen in this real-life example.

No one can deny that abused children are exposed to powerful models of aggression. Unfortunately, the parents who abuse them are reinforced for their aggressive behavior when they get what they want from the child. No one can deny that there are people who were abused as children who then go on to become abusers. Contrary to popular belief, most children who suffer abuse do *not* grow up to become abusers themselves—in fact, only one-third of abused children do so (Glasser et al., 2001; Kaufman & Zigler, 1993; Oliver, 1993). Instead of becoming the abuser, some abused children receive help in the form of counseling and/or removal from the abusive situation, overcoming the damage from their childhood, whereas others withdraw, isolating themselves rather than becoming abusive (Dodge et al., 1990).



I've heard that violent television programs can cause children to become more aggressive. How true is that?

VIOLENCE IN THE MEDIA AND AGGRESSION Bandura's early study in which small children viewed a video of an aggressive model was one of the first attempts to investigate the effect of violence in the media on children's aggressive behavior (Bandura et al., 1963). **LINK** to Learning Objective 5.12. Since then, researchers have examined the impact of television and other media violence on the aggressive behavior of children of various ages. The conclusions have all been similar: Children who are exposed



This photograph shows a “guard” searching a “prisoner” in Zimbardo’s famous Stanford prison experiment. The students in the experiment became so deeply involved in their assigned roles that Zimbardo had to cancel the experiment after only 5 days—less than half the time originally scheduled for the study.



A U.S. soldier mistreats an Iraqi prisoner at the Abu Ghraib prison in Iraq. Investigators into alleged abuses at this prison found numerous sadistic and brutal acts committed by U.S. military personnel upon the prisoners.

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to high levels of violent media are more aggressive than children who are not (Baron & Reiss, 1985; Bushman & Huesmann, 2000; Centerwall, 1989; Geen & Thomas, 1986; Huesmann & Miller, 1994; Huesmann et al., 1997; Huesmann et al., 2003; Villani, 2001). These studies have found that there are several contributing factors involving the normal aggressive tendencies of the child, with more aggressive children preferring to watch more aggressive media, as well as the age at which exposure begins: The younger the child, the greater the impact. Parenting issues also have an influence, as the aggressive impact of television is lessened in homes where hostile behavior is not tolerated and punishment is not physical.

Violent video games have also come under fire as causing violent acting-out in children, especially young adolescents. The tragic shootings at schools all over the United States have, at least in part, been blamed on violent video games that the students seemed to be imitating. This was especially a concern in the Littleton, Colorado, shootings because the adolescent boys involved in those incidents had not only played a violent video game in which two shooters killed people who could not fight back but also had made a video of themselves in trench coats, shooting school athletes. This occurred less than a year before these same boys killed 13 of their fellow students at Columbine High School and wounded 23 others (Anderson & Dill, 2000). In one study, second-grade boys were allowed to play either an aggressive or a nonaggressive video game. After playing the game, the boys who had played the aggressive video game demonstrated more verbal and physical aggression both to objects around them and to their playmates while playing in a free period than did the boys who had played the nonaggressive video game (Irwin & Gross, 1995).

In a massive meta-analysis of research into the connection between violent media and aggressive behavior in children, social psychologist Craig Anderson and colleagues found clear and consistent evidence that even short-term exposure to violent media significantly increases the likelihood that children will engage in both physical and verbal aggression as well as aggressive thoughts and emotions (Anderson et al., 2003). Clearly, violent video games do correlate with increased aggression levels of the children who play them, both young children and adolescents (Anderson, 2003; Anderson & Bushman, 2001; Anderson et al., 2008; Bartlett et al., 2008; Ferguson et al., 2008). (Remember, correlation does NOT prove causation—the studies mentioned here have not proven that playing violent video games *causes* increased aggression!  to Learning Objective 1.9.)

PROSOCIAL BEHAVIOR

What is altruism, and how is deciding to help someone related to the presence of others?

Another and far more pleasant form of human social interaction is **prosocial behavior**, or socially desirable behavior that benefits others rather than brings them harm.

ALTRUISM One form of prosocial behavior that almost always makes people feel good about other people is **altruism**, or helping someone in trouble with no expectation of reward and often without fear for one's own safety, as Charles Ramsey did in the Ohio kidnapping case discussed at the beginning of this chapter. Although no one is surprised by the behavior of a mother who enters a burning house to save her child, some people are often surprised when total strangers step in to help, risking their own lives for people they do not know. Take the survey experiment *Could You Be a Hero?* to learn more about your own tendencies to take risks to help others.

Simulation

Could You Be a Hero?

Many people believe that a hero is an extraordinary person who is able to protect and defend others because he or she has special skills or a particular type of personality. What then do we make of the thousands of average, ordinary people that help, protect, and rescue people every day? How about you? Have you ever been a hero? Could you be a hero?

[Go to the Experiment ►](#)

Thinking of your overall experiences with heroism - defending or protecting others from harm or injustice - please indicate the extent of your agreement with the statements below.

Acting heroically requires personality traits that I do not have.

- Strongly Disagree
- Moderately Disagree
- Neither Agree nor Disagree
- Moderately Agree
- Strongly Agree
- Prefer Not To State

Simulate the Experiment, Could You Be a Hero?, on [MyPsychLab](#)

Sociobiologists, scientists who study the evolutionary and genetic bases of social organizations in both animals and humans, see altruistic behavior as a way of preserving one's genetic material, even at the cost of one's own life. This is why the males of certain species of spiders, for example, seem to willingly become "dinner" for the female mates they have just fertilized, ensuring the continuation of their genes through the offspring she will produce (Koh, 1996). It also explains the mother or father who risks life and limb to save a child.

But why do people risk their own lives to help total strangers? One answer may lie in the structure of the brain. Using brain-imaging techniques, researchers have found evidence that a brain region known as the temporoparietal junction (TPJ) is larger in individuals who make altruistic choices, particularly in the right hemisphere (Morishima et al., 2012). This area was also more active during decision making that involved a greater cost of helping the individual.

More importantly, why do people sometimes refuse to help when their own lives are not at risk?

WHY PEOPLE WON'T HELP On March 13, 1964, at about 3:15 in the morning, a man who didn't even know Catherine "Kitty" Genovese caught her in the parking lot of her apartment complex, stabbed her, left, and then came back nearly half an hour later to rape and stab her to death in the entryway of the complex. A police investigation determined that at least 38 people heard or watched some part of the fatal attack from their apartment windows. Not one of these people—Kitty's neighbors—called the police until after the attack was over (Delfiner, 2001; Gado, 2004; Rosenthal, 1964).

People were outraged by the apparent indifference and lack of sympathy for the poor woman's plight. Why did those people simply stand by and watch or listen? Social psychologists would explain that the lack of response to Kitty Genovese's screams for help was not due to indifference or a lack of sympathy but instead to the presence of other people.

Forty-three years later on June 23, 2007, 27-year-old LaShanda Calloway was stabbed to death during an argument in a convenience store. It took two minutes for someone to call 9-1-1. Surveillance video captured the attack, including the five shoppers who stepped over her bleeding form and continued shopping. One customer did stop—to

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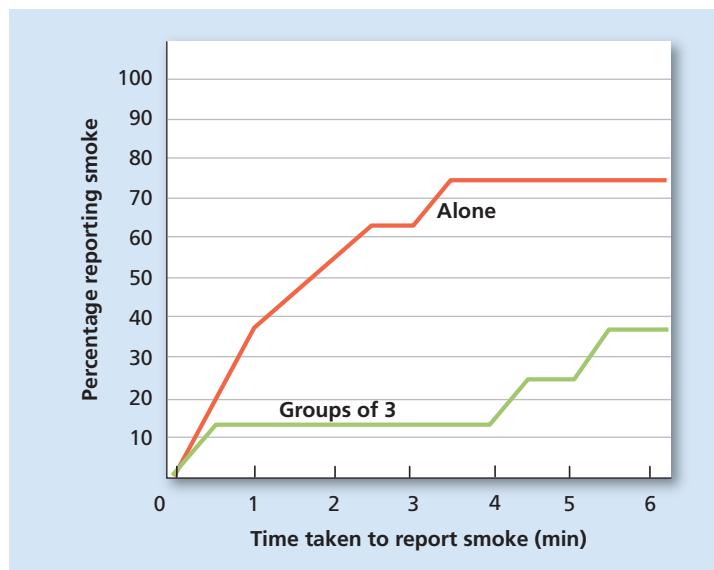


Figure 12.6 Elements Involved in Bystander Response

In a classic experiment, participants were filling out surveys as the room began to fill with smoke. As you can see in the accompanying graph, the time taken to report smoke and the percentage of people reporting smoke both depended on how many people were in the room at the time the smoke was observed. If a person was alone, he or she was far more likely to report the smoke and report it more quickly than when there were three people.

Source: Latané & Darley (1969).

take a picture of Ms. Calloway as she lay dying on the floor (Hegeman, 2007). When other people are present at the scene or are assumed to be present, individuals are affected by two basic principles of social psychology: the bystander effect and diffusion of responsibility.

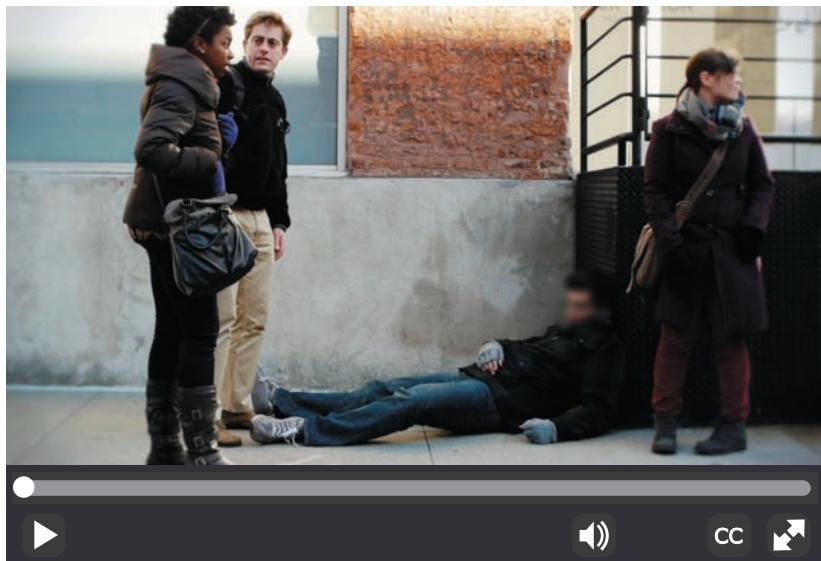
The **bystander effect** refers to the finding that the likelihood of a bystander (someone observing an event and close enough to offer help) to help someone in trouble decreases as the number of bystanders increases. If only one person is standing by, that person is far more likely to help than if there is another person, and the addition of each new bystander decreases the possibility of helping behavior even more (Darley & Latané, 1968; Eagly & Crowley, 1986; Latané & Darley, 1969). In the case of Kitty Genovese, there were 38 “bystanders” at the windows of the apartment buildings, and none of them helped. There is some evidence that only six or seven people actually *saw* parts of the attack, while others heard what some interpreted as a lover’s quarrel. No one apparently witnessed the entire event from start to finish, and the greater part of the assault actually took place out of the hearing of any witnesses (Rasenberger, 2006). Still, not one person called the police.

Social psychologists Bibb Latané and John Darley conducted several classic experiments about the bystander effect. In one study, participants were filling out questionnaires in a room that began to fill with smoke. Some participants were alone in the room, whereas in another condition there were three participants in the room. In a third condition one participant was in the room with two confederates of the experimenter, who were instructed to notice the smoke but ignore it afterwards. In the “participant alone” condition, three-fourths of the participants left the room to report the smoke. In the “three participants” condition, only a little over one-third of the participants reported the smoke, whereas only one-tenth of the participants who were in the room with confederates did so (**Figure 12.6**).

But why does the number of bystanders matter?

Diffusion of responsibility is the phenomenon in which a person fails to take responsibility for either action or inaction because of the presence of other people who are seen to share the responsibility (Leary & Forsyth, 1987). Diffusion of responsibility is a form of attribution in which people explain why they acted (or failed to act) as they did because of others. “I was just following orders,” “Other people were doing it,” and “There were a lot of people there, and I thought one of them would do something” are all examples of statements made in such situations. Kitty Genovese and LaShanda Calloway received no help because there were too many potential “helpers,” and not one of the people listening to cries for help took the responsibility to intervene—they thought surely someone else was doing something about it.

FIVE DECISION POINTS IN HELPING BEHAVIOR What kind of decision-making process do people go through before deciding to help? What are the requirements for deciding when help is needed? Darley and Latané (1968) identified several cognitive decision points that a bystander must face before helping someone in trouble. These decision points, which are discussed in the video *The Basics: Under the Influence of Others: Deciding to Help* and outlined in **Table 12.3**, are still considered valid over 40 years later.



Watch the Video, *The Basics: Under the Influence of Others: Deciding to Help*, at [MyPsychLab](#)

Aside from the factors listed in the table, there are other influences on the decision to help. For example, the more ambiguity* in a situation, the less likely it will be defined as an emergency. (Remember, many of those who heard the attack on Kitty Genovese were not sure if it was a lover's quarrel or not.) If there are other people nearby, especially if the situation is ambiguous, bystanders may rely on the actions of the others to help determine if the situation is an emergency or not. Since all the bystanders may be doing this, it is very likely that the situation will be seen as a nonemergency because no one is moving to help.

Another factor is the mood of the bystanders. People in a good mood are generally more likely to help than people in a bad mood, but oddly enough, they are not as likely to help if helping would destroy the good mood. Gender of the victim is also a factor, with women more likely to receive help than men if the bystander is male, but not if the bystander is female. Physically attractive people are more likely to be helped. Victims who look like “they deserve what is happening” are also less likely to be helped. For example, a man lying on the side of the street who is dressed in shabby clothing and appears to be drunk will be passed by, but if he is dressed in a business suit, people are more likely to stop and help. Racial and ethnicity differences between victim and bystander also decrease the probability of helping (Richards & Lowe, 2003; Tukuitonga & Bindman, 2002).

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Table 12.3

Help or Don't Help: Five Decision Points

DECISION POINT	DESCRIPTION	FACTORS INFLUENCING DECISION
Noticing	Realizing that there is a situation that might be an emergency.	Hearing a loud crash or a cry for help.
Defining an Emergency	Interpreting the cues as signaling an emergency.	Loud crash is associated with a car accident, people are obviously hurt.
Taking Responsibility	Personally assuming the responsibility to act.	A single bystander is much more likely to act than when others are present (Latané & Darley, 1969).
Planning a Course of Action	Deciding how to help and what skills might be needed.	People who feel they have the necessary skills to help are more likely to help.
Taking Action	Actually helping.	Costs of helping (e.g., danger to self) must not outweigh the rewards of helping.

*ambiguity: having the quality of being difficult to identify specific elements of the situation.

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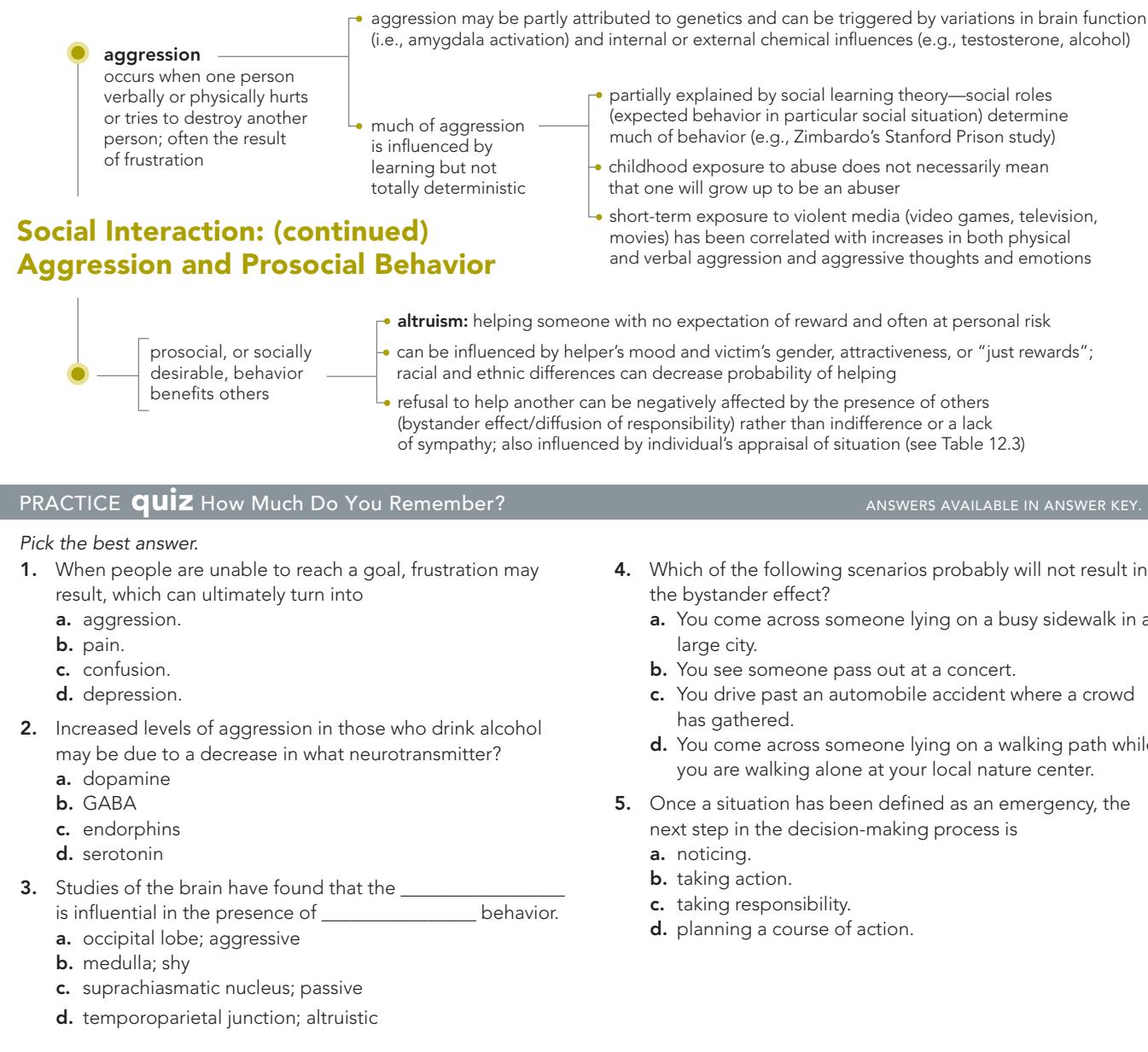
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 Explore the Concept at MyPsychLab
CONCEPT MAP

Applying Psychology to Everyday Life: Peeking Inside the Social Brain

What is social neuroscience?

As scientists develop better techniques for studying the workings of the brain, researchers in many fields of psychology are able to find the neural bases for human behavior. Social psychology is no exception, and the study of how our bodies and brains work during

social behavior is called **social neuroscience** (Cacioppo & Berntson, 1992). In the discussion of altruism, the temporoparietal junction, or TPJ, was named as one of the areas of the brain involved in prosocial behavior (Morishima et al., 2012). That research was accomplished with an fMRI, a brain-scanning technique that allows not only the structure but also the functioning of the living brain to be examined during various tasks and activities.  to Learning Objective 2.6.

The TPJ, located where the temporal and parietal lobes meet, is also a key neural structure involved in competitive behavior. Researchers pitted people against either a computer or another person, and found that the TPJ is active when the person is trying to predict the actions of the human opponent, but not the computer opponent (Carter et al., 2012). Research with nonhuman primates highlights the importance of the prefrontal cortex, the area of the brain at the very front of the large frontal lobes. The findings of that study suggest that primates make decisions about sharing behavior in three different parts of the prefrontal lobe (Chang et al., 2013). One can only guess that human sharing decisions are at least as complex, if not more so.

What all of these studies (and many, many more) mean is that there are specific structures and places in our brains for social interactions and decisions. It is important that we try to understand as much as we can about the “social brain” for many reasons, but chief among them is gaining an understanding of diseases and disorders which may be linked to the social areas of the brain (Adolphs, 2010). Consider autism, a developmental disorder than includes impaired social functioning, or Alzheimer’s, Parkinson’s, or Huntington’s disease, all of which also have impaired social functioning. Many psychological disorders also involve abnormal social behavior—depression, the various personality disorders, and anxiety disorders, to name a few. Understanding how these malfunctions occur within the brain is a huge step on the road to changing that behavior. Where social psychologists once studied human interactions through observing outward behavior, social neuroscientists now study the most intimate workings of the social brain.

Questions for Further Discussion

1. Can you think of other diseases or disorders which include disrupted social behavior?
2. What are the drawbacks of drawing parallels between nonhuman primate behavior and human behavior?

Writing Prompt

- ▼ Discuss the factors that contribute to prejudice and discrimination and identify some techniques for reducing the development of prejudice and discrimination.

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chapter summary

 Listen to the **Audio File** of your chapter at **MyPsychLab**

- Social psychology is the scientific study of how a person's thoughts, feelings, and behavior are influenced by the real, imagined, or implied presence of other people.

Social Influence: Conformity, Group Behavior, Compliance, and Obedience

12.1 What factors influence people or groups to conform to the actions of others, and how does the presence of others affect individual task performance?

- Asch used a set of comparison lines and a standard line to experiment with conformity, finding that subjects conformed to group opinion about one-third of the time, increased as the number of confederates rose to four, and decreased if just one confederate gave the correct answer.
- Cross-cultural research has found that collectivistic cultures show more conformity than individualistic cultures. Gender differences do not exist in conformity unless the response is not private, in which case women are more conforming than men.
- Groupthink occurs when a decision-making group feels that it is more important to maintain group unanimity and cohesiveness than to consider the facts realistically. Minimizing groupthink involves holding group members responsible for the decisions made by the group.
- Group polarization occurs when members take somewhat more extreme positions and take greater risks as compared to those made by individuals.
- When the performance of an individual on a relatively easy task is improved by the presence of others, it is called social facilitation. When the performance of an individual on a relatively difficult task is negatively affected by the presence of others, it is called social impairment.
- When a person who is lazy is able to work in a group of people, that person often performs less well than if the person were working alone, in a phenomenon called social loafing.
- Deindividuation occurs when group members feel anonymous and personally less responsible for their actions.

12.2 How is compliance defined, and what are some ways to gain the compliance of another?

- Compliance occurs when a person changes behavior as a result of another person asking or directing that person to change.
- Three common ways of getting compliance from others are the foot-in-the-door technique, the door-in-the-face technique, and the low-ball technique.
- People who join cults tend to be under stress, unhappy, unassertive, gullible, dependent, idealistic, and they want to belong. Young people are also likelier to join cults than are older people. Cults use love-bombing, isolation, rituals, and activities to keep the new recruits from questioning and critical thinking. Cults also use the foot-in-the-door technique.

12.3 What factors make obedience more likely?

- Obedience involves changing one's behavior at the direct order of an authority figure.
- Milgram did experiments in which he found that 65 percent of people obeyed an authority figure even if they believed they were hurting, injuring, or possibly killing another person with electric shock.

Social Cognition: Attitudes, Impression Formation, and Attribution

12.4 What are the three components of an attitude, how are attitudes formed, and how can attitudes be changed?

- Attitudes are tendencies to respond positively or negatively toward ideas, persons, objects, or situations.
- The three components of an attitude are the affective (emotional) component, the behavior component, and the cognitive component.
- Attitudes are often poor predictors of behavior unless the attitude is very specific or very strong.
- Direct contact with the person, situation, object, or idea can help form attitudes.
- Attitudes can be formed through direct instruction from parents or others.
- Interacting with other people who hold a certain attitude can help an individual form that attitude.
- Attitudes can also be formed through watching the actions and reactions of others to ideas, people, objects, and situations.
- Persuasion is the process by which one person tries to change the belief, opinion, position, or course of action of another person through argument, pleading, or explanation.
- The key elements in persuasion are the source of the message, the message itself, and the target audience.
- In the elaboration likelihood model, central-route processing involves attending to the content of the message itself, whereas peripheral-route processing involves attending to factors not involved in the message, such as the appearance of the source of the message, the length of the message, and other noncontent factors.

12.5 How do people react when attitudes and behavior are not the same?

- Cognitive dissonance is discomfort or distress that occurs when a person's actions do not match the person's attitudes.
- Cognitive dissonance is lessened by changing the conflicting behavior, changing the conflicting attitude, or forming a new attitude to justify the behavior.

12.6 How are social categorization and implicit personality theories used in impression formation?

- Impression formation is the forming of the first knowledge a person has about another person.
- The primacy effect in impression formation means that the very first impression one has about a person tends to persist even in the face of evidence to the contrary.
- Impression formation is part of social cognition, or the mental processes that people use to make sense out of the world around them.
- Social categorization is a process of social cognition in which a person, upon meeting someone new, assigns that person to a category or group on the basis of characteristics the person has in common with other people or groups with whom the perceiver has prior experience.
- One form of a social category is the stereotype, in which the characteristics used to assign a person to a category are superficial and believed to be true of all members of the category.

- An implicit personality theory is a form of social cognition in which a person has sets of assumptions about different types of people, personality traits, and actions that are assumed to be related to each other.
- Schemas are mental patterns that represent what a person believes about certain types of people. Schemas can become stereotypes.

12.7 How do people try to explain the actions of others?

- Attribution is the process of explaining the behavior of others as well as one's own behavior.
- A situational cause is an explanation of behavior based on factors in the surrounding environment or situation.
- A dispositional cause is an explanation of behavior based on the internal personality characteristics of the person being observed.
- The fundamental attribution error is the tendency to overestimate the influence of internal factors on behavior while underestimating the influence of the situation.

Social Interaction: Prejudice and Aggression

12.8 How are prejudice and discrimination different?

- Prejudice is a negative attitude that a person holds about the members of a particular social group. Discrimination occurs when members of a social group are treated differently because of prejudice toward that group.
- There are many forms of prejudice, including ageism, sexism, racism, and prejudice toward those who are too fat or too thin.
- In-groups are the people with whom a person identifies, whereas out-groups are everyone else at whom prejudice tends to be directed.
- Scapegoating refers to the tendency to direct prejudice and discrimination at out-group members who have little social power or influence. New immigrants are often the scapegoats for the frustration and anger of the in-group.

12.9 Why are people prejudiced, and how can prejudice be stopped?

- Social cognitive theory views prejudice as an attitude acquired through direct instruction, modeling, and other social influences.
- Conflict between groups increases prejudice and discrimination according to realistic conflict theory.
- Social identity theory sees a person's formation of a social sense of self within a particular group as being due to three things: social categorization (which may involve the use of reference groups), social identity (the person's sense of belonging to a particular social group), and social comparison (in which people compare themselves to others to improve their own self-esteem).
- Stereotype vulnerability refers to the effect that a person's knowledge of the stereotypes that exist against his or her social group can have on that person's behavior.
- People who are aware of stereotypes may unintentionally come to behave in a way that makes the stereotype real in a self-fulfilling prophecy.
- Intergroup contact is more effective in reducing prejudice if the groups have equal status.
- Prejudice and discrimination can also be reduced when a superordinate goal that is large enough to override all other goals needs to be achieved by all groups.
- Prejudice and discrimination are reduced when people must work together to solve a problem because each person has an impor-

tant key to solving the problem, creating a mutual interdependence. This technique used in education is called the "jigsaw class-room."

Liking and Loving: Interpersonal Attraction

12.10 What factors govern attraction and love, and what are some different kinds of love?

- Interpersonal attraction refers to liking or having the desire for a relationship with another person.
- People tend to form relationships with people who are in physical proximity to them.
- People are attracted to others who are similar to them in some way.
- People may also be attracted to people who are different from themselves, with the differences acting as a complementary support for areas in which each may be lacking.
- People tend to like other people who like them in return, a phenomenon called the reciprocity of liking.
- Use of a specific social networking site may be partially determined by racial identity and ethnic identity. The ways sites are used are influenced by both gender and the status of current social relationships.
- Love is a strong affection for another person due to kinship, personal ties, sexual attraction, admiration, or common interests.
- Sternberg states that the three components of love are intimacy, passion, and commitment.
- Romantic love is intimacy with passion, companionate love is intimacy with commitment, and consummate love contains all three components.

Aggression and Prosocial Behavior

12.11 How is aggressive behavior determined by biology and learning?

- Aggression is behavior intended to hurt or destroy another person in a way that may be physical or verbal. Frustration is a major source of aggression.
- Biological influences on aggression may include genetics, the amygdala and limbic system, and testosterone and serotonin levels.
- Social roles are powerful influences on the expression of aggression. Social learning theory states that aggression can be learned through direct reinforcement and through the imitation of successful aggression by a model.
- Studies have concluded that violent television, movies, and video games stimulate aggressive behavior, both by increasing aggressive tendencies and providing models of aggressive behavior.

12.12 What is altruism, and how is deciding to help someone related to the presence of others?

- Prosocial behavior is behavior that is socially desirable and benefits others.
- Altruism is prosocial behavior in which a person helps someone else without expectation of reward or recognition, often without fear for his or her own safety.
- The bystander effect means that people are more likely to get help from others if there are one or only a few people nearby rather than a larger number. The more people nearby, the less likely it is that help will be offered.

- When others are present at a situation in which help could be offered, there is a diffusion of responsibility among all the bystanders, reducing the likelihood that any one person or persons will feel responsibility for helping.
- Researchers Latané and Darley found that people who were alone were more likely to help in an emergency than people who were with others.
- The five steps in making a decision to help are noticing, defining an emergency, taking responsibility, planning a course of action, and taking action.

test YOURSELF

ANSWERS AVAILABLE IN ANSWER KEY.

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Pick the best answer.

- Saul admits that he conforms so as to be liked by others. This is known as
 - compliance.
 - obedience.
 - informational social influence.
 - normative social influence.
- According to the text, in which of the following has groupthink been known to occur?
 - presidential elections
 - the fall of communism
 - mass suicides by cults
 - the sinking of the *Titanic*
- Many businesses now require their employees to work in teams, believing that a group of four to five employees will accomplish more than four to five individuals working alone. This is an example of what concept?
 - social facilitation
 - social impairment
 - social loafing
 - social laziness
- Maria was approached by her neighbor asking her to adopt two to three kittens that were abandoned by their mother. While Maria refused to take in three kittens, she did agree to adopt just one. What compliance technique did her neighbor use on Maria?
 - foot-in-the-door
 - door-in-the-face
 - lowball
 - double foot-in-the-door
- Which of the following people would probably not be a prime candidate for membership into a cult?
 - Lewis, who is mad at the world, especially his parents
 - Leticia, who is open to new ideas and wants world peace and harmony among people
 - Lauren, who is under a lot of stress and dissatisfied with her life
 - Lawrence, who has only has a high school diploma but tends to be independent and happy with his life
- Follow-up studies to Stanley Milgram's research have suggested that a teacher's willingness to deliver potentially lethal shocks may be more a product of _____ than of obedience.
 - conformity
 - compliance
 - social identity
 - deindividuation

Applying Psychology to Everyday Life: Peeking Inside the Social Brain

12.13 What is social neuroscience?

- Social neuroscience is the study of how biological processes influence social behavior. Studies use fMRI and other imaging techniques to discover areas of the brain involved in social actions.

- The public service messages that encourage parents to sit down with their children and talk frankly about drugs are promoting which method of attitude formation?
 - direct contact
 - direct instruction
 - vicarious conditioning
 - observational learning
- Researchers have found that a _____ degree of fear in a message makes it more effective, particularly when it is combined with _____.
 - maximum; information about how to prevent the fearful consequences
 - minimum; threats
 - moderate; threats
 - moderate; information about how to prevent the fearful consequences
- Sandy was a juror in the trial for a man accused of stealing guns from a sporting goods store. The defendant was not very well spoken and came from a very poor background, but Sandy listened carefully to the evidence presented and made her decision based on that. Sandy was using _____ processing.
 - central-route
 - peripheral-route
 - cognitive-route
 - visual-route
- Which of the following should LaShonda avoid if she wants to reduce cognitive dissonance?
 - changing her behavior
 - changing her attitude
 - forming a completely new attitude
 - ignoring the conflict altogether
- Gerard goes to a job interview dressed in patched blue jeans, a torn T-shirt, and sandals. His hair is uncombed and he hasn't shaved in a few days. Obviously, Gerard knows nothing about
 - cognitive dissonance.
 - attitude formation.
 - impression formation.
 - groupthink.
- If behavior is assumed to be caused by external characteristics, this is known as
 - a situational cause.
 - a dispositional cause.
 - a fundamental attribution error.
 - actor-observer bias.

13. Thomas likes to "hang with the guys." These people with whom Thomas identifies most strongly with are called a(n)
- referent group.
 - in-group.
 - out-group.
 - "them" group.
14. The "Robber's Cave" experiment showed the value of _____ in combating prejudice.
- "jigsaw classrooms"
 - equal status contact
 - subordinate goals
 - stereotyping vulnerability
15. Vivian and Steve met at work. At first they were just friends, but over time, they found themselves falling in love—or as Vivian tells her friends, "Steve just grew on me!" According to research in interpersonal attraction, the most likely explanation for their attraction is
- mere exposure.
 - personal attractiveness.
 - fate.
 - reciprocity of liking
16. According to Sternberg, a couple whose love is based off of intimacy and passion but who are not yet committed to a long-term relationship are in the form of love called _____ love.
- companionate
 - romantic
 - affectionate
 - consummate
17. The concept that aggression results from a social role is based on what psychological theory?
- humanistic
 - learning
 - psychoanalytical
 - cognitive
18. To which two processes do most social psychologists attribute the failure of those around LaShanda Calloway to help her?
- bystander effect and altruism
 - aggression and diffusion of responsibility
 - altruism and diffusion of responsibility
 - bystander effect and diffusion of responsibility
19. Cara knows that she can help people simply by dialing 9-1-1 on her cell phone if an emergency arises. Which step in the decision process for helping would Cara be at?
- noticing
 - taking action
 - taking responsibility
 - planning a course of action
20. Which of the following would the field of social neuroscience be most likely to study?
- what parts of the brain influence social behavior
 - how influential is heredity on social behavior
 - what impact does head trauma play on developing relationships
 - what impact do friends have in resolving conflicts

13

theories of personality

Many people have heard the story of the “Jim” twins, James Arthur Springer and James Edward Lewis, identical twins separated just after birth. At age 39 Springer and Lewis were the first set of twins studied by University of Minnesota psychologist Thomas Bouchard, who examined the differences and similarities between identical and fraternal twins raised apart from each other (Bouchard et al., 1990).

The two “Jims” were remarkably similar. They shared interests in mechanical drawing and carpentry, they smoked and drank the same amount, and they even both divorced women named Linda before marrying women named Betty. It is easy to attribute these similarities to their shared genetics. But Springer and Lewis were both raised in Ohio by parents from relatively similar socioeconomic backgrounds—how much of their similarity to each other might be due to those conditions?

In what ways are you similar to and different from your siblings? How has your personality been shaped by your environment?

A young woman with long dark hair, wearing a blue dress, is smiling. Two butterflies are flying around her. The background is white with blue circles and a video player interface at the bottom.

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Why study personality?

Personality is the sum total of who you are—your attitudes and reactions, both physical and emotional. It's what makes each person different from every other person in the world. How can any study of human behavior not include the study of who we are and how we got to be that way?

Learning objectives

13.1

What is personality, and how do the various perspectives in psychology view personality?

13.2

How did Freud's view of the mind and personality form a basis for psychodynamic theory?

13.3

How did the neo-Freudians modify Freud's theory, and how does modern psychodynamic theory differ from that of Freud's?

13.4

How do behaviorists and social cognitive theorists explain personality?

13.5

How do humanists such as Carl Rogers explain personality?

13.6

How does the trait perspective conceptualize personality?

13.7

What part do biology, heredity, and culture play in personality?

13.8

What are the advantages and disadvantages of various measures of personality?

13.9

What are some biological bases of the Big Five theory of personality?



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Theories of Personality

What is personality, and how do the various perspectives in psychology view personality?

Personality is the unique way in which each individual thinks, acts, and feels throughout life. Personality should not be confused with **character**, which refers to value judgments made about a person's morals or ethical behavior; nor should it be confused with **temperament**, the enduring characteristics with which each person is born, such as irritability or adaptability. Temperament is based in one's biology, either through genetic influences, prenatal influences, or a combination of those influences, and forms the basis upon which one's larger personality is built. Both character and temperament are vital parts of personality, however. Every adult personality is a combination of temperaments and personal history of family, culture, and the time during which they grew up (Kagan, 2010).  Watch the Video, *The Big Picture: What Is Personality?*, at [MyPsychLab](#)

Personality is an area of the still relatively young field of psychology in which there are several ways in which the characteristic behavior of human beings can be explained. However, the investigation of personality goes back quite some time. For example, physiological roots of personality were suggested as early as the fourth century B.C.E. by Empedocles and later by Hippocrates, with Hippocrates's work later influencing Galen in the second century C.E. (Dumont, 2010). Hippocrates and Galen believed that temperament or personality was related to the relative balance of the four physical humors of the body: blood, black bile, yellow bile, and phlegm.

One reason no single explanation of personality exists is because personality is still difficult to measure precisely and scientifically, and different perspectives of personality have arisen. Overall these tend to examine the source of personality, such as individual behavioral dispositions or situational processes, mediating factors that may be conscious or unconscious (Mischel & Shoda, 1995). Sources likely overlap and influence each other, such as the interaction of biological, developmental, social, and cultural factors. Perspectives also examine sources from different ways. In addition to those highlighted below, some are influenced by early schools of thought in psychology such as structuralism, functionalism, Gestalt learning, or the cognitive perspective. And among others, theories or perspectives may also use a "lens" stemming from such areas as motivated-cognition, cognitive-affective processing, self-narrative, evolution, or social adaption (Buss, 2009, 2011; Higgins & Scholer, 2010; McAdams & Olson, 2010; Mischel & Shoda, 1995). From a foundational aspect, we will focus on several traditional perspectives in personality theory:

- The *psychodynamic perspective* had its beginnings in the work of Sigmund Freud and still exists today. It focuses on the role of the unconscious mind in the development of personality. This perspective is also heavily focused on biological causes of personality differences.
- The *behaviorist perspective* is based on the theories of learning as discussed in Chapter Five. This approach focuses on the effect of the environment on behavior and as addressed here, includes aspects of social cognitive theory in that interactions with others and personal thought processes also influence learning and personality.
- The *humanistic perspective* first arose as a reaction against the psychoanalytic and behaviorist perspectives and focuses on the role of each person's conscious life experiences and choices in personality development.
- The *trait perspective* differs from the other three in its basic goals: The psychodynamic, behaviorist, and humanistic perspectives all seek to explain the process that causes personality to form into its unique characteristics, whereas trait theorists

are more concerned with the end result—the characteristics themselves. Although some trait theorists assume that traits are biologically determined, others make no such assumption.

Before we begin our study of the various personality perspectives, take a moment to participate in the survey experiment, *What Has Shaped Your Personality?*, to learn more about what factors may have influenced your own personality.

Simulation

What Has Shaped Your Personality?

This survey asks you about your beliefs regarding the factors that influence personality development and your experiences with personality assessment.

How often do the expectations and desires that other people have for you become more important than what you want for yourself?

- Very Rarely
- Rarely
- Occasionally
- Frequently
- Very Frequently

[Go to the Experiment ►](#)

Simulate the Experiment, *What Has Shaped Your Personality?* on [MyPsychLab](#)

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The Man and the Couch: Sigmund Freud and the Origins of the Psychodynamic Perspective

It's hard to understand how Freud developed his ideas about personality unless we have some knowledge of the world in which he and his patients lived. He was born and raised in Europe during the Victorian Age, a time of sexual repression. People growing up in this period were told by their church that sex should take place only in the context of marriage and then only to make babies. To enjoy sexual intercourse was considered a sin. Men were understood to be unable to control their "animal" desires at times, and a good Victorian husband would father several children with his wife and then turn to a mistress for sexual comfort, leaving his virtuous* wife untouched. Women, especially those of the upper classes, were not supposed to have sexual urges. It is no wonder that many of Freud's patients were wealthy women with problems stemming from unfulfilled sexual desires or sexual repression. Freud's "obsession" with sexual explanations for abnormal behavior seems more understandable in light of his cultural background and that of his patients.

Freud came to believe that there were layers of consciousness in the mind. His belief in the influence of the unconscious mind on conscious behavior, published in *The Psychopathology of Everyday Life* (Freud, 1901), shocked the Victorian world.



Sigmund Freud (1856–1939) was the founder of the psychodynamic movement in psychology. Many of his patients sat or reclined on the couch above while he sat in a chair, listening to them and developing his psychoanalytic theory of personality.

*virtuous: morally excellent.

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THE UNCONSCIOUS MIND

How did Freud's view of the mind and personality form a basis for psychodynamic theory?

Freud believed that the mind was divided into three parts: the preconscious, conscious, and unconscious minds (Freud, 1900). (See **Figure 13.1**.) While no one really disagreed with the idea of a conscious mind in which one's current awareness exists, or even of a preconscious mind containing memories, information, and events of which one can easily become aware, the **unconscious mind** (also called "the unconscious") was the real departure for the professionals of Freud's day. Freud theorized that there is a part of the mind that remains hidden at all times, surfacing only in symbolic form in dreams and in some of the behavior people engage in without knowing why they have done so. Even when a person makes a determined effort to bring a memory out of the unconscious mind, it will not appear directly, according to Freud. Freud believed that the unconscious mind was the most important determining factor in human behavior and personality.

 [Watch the Video, The Basics: Personality Theories: Psychodynamic, at MyPsychLab](#)

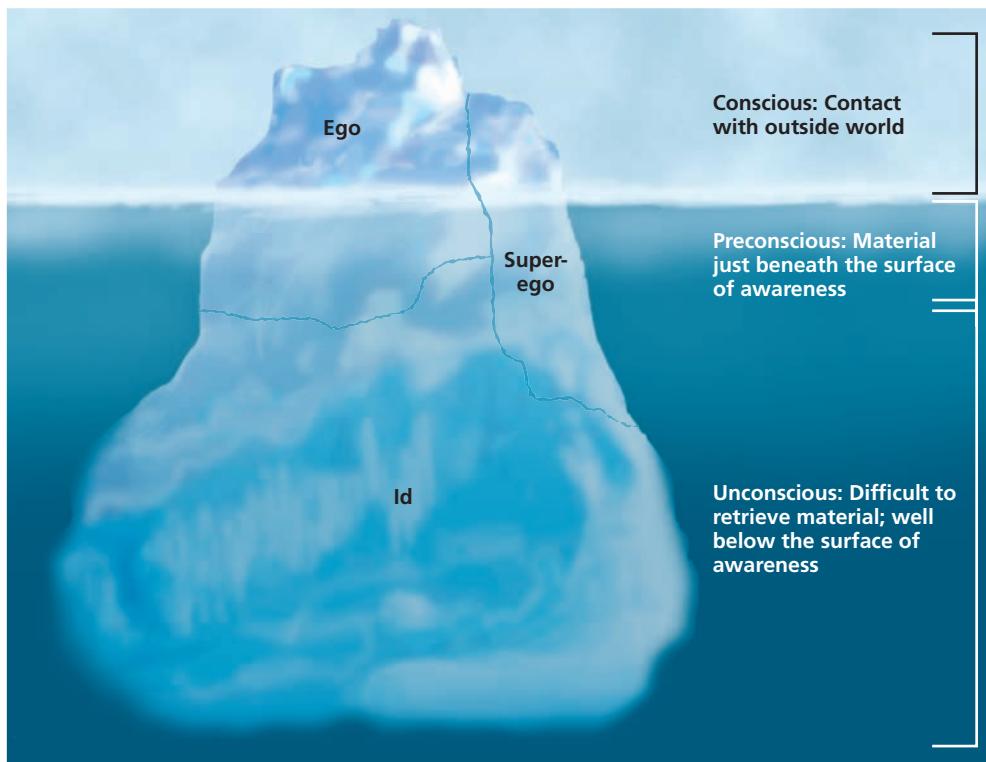
FREUD'S DIVISIONS OF THE PERSONALITY

Freud believed, based on observations of his patients, that personality itself could be divided into three parts, each existing at one or more levels of conscious awareness (see Figure 13.1). The way these three parts of the personality develop and interact with one another became the heart of his theory (Freud, 1923, 1933, 1940).

ID: IF IT FEELS GOOD, DO IT The first and most primitive part of the personality, present in the infant, is the **id**. *Id* is a Latin word that means "it." The id is a completely unconscious, pleasure-seeking, amoral part of the personality that exists at birth, containing all of the basic biological drives: hunger, thirst, self-preservation, and sex, for example.

Figure 13.1 Freud's Conception of the Personality

This iceberg represents the three levels of the mind. The part of the iceberg visible above the surface is the conscious mind. Just below the surface is the preconscious mind, everything that is not yet part of the conscious mind. Hidden deep below the surface is the unconscious mind, feelings, memories, thoughts, and urges that cannot be easily brought into consciousness. While two of the three parts of the personality (ego and superego) exist at all three levels of awareness, the id is completely in the unconscious mind.





Wait a minute—Freud thought babies have sex drives?

13.1

Yes, Freud thought babies have sex drives, which shocked and outraged his colleagues and fellow Victorians. By “sex drive” he really meant “pleasure drive,” the need to seek out pleasurable sensations. People do seem to be pleasure-seeking creatures, and even infants seek pleasure from sucking and chewing on anything they can get into their mouths. In fact, thinking about what infants are like when they are just born provides a good picture of the id. Infants are demanding, irrational, illogical, and impulsive. They want their needs satisfied immediately, and they don’t care about anyone else’s needs or desires. (A word of caution: The fact that infant behavior seems to fit Freud’s concept of the id is not proof that the id exists. It simply means that Freud came up with the concept of the id to fit what he already knew about infants.)

Freud called this need for satisfaction the **pleasure principle**, which can be defined as the desire for immediate gratification of needs with no regard for the consequences. The pleasure principle can be summed up simply as “if it feels good, do it.”

EGO: THE EXECUTIVE DIRECTOR People normally try to satisfy an infant’s needs as quickly as possible. Infants are fed when hungry, changed when wet, and tended to whenever they cry. But as infants begin to grow, adults start denying them their every wish. There will be things they cannot touch or hold, and they must learn to wait for certain things, such as food. Freud would say that reality has reared its ugly head, and the id simply cannot deal with the reality of having to wait or not getting what it wants. Worse still would be the possibility of punishment as a result of the id’s unrestrained actions.

According to Freud, to deal with reality, a second part of the personality develops called the **ego**. The ego, from the Latin word for “I,” is mostly conscious and is far more rational, logical, and cunning than the id. The ego works on the **reality principle**, which is the need to satisfy the demands of the id only in ways that will not lead to negative consequences. This means that sometimes the ego decides to deny the id its desires because the consequences would be painful or too unpleasant.

For example, while an infant might reach out and take an object despite a parent’s protests, a toddler with the developing ego will avoid taking the object when the parent says, “No!” to avoid punishment—but may go back for the object when the parent is not looking. A simpler way of stating the reality principle, then, is “if it feels good, do it, but only if you can get away with it.”



If everyone acted on the pleasure principle, the world would be pretty scary. How does knowing right from wrong come into Freud’s theory?

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SUPEREGO: THE MORAL WATCHDOG Freud called the third and final part of the personality, the moral center of personality, the **superego**. The superego (also Latin, meaning “over the self”) develops as a preschool-aged child learns the rules, customs, and expectations of society. The super ego contains the **conscience**, the part of the personality that makes people feel guilt, or *moral anxiety*, when they do the wrong thing. It is not until the conscience develops that children have a sense of right and wrong. (Note that the term *conscience* is a different word from *conscious*. They may look and sound similar, but they represent totally different concepts.)  Explore the Concept, Freud: Id, Ego, and Superego, at [MyPsychLab](#)

THE ANGEL, THE DEVIL, AND ME: HOW THE THREE PARTS OF THE PERSONALITY WORK TOGETHER Anyone who has ever watched cartoons while growing up has probably seen these three parts of the personality shown in animated form—the id is usually a little devil, the superego an angel, and the ego is the person or animal caught in the middle, trying to

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decide what action to take. So, the id makes demands, the superego puts restrictions on how those demands can be met, and the ego has to come up with a plan that will quiet the id but satisfy the superego. Sometimes the id or the superego does not get its way, resulting in a great deal of anxiety for the ego itself. This constant state of conflict is Freud's view of how personality works; it is only when the anxiety created by this conflict gets out of hand that disordered behavior arises. Note that despite the id being portrayed as the devil in the example, the id is not "evil," it is concerned with survival and immediate gratification.

The **psychological defense mechanisms** are ways of dealing with anxiety through unconsciously distorting one's perception of reality. These defense mechanisms were mainly outlined and studied by Freud's daughter, Anna Freud, who was a psychoanalyst (Benjafield, 1996; A. Freud, 1946). In order for the three parts of the personality to function, the constant conflict among them must be managed, and Freud assumed that the defense mechanisms were one of the most important tools for dealing with the anxiety caused by this conflict. A list of the defense mechanisms, their definitions, and examples of each appears in **Table 13.1**.

STAGES OF PERSONALITY DEVELOPMENT

 So the id exists at birth, but the other two parts of the personality develop later—how much later? When is personality finished?

Freud believed that personality development occurs in a series of **psychosexual stages** that are determined by the developing sexuality of the child. At each stage, a different *erogenous zone*, or area of the body that produces pleasurable feelings, becomes important

Table 13.1

The Psychological Defense Mechanisms

DEFENSE MECHANISM AND DEFINITION	EXAMPLE
Denial: refusal to recognize or acknowledge a threatening situation.	Pat is an alcoholic who denies being an alcoholic.
Repression: "pushing" threatening or conflicting events or situations out of conscious memory.	Regan, who was sexually abused as a child, cannot remember the abuse at all.
Rationalization: making up acceptable excuses for unacceptable behavior.	"If I don't have breakfast, I can have that piece of cake later on without hurting my diet."
Projection: placing one's own unacceptable thoughts onto others, as if the thoughts belonged to them and not to oneself.	Britni is attracted to her sister's husband but denies this and believes the husband is attracted to her.
Reaction formation: forming an emotional reaction or attitude that is the opposite of one's threatening or unacceptable actual thoughts.	Charley is unconsciously attracted to Sean but outwardly voices an extreme hatred of homosexuals.
Displacement: expressing feelings that would be threatening if directed at the real target onto a less threatening substitute target.	Sandra gets reprimanded by her boss and goes home to angrily pick a fight with her husband.
Regression: falling back on childlike patterns as a way of coping with stressful situations.	Four-year-old Blaine starts wetting his bed after his parents bring home a new baby.
Identification: trying to become like someone else to deal with one's anxiety.	Samantha really admires Emily, the most popular girl in school, and tries to copy her behavior and dress.
Compensation (substitution): trying to make up for areas in which a lack is perceived by becoming superior in some other area.	Ethan is not good at athletics, so he puts all of his energies into becoming an academic scholar.
Sublimation: turning socially unacceptable urges into socially acceptable behavior.	Ryder, who is very aggressive, becomes a mixed martial arts fighter.

and can become the source of conflicts. Conflicts that are not fully resolved can result in **fixation**, or getting “stuck” to some degree in a stage of development. The child may grow into an adult but will still carry emotional and psychological “baggage” from that earlier fixated stage.

ORAL STAGE (FIRST 18 MONTHS) The first stage is called the **oral stage** because the erogenous zone is the mouth. The conflict that can arise here, according to Freud, will be over weaning (taking the mother’s breast away from the child, who will now drink from a cup). Weaning that occurs too soon or too late can result in too little or too much satisfaction of the child’s oral needs, resulting in the activities and personality traits associated with an orally fixated adult personality: overeating, drinking too much, chain smoking, talking too much, nail biting, gum chewing, and a tendency to be either too dependent and optimistic (when the oral needs are overindulged) or too aggressive and pessimistic (when the oral needs are denied).

ANAL STAGE (18 TO 36 MONTHS) As the child becomes a toddler, Freud believed that the erogenous zone moves from the mouth to the anus, because he also believed that children got a great deal of pleasure from both withholding and releasing their feces at will. This stage is, therefore, called the **anal stage**.

Obviously, Freud thought that the main area of conflict here is toilet training, the demand that the child use the toilet at a particular time and in a particular way. This invasion of reality is part of the process that stimulates the development of the ego during this stage. Fixation in the anal stage, from toilet training that is too harsh, can take one of two forms. The child who rebels openly will refuse to go in the toilet and, according to Freud, translate in the adult as an *anal expulsive personality*, someone who sees messiness as a statement of personal control and who is somewhat destructive and hostile. Some children, however, are terrified of making a mess and rebel passively—refusing to go at all or retaining the feces. No mess, no punishment. As adults, they are stingy, stubborn, and excessively neat. This type is called the *anal retentive personality*.

PHALLIC STAGE (3 TO 6 YEARS) As the child grows older, the erogenous zone shifts to the genitals. Children have discovered the differences between the sexes by now, and most have also engaged in perfectly normal self-stimulation of the genitals, or masturbation. One can only imagine the horror of the Victorian parent who discovered a child engaged in masturbation. People of that era believed that masturbation led to all manner of evils, including mental illness.

This awakening of sexual curiosity and interest in the genitals is the beginning of what Freud termed the **phallic stage**. (The word *phallic* comes from the Greek word *phallos* and means “penis.”) Freud believed that when boys realized that the little girl down the street had no penis they developed a fear of losing the penis called *castration anxiety*, while girls developed *penis envy* because they were missing a penis. If this seems an odd focus on male anatomy, remember the era—the Western world at that time was very male-oriented and male-dominated. Fortunately, nearly all psychoanalysts have long since abandoned the concept of penis envy (Horney, 1939, 1973; Slipp, 1993). The conflict in the phallic stage centers on the awakening sexual feelings of the child. Freud essentially believed that boys develop both sexual attraction to their mothers and jealousy of their fathers during this stage, a phenomenon called the **Oedipus complex**. (Oedipus was a king in a Greek tragedy who unknowingly killed his father and married his mother.)

The sexual attraction is not that of an adult male for a female but more of a sexual curiosity that becomes mixed up with the boy’s feelings of love and affection for his mother. Of course, his jealousy of his father leads to feelings of anxiety and fears that his father, a powerful authority figure, might get angry and do something terrible—remember that castration anxiety? To deal with this anxiety, two things must occur by the time the phallic stage ends. The boy will *repress* his sexual feelings for his mother and *identify* with his father.

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For females, chastity belts like this were occasionally used to prevent intercourse or masturbation. The openings allowed for urination and defecation but their size and design, such as metal teeth in this one, did not allow for intercourse or masturbation to easily take place.

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(*Identification* is one of the defense mechanisms used to combat anxiety.) The boy tries to be just like his father in every way, taking on the father's behavior, mannerisms, values, and moral beliefs as his own, so that Daddy won't be able to get angry with the boy. Girls go through a similar process called the **Electra complex** with their father as the target of their affections and their mother as the rival. The result of identification is the development of the superego, the internalized moral values of the same-sex parent.

What happens when things go wrong? If a child does not have a same-sex parent with whom to identify, or if the opposite-sex parent encourages the sexual attraction, fixation can occur. Fixation in the phallic stage usually involves immature sexual attitudes as an adult. People who are fixated in this stage, according to Freud, will often exhibit promiscuous* sexual behavior and be very vain. The vanity is seen as a cover-up for feelings of low self-worth arising from the failure to resolve the complex, and the lack of moral sexual behavior stems from the failure of identification and the inadequate formation of the superego. Additionally, men with this fixation may be "mama's boys" who never quite grow up, and women with this fixation may look for much older father figures to marry.

LATENCY STAGE (6 YEARS TO PUBERTY) Remember that by the end of the phallic stage, children have pushed their sexual feelings for the opposite sex into the unconscious in another defensive reaction, repression. From age 6 to the onset of puberty, children will remain in this stage of hidden, or *latent*, sexual feelings, so this stage is called **latency**. In this stage, children grow and develop intellectually, physically, and socially but not sexually. This is the age at which boys play only with boys, girls play only with girls, and each thinks the opposite sex is pretty awful.

GENITAL STAGE (PUBERTY ON) When puberty does begin, the sexual feelings that were once repressed can no longer be ignored. Bodies are changing and sexual urges are once more allowed into consciousness, but these urges will no longer have the parents as their targets. Instead, the focus of sexual curiosity and attraction will become other adolescents, celebrities, and other objects of adoration. Since Freud tied personality development into sexual development, the genital stage represented the final process in Freud's personality theory, as well as the entry into adult social and sexual behavior.

THE NEO-FREUDIANS

How did the neo-Freudians modify Freud's theory, and how does modern psychodynamic theory differ from that of Freud's?

At first Freud's ideas were met with resistance and ridicule by the growing community of doctors and psychologists. Eventually, a number of early psychoanalysts, objecting to Freud's emphasis on biology and particularly on sexuality, broke away from a strict interpretation of psychoanalytic theory, instead altering the focus of **psychoanalysis** (the term Freud applied to both his explanation of the workings of the unconscious mind and the development of personality and the therapy he based on that theory) to the impact of the social environment.  to Learning Objective 1.3. At the same time they retained many of Freud's original concepts such as the id, ego, superego, and defense mechanisms. These early psychoanalysts became the **neo-Freudians**, or "new" Freudian psychoanalysts. This section briefly covers some of the more famous neo-Freudians.

JUNG Carl Gustav Jung ("YOONG") disagreed with Freud about the nature of the unconscious mind. Jung believed that the unconscious held much more than personal fears, urges, and memories. He believed that there was not only a **personal unconscious**, as described by Freud, but a **collective unconscious** as well (Jung, 1933).

According to Jung, the collective unconscious contains a kind of "species" memory, memories of ancient fears and themes that seem to occur in many folktales and cultures.

*promiscuous: having sexual relations with more than one partner.

These collective, universal human memories were called **archetypes** by Jung. There are many archetypes, but two of the more well known are the *anima/animus* (the feminine side of a man/the masculine side of a woman) and the *shadow* (the dark side of personality, called the “devil” in Western cultures). The side of one’s personality that is shown to the world is termed the *persona*.

ADLER Alfred Adler was also in disagreement with Freud over the importance of sexuality in personality development. Adler (1954) developed the theory that as young, helpless children, people all develop feelings of inferiority when comparing themselves to the more powerful, superior adults in their world. The driving force behind all human endeavors, emotions, and thoughts for Adler was not the seeking of pleasure but the seeking of superiority. The defense mechanism of *compensation*, in which people try to overcome feelings of inferiority in one area of life by striving to be superior in another area, figured prominently in Adler’s theory (see Table 13.1).

Adler (1954) also developed a theory that the birth order of a child affected personality. Firstborn children with younger siblings feel inferior once those younger siblings get all the attention and often overcompensate by becoming overachievers. Middle children have it slightly easier, getting to feel superior over the dethroned older child while dominating younger siblings. They tend to be very competitive. Younger children are supposedly pampered and protected but feel inferior because they are not allowed the freedom and responsibility of the older children. Although some researchers have found evidence to support Adler’s birth order theory (Stein, 2001; Sulloway, 1996), and some have even linked birth order to career choices (Leong et al., 2001; Watkins & Savickas, 1990), other researchers point to sloppy methodology and the bias of researchers toward the birth order idea (Beer & Horn, 2001; Freese et al., 1999; Ioannidis, 1998).

HORNEY Karen Horney (horn-EYE) disagreed with Freudian views about the differences between males and females and most notably with the concept of penis envy. She countered with her own concept of “womb envy,” stating that men felt the need to compensate for their lack of child-bearing ability by striving for success in other areas (Burger, 1997).

Rather than focusing on sexuality, Horney focused on the **basic anxiety** created in a child born into a world that is so much bigger and more powerful than the child. While people whose parents gave them love, affection, and security would overcome this anxiety, others with less secure up-bringings would develop **neurotic personalities** and maladaptive ways of dealing with relationships. Some children, according to Horney, try to deal with their anxiety by moving toward people, becoming dependent and clingy. Others move against people, becoming aggressive, demanding, and cruel. A third way of coping would be to move away from people by withdrawing from personal relationships.

ERIKSON Erik Erikson (1950, 1959, 1982) was an art teacher who became a psychoanalyst by studying with Anna Freud. He also broke away from Freud’s emphasis on sex, preferring instead to emphasize the social relationships that are important at every stage of life. Erikson’s eight psychosocial stages are discussed in detail in Chapter Eight.  to [Learning Objective 8.7](#).



It sounds as if all of these theorists became famous by ditching some of Freud’s original ideas. Is Freud even worth studying anymore?



Of the three ways children deal with anxiety according to Horney, which way do you think this child might be using?

CURRENT THOUGHTS ON FREUD AND THE PSYCHODYNAMIC PERSPECTIVE

Although Freud’s original psychoanalytic theory seems less relevant in today’s sexually saturated world, many of his concepts have remained useful and still form a basis for many modern personality theories, and the psychodynamic perspective. The idea of the

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defense mechanisms has had some research support and has remained useful in clinical psychology as a way of describing people's defensive behavior and irrational thinking. The concept of an unconscious mind also has some research support.

As strange as the idea of an unconscious mind that guides behavior must have seemed to Freud's contemporaries, modern researchers have had to admit that there are influences on human behavior that exist outside of normal conscious awareness. Although much of this research has taken place in the area of hypnosis and subliminal perception (Borgeat & Goulet, 1983; Bryant & McConkey, 1989; Kihlstrom, 1987, 1999, 2001), other researchers have looked at the concept of implicit memory and implicit learning (Frensch & Runger, 2003).  to Learning Objective 6.5.

This might be a good time to point out a very important fact about Freud's theory: He did no experiments to arrive at his conclusions about personality. His theory is based on his own observations (case studies) of numerous patients. Basing his suppositions on his patients' detailed memories of their childhoods and life experiences, he interpreted their behavior and reminiscences to develop his theory of psychoanalysis. He felt free to interpret what his patients told him of their childhoods as fantasy or fact, depending on how well those memories fit in with his developing theory. For example, many of Freud's patients told him that they were sexually abused by fathers, brothers, and other close family members. Freud was apparently unable to accept these memories as real and decided that they were fantasies, making them the basis of the Oedipal conflict. He actually revised his original perceptions of his patients' memories of abuse as real in the face of both public and professional criticism from his German colleagues (Masson, 1984).

Freud based much of his diagnoses of patients' problems on the interpretations of dreams ( to Learning Objective 4.5) and the results of the patient's free association (talking about anything without fear of negative feedback). These "sources" of information are often criticized as being too ambiguous and without scientific support for the validity of his interpretations. The very ambiguity of these sources of information allowed Freud to fit the patient's words and recollections to his own preferred interpretation, as well as increasing the possibility that his own suggestions and interpretations, if conveyed to the patient, might alter the actual memories of the patient, who would no doubt be in a very suggestible state of mind during therapy (Grünbaum, 1984).

Another criticism of Freud's theory concerns the people upon whose dreams, recollections, and comments the theory of psychoanalysis was based. Freud's clients were almost all wealthy Austrian women living in the Victorian era of sexual repression. Critics state that basing his theory on observations made with such a demographically limited group of clients promoted his emphasis on sexuality as the root of all problems in personality, as women of that social class and era were often sexually frustrated. Freud rarely had clients who did not fit this description, and so his theory is biased in terms of sexual frustrations (Robinson, 1993).

Although most professionals today view Freud's theory with a great deal of skepticism, his influence on the modern world cannot be ignored. Freudian concepts have had an impact on literature, movies, and even children's cartoons. People who have never taken a course in psychology are familiar with some of Freud's most basic concepts, such as the defense mechanisms. He was also one of the first theorists to emphasize the importance of childhood experiences on personality development—in spite of the fact that he did not work extensively with children.

It has only been in the last several decades that people have had the necessary tools to examine the concepts of the unconscious mind. One can only wonder how Freud might have changed his theory in light of what is known about the workings of the human brain and the changes in society that exist today.

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 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP

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personality

unique way in which each individual thinks, acts, and feels throughout life

Theories of Personality**perspectives/theories**

different ways of viewing and explaining personality

- **psychodynamic:** based on work of Freud; primary focus is on role of unconscious mind
- **behavioral and social cognitive views:** focus on the effect of the environment on behavior; based on theories of learning
- **humanistic:** focuses on conscious life experiences and choices
- **trait:** focuses on characteristics themselves, not roots of personality

basic aspects

- mind made up of different levels of awareness—conscious, preconscious, and unconscious
- personality stems from interplay and conflict between demands made by the id, restrictions set forth by the superego, and direction by the ego
- disordered behavior is product of constant conflict and anxiety; ego uses unconscious defense mechanisms as ways to manage anxiety/conflict between three parts of personality (see Table 13.1)

psychosexual stages of personality development

- id exists at birth; ego and superego develop in childhood
- different erogenous zones are sources of conflict as individual ages; unresolved conflicts result in individuals getting stuck or fixated at that stage

- oral
- anal
- phallic
- latency
- genital

Psychodynamic Perspective

- a group of Freud's students and followers of the psychoanalytic perspective, called the neo-Freudians, modified his theory and altered the focus of psychoanalysis

modern psychodynamic theory maintains focus on unconscious mind, concept of defense mechanisms is still useful

- **Jung:** believed in both a personal unconscious and a collective unconscious that holds universal human memories called archetypes
- **Adler:** focused on feelings of inferiority and seeking feelings of superiority as opposed to importance of sexuality; birth order also important
- **Horney:** disagreed with concept of penis envy, developed womb envy; rather than sexuality, focused on basic anxiety
- **Erikson:** emphasized social relationships at every stage of life (see Table 8.4)

despite several criticisms, Freud's theory still important—first to suggest that personality develops through stages, that we are not always consciously aware of reasons for behavior, and that early life experiences influence who we are later in life

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. If you are asked to describe your best friends by explaining how they act, typically feel, and what they think about, you would be describing their
 - a. temperament.
 - b. character.
 - c. personality.
 - d. mood.
2. According to Freud, the _____ mind was the most important determining factor in human behavior and personality.
 - a. preconscious
 - b. conscious
 - c. conscience
 - d. unconscious
3. According to Freud, which part of the personality is totally buried within each individual?
 - a. ego
 - b. superego
 - c. id
 - d. conscience
4. The awakening of sexual curiosity and interest in the genitals is the beginning of what Freud termed the
 - a. oral stage.
 - b. anal stage.
 - c. phallic stage.
 - d. latency stage.
5. Many of Kyle's friends like to dress up on Halloween as devils, vampires, and zombies. According to Carl Jung's theory, what archetype is being expressed?
 - a. anima
 - b. animus
 - c. persona
 - d. shadow
6. Which neo-Freudian believed personality was mostly a product of dealing with anxieties during childhood?
 - a. Karen Horney
 - b. Erik Erikson
 - c. Carl Jung
 - d. Alfred Adler

THINKING CRITICALLY:

What aspects of psychodynamic theory do you think still have relevance in today's world? Was there one neo-Freudian whose theory appealed to you, and if so, why?

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The Behaviorist and Social Cognitive View of Personality

How do behaviorists and social cognitive theorists explain personality?

At the time that Freud's theory was shocking the Western world, another psychological perspective was also making its influence known. In Chapter Five the theories of classical and operant conditioning were discussed in some detail. *Behaviorists* (researchers who use the principles of conditioning to explain the actions and reactions of both animals and humans) and *social cognitive theorists* (researchers who emphasize the influence of social and cognitive factors on learning) have a very different view of personality.

For the behaviorist, personality is nothing more than a set of learned responses or **habits** (DeGrandpre, 2000; Dollard & Miller, 1950). In the strictest traditional view of Watson and Skinner, everything a person or animal does is a response to some environmental stimulus that has been reinforced or strengthened by a reward in some way.

 Watch the Video, *The Basics: Personality Theories: Behavioral*, at [MyPsychLab](#)



So how does a pattern of rewarding certain behavior end up becoming part of some kind of personality pattern?

Think about how a traditional behaviorist might explain a shy personality. Beginning in childhood, a person might be exposed to a parent with a rather harsh discipline style (stimulus). Avoiding the attention of that parent would result in fewer punishments and scoldings, so that avoidance response is negatively reinforced—the “bad thing” or punishment is avoided by keeping out of sight and quiet. Later, that child might generalize that avoidance response to other authority figures and adults, such as teachers. In this way, a pattern (habit) of shyness would develop.

Of course, many learning theorists today do not use only classical and operant conditioning to explain the development of the behavior patterns referred to as personality. **Social cognitive learning theorists**, who emphasize the importance of both the influences of other people's behavior and of a person's own expectancies on learning, hold that observational learning, modeling, and other cognitive learning techniques can lead to the formation of patterns of personality.  to Learning Objective 5.11.

One of the more well-researched learning theories that includes the concept of cognitive processes as influences on behavior is the social cognitive theory of Albert Bandura. In the **social cognitive view**, behavior is governed not just by the influence of external stimuli and response patterns but also by cognitive processes such as anticipating, judging, and memory as well as learning through the imitation of models. In fact, you might remember Bandura's work with observation learning and imitation of models from his Bobo doll study.  to Learning Objective 5.12.

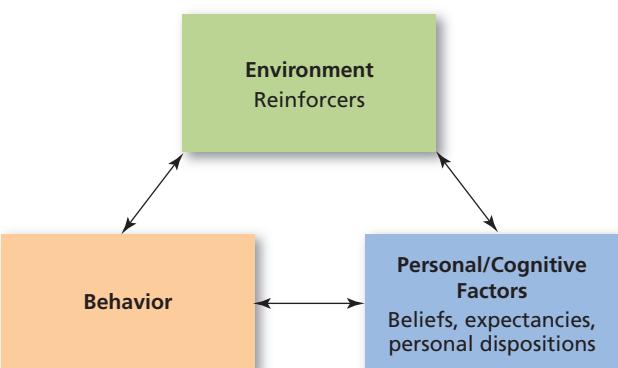
BANDURA'S RECIPROCAL DETERMINISM AND SELF-EFFICACY

Bandura (1989) believes that three factors influence one another in determining the patterns of behavior that make up personality: the environment, the behavior itself, and personal or cognitive factors that the person brings into the situation from earlier experiences (see Figure 13.2). These three factors each affect the other two in a reciprocal, or give-and-take, relationship. Bandura calls this relationship **reciprocal determinism**.

Take a look at Figure 13.2. The environment includes the actual physical surroundings, the other people who may or may not be present, and the potential for reinforcement in those surroundings. The intensity and

Figure 13.2 Reciprocal Determinism

In Bandura's model of reciprocal determinism, three factors influence behavior: the environment, which consists of the physical surroundings and the potential for reinforcement; the person (personal/cognitive characteristics that have been rewarded in the past); and the behavior itself, which may or may not be reinforced at this particular time and place.



frequency of the behavior will not only be influenced by the environment but will also have an impact on that environment. The person brings into the situation previously reinforced responses (personality, in other words) and mental processes such as thinking and anticipating.

Here's how this might work: Richard walks into a classroom filled with other students, but no teacher is present at this time. (This is the *environment*.) Part of Richard's *personal characteristics* includes the desire to have attention from other people by talking loudly and telling jokes, which has been very rewarding to him in the past (past reinforcements are part of his cognitive processes, or expectancies of future rewards for his behavior). Also in the past, he has found that he gets more attention when an authority figure is not present. His *behavior* will most likely be to start talking and telling jokes, which will continue if he gets the reaction he expects from his fellow students. If the teacher walks in (the *environment* changes), his behavior will change. If the other students don't laugh, his behavior will change. In the future Richard might be less likely to behave in the same way because his expectations for reward (a cognitive element of his *personal variables*) are different.

One of the more important personal variables that Bandura talks about is **self-efficacy**, a person's expectancy of how effective his or her efforts to accomplish a goal will be in any particular circumstance (Bandura, 1998). (Self-efficacy is not the same concept as *self-esteem*, which is the positive values a person places on his or her sense of worth.)

People's sense of self-efficacy can be high or low, depending on what has happened in similar circumstances in the past (success or failure), what other people tell them about their competence, and their own assessment of their abilities. For example, if Fiona has an opportunity to write an extracredit paper to improve her grade in psychology, she will be more likely to do so if her self-efficacy is high: She has gotten good grades on such papers in the past, her teachers have told her that she writes well, and she knows she can write a good paper. According to Bandura, people high in self-efficacy are more persistent and expect to succeed, whereas people low in self-efficacy expect to fail and tend to avoid challenges (Bandura, 1998).

ROTTER'S SOCIAL LEARNING THEORY: EXPECTANCIES

Julian Rotter (1966, 1978, 1981, 1990) devised a theory based on a basic principle of motivation derived from Thorndike's law of effect: People are motivated to seek reinforcement and avoid punishment. He viewed personality as a relatively stable set of *potential responses* to various situations. If in the past, a certain way of responding led to a reinforcing or pleasurable consequence, that way of responding would become a pattern of responding, or part of the "personality" as learning theorists see it.

One very important pattern of responding in Rotter's view became his concept of **locus of control**, the tendency for people to assume that they either have control or do not have control over events and consequences in their lives.  to Learning Objective 9.2. People who assume that their own actions and decisions directly affect the consequences they experience are said to be *internal* in locus of control, whereas people who assume that their lives are more controlled by powerful others, luck, or fate are *external* in locus of control (MacDonald, 1970; Rotter, 1966). Rotter associated people high in internal locus of control with the personality characteristics of high achievement motivation (the will to succeed in any attempted task). Those who give up too quickly or who attribute events in their lives to external causes can fall into patterns of learned helplessness and depression (Abramson et al., 1978, 1980; GongGuy & Hammen, 1980).

Like Bandura, Rotter (1978, 1981) also believed that an interaction of factors would determine the behavioral patterns that become personality for an individual. For Rotter, there are two key factors influencing a person's decision to act in a certain way given a particular situation: expectancy and reinforcement value. **Expectancy** is fairly similar to Bandura's concept of self-efficacy in that it refers to the person's subjective feeling that a particular behavior will lead to a reinforcing consequence. A high expectancy for success is similar to a high sense of self-efficacy and is also based on past experiences with successes and failures.

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According to Rotter, what would be the most likely form of locus of control experienced by this young woman?

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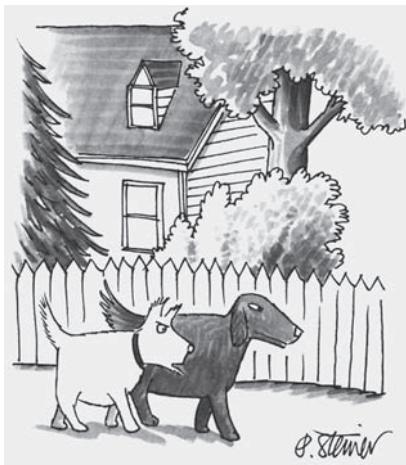
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Reinforcement value refers to an individual's preference for a particular reinforcer over all other possible reinforcing consequences. Things or circumstances that are particularly appealing to us have a higher reinforcement value than other possible reinforcers.

CURRENT THOUGHTS ON THE BEHAVIORIST AND SOCIAL COGNITIVE VIEWS

Behaviorism as an explanation of the formation of personality has its limitations. The classic theory does not take mental processes into account when explaining behavior, nor does it give weight to social influences on learning. The social cognitive view of personality, unlike traditional behaviorism, does include social and mental processes and their influence on behavior. Unlike psychoanalysis, the concepts in this theory can and have been tested under scientific conditions (Backenstrass et al., 2008; Bandura, 1965; Catanzaro et al., 2000; DeGrandpre, 2000; Domjan et al., 2000; Skinner, 1989). Some of this research has investigated how people's expectancies can influence their control of their own negative moods. Although some critics think that human personality and behavior are too complex to explain as the result of cognitions and external stimuli interacting, others point out that this viewpoint has enabled the development of therapies based on learning theory that have become effective in changing undesirable behavior.  to Learning Objective 15.4.



"It's always 'Sit,' 'Stay,' 'Heel'—never 'Think,' 'Innovate,' 'Be yourself.'"

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The Third Force: Humanism and Personality

How do humanists such as Carl Rogers explain personality?

As first discussed in Chapter One, in the middle of the twentieth century the pessimism of Freudian psychodynamic theory with its emphasis on conflict and animalistic needs, together with the emphasis of behaviorism on external control of behavior, gave rise to a third force in psychology: the **humanistic perspective**. Humanists such as Carl Rogers and Abraham Maslow wanted psychology to focus on the things that make people uniquely human, such as subjective emotions and the freedom to choose one's own destiny. As Maslow's theory was discussed more fully in Chapter Nine, in this chapter the discussion of the humanistic view of personality will focus on the theory of Carl Rogers. A brief overview of the humanistic perspective is also offered in the video, *The Basics: Personality Theories: Humanistic*.

Humanistic Theories

free will +
self development

= Personality

Watch the Video, *The Basics: Personality Theories: Humanistic*, at [MyPsychLab](#)

CARL ROGERS AND SELF-CONCEPT

Both Maslow and Rogers (1961) believed that human beings are always striving to fulfill their innate capacities and capabilities and to become everything that their genetic potential will allow them to become. This striving for fulfillment is called the **self-actualizing tendency**. An important tool in human self-actualization is the development of an image of oneself, or the **self-concept**. The self-concept is based on what people are told by others and how the sense of **self** is reflected in the words and actions of important people in one's life, such as parents, siblings, coworkers, friends, and teachers.

REAL AND IDEAL SELF Two important components of the self-concept are the *real self* (one's actual perception of characteristics, traits, and abilities that form the basis of the striving for self-actualization) and the *ideal self* (the perception of what one should be or would like to be). The ideal self primarily comes from important, significant others in a person's life, especially our parents when we are children. Rogers believed that when the real self and the ideal self are very close or similar to each other, people feel competent and capable, but when there is a mismatch between the real self and ideal self, anxiety and neurotic behavior can be the result. (See **Figure 13.3**.)

The two halves of the self are more likely to match if they aren't that far apart at the start. When a person has a realistic view of the real self, and the ideal self is something that is actually attainable, there usually isn't a problem of a mismatch. It is when a person's view of self is distorted or the ideal self is impossible to attain that problems arise. Once again, how the important people (who can be either good or bad influences) in a person's life react to the person can greatly impact the degree of agreement, or congruence, between real and ideal selves. However, as an individual develops, they look less to others for approval and disapproval, and more within themselves to decide if they are living in a way that is satisfying to them (Rogers, 1951, 1961).

CONDITIONAL AND UNCONDITIONAL POSITIVE REGARD Rogers defined **positive regard** as warmth, affection, love, and respect that come from the significant others (parents, admired adults, friends, and teachers) in people's experience. Positive regard is vital to people's ability to cope with stress and to strive to achieve self-actualization. Rogers believed that **unconditional positive regard**, or love, affection, and respect with no strings attached, is necessary for people to be able to explore fully all that they can achieve and become. Unfortunately, some parents, spouses, and friends give **conditional positive regard**, which is love, affection, respect, and warmth that depend, or seem to depend, on doing what those people want.

Here is an example: As a freshman, Sasha was thinking about becoming a math teacher, a computer programmer, or an elementary school teacher. Karen, also a freshman, already knew that she was going to be a doctor. Whereas Sasha's parents had told her that what she wanted to become was up to her and that they would love her no matter what, Karen's parents had made it very clear to her as a small child that they expected her to become a doctor. She was under the very strong impression that if she tried to choose any other career, she would lose her parents' love and respect. Sasha's parents were giving her unconditional positive regard, but Karen's parents (whether they intended to do so or not) were giving her conditional positive regard. Karen was obviously not as free as Sasha to explore her potential and abilities.

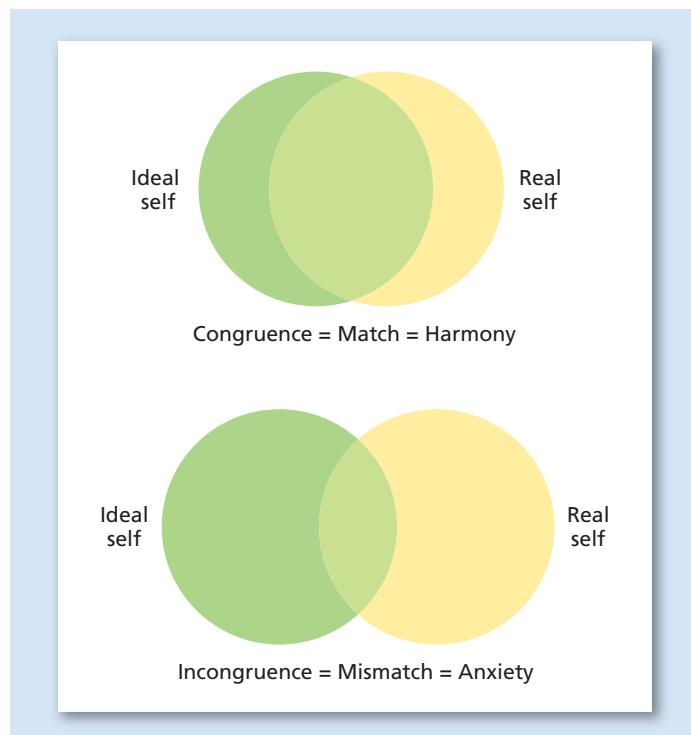


Figure 13.3 Real and Ideal Selves

According to Rogers, the self-concept includes the real self and the ideal self. The real self is a person's actual perception of traits and abilities, whereas the ideal self is the perception of what a person would like to be or thinks he or she should be. When the ideal self and the real self are very similar (matching), the person experiences harmony and contentment. When there is a mismatch between the two selves, the person experiences anxiety and may engage in neurotic behavior.

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These proud parents are giving their daughter unconditional positive regard.

For Rogers, a person who is in the process of self-actualizing, actively exploring potentials and abilities and experiencing a match between the real self and ideal self, is a **fully functioning person**. Fully functioning people are in touch with their own feelings and abilities and are able to trust their innermost urges and intuitions (Rogers, 1961). To become fully functioning, a person needs unconditional positive regard. In Rogers's view, Karen would not have been a fully functioning person.



What kind of people are considered to be fully functioning? Is it the same thing as being self-actualized?

Although the two concepts are highly related, there are some subtle differences. Self-actualization is a goal that people are always striving to reach, according to Maslow (1987). [LINK](#) to Learning Objective 9.4. In Rogers's view, only a person who is fully functioning is capable of reaching the goal of self-actualization. To be fully functioning is a necessary step in the process of self-actualization. Maslow (1987) listed several people who he considered to be self-actualized people: Albert Einstein, Mahatma Gandhi, and Eleanor Roosevelt, for example. These were people who Maslow found to have the self-actualized qualities of being creative, autonomous, and unprejudiced. In Rogers's view, these same people would be seen as having trusted their true feelings and innermost needs rather than just going along with the crowd.

CURRENT THOUGHTS ON THE HUMANISTIC VIEW OF PERSONALITY

Humanistic views of personality paint a very rosy picture. Some critics believe that the picture is a little too rosy, ignoring the more negative aspects of human nature. For example, would humanistic theory easily explain the development of sociopathic personalities who have no conscience or moral nature? Or could a humanist explain the motivation behind terrorism?

Humanistic theory is also very difficult to test scientifically. Little research support exists for this viewpoint, which could be considered more a philosophical view of human behavior than it is a psychological explanation. Its greatest impact has been in the development of therapies designed to promote self-growth and help people better understand themselves and others. [LINK](#) to Learning Objective 15.3.

Despite these apparent flaws, some of the premises of positive psychology have their roots in humanistic psychology. The term “positive psychology” was first used by Maslow in 1954 when he stressed the need for psychology to focus on human potential, rather than problems (Maslow, 1954). And some have pointed out that related views go back to the work of William James and beyond (Froh, 2004; Taylor, 2001). However, the field of positive psychology itself has emerged more recently and strives to understand how human beings prosper during difficult times and focuses on the science of subjective, individual, and group factors that foster positive experiences (Seligman & Csikszentmihalyi, 2000). There has been debate between the two fields, primarily on the choice of research approaches and some philosophical nuances, but nonetheless, positive psychology shares many facets with humanism and other areas in psychology in its focus on human potential, identification of strengths, and the positive aspects of what it means to be a human (Mahoney, 2005; Seligman, 2005; Snyder & Lopez, 2005; Waterman, 2013).

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 Explore the Concept at [MyPsychLab](#)
CONCEPT MAP

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behavioral and social cognitive

- for behaviorists, personality is a set of learned responses and habits, gained through classical and operant conditioning
- in social cognitive view, both learning (individual and through imitation of models) and cognitive processes (such as anticipation, judgment, and memory) are important

- **Bandura:** concept of self-efficacy; believed three factors were important: the environment, the behavior itself, and personal or cognitive experiences from earlier experiences; each affect the other two in a reciprocal way—reciprocal determinism (see Figure 13.2)
- **Rotter:** theory based on principles of motivation derived from Thorndike's law of effect; personality is set of potential responses to various situations, including one's locus of control (internal vs. external), sense of expectancy, and preference for particular reinforcers.

Behavioral, Social Cognitive, and Humanistic Perspectives**humanistic**

referred to as the third force in psychology (after psychoanalysis and behaviorism); based largely on work of Rogers and Maslow

- **Rogers:** believed that humans are always striving to fulfill their innate capacities and capabilities (self-actualizing tendency)
- **self-concept** is based on an individual's view of his or her real self and ideal self; when close/similar, people feel capable and competent; when there is mismatch, anxiety and neurotic behavior can occur
- **self-actualization** is facilitated through positive regard, especially unconditional positive regard
- when there is congruence between real and ideal selves, one is considered to be fully functioning and capable of reaching the goal of self-actualization

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. According to the behavioral theory, personality primarily consists of
 - a. unconscious forces.
 - b. learned responses.
 - c. biologically driven traits.
 - d. personal choices.
2. Albert Bandura considers _____ as a person's expectancy of how effective his or her efforts to accomplish a goal will be in any particular circumstance.
 - a. self-image
 - b. self-esteem
 - c. self-awareness
 - d. self-efficacy
3. You have walked in late to class and your psychology professor is explaining how one personality theorist sees personality as a relatively stable set of potential responses to various situations. You know immediately that your professor is talking about the theories of
 - a. Julian Rotter.
 - b. B. F. Skinner.
 - c. Albert Bandura.
 - d. John Watson.
4. Nina appreciates compliments about her new photography business but really values constructive criticism, as she can then address particular issues. According to Julian Rotter, Nina has a(n)
 - a. strong self-concept.
 - b. real self.
 - c. internal locus of control.
 - d. external locus of control.

5. What did Carl Rogers mean by the term "fully functioning person"?
 - a. Someone who is working to discover his or her real self.
 - b. Someone who is working to discover his or her ideal self.
 - c. Someone who is experiencing a match between his or her real and ideal self, and who is also trusting of their innermost intuitions and urges.
 - d. Someone who has discovered his or her self-efficacy.

THINKING CRITICALLY:

Some psychologists theorize that individuals with personality disorders act as they do because of the attention they receive, which becomes a form of positive reinforcement. What are your thoughts about such a theory?

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Trait Theories: Who Are You?

How does the trait perspective conceptualize personality?

Trait theories are less concerned with the explanation for personality development and changing personality than they are with describing personality and predicting behavior based on that description. A **trait** is a consistent, enduring way of thinking, feeling, or behaving, and trait theories attempt to describe personality in terms of a person's traits. The video, *The Basics: Personality Theories: Trait*, describes this perspective in more detail.



Watch the Video, *The Basics: Personality Theories: Trait*, at [MyPsychLab](#)

ALLPORT

One of the earliest attempts to list and describe the traits that make up personality can be found in the work of Gordon Allport (Allport & Odber, 1936). Allport and his colleague H. S. Odber literally scanned the dictionary for words that could be traits, finding about 18,000, then paring that down to 200 traits after eliminating synonyms. Allport believed (with no scientific evidence, however) that these traits were literally wired into the nervous system to guide one's behavior across many different situations and that each person's "constellation" of traits was unique. (In spite of Allport's lack of evidence, behavioral geneticists have found support for the heritability of personality traits, and these findings are discussed in the next section of this chapter.) Watch the Video, *Classic Footage of Gordon Allport on Personality Traits*, at [MyPsychLab](#)

CATTELL AND THE 16PF

Two hundred traits is still a very large number of descriptors. How might an employer be able to judge the personality of a potential employee by looking at a list of 200 traits? A more compact way of describing personality was needed. Raymond Cattell (1990) defined two types of traits as *surface traits* and *source traits*. **Surface traits** are like those found by Allport, representing the personality characteristics easily seen by other



"Can't you give him one of those personalities in a bottle I keep reading about?"
© The New Yorker Collection 1994 Lee Lorenz from cartoonbank.com. All Rights Reserved.

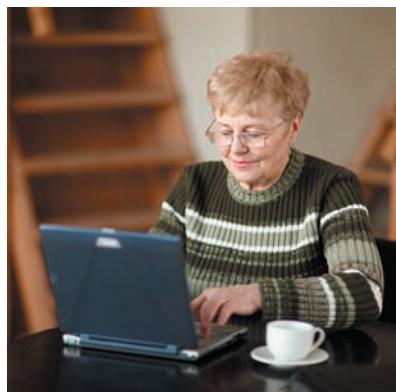


Figure 13.4 Cattell's Self-Report Inventory

The personality profiles of individuals working in various occupations may be characterized by using such tools as Cattell's 16PF self-report inventory. For example, airline pilots versus writers. Airline pilots, when compared to writers, tend to be more conscientious, relaxed, self-assured, and far less sensitive. Writers, on the other hand, were more imaginative and better able to think abstractly.

Based on Cattell (1973).

people. **Source traits** are those more basic traits that underlie the surface traits. For example, shyness, being quiet, and disliking crowds might all be surface traits related to the more basic source trait of **introversion**, a tendency to withdraw from excessive stimulation.

Using a statistical technique that looks for groupings and commonalities in numerical data called *factor analysis*, Cattell identified 16 source traits (Cattell, 1950, 1966), and although he later determined that there might be another 7 source traits to make a total of 23 (Cattell & Kline, 1977), he developed his assessment questionnaire, *The Sixteen Personality Factor (16PF) Questionnaire* (Cattell, 1995), based on just 16 source traits (see **Figure 13.4**). These 16 source traits are seen as trait dimensions, or continuums, in which there are two opposite traits at each end with a range of possible degrees for each trait measurable along the dimension. For example, someone scoring near the “reserved” end of the “reserved/outgoing” dimension would be more introverted than someone scoring in the middle or at the opposite end.

THE BIG FIVE: OCEAN, OR THE FIVE-FACTOR MODEL OF PERSONALITY

Sixteen factors are still quite a lot to discuss when talking about someone's personality. Later researchers attempted to reduce the number of trait dimensions to a more manageable number, with several groups of researchers arriving at more or less the same five trait dimensions (Botwin & Buss, 1989; Jang et al., 1998; McCrae & Costa, 1996). These five dimensions have become known as the **five-factor model**, or the **Big Five** (see **Table 13.2**), and represent the core description of human personality—that is, the only dimensions necessary to understand what makes us tick.

Table 13.2

The Big Five

HIGH SCORER CHARACTERISTICS	FACTOR (OCEAN)	LOW SCORER CHARACTERISTICS
Creative, artistic, curious, imaginative,	Openness (O)	Conventional, down-to-earth, uncreative nonconforming
Organized, reliable, neat, ambitious	Conscientiousness (C)	Unreliable, lazy, careless, negligent, spontaneous
Talkative, optimistic, sociable, affectionate	Extraversion (E)	Reserved, comfortable being alone, stays in the background
Good-natured, trusting, helpful	Agreeableness (A)	Rude, uncooperative, irritable, aggressive, competitive
Worrying, insecure, anxious, temperamental	Neuroticism (N)	Calm, secure, relaxed, stable

Source: Adapted from McCrae & Costa (1990).

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As shown in the table, these five trait dimensions can be remembered by using the acronym OCEAN, in which each of the letters is the first letter of one of the five dimensions of personality.

- **Openness** can best be described as a person's willingness to try new things and be open to new experiences. People who try to maintain the status quo and who don't like to change things would score low on openness.
- **Conscientiousness** refers to a person's organization and motivation, with people who score high in this dimension being those who are careful about being places on time and careful with belongings as well. Someone scoring low on this dimension, for example, might always be late to important social events or borrow belongings and fail to return them or return them in poor condition.
- **Extraversion** is a term first used by Carl Jung (1933), who believed that all people could be divided into two personality types: **extraverts** and **introverts**. Extraverts are outgoing and sociable, whereas introverts are more solitary and dislike being the center of attention.
- **Agreeableness** refers to the basic emotional style of a person, who may be easy-going, friendly, and pleasant (at the high end of the scale) or grumpy, crabby, and hard to get along with (at the low end).
- **Neuroticism** refers to emotional instability or stability. People who are excessive worriers, overanxious, and moody would score high on this dimension, whereas those who are more even-tempered and calm would score low.

Robert McCrae and Paul Costa proposed that these five traits are not interdependent. In other words, knowing someone's score on extraversion would not give any information about scores on the other four dimensions, allowing for a tremendous amount of variety in personality descriptions.

CURRENT THOUGHTS ON THE TRAIT PERSPECTIVE

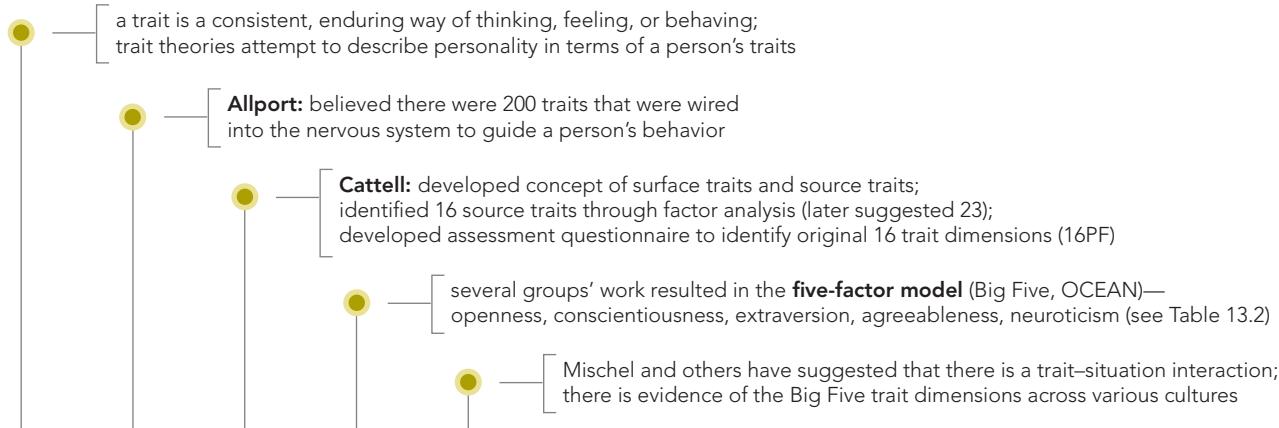
Some theorists have cautioned that personality traits will not always be expressed in the same way across different situations. Walter Mischel, a social cognitive theorist, has emphasized that there is a **trait-situation interaction** in which the particular circumstances of any given situation are assumed to influence the way in which a trait is expressed (Mischel & Shoda, 1995). An outgoing extravert, for example, might laugh, talk to strangers, and tell jokes at a party. That same person, if at a funeral, would still talk and be open, but the jokes and laughter would be less likely to occur. However, the five-factor model provides a dimensional approach to classifying personality structure (as opposed to a categorical approach), which is consistent with possible alternative approaches to diagnosing personality disorders discussed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association, 2013).  to Learning Objective 14.3

As mentioned earlier, the five-factor model has been studied and tested by numerous researchers. Although regional variations exist, cross-cultural research from 56 countries has found evidence of these five trait dimensions in all primary cultural regions of the world (Schmitt et al., 2007). Furthermore, it appears these dimensions are evident or recognizable not only in most languages and cultures, they are also consistent when assessed by either self-ratings or observers (Allik et al., 2013; McCrae & Terracciano, 2005). This cultural commonality raises the question of the origins of the Big Five trait dimensions: Are child-rearing practices across all those cultures similar enough to result in these five aspects of personality, or could these five dimensions have a genetic component that transcends cultural differences? The next section will discuss the evidence for a genetic basis of the Big Five. The Applying Psychology section at the end of the chapter will highlight research into insights about these dimensions offered by brain imaging and personality neuroscience.

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 Explore the Concept at **MyPsychLab**

CONCEPT MAP



Trait Theories

Practice **quiz** How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

THINKING CRITICALLY:

With regard to surface and source traits, what aspects of your personality are consistent between the two? Are you aware of any surface traits that when first seen by others, may not be a true representation of your source traits?



What part do biology, heredity, and culture play in personality?

What part do biology, heredity, and culture play in personality?

What about genetics? How much of our personality is inherited?

The field of **behavioral genetics** is devoted to the study of just how much of an individual's personality is due to inherited traits. Animal breeders have known for a long time that selective breeding of certain animals with specific desirable traits can produce changes not only in size, fur color, and other physical characteristics but also in the temperament of the animals (Isabel, 2003; Trut, 1999). As stated earlier in this chapter, temperament consists of the characteristics with which each person is born and is, therefore, determined by biology to a great degree. If the temperaments of animals can be influenced by manipulating patterns of genetic inheritance, then it is only one small step to

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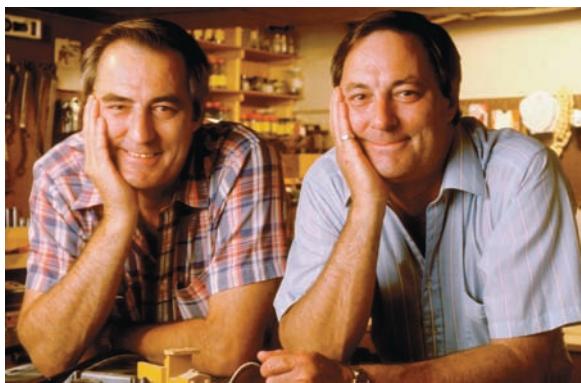
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assume that at least those personality characteristics related to temperament in human beings may also be influenced by heredity.

Animal breeders have an advantage over those who are studying the influence of genes in human behavior. Those who breed animals can control the mating of certain animals and the conditions under which those animals are raised. Human research cannot ethically or practically develop that degree of control and so must fall back on the accidental “experiments” of nature and opportunity, studies of twins and adopted persons.

TWIN STUDIES

The difference between monozygotic (identical) and dizygotic (fraternal) twins was discussed in Chapter Eight. [LINK](#) to [Learning Objective 8.4](#). As discussed previously, identical twins share 100 percent of their genetic material, having come from one fertilized egg



originally, whereas fraternal twins share only about 50 percent of their genetic material, as any other pair of siblings would. By comparing identical twins to fraternal twins, especially when twins can be found who were not raised in the same environment, researchers can begin to find evidence of possible genetic influences on various traits, including personality. (See [Figure 13.5](#).)

The results of the Minnesota twin study have revealed that identical twins are more similar than fraternal twins or unrelated people in intelligence, leadership abilities, the tendency

to follow rules, and the tendency to uphold traditional cultural expectations (Bouchard, 1997; Finkel & McGue, 1997). They are also more alike with regard to nurturance,* empathy,** and assertiveness (Neale et al., 1986); and aggressiveness (Miles & Carey, 1997). This similarity holds even if the twins are raised in separate environments. [Watch](#) the [Video](#), *Special Topics: Twins and Personality*, at [MyPsychLab](#)

ADOPTION STUDIES

Another tool of behavioral geneticists is to study adopted children and their adoptive and birth families. If studying genetically identical twins raised in different environments can help investigators understand the genetic influences on personality, then studying *unrelated* people who are raised in the *same* environment should help investigators discover the influence of environment. By comparing adopted children to their adoptive parents and siblings and, if possible, to their biological parents who have not raised them, researchers can uncover some of the shared and nonshared environmental and genetic influences on personality.

Adoption studies have confirmed what twin studies have shown: Genetic influences account for a great deal of personality development, regardless of shared or non-shared environments (Hershberger et al., 1995; Loehlin et al., 1985; Loehlin et al., 1998). Through this kind of study, for example, a genetic basis has been suggested for shyness (Plomin et al., 1988) and aggressiveness (Brennan et al., 1997).

*nurturance: affectionate care and attention.

**empathy: the ability to understand the feelings of others.

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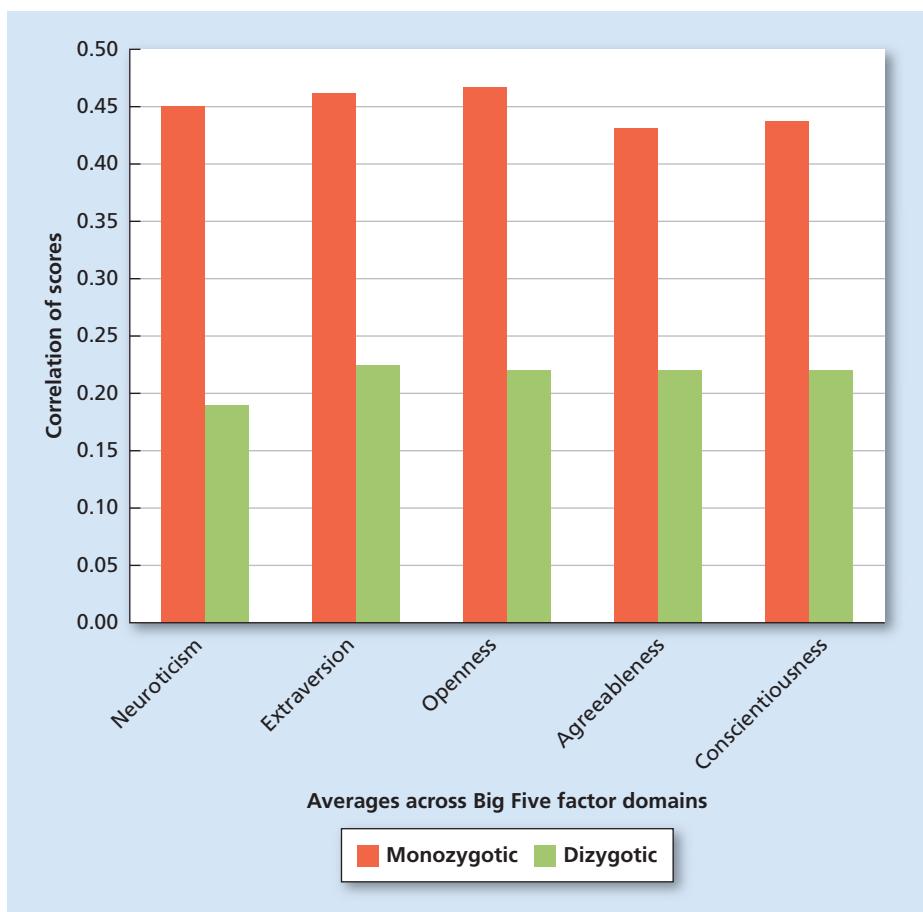


Figure 13.5 Personalities of Identical and Fraternal Twins

Identical and fraternal twins differ in the way they express the Big Five personality factors. In a recent study, data from 696 twin pairs suggest identical twins have a correlation of about 45 percent for self-ratings across each of the Big Five factor domains, whereas fraternal twins have a correlation of about 22 percent. These findings give support to the idea that some aspects of personality are genetically based.

Based on: Kandler, et al. (2010)

CURRENT FINDINGS

One important aspect of genetic studies is the concept of **heritability**, or how much some trait within a population can be attributed to genetic influences, and the extent individual genetic variation impacts differences in observed behavior. Several studies have found that the five personality factors of the five-factor model have nearly a 50 percent rate of heritability across several cultures (Bouchard, 1994; Herbst et al., 2000; Jang et al., 1996; Loehlin, 1992; Loehlin et al., 1998). Personality's relationship to psychopathology is also being investigated via genetic techniques (Plomin & Spinath, 2004). Together with the results of the Minnesota twin study and other research (Lubinski, 2000; Lykken & Tellegen, 1996; Plomin, 1994), the studies of genetics and personality seem to indicate that variations in personality traits are about 25 to 50 percent inherited (Jang et al., 1998). This also means that environmental influences apparently account for about half of the variation in personality traits as well.

Although the five factors have been found across several cultures, this does not mean that different cultures do not have an impact on personality. For more on this topic, see the Classic Studies in Psychology section that follows.

classic studies in psychology



Geert Hofstede's Four Dimensions of Cultural Personality



In the early 1980s, organizational management specialist Geert Hofstede conducted a massive study into the work-related values of employees of IBM, a multinational corporation (Hofstede, 1980; Hofstede et al., 2002). The study

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surveyed workers in 64 countries across the world. Hofstede analyzed the data collected from this survey and found four basic dimensions of personality along which cultures differed.

1. **Individualism/collectivism:** Individualistic cultures tend to have loose ties between individuals, with people tending to look after themselves and their immediate families only. Members of such cultures have friends based on shared activities and interests and may belong to many different loosely organized social groups. Autonomy,* change, youth, security of the individual, and equality are all highly valued. In contrast, in a collectivistic culture, people are from birth deeply tied into very strong in-groups, typically extended families that include grandparents, aunts and uncles, and cousins. Loyalty to the family is highly stressed, and the care of the family is placed before the care of the individual. Group membership is limited to only a few permanent groups that have tremendous influence over the individual. The values of this kind of culture are duty, order, tradition, respect for the elderly, group security, and respect for the group status and hierarchy.** Whereas the United States and Great Britain are examples of individualistic cultures, Japan, China, Korea, Mexico, and Central America are much more collectivistic.
2. **Power distance:** This dimension refers to the degree to which the less powerful members of a culture accept and even expect that the power within the culture is held in the hands of a select few rather than being more evenly distributed. Countries such as the Philippines, Mexico, many Arab countries, and India were found to be high in such expectations, whereas countries such as Austria, Sweden, Australia, Great Britain, and the United States were low in power distance.
3. **Masculinity/femininity:** Referring to how a culture distributes the roles played by men and women within the culture, this dimension varies more for the men within a culture than for the women. "Masculine" cultures are assertive and competitive, although more so for men than for women, and "feminine" cultures are more modest and caring. Both men and women in "feminine" countries have similar, caring values, but in "masculine" countries, the women are not quite as assertive and competitive as the men, leading to a greater difference between the sexes in masculine countries. Japan, Austria, Venezuela, Italy, Switzerland, Mexico, Ireland, Jamaica, the United States, Great Britain, and Germany were found to be masculine countries, whereas Sweden, Norway, the Netherlands, Denmark, Costa Rica, Yugoslavia, Finland, Chile, Portugal, Thailand, and Guatemala were ranked as more feminine.
4. **Uncertainty avoidance:** Some cultures are more tolerant of uncertainty, ambiguity,*** and unstructured situations. Cultures that do not tolerate such uncertainty and lack of structure tend to have strict rules and laws with lots of security and safety measures and tend toward a philosophical/religious belief of One Truth (and "we have it!"). Cultures that are more accepting of uncertainty are more tolerant of different opinions and have fewer rules. They tend to allow many different religious beliefs to exist side by side and are less anxious and emotional than people in uncertainty-avoiding countries. Uncertainty-avoiding countries include Greece, Portugal, Guatemala, Uruguay, Belgium, El Salvador, Japan, Yugoslavia, and Peru, whereas those that are more tolerant of uncertainty include Singapore, Jamaica, Denmark, Sweden, Hong Kong, Ireland, Great Britain, Malaysia, India, Philippines, the United States, Canada, and Indonesia.

*autonomy: the quality of being self-directed or self-controlled.

**hierarchy: in this sense, a body of persons in authority over others.

***ambiguity: the quality of being uncertain and indistinct.

Note that the Big Five personality dimensions of Costa and McCrae (2000) are not necessarily in competition with Hofstede's dimensions. Hofstede's dimensions are cultural personality traits, whereas those of the Big Five refer to individuals.

Questions for Further Discussion

- Was your own culture listed for any of these dimensions? If so, do you agree with the personality dimension assigned to your culture?
 - If your culture was not listed for a personality dimension, where do you think your culture would fall on that dimension?
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Assessment of Personality

What are the advantages and disadvantages of various measures of personality?

With all the different theories of personality, how do people find out what kind of personality they have?

The methods for measuring or assessing personality vary according to the theory of personality used to develop those methods, as one might expect. However, most psychological professionals doing a personality assessment on a client do not necessarily tie themselves down to one theoretical viewpoint only, preferring to take a more *eclectic* view of personality. The eclectic view is a way of choosing the parts of different theories that seem to best fit a particular situation, rather than using only one theory to explain a phenomenon. In fact, looking at behavior from multiple perspectives can often bring insights into a person's behavior that would not easily come from taking only one perspective. Many professionals will not only use several different perspectives but also several of the assessment techniques that follow. Even so, certain methods are more commonly used by certain kinds of theorists, as can be seen in **Table 13.3**.

Table 13.3

Who Uses What Method?

TYPE OF ASSESSMENT	MOST LIKELY USED BY ...
Interviews	Psychoanalysts, humanistic therapists
Projective Tests Rorschach Thematic Apperception Test	Psychoanalysts
Behavioral Assessments Direct observation Rating scales Frequency counts	Behavioral and social cognitive therapists
Personality Inventories Sixteen Personality Factor Questionnaire (16PF) Revised Neuroticism/Extraversion/Openness Personality Inventory (NEO-PI-R) Myers-Briggs Type Indicator (MBTI) Eysenck Personality Questionnaire (EPQ) Keirsey Temperament Sorter II California Psychological Inventory (CPI) Minnesota Multiphasic Personality Inventory, Version II (MMPI-2)	Trait theorists

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Personality assessments may also differ in the purposes for which they are conducted. For example, sometimes a researcher may administer a personality test of some sort to participants in a research study so that the participants may be classified according to certain personality traits. There are tests available to people who simply want to learn more about their own personalities. Finally, clinical and counseling psychologists, psychiatrists, and other psychological professionals use these personality assessment tools in the diagnosis of disorders of personality.  [LINK](#) to [Learning Objective 14.9](#).

 [Watch the Video](#), *In the Real World: Putting Popular Personality Assessments to the Test*, at [MyPsychLab](#)

INTERVIEWS

Some therapists ask questions and note down the answers in a survey process called an **interview**.  [LINK](#) to [Learning Objective 1.8](#). This type of interview, unlike a job interview, is likely to be *unstructured* and flow naturally from the beginning dialogue between the client and the psychologist.



So an interview is a kind of self-report process?

Yes, when psychologists interview clients, clients must report on their innermost feelings, urges, and concerns—all things that only they can directly know. The same problems that exist with self-report data (such as surveys) exist with interviews. Clients can lie, distort the truth, misremember, or give what they think is a socially acceptable answer instead of true information. Interviewers themselves can be biased, interpreting what the client says in light of their own belief systems or prejudices. Freud certainly did this when he refused to believe that his patients had actually been sexually molested as children, preferring to interpret that information as a fantasy instead of reality (Russell, 1986).

Another problem with interviews is something called the **halo effect**, which is a tendency to form a favorable or unfavorable impression of someone at the first meeting, so that all of a person's comments and behavior after that first impression will be interpreted to agree with the impression—positively or negatively. The halo effect can happen in any social situation, including interviews between a psychological professional and a client. First impressions really do count, and people who make a good first impression because of clothing, personal appearance, or some other irrelevant* characteristic will seem to have a “halo” hanging over their heads—they can do no wrong after that (Lance et al., 1994; Thorndike, 1920). (Sometimes the negative impression is called the “horn effect.”)

PROJECTIVE TESTS

Have you ever tried to see “shapes” in the clouds? You might see a house where another person might see the same cloud as a horse. The cloud isn’t really either of those things but can be *interpreted* as one or the other, depending on the person doing the interpretation. That makes a cloud an ambiguous stimulus—one that is capable of being interpreted in more than one way.

In just this way, psychoanalysts (and a few other psychologists) show their clients ambiguous visual stimuli and ask the clients to tell them what they see. The hope is that the client will project unconscious concerns onto the visual stimulus, revealing them to the examiner. Tests using this method are called **projective tests**. Such tests can be used to explore a client’s personality or used as a diagnostic tool to uncover problems in personality.

THE RORSCHACH INKBLOTS One of the more well-known projective tests is the **Rorschach inkblot test**, developed in 1921 by Swiss psychiatrist Hermann Rorschach (ROR-shok). There are 10 inkblots, 5 in black ink on a white background and 5 in colored inks on a white background. (See **Figure 13.6** for an image similar to a Rorschach-type inkblot.)

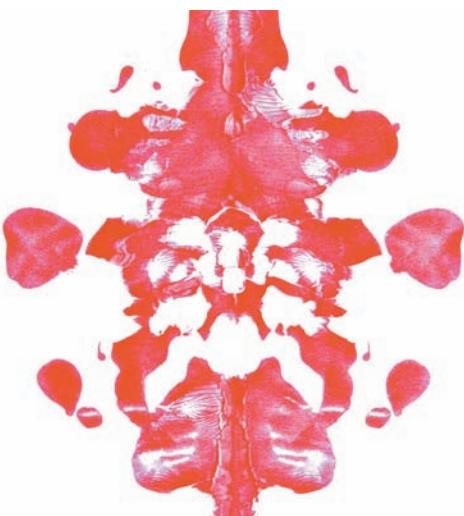


Figure 13.6 Rorschach Inkblot Example

A facsimile of a Rorschach inkblot. A person being tested is asked to tell the interviewer what he or she sees in an inkblot similar to the one shown. Answers are neither right nor wrong but may reveal unconscious concerns. What do you see in this inkblot?

*irrelevant: not applying to the case or example at hand.

People being tested are asked to look at each inkblot and simply say whatever it might look like to them. Using predetermined categories and responses commonly given by people to each picture (Exner, 1980), psychologists score responses on key factors, such as reference to color, shape, figures seen in the blot, and response to the whole or to details.

Rorschach tested thousands of inkblots until he narrowed them down to the 10 in use today. They are still used to describe personality, diagnose mental disorders, and predict behavior (Watkins et al., 1995; Weiner, 1997). However, along with the use of other projective techniques in general, their use is controversial given questions about some scoring methods and overall validity (Lilienfeld et al., 2000).

THE TAT First developed in 1935 by psychologist Henry Murray and his colleagues (Morgan & Murray, 1935), the **Thematic Apperception Test (TAT)** consists of 20 pictures, all black and white, that are shown to a client. The client is asked to tell a story about the person or people in the picture, who are all deliberately drawn in ambiguous situations (see **Figure 13.7**). Again, the story developed by the client is interpreted by the psychoanalyst, who looks for revealing statements and projection of the client's own problems onto the people in the pictures.

These are only two of the more well-known projective tests. Other types of projective tests include the Sentence Completion test, Draw-A-Person, and House-Tree-Person. In the Sentence Completion test, the client is given a series of sentence beginnings, such as "I wish my mother ..." or "Almost every day I feel ...," and asked to finish the sentence, whereas in the Draw-A-Person and House-Tree-Person, the client is asked to draw the named items.

But how can anyone know if the interpretation is correct? Isn't there a lot of room for error?

PROBLEMS WITH PROJECTIVE TESTS Projective tests are by their nature very **subjective** (valid only within the person's own perception), and interpreting the answers of clients is almost an art. It is certainly not a science and is not known for its accuracy. Problems lie in the areas of reliability and validity. In Chapter Seven, *reliability* was defined as the tendency of a test to give the same score every time it is administered to the same person or group of people, and *validity* was defined as the ability of the test to measure what it is intended to measure.  to Learning Objective 7.5. Projective tests, with no standard grading scales, have both low reliability and low validity (Gittelman-Klein, 1978; Lilienfeld, 1999; Lilienfeld et al., 2000; Wood et al., 1996). A person's answers to the Rorschach, for example, might be quite different from one day to the next, depending on the person's mood and what scary movie might have been on television the previous night.

Projective tests may sound somewhat outdated, but many psychologists and psychiatrists still use this type of testing (McGrath & Carroll, 2012). Some psychologists believe that the latest versions of these tests and others like them still have practical use and some validity (Choca, 2013; Meyer & Kurtz, 2006; Weiner, 2013), especially when a client's answers on these tests are used as a starting point for digging deeper into the client's recollections, concerns, and anxieties. However, more reliable and objective methods for assessing personality are available, as the next section discusses.

Somehow, I can't see a behaviorist using any of these tests, they're too "mental"—do behaviorists even measure personality?

BEHAVIORAL ASSESSMENTS

Behaviorists do not typically want to "look into the mind." Because behaviorists assume that personality is merely habitually learned responses to stimuli in the environment, the preferred method for a behaviorist would be to watch that behavior unfold in the real world.

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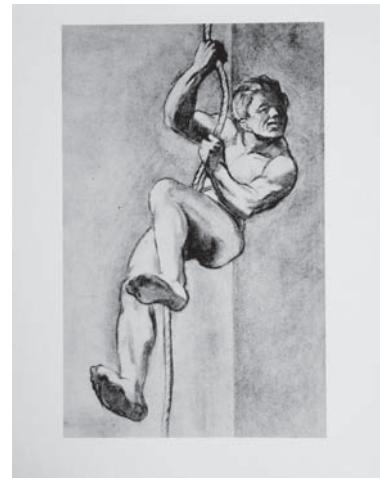


Figure 13.7 Thematic Apperception Test Example

A sample from the Thematic Apperception Test (TAT). When you look at this picture, what story does it suggest to you? Who is the person? Why is he climbing a rope?

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In **direct observation**, the psychologist observes the client engaging in ordinary, everyday behavior, preferably in the natural setting of home, school, or workplace, for example. A therapist who goes to the classroom and observes that tantrum behavior only happens when a child is asked to do something involving fine motor abilities (like drawing or writing) might be able to conclude that the child has difficulty with those skills and throws a tantrum to avoid the task.

Other methods often used by behavioral therapists and other assessors are rating scales and frequency counts. In a **rating scale**, a numerical rating is assigned, either by the assessor or the client, for specific behaviors (Nadeau et al., 2001). In a **frequency count**, the assessor literally counts the frequency of certain behaviors within a specified time limit. Educators make use of both rating scales and frequency counts to diagnose behavioral problems such as attention-deficit/hyperactivity disorder (ADHD) and aspects of personality such as social-skill level through the various grade levels.

Problems with these assessments can include the observer effect (when a person's behavior is affected by being watched) and observer bias, which can be controlled by having multiple observers and correlating their observations with each other.  [LINK](#) to Learning Objective 1.7. As with any kind of observational method, there is no control over the external environment. A person observing a client for a particular behavior may not see that behavior occur within the observation time—much as some car problems never seem to show up when the mechanic is examining the car.

PERSONALITY INVENTORIES

Trait theorists are typically more interested in personality descriptions. They tend to use an assessment known as a **personality inventory**, a questionnaire that has a standard list of questions and only requires certain specific answers, such as "yes," "no," and "can't decide." The standard nature of the questions (everyone gets the same list) and the lack of open-ended answers make these assessments far more objective and reliable than projective tests (Garb et al., 1998), although they are still a form of self-report. One such personality inventory is Cattell's 16PF, described earlier in this chapter. Costa and McCrae have recently revised their Revised *Neuroticism/Extraversion/Openness Personality Inventory (NEO-PI-R)*, which is based on the five-factor model of personality traits and still being published. The newer version is the NEO-PI-3, which has been made easier to read for use with adolescents and has new norms (McCrae et al., 2005; McCrae, Martin, et al., 2005). You can answer select questions from the NEO-PI for yourself by completing the experiment, *IPIP Neo Personality Inventory*.

Simulation

IPIP Neo Personality Inventory

In this activity, you will be completing an inventory called the Short Form for the IPIP-NEO (International Personality Item Pool Representation of the NEO PI-R™). The short IPIP-NEO was designed to measure exactly the same traits as the original IPIP-NEO but more efficiently and with fewer items.

Love to help others.

<input type="radio"/> Very Inaccurate
<input type="radio"/> Moderately Inaccurate
<input type="radio"/> Neither Accurate nor Inaccurate
<input type="radio"/> Moderately Accurate
<input type="radio"/> Very Accurate

[Go to the Experiment ►](#)

Another inventory in common use is the *Myers-Briggs Type Indicator (MBTI)*. This inventory is based on the ideas of Carl Jung and looks at four personality dimensions. The *sensing/intuition* (S/N) dimension includes people who prefer to rely on what they can see, hear, and so on through their own physical senses (sensing) and, on its opposite end, those who look for patterns and trust their hunches (intuition). Sensing people are very detail oriented, preferring to work only with the known facts, whereas intuitive people are more willing to use metaphors, analogies, and look for possibilities. The *thinking/feeling* (T/F) dimension runs from those who prefer to use logic, analysis, and experiences that can be verified as facts (thinkers) to those who tend to make decisions based on their personal values and emotional reactions (feeling). *Introversion/extraversion* (I/E) is the same classic dimension that began with Jung and is represented in nearly every personality theory, including the Big Five. *Perceiving/judging* (P/J) describes those who are willing to adapt and modify decisions, be spontaneous, and who are naturally curious and tend to put off making a final decision so that all possibilities are covered (perceiving) as well as those who are the opposite: the action-oriented, decisive, get-the-task-done-and-don't-look-back type (judging). These four dimensions can differ for each individual, resulting in 16 (4×4) possible personality types: ISTJ, ISTP, ISFP, ISFJ, and so on (Briggs & Myers, 1998).

The Myers-Briggs is often used to assess personality to help people know the kinds of careers for which they may best be suited. For example, a person who scored high on the extravert, sensing, thinking, and judging dimensions would be an ESTJ. A typical description of this personality type would be a person who needs to analyze information and bring order to the outer world. Such people are organizers, energetic in completing tasks, and practical. They also take their responsibilities seriously and expect others to do so as well. School administrators, for example, are often ESTJs.

Other common personality tests include the Eysenck Personality Questionnaire (Eysenck & Eysenck, 1993), the Keirsey Temperament Sorter II (Keirsey, 1998), the California Psychological Inventory (Gough, 1995), and the Sixteen Personality Factor Questionnaire (Cattell, 1994).

THE MMPI-2 By far the most common personality inventory is the *Minnesota Multiphasic Personality Inventory, Version II*, or *MMPI-2*, which specifically tests for abnormal behavior and thinking patterns in personality (Butcher & Rouse, 1996; Butcher et al., 2000, 2001). This questionnaire consists of 567 statements such as “I am often very tense” or “I believe I am being plotted against.” The person taking the test must answer “true,” “false,” or “cannot say.” The MMPI has 10 clinical scales and 8 validity scales in addition to numerous subscales. Each scale tests for a particular kind of behavior. The thinking and behavior patterns include relatively mild personality problems such as excessive worrying and shyness as well as more serious disorders such as schizophrenia and depression.  to Learning Objectives 14.5 and 14.8.



 How can you tell if a person is telling the truth on a personality inventory?

Validity scales, which are built into any well-designed psychological inventory, are intended to indicate whether or not a person taking the inventory is responding honestly. Responses to certain items on the test will indicate if people are trying to make themselves look better or worse than they are, for example, and certain items are repeated throughout the test in a slightly different form, so that anyone trying to “fake” the test will have difficulty responding to those items consistently (Butcher et al., 2001). For example, if one of the statements is “I am always happy” and a person responds “true” to that statement, the suspicion would be that this person is trying to look better than he or

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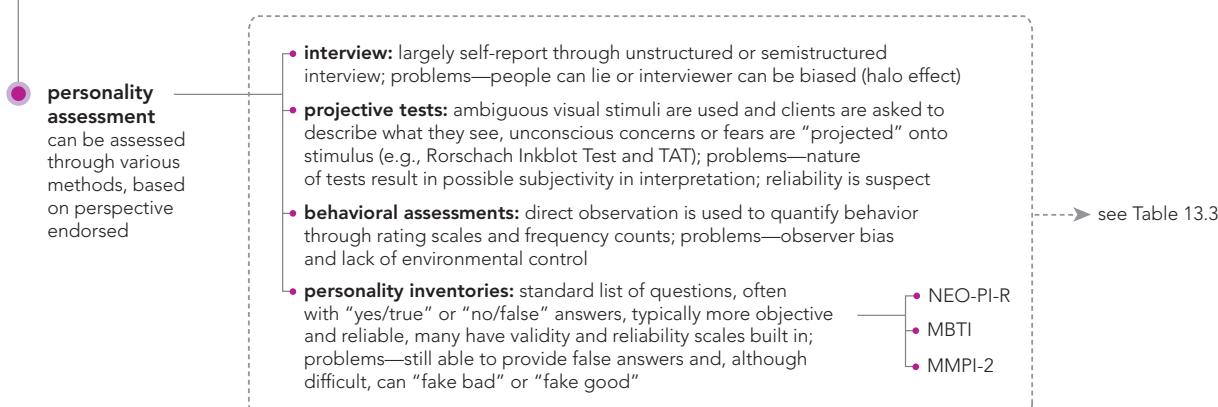


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CONCEPT MAP

- behavioral genetics studies how much of an individual's personality is due to inherited traits
- identical twins are more similar than fraternal twins or unrelated people in many facets of personality
- adoption studies of twins have confirmed that genetic influences account for a great deal of personality development, regardless of shared or nonshared environments
- personality factors of the five-factor model have nearly a 50% rate of heritability across cultures; variations in personality are about 25–50% inherited

Personality: Biological Roots and Assessment



Practice quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. What is a major shortcoming in the field of behavioral genetics in terms of their studies on human personality traits?
 - a. Behavioral geneticists are unable to conduct controlled research studies on human subjects.
 - b. Behavioral geneticists are unable to scientifically validate anything.
 - c. Behavioral geneticists are unable to conduct studies on animals, only on humans.
 - d. Behavioral geneticists conduct their studies by looking at single individuals over a long period of time, thus slowing the rate by which they can gather data.

 2. What, if anything, have adoption studies taught us regarding the relationship between heredity and personality?
 - a. Adoption studies are a new area of study and have yet to offer any information on the effects of heredity on personality.
 - b. Adoption studies have confirmed that personality can be strongly influenced by genetics.
 - c. Adoption studies have not supported many behavioral genetics studies, thus questioning the idea that personality can be influenced by genetics.
 - d. Adoption studies have resulted in conflicting findings, with some strongly supporting the influence of heredity on personality while others suggest that heredity has no influence whatsoever.

 3. Which of the following is an example of a halo effect?
 - a. Terrance unknowingly tends to rate his new client's behavior slightly higher during testing after noticing the client is wearing a class ring from his own alma mater.
-
- b. James tends to distrust all instructors, regardless if they are new or if he has had them for multiple classes.
 - c. Madeline always seems to like the last person she interviews for a job because she remembers the most about them.
 - d. Aileen provided her diagnosis only after conducting her own assessment and compiling information from two of her professional colleagues.
4. Frequency counts and rating scales are especially helpful in assessing
 - a. internal thought processes.
 - b. observable behaviors.
 - c. self efficacy.
 - d. personal values.

 5. Which of the following personality assessments might be best suited for objectively identifying abnormal patterns of behavior or thinking?

a. Personal interview	c. MMPI-2
b. MBTI	d. TAT

 6. What is the function of a validity scale?
 - a. to determine if a person is giving an accurate response
 - b. to determine how a subject really feels
 - c. to help better explain the results of a personality test
 - d. to offer both a diagnosis of abnormal behavior plus a positive therapeutic treatment

THINKING CRITICALLY:

Should employers require prospective employees to take a personality test? Why or why not? Would such a requirement make more sense in certain professions, and, if so, what professions might those be?

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Applying Psychology to Everyday Life: Biological Bases of the Big Five

What are some biological bases of the Big Five theory of personality?

In 1796, Dr. Franz Joseph Gall, a German physician, developed a theory of personality traits based on the shape of a person's skull. This theory became very popular in the nineteenth century and was known as *phrenology*. Gall believed that certain areas of the brain were responsible for certain aspects of personality, and that the skull itself would bulge out according to which of these traits were dominant (Finger, 1994; Simpson, 2005). As psychology became a scientific area of its own, nonscience-based ideas such as phrenology were soon relegated to the realm of pseudoscience.

How odd, then, that a study by Dr. Colin DeYoung and colleagues (DeYoung et al., 2010) seems to suggest that there are indeed certain areas of the brain associated with certain personality traits. Specifically, DeYoung and colleagues believe they have evidence for the biological seat of four of the Big Five: extraversion, neuroticism, agreeableness, and conscientiousness.

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In their study, 116 volunteers answered a questionnaire about their Big Five personality traits. The participants were then subjected to a structural magnetic resonance imaging technique for identifying the volume of specific areas of the brain. One participant was found to be near the group average for personality traits, and that individual's brain image was used as a reference image to which the other participants' scans were compared.

The trait of *extraversion* was associated with a higher volume in the medial orbitofrontal cortex (underside of frontal lobe, directly above the eyes). This area of the brain is associated with recognizing the value of rewarding information. *Neuroticism* was associated with lower brain volume in several areas responding to threat, punishment, and negative emotions. Reduced volumes were found in the dorsomedial prefrontal cortex (toward the top and middle of the prefrontal cortex) and in the left posterior hippocampus. Neuroticism was also associated with higher brain volume in the middle cingulate cortex (cortical component of limbic system), associated with error detection and response to pain. Areas of the brain associated with the intentions of actions and mental states of others were correlated to *agreeableness*, with the area of the posterior cingulate cortex showing a greater volume in individuals high in that trait and a lesser volume in the left superior temporal sulcus. *Conscientiousness* seemed associated with the left lateral prefrontal cortex, an area located on the side of the frontal lobes involved in planning, working memory, and voluntary control of behavior. (The researchers did look at areas that might be associated with the fifth of the Big Five traits, *openness*, but failed to find any significant differences.)

This study, and the others like it that are sure to follow, is part of the growing area of personality neuroscience and an important step in linking personality to the physical structure and functioning of the brain. No skull bulges needed!

Questions for Further Discussion

1. We use personality assessments to make predictions about employment, marriage, and stability, among others. What might it mean for the future if a brain scan becomes part of personality assessment?
2. If personality traits are so closely linked with brain structure, what does that say about the plasticity of personality? Are people able to change their traits? Their behavior?

Writing Prompt

- ▼ Describe the four major theories of personality (psychodynamic, trait or five-factor model, humanistic, and social-cognitive) and identify advantages and disadvantages of each theory.

Words: 0

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chapter summary

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Theories of Personality

13.1 What is personality, and how do the various perspectives in psychology view personality?

- Personality is the unique way individuals think, feel, and act. It is different from character and temperament but includes those aspects.
- The four traditional perspectives in the study of personality are the psychodynamic, behavioristic (including social cognitive theory), humanistic, and trait perspectives.

The Man and the Couch: Sigmund Freud and the Origins of the Psychodynamic Perspective

13.2 How did Freud's historical view of the mind and personality form a basis for psychodynamic theory?

- The three divisions of the mind are the conscious, preconscious, and unconscious. The unconscious can be revealed in dreams.
- The three parts of the personality are the id, ego, and superego.
- The id works on the pleasure principle and the ego works on the reality principle.
- The superego is the moral center of personality, containing the conscience, and is the source of moral anxiety.
- The conflicts between the demands of the id and the rules and restrictions of the superego lead to anxiety for the ego, which uses defense mechanisms to deal with that anxiety.
- The personality develops in a series of psychosexual stages: oral (id dominates), anal (ego develops), phallic (superego develops), latency (period of sexual repression), and genital (sexual feelings reawaken with appropriate targets).
- The Oedipus and Electra complexes (sexual "crushes" on the opposite-sex parent) create anxiety in the phallic stage, which is resolved through identification with the same-sex parent.
- Fixation occurs when conflicts are not fully resolved during a stage, resulting in adult personality characteristics reflecting childhood inadequacies.

13.3 How did the neo-Freudians modify Freud's theory, and how does modern psychodynamic theory differ from that of Freud's?

- The neo-Freudians changed the focus of psychoanalysis to fit their own interpretation of the personality, leading to the more modern version known as the psychodynamic perspective.
- Jung developed a theory of a collective unconscious.
- Adler proposed feelings of inferiority as the driving force behind personality and developed birth order theory.
- Horney developed a theory based on basic anxiety and rejected the concept of penis envy.
- Erikson developed a theory based on social rather than sexual relationships, covering the entire life span.
- Current research has found support for the defense mechanisms and the concept of an unconscious mind that can influence conscious behavior, but other concepts cannot be scientifically researched.

The Behaviorist and Social Cognitive View of Personality

13.4 How do behaviorists and social cognitive theorists explain personality?

- Behaviorists define personality as a set of learned responses or habits.
- The social cognitive view of personality includes the concept of reciprocal determinism, in which the environment, characteristics of the person, and the behavior itself all interact.
- Self-efficacy is a characteristic in which a person perceives a behavior as more or less effective based on previous experiences, the opinions of others, and perceived personal competencies.
- Locus of control is a determinant of personality in which one either assumes that one's actions directly affect events and reinforcements one experiences or that such events and reinforcements are the result of luck, fate, or powerful others.
- Personality, in the form of potential behavior patterns, is also determined by an interaction between one's expectancies for success and the perceived value of the potential reinforcement.
- Behaviorist personality theory has scientific support but is criticized as being too simplistic.

The Third Force: Humanism and Personality

13.5 How do humanists such as Carl Rogers explain personality?

- Humanism developed as a reaction against the negativity of psychoanalysis and the deterministic nature of behaviorism.
- Carl Rogers proposed that self-actualization depends on proper development of the self-concept.
- The self-concept includes the real self and the ideal self. When these two components do not match or agree, anxiety and disordered behavior result.
- Unconditional positive regard from important others in a person's life helps the formation of the self-concept and the congruity of the real and ideal selves, leading to a fully functioning person.
- Humanistic theory is not scientifically researched but has been effective in therapy situations.

Trait Theories: Who Are You?

13.6 How does the trait perspective conceptualize personality?

- Trait theorists describe personality traits in order to predict behavior.
- Allport first developed a list of about 200 traits and believed that these traits were part of the nervous system.
- Cattell reduced the number of traits to between 16 and 23 with a computer method called factor analysis.
- Several researchers have arrived at five trait dimensions that have research support across cultures, called the Big Five or

five-factor model. The five factors are openness, conscientiousness, extraversion, agreeableness, and neuroticism.

- Cross-cultural research has found support for the five-factor model of personality traits in a number of different cultures.
- Future research will explore the degree to which child-rearing practices and heredity may influence the five personality factors.

The Biology of Personality: Behavioral Genetics

13.7 What part do biology, heredity, and culture play in personality?

- Behavioral genetics is a field of study of the relationship between heredity and personality.
- Studies of twins and adopted children have found support for a genetic influence on many personality traits, including intelligence, leadership abilities, traditionalism, nurturance, empathy, assertiveness, neuroticism, and extraversion.

Assessment of Personality

13.8 What are the advantages and disadvantages of various measures of personality?

- Interviews are used primarily by psychoanalysts and humanists and can include structured or unstructured interviews.
- Disadvantages of interviews can include the halo effect and bias of the interpretation on the part of the interviewer.
- Projective tests are based on the defense mechanism of projection and are used by psychoanalysts. Projective tests include the Rorschach inkblot test and the Thematic Apperception Test.

- Projective tests can be useful in finding starting points to open a dialogue between therapist and client but have been criticized for being low in reliability and validity.
- Behavioral assessments are primarily used by behaviorists and include direct observation of behavior, rating scales of specific behavior, and frequency counts of behavior.
- Behavioral assessments have the disadvantage of the observer effect, which causes an observed person's behavior to change, and observer bias on the part of the person doing the assessment.
- Personality inventories are typically developed by trait theorists and provide a detailed description of certain personality traits. They are objective tests rather than subjective.
- The NEO-PI-R is based on the five-factor model, whereas the Myers-Briggs Type Indicator is based on Jung's theory of personality types.
- The MMPI-2 is designed to detect abnormal personality.
- Personality inventories include validity scales to prevent cheating, but such measures are not perfect and cheating is sometimes possible.

Applying Psychology to Everyday Life: Biological Bases of the Big Five

13.9 What are some biological bases of the Big Five theory of personality?

- Personality neuroscience is a growing area of research, and brain structure differences associated with some aspects of the Big Five dimensions of personality have been identified using structural MRI.

test YOURSELF

ANSWERS AVAILABLE IN ANSWER KEY.

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Pick the best answer.

- If you are describing characteristics of your child such as irritability or adaptability, psychologists would say you are not describing their personality but rather their
 - character.
 - consciousness.
 - mood.
 - temperament.
- According to Freud, the _____ works off of the pleasure principle while the _____ is often perceived as the executive director of your personality.
 - id; ego
 - ego; superego
 - superego; id
 - superego; ego
- You are shocked to hear that two of your coworkers who seemingly hated one another are now getting married. According to Freud, what defense mechanism best explains their prior behavior?
 - projection
 - reaction formation
 - repression
 - regression
- Four-year-old Brandon has watched his father as he has mowed the lawn. This year, Brandon has asked for a lawn mower of his own for his birthday. Freud would say that Brandon is beginning the process of _____ as a way of resolving his Oedipal conflict.
 - compensation
 - identification
 - sublimation
 - denial
- Your professor explains how all females have an inner masculine side that adds to their personality. This concept is known as a(n)
 - anima.
 - animus.
 - shadow.
 - source trait.
- According to Adler, firstborn children with younger siblings tend to be
 - overachieving.
 - competitive.
 - pampered.
 - filled with feelings of inferiority.
- Karen Horney's study of one's personality focused on
 - anxiety during childhood.
 - biological changes during adolescence.
 - trait-based characteristics that were present in infancy.
 - environmental influences through adulthood.
- Candice believes that fate will help her find the right man with whom to live her life. According to Rotter, she has a(n)
 - external locus of control.
 - internal locus of control.
 - strong self-efficacy.
 - perceived sense of control.
- Keisha works hard at her job because she believes it will increase her chances for a promotion. According to Julian Rotter's theory, her effort is an example of what he calls
 - reinforcement value.
 - expectancy.
 - archetypes.
 - latency stage.

- 10.** What is a primary advantage of the social cognitive view of personality over the psychodynamic view?
- The social cognitive view tries to explain how people become the people they are.
 - The social cognitive view stresses the importance of early childhood in personality development.
 - The social cognitive view is fully able to explain all the complexities of human behavior.
 - The social cognitive view has concepts that can be tested scientifically.
- 11.** Which perspective of psychology focuses on the role of each person's conscious life experiences and choices in personality development?
- trait
 - behavior
 - humanistic
 - psychodynamic
- 12.** An old motto of the U.S. Army was, "Be all you can be." This concept fits well with Carl Rogers's theory of
- unconditional positive regard.
 - empathy.
 - self-actualizing tendency.
 - real versus the ideal self.
- 13.** According to Rogers, a mismatch between the real and ideal self
- typically motivates individuals to close the gap.
 - can result in anxiety and neurotic behavior.
 - causes one to better understand their unconscious motives.
 - causes an increase in unconditional positive regard.
- 14.** Dr. Hill is constantly late for meetings. She often arrives to her classes 5–10 minutes late and leaves students waiting at her door during office hours for up to 30 minutes. Using the five-factor model, which dimension would show a very low score for Dr. Hill?
- self-sufficiency
 - openness
 - agreeableness
 - conscientiousness
- 15.** To explain an individual's personality, trait theorists would look to
- early childhood emotional traumas.
 - the kind of love, warmth, and affection given to the person by his or her parents.
 - the early experiences of rewards and punishments for certain behavior.
 - the constellation of personality characteristics possessed by the person.
- 16.** Studies of the heritability of personality traits have found
- little evidence to support the belief that personality can be passed by genetics.
 - evidence to support the belief that personality can be passed by genetics but only in highly developed countries.
 - strong evidence to support some personality traits can be passed by genetics.
 - strong evidence that personality is passed exclusively by genetics.
- 17.** As examples of what might be required as parts of specific projective tests, the _____ asks clients to look at a picture and tell a story while the _____ asks clients to report everything they see in an ambiguous figure.
- Rorschach; Thematic Apperception Test
 - MMPI; Thematic Apperception Test
 - MMPI; NEO-PI-R
 - Thematic Apperception Test; Rorschach
- 18.** Which type of assessment would be the most reliable?
- subjective test
 - projective test
 - personality inventory
 - observational study
- 19.** The _____ is based on the five-factor model while _____ is based on the work of Raymond Cattell.
- NEO-PI-R; 16PF
 - MBTI; NEO-PI-R
 - MMPI-2; MBTI
 - 16PF; MMPI-2
- 20.** Personality neuroscience is an emerging field offering evidence of a possible relationship between various aspects of personality with
- brain structure and function.
 - the structure and function of individual neurons.
 - skull shape and size.
 - neuroticism.

14

psychological disorders

Do you or someone you know have any quirky beliefs or behaviors? Have you ever been sad for more than a day? What about being very energetic or extremely happy for the better part of a week? Maybe you are a “checker.” Have you ever double- or triple-checked a door to see if you locked it? Today it may not be that uncommon to observe someone walking down the street and apparently talking to herself or himself, only then to observe they are actually wearing a Bluetooth headset. It also may mean one thing to see someone lying down on the sidewalk outside a local restaurant, and something slightly different if you see someone lying on the sidewalk outside a campus dorm or classroom building. And yet still, different meanings if it is a student, versus a faculty member.

How have ever questioned if someone’s way of thinking or acting was normal? How do you know if a behavior is normal or abnormal?

A video player interface featuring a woman with brown hair and blue eyes, smiling. She is wearing a black tank top. To her left is a magnifying glass icon. The video player includes standard controls: a play button, a volume icon, a closed captioning (CC) icon, and a share icon. The background of the video player has several large, semi-transparent blue circles of varying sizes. The entire video player is set against a white background with decorative blue circles on the sides.

Watch the Video at MyPsychLab.com

Why study abnormal behavior and mental processes?

Because it is all around us, which raises many questions: How should one react? What should be done to help? What kind of person develops a mental illness? Could this happen to someone close to you? The key to answering these questions is to develop an understanding of just what is meant by abnormal behavior and thinking, and the different ways in which thinking and behavior can depart from the “normal” path.

Learning objectives

14.1

How has mental illness been explained in the past and how is abnormal behavior and thinking defined today?

14.2

What are some of the models used to explain psychological disorders?

14.3

What are the different types of psychological disorders, and how common are they?

14.4

What are different types of anxiety disorders, obsessive-compulsive disorder, and stress-related disorders, and what are their symptoms and causes?

14.5

What are different disorders of mood and their causes?

14.6

What are different types of eating disorders, how do they differ, and who are they most likely to affect?

14.7

How do the various dissociative disorders differ, and how do they develop?

14.8

What are the main symptoms and causes of schizophrenia?

14.9

How do various personality disorders differ, and what is thought to be the cause of personality disorders?

14.10

What are some ways to overcome test anxiety?



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What Is Abnormality?

I've heard people call the different things other people do "crazy" or "weird." How do psychologists decide when people are really mentally ill and not just a little odd?

Exactly what is meant by the term *abnormal behavior*? When is thinking, or a mental process *maladaptive*? Abnormal or maladaptive as compared to what? Who gets to decide what is normal and what is not? Has the term always meant what it means now? These are just a few questions that come to mind when thinking about the study of abnormal behavior and psychological dysfunction, or **psychopathology**. Before we explore how views of abnormality and mental illness have changed throughout history, take a moment to reflect on your own beliefs in the experiment, *Are You Normal?*

Simulation

Are You Normal?

This survey asks you about your attitudes towards and experiences with mental disorders and their symptoms.

Below is a list of behaviors that were once considered deviant but may now be considered common and part of our culture. Which of these behaviors do you think are normal? (Select all that apply.)

Please check all that apply

- Holding a job for less than five years before finding a new job (at a different company)
- Being unmarried after age 21
- Waiting to have children until you're 25 years or older
- Being a single parent
- Having a same-sex domestic partnership
- Being transgendered (a man/woman who lives as and/or becomes a woman/man)

[Go to the Experiment ►](#)

Simulate the Experiment, Are You Normal?, on MyPsychLab

A VERY BRIEF HISTORY OF PSYCHOLOGICAL DISORDERS

How has mental illness been explained in the past and how is abnormal behavior and thinking defined today?

Dating from as early as 3000 B.C.E., archaeologists have found human skulls with small holes cut into them, and close examination indicates that the holes were made while the person was still alive. Many of the holes show evidence of healing, meaning that the person survived the process. Although *trephining*, or cutting holes into the skull of a living person, is still done today to relieve pressure of fluids on the brain, in ancient times the reason may have had more to do with releasing the "demons" possessing the poor victim (Gross, 1999).

Hippocrates (460–377 B.C.E.), a Greek physician during the time in which the rest of the world and even many Greeks believed in the demonic possession explanation of mental illness, challenged that belief with his assertion that illnesses of both the body and the mind were the result of imbalances in the body's vital fluids, or *humors*. Although Hippocrates was not correct in his assumptions about the humors of the body (phlegm, black bile, blood, and yellow bile), his was the first recorded attempt to explain abnormal thinking or behavior as due to some biological process.

Moving forward in time, people of the Middle Ages believed in spirit possession (a belief influenced by the teachings of the Roman Catholic Church and the remnants of other religious/cultural systems) as one cause of abnormality. The treatment of choice for such maladies was a religious one: *exorcism*, or the formal casting out of the demon through a religious ritual (Lewis, 1995). During the Renaissance, belief in demonic possession (in which the possessed person was seen as a victim) gave way to a belief in witchcraft, and mentally ill persons were most likely called witches and put to death.

Fast forward to the present day, psychological disorders are often viewed from a *medical model* in that they can be diagnosed according to various symptoms and have an *etiology**, *course*, and *prognosis* (Kihlstrom, 2002). In turn, psychological disorders can be treated, and like many physical ailments, some may be “cured” whereas other psychological disorders will require lifelong attention. And while numerous perspectives in psychology are not medical in nature, the idea of diagnosis and treatment of symptoms bridges many of them. This chapter will focus on the types of psychological disorders and some of their possible causes. We will focus more on psychological treatment and therapies in the next chapter,  to [Chapter Fifteen: Psychological Therapies](#).

WHAT IS ABNORMAL?

Defining abnormal behavior, abnormal thinking, or abnormality is not as simple as it might seem at first. The easy way out is to say that abnormal behavior is behavior that is not normal, abnormal thinking is thinking that is not normal, but what does that mean? It's complicated, as you'll see by considering different criteria for determining abnormality.

STATISTICAL OR SOCIAL NORM DEVIANCE One way to define *normal* and *abnormal* is to use a statistical definition. Frequently occurring behavior would be considered normal, and behavior that is rare would be abnormal. Or how much behavior or thinking deviates from the norms of a society. For example, refusing to wear clothing in a society that does not permit nudity would likely be rare and be seen as abnormal. But deviance (variation) from social norms is not always labeled as negative or abnormal. For instance, a person who decides to become a monk and live in a monastery in the United States would be exhibiting unusual behavior, and certainly not what the society considers a standard behavior, but it wouldn't be a sign of abnormality.

The **situational context** (the social or environmental setting of a person's behavior) can also make a difference in how behavior or thinking is labeled. For example, if a man comes to a therapist complaining of people listening in on his phone conversations and spying on all his activities, the therapist's first thought might be that the man is suffering from thoughts of persecution. But if the man then explains that he is in a witness protection program, the complaints take on an entirely different and quite understandable tone.



These human skull casts show signs of trephining, a process in which holes were cut into the skulls of a living person, perhaps to release “demons” that were making the person’s behavior or thinking odd or disturbed. Some who were treated in this way must have survived, as some of the holes show evidence of healing.

Source: New York Public Library / Science Source.

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*etiology—the origin, cause, or set of causes for a disorder.

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By what criterion (or criteria) of abnormality might this person be considered abnormal? Would your perception of him change if the context were a Fourth of July celebration? What if he was in a park and not in front of a tax office?

SUBJECTIVE DISCOMFORT One sign of abnormality is when the person experiences a great deal of **subjective discomfort**, or emotional distress while engaging in a particular behavior or thought process. A woman who suffers from a fear of going outside her house, for example, would experience a great deal of anxiety when trying to leave home and distress over being unable to leave. However, all thoughts or behavior that might be considered abnormal do not necessarily create subjective discomfort in the person having them or committing the act—a serial killer, for example, does not experience emotional distress after taking someone's life, and some forms of disordered behavior involve showing no emotions at all.

INABILITY TO FUNCTION NORMALLY Thinking or behavior that does not allow a person to fit into society or function normally can also be labeled abnormal. These may be termed **maladaptive**, meaning that the person finds it hard to adapt to the demands of day-to-day living. Maladaptive thinking or behavior may initially help a person cope but has harmful or damaging effects. For example, a woman who cuts herself to relieve anxiety does experience initial relief but is harmed by the action. Maladaptive thinking or behavior are key elements in the definition of abnormality.

A WORKING DEFINITION OF ABNORMALITY



So how do psychologists decide what is abnormal?

To get a clear picture of abnormality, it is often necessary to take all of the factors just discussed into account. Psychologists and other psychological professionals must consider several different criteria when determining whether or not psychological functioning or behavior are abnormal (at least two of these criteria must be met to form a diagnosis of abnormality):

1. Is the thinking or behavior unusual, such as experiencing severe panic when faced with a stranger or being severely depressed in the absence of any stressful life situations?
2. Does the thinking or behavior go against social norms? (And keep in mind that social norms change over time—e.g., homosexuality was once considered a psychological disorder rather than a variation in sexual orientation.)
3. Does the behavior or psychological function cause the person significant subjective discomfort?
4. Is the thought process or behavior maladaptive, or does it result in an inability to function?
5. Does the thought process or behavior cause the person to be dangerous to self or others, as in the case of someone who tries to commit suicide or who attacks other people without reason?

Abnormal thinking or behavior that includes at least two of these five criteria are perhaps best classified by the term **psychological disorder**, which is defined as any pattern of behavior or psychological functioning that causes people significant distress, causes them to harm themselves or others, or harms their ability to function in daily life.

Watch the Video, *The Big Picture: What Does It Mean to Have a Mental Disorder?*, at **MyPsychLab**

Before moving on, it is important to clarify how the term *abnormality* is different from the term *insanity*. Only psychological professionals can diagnose disorders and determine the best course of treatment for someone who suffers from mental illness. Lawyers and judges are sometimes charged with determining how the law should address crimes committed under the influence of mental illness. Psychologists and psychiatrists determine whether or not certain thinking or behavior are abnormal, but they do not decide whether a certain person is insane. In the United States, *insanity* is not a psychological term; it is a legal term used to argue that a mentally ill person who has committed a crime should not be held responsible for his or her actions because that person was unable to understand the difference between right and wrong at the time of the offense. This argument is called the *insanity defense*.

MODELS OF ABNORMALITY

14.2 What are some of the models used to explain psychological disorders?



What causes psychological disorders?

Recognition of abnormal behavior and thinking depends on the “lens,” or perspective, from which it is viewed. Different perspectives determine how the disordered behavior or thinking is explained. And as we will see in Chapter Fifteen, those same perspectives influence how psychological disorders are treated.

THE BIOLOGICAL MODEL: MEDICAL CAUSES FOR PSYCHOLOGICAL DISORDERS The **biological model** proposes that psychological disorders have a biological or medical cause (Gamwell & Tomes, 1995). This model explains disorders such as anxiety, depression, and schizophrenia as caused by faulty neurotransmitter systems, genetic problems, brain damage and dysfunction, or some combination of those causes. For example, as you may recall from the discussion of trait theory and the five-factor theory of personality traits, [LINK](#) to Learning Objective 13.6, a growing body of evidence suggests that basic personality traits are as much influenced by genetic inheritance as they are by experience and upbringing, even across cultures (Bouchard, 1994; Herbst et al., 2000; Jang et al., 1996; Loehlin, 1992; Loehlin et al., 1998). One of the Big Five factors was neuroticism, for example, and it is easy to see how someone who scores high in neuroticism would be at greater risk for anxiety-based disorders.

As discussed earlier in the chapter, the biological or medical model has had a great deal of influence, especially in the language used to describe disorders: *mental illness*, *symptoms of disorder*, and terms such as *diagnosis*, *mental patient*, *mental hospital*, *therapy*, and *remission* all come from medical terminology. The use of such terms, although still widespread, may tend to bias the assumptions of professionals who are not psychiatrists or medical doctors toward a biological cause for disordered psychological functioning or behavior, or the idea that disorders might be diseases that can be “cured.” Many disorders can effectively be controlled but may not be fully resolved.

THE PSYCHOLOGICAL MODELS Although biological explanations of psychological disorders are influential, they are not the only ways or even the first ways in which disorders are explained. Several different theories of personality were discussed in Chapter Thirteen. These theories of personality can be used to describe and explain the formation of not only personality but disordered thinking, behavior, and abnormal personality as well.

Psychodynamic View: Hiding Problems The psychodynamic model, based on the work of Freud and his followers, [LINK](#) to Learning Objectives 13.2, 13.3, explains disordered thinking and behavior as the result of repressing one’s threatening thoughts, memories, and concerns in the unconscious mind (Carducci, 1998). These repressed thoughts and urges try to resurface, and disordered functioning develops as a way of keeping the thoughts repressed. According to this view, a woman who has unacceptable thoughts of sleeping with her brother-in-law might feel “dirty” and be compelled to wash her hands every time those thoughts threaten to become conscious, ridding herself symbolically of the “dirty” thoughts.

Behaviorism: Learning Problems Behaviorists, who define personality as a set of learned responses, have no trouble explaining disordered behavior as being learned just like normal behavior (Skinner, 1971; Watson, 1913). For example, when Emma was a small child, a spider dropped onto her leg, causing her to scream and react with fear. Her mother made a big fuss over her, giving her lots of attention. Each time Emma saw a spider after this, she screamed again, drawing attention to herself. Behaviorists would say that Emma’s fear of the spider was classically conditioned, and her screaming reaction was positively reinforced by all the attention. [LINK](#) to Learning Objectives 5.2 and 5.5.

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Cognitive Perspective: Thinking Problems Cognitive psychologists study the way people think, remember, and mentally organize information; they see maladaptive functioning as resulting from illogical thinking patterns (Mora, 1985). A cognitive psychologist might explain Emma's fear of spiders as distorted thinking: "All spiders are vicious and will bite me, and I will die!" Emma's particular thinking patterns put her at a higher risk of depression and anxiety than those of a person who thinks more logically.

THE SOCIOCULTURAL PERSPECTIVE What's normal in one culture may be abnormal in another culture. In the **sociocultural perspective** of abnormality, abnormal thinking or behavior (as well as normal) is seen as the product of behavioral shaping within the context of family influences, the social group to which one belongs, and the culture within which the family and social group exist. In particular, cultural differences in abnormal thoughts or actions must be addressed when psychological professionals are attempting to assess and treat members of a culture different from that of the professional. **Cultural relativity** is a term that refers to the need to consider the unique characteristics of the culture in which the person with a disorder was nurtured to be able to correctly diagnose and treat the disorder (Castillo, 1997). For example, in most traditional Asian cultures, mental illness is often seen as a shameful thing that brings disgrace to one's family. It may be seen as something inherited and, therefore, something that would hurt the marriage chances of other family members, or it may be seen as stemming from something the family's ancestors did wrong in the past (Ritts, 1999; Ying, 1990). This leads many Asian people suffering from disorders that would be labeled as depression or even schizophrenia to report bodily symptoms rather than emotional or mental ones, because bodily ailments are more socially acceptable (Fedoroff & McFarlane, 1998; Lee, 1995; Ritts, 1999). Disorders unique to specific cultures have previously been referred to as *culture-bound syndromes*. For example, anorexia nervosa and bulimia nervosa have traditionally been most often found in Western societies.

The conceptualization of culture and its influences on psychological function and disorders has been expanded in the most recent publication of the *Diagnostic and Statistical Manual of Mental Disorders*, the *DSM-5*. The idea of "culture-bound" has been replaced by three concepts: **cultural syndromes**, **cultural idioms of distress**, and **cultural explanations or perceived cause** (American Psychiatric Association, 2013). Cultural syndromes may or may not be recognized as an illness within the culture but are nonetheless recognizable as a distinct set of symptoms or characteristics of distress. Cultural idioms of distress refer to terms or phrases used to describe suffering or distress within a given cultural context. And cultural explanations or perceived cause are culturally defined ways of explaining the source or cause of symptoms or illness (American Psychiatric Association, 2013).

It is important to take into account other background and influential factors such as socioeconomic status and education level. Another area of awareness should be primary language and, if applicable, degree of acculturation (adapting to or merging with another culture). Psychosocial functioning has been part of the diagnostic process for some time now, but traditionally, greater attention has been paid to specifically identifying symptoms of pathology rather than focusing on the environmental factors that influence an individual's overall level of functioning (Ro & Clark, 2009). For example, in one recent study, college students of Mexican heritage with migrant farming backgrounds reported more symptoms of anxiety and depression as compared to nonmigrant college students of Mexican heritage (Mejía & McCarthy, 2010). The nature of migrant farming poses different stressors than those faced by nonmigrant families.

BIOPSYCHOSOCIAL PERSPECTIVE: ALL OF THE ABOVE In recent years, the biological, psychological, and sociocultural influences on abnormality are no longer seen as independent causes. Instead, these influences interact with one another to cause the various forms of disorders. For example, a person may have a genetically inherited tendency for a type of disorder, such as anxiety, but may not develop a full-blown disorder unless the family and social environments produce the right stressors at the right time in development. We will see later how this idea specifically applies to a theory of



A migrant farming background has been found to be related to increased symptoms of anxiety and depression among college students of Mexican heritage when compared to those without a migrant background.

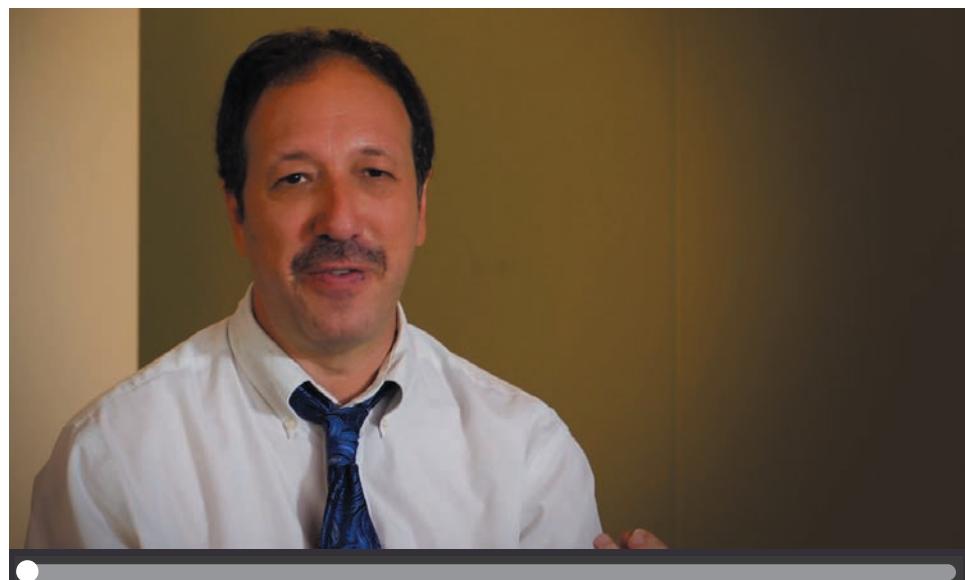
schizophrenia. How accepting a particular culture is of a specific disorder will also play a part in determining the exact degree and form that disorder might take. This is known as the **biopsychosocial model** of disorder, which has become a very influential way to view the connection between mind and body.

Diagnosing and Classifying Disorders

- 14.3** What are the different types of psychological disorders, and how common are they?

Have you ever asked a young child, or remember from being one yourself, “what’s wrong?” when they reported not feeling well? If so, you likely received a variety of answers describing their tummy ache, ouchie, or boo boo. And in turn, you may have not known exactly what was wrong due to differences in their descriptive language and yours, especially when you could not see where or why they were hurting. The same applies to understanding and treating psychological disorders. Having a common set of terms and systematic way of describing psychological and behavioral symptoms is vital to not only correct identification and diagnosis, but also in communication among and between psychological professionals and other health-care providers.

One international resource is the World Health Organization’s (WHO’s) *International Classification of Diseases (ICD)*, currently in its tenth edition (*ICD-10*). In the United States, the prevalent resource to help psychological professionals diagnose psychological disorders has been the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, first published in 1952. The DSM has been revised multiple times as our knowledge and ways of thinking about psychological disorders has changed. The most recent version, which was released in 2013, is the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* (American Psychiatric Association, 2013). It also includes changes in organization of disorders, modifications in terminology used to describe disorders and their symptoms, and discusses the possibility of dimensional assessments for some disorders in future versions of the manual. The DSM has been useful in providing clinicians with descriptions and criteria for diagnosing mental disorders but it has not been without its share of controversy as the video *Special Topics: Diagnosing Mental Disorders: The DSM* explains.



Watch the Video, Special Topics: Diagnosing Mental Disorders: The DSM, at [MyPsychLab](#)

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DISORDERS IN THE DSM-5

The *DSM-5* describes about 250 different psychological disorders. Each disorder is described in terms of its symptoms, the typical path the disorder takes as it progresses, and a checklist of specific criteria that must be met in order for the diagnosis of that disorder to be made. Whereas previous editions of the manual divided disorders and relevant facts about the person being diagnosed along five different categories, or axes, the *DSM-5* uses a single axis for all disorders, with provisions for also noting significant and relevant facts about the individual. For example, whereas the *DSM-IV* used Axis I for mental disorders, Axis II for personality disorders and mental retardation (now called *intellectual disability*), and Axis III for medical diagnoses, the *DSM-5* combines all of these disorders and diagnoses into a single list (American Psychiatric Association, 2013).

A few of the 20 categories of disorders that can be diagnosed include depressive disorders, anxiety disorders, schizophrenia spectrum and other psychotic disorders, feeding and eating disorders, and neurodevelopmental disorders such as ADHD (American Psychiatric Association, 2013). Other categories include personality disorders, intellectual disability, trauma- and stressor-related disorders, and obsessive-compulsive and related disorders.

HOW COMMON ARE PSYCHOLOGICAL DISORDERS?



That sounds like a lot of possible disorders, but most people don't get these problems, right?

Actually, psychological disorders are more common than most people might think. In any given year, about 26.2 percent of American adults over age 18 suffer from a mental disorder (National Institute of Mental Health, 2010); that comes to about 61.5 million people in the United States using 2010 census data. Fortunately, only about 5.8 percent of the U.S. population, or 1 in 17 adults, suffers from a severe mental disorder. Statistically, mental disorders are the leading cause of disability in the United States and Canada (National Institute of Mental Health, 2010). In fact, it is quite common for people to suffer from more than one mental disorder at a time, such as a person with depression who also has a substance-abuse disorder, or a person with an anxiety disorder who also suffers from sleep disorders. Approximately 45 percent of individuals with a mental disorder meet criteria for 2 or more disorders (National Institute of Mental Health, 2010). Table 14.1 has percentages of selected psychological disorders in the United States. (Note that this table does not include all of the disorders that occur in the 61.5 million adults in the United States mentioned earlier in this paragraph.)

THE PROS AND CONS OF LABELS

With its lists of disorders and their corresponding symptoms, the *DSM-5* helps psychological professionals diagnose patients and provide those patients with labels that explain their conditions. In the world of psychological diagnosis and treatment, labels like *depression*, *anxiety*, and *schizophrenia* can be very helpful: They make up a common language in the mental health community, allowing psychological professionals to communicate with each other clearly and efficiently. Labels establish distinct diagnostic categories that all professionals recognize and understand, and they help patients receive effective treatment.

However, labels can also be dangerous—or, at the very least, overly prejudicial. In 1972, researcher David Rosenhan asked healthy participants to enter psychiatric hospitals and complain that they were hearing voices. All of the participants, whom Rosenhan called “pseudopatients,” were admitted into the hospitals and diagnosed with either schizophrenia or manic depression (now called bipolar disorder). Once the pseudopatients were admitted, they stopped pretending to be ill and acted as they normally would,



Statistically speaking, about 1 out of every 5 of the people in this crowd probably suffers from some form of psychological disorder.

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Table 14.1**Yearly Occurrence of Psychological Disorders in the United States**

CATEGORY OF DISORDER	SPECIFIC DISORDER	PERCENTAGE OF U.S. POPULATION AND NUMBER AFFECTED*
Bipolar and Depressive disorders	All types	9.5% or 22.3 million
	Major depressive disorder	6.7% or 15.7 million
	Persistent depressive disorder (dysthymia)	1.5% or 3.5 million
	Bipolar disorder	2.6% or 6.1 million
Anxiety, Obsessive-Compulsive, and Trauma-Related disorders	All types	18.1% or 42.5 million
	Specific phobia	8.7% or 20.4 million
	Social anxiety disorder (social phobia)	6.8% or 16 million
	Panic disorder	2.7% or 6.3 million
	Agoraphobia	0.8% or 1.9 million
	Generalized anxiety disorder	3.1% or 7.3 million
	Obsessive-compulsive disorder	1% or 2.3 million
Schizophrenia	Posttraumatic stress disorder	3.5% or 8.2 million
	All types	1.1% or 2.6 million

*Percentage of adults over age 18 affected annually and approximate number within the population based on 2010 United States Census data.

Adapted from National Institute of Mental Health (2013). Table uses terminology from both the *DSM-IV* and *DSM-5* (American Psychiatric Association, 2000, 2013).

but the hospital staff's interpretation of the pseudopatients' normal behavior was skewed by the label of mental illness. For example, hospital workers described one pseudopatient's relatively normal relationships with family and friends as evidence of a psychological disorder, and another pseudopatient's note-taking habits were considered to be a pathological behavior. The pseudopatients had been diagnosed and labeled, and those labels stuck, even when actual symptoms of mental illness disappeared. Rosenhan concluded that psychological labels are long-lasting and powerful, affecting not only how other people see mental patients but how patients see themselves (Rosenhan, 1973).

Labels can be time-saving and even life-saving tools, but they can also bias us, affect our judgment, and give us preconceived notions that may very well turn out to be false. Just to be clear, the diagnostic labels listed in the *DSM-5* are intended to help both psychologists and patients, and they *do* help. As you read on, remember the power that labels have to shape our perceptions of reality.

Before describing the various categories and types of disorders, here is a word of caution: It's very easy to see oneself in these disorders. Medical students often become convinced that they have every one of the symptoms for some rare, exotic disease they have been studying. Psychology students studying abnormal behavior can also become convinced that they have some mental disorder, a problem that can be called "psychology student's syndrome." The problem is that so many psychological disorders are really ordinary variations in human behavior taken to an extreme. For example, some people are natural-born worriers. They look for things that can go wrong around every corner. That doesn't make them disordered—it makes them pessimistic worriers. Remember, it doesn't become a disorder until the worrying causes them significant distress, causes them to harm themselves or others, or harms their ability to function in everyday life. So if you start "seeing" yourself or even your friends and family in any of the following discussions, don't panic—all of you are *probably* okay.

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 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP

what is abnormality?

- **psychopathology** is the study of abnormal behavior and psychological dysfunction; mental illness has been defined in various ways throughout history (e.g., possession, evil spirits, bodily imbalances)
- current definitions of abnormality are based on several factors
- disorders vary according to culture; cultural sensitivity and relativity are necessary in diagnosing and treating psychological disorders
- overall, psychological disorders are any pattern of behavior or thinking that causes significant distress, causes people to harm themselves or others, or harms their ability to function in daily life

- statistical or social norm deviance
- subjective discomfort
- inability to function normally

Psychological Disorders

models of abnormality

explanations for disordered thinking or behavior depend on theoretical model used to explain personality in general

- **biological model:** proposes that psychological disorders have a biological or medical cause; the medical model also influences approaches to diagnosis, treatment, and possible outcomes for a given disorder
- **psychological models:** propose that disorders are the result of various forms of emotional, behavioral, or thought-related malfunctioning
 - **psychodynamic**
 - **behavioral**
 - **cognitive**
- **sociocultural perspective:** thinking and behavior are the products of family, social, and cultural influences; what is normal in one culture may be abnormal in another
- **biopsychosocial perspective:** incorporates biological, psychological, and sociocultural factors

Diagnosing and Classifying Disorders

- the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* was first published in 1952, current version (*DSM-5*) published in 2013
- describes and provides diagnostic criteria for approximately 250 different psychological disorders
- in general, approximately 26% of adults over age 18 in the United States suffer from a mental disorder (see Table 14.1)

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. How would the Greek physician Hippocrates have typically dealt with someone suffering from mental illness?
 - a. He would have made a hole in the patient's skull to release the pressure, a process known today as trephining.
 - b. He would focus on correcting the imbalance of bodily fluids, or humors.
 - c. He would have someone conduct the religious ritual known as an exorcism.
 - d. He would have tried to understand the person's unconscious and the forces at work there.
2. Lisa has just been fired from her new job for consistently arriving 2 hours late for work. Lisa tries to explain that she must often drive back home to ensure that all the doors are locked and that no appliances have been left on. Lisa's condition is abnormal from the _____ definition.

a. maladaptive	c. social deviance
b. situational context	d. subjective discomfort
3. In the United States, insanity is a term typically used by
 - a. psychologists.
 - b. psychiatrists.
 - c. the social work system.
 - d. the legal system.
4. Elliot became widowed after nearly 40 years of marriage. He has convinced himself that no one will ever love him again. His irrational thinking has caused him to suffer from depression, and he rarely leaves his house. What perspective might best explain his behavior?
 - a. psychodynamic
 - b. cognitive
 - c. behavioral
 - d. biological
5. Which of the following concepts is not specifically associated with the DSM-5 examination of culture-related disorders?
 - a. cultural syndrome
 - b. cultural idioms of distress
 - c. cultural explanations or perceived cause
 - d. cultural binding

THINKING CRITICALLY:

In today's growing technological age, can you think of any new criteria that should be considered in defining abnormal behavior or thinking?

Disorders of Anxiety, Trauma, and Stress: What, Me Worry?

- 14.4** What are different types of anxiety disorders, obsessive-compulsive disorder, and stress-related disorders, and what are their symptoms and causes?

The category of **anxiety disorders** includes disorders in which the most dominant symptom is excessive or unrealistic anxiety. Anxiety can take very specific forms, such as a fear of a specific object, or it can be a very general emotion, such as that experienced by someone who is worried and doesn't know why. In this section we will also address disorders that many people associate with anxiety symptoms and which were classified as anxiety disorders in previous editions of the *DSM*. However, they now fall under different categories in the *DSM-5*. *Obsessive-compulsive disorder* now falls in the category of "Obsessive-Compulsive and Related Disorders" while *posttraumatic stress disorder* and *acute stress disorder* are found under "Trauma-and Stressor-Related Disorders" (American Psychiatric Association, 2013).



But doesn't everybody have anxiety sometimes? What makes it a disorder?

Everyone does have anxiety, and some people have a great deal of anxiety at times. When talking about anxiety disorders, the anxiety is either excessive—greater than it should be given the circumstances—or unrealistic. If final exams are coming up and a student hasn't studied enough, that student's anxiety is understandable and realistic. But a student who has studied, has done well in all the exams, and is very prepared and still worries *excessively* about passing is showing an unrealistic amount of anxiety. For more about test anxiety, see the Applying Psychology to Everyday Life section in this chapter. People who are in danger of losing their job might experience quite a bit of anxiety, but its source is obvious and understandable. But someone whose life is going well, and for whom nothing bad is looming in the future, and who still feels extremely anxious may be experiencing an anxiety disorder. **Free-floating anxiety** is the term given to anxiety that seems to be unrelated to any realistic and specific, known factor, and it is often a symptom of an anxiety disorder (Freud, 1977).

PHOBIC DISORDERS: WHEN FEARS GET OUT OF HAND

One of the more specific anxiety disorders is a **phobia**, an irrational, persistent fear of something. The "something" might be an object or a situation or may involve social interactions. For example, many people would feel fear if they suddenly came upon a live snake as they were walking and would take steps to avoid the snake. Although those same people would not necessarily avoid a *picture* of a snake in a book, a person with a phobia of snakes would. Avoiding a live snake is rational; avoiding a picture of a snake is not.

SOCIAL ANXIETY DISORDER (SOCIAL PHOBIA) **Social anxiety disorder** (also called *social phobia*) involves a fear of interacting with others or being in a social situation and is one of the most common phobias people experience (Kessler et al., 2012). People with social anxiety disorder are afraid of being evaluated in some negative way by others, so they tend to avoid situations that could lead to something embarrassing or humiliating. They are very self-conscious as a result. Common types of social phobia are stage fright, fear of public speaking, and fear of urinating in a public restroom. Not surprisingly, people with social phobias often have a history of being shy as children (Sternberger et al., 1995).

SPECIFIC PHOBIAS A **specific phobia** is an irrational fear of some object or specific situation, such as a fear of dogs, or a fear of being in small, enclosed spaces (**claustrophobia**). Other specific phobias include a fear of injections (*trypanophobia*), fear of dental work (*odontophobia*), fear of blood (*hematophobia*), and fear of heights (**acrophobia**). For a listing of common phobias, see **Table 14.2** on the next page.

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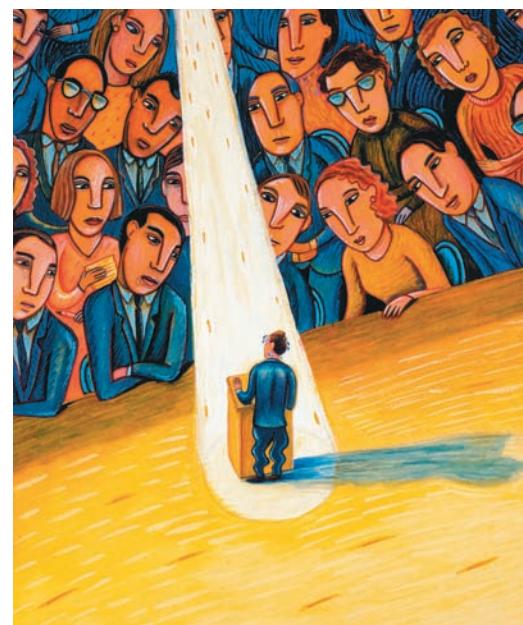
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Many people get nervous when they have to speak in front of an audience. Fear of public speaking is a common social phobia. Can you remember a time when you experienced a fear like this?

Table 14.2

Common Phobias and Their Scientific Names

FEAR OF	SCIENTIFIC NAME
Washing and bathing	Ablutophobia
Spiders	Arachnophobia
Lightning	Ceraunophobia
Dirt, germs	Mysophobia
Snakes	Ophidiophobia
Darkness	Nyctophobia
Fire	Pyrophobia
Foreigners, strangers	Xenophobia
Animals	Zoophobia

Source: Adapted from Culbertson (2003).



Agoraphobia may include a fear of crossing bridges, although this bridge is enough to test anyone's courage.

AGORAPHOBIA A third type of phobia is **agoraphobia**, a Greek name that literally means “fear of the marketplace.” It is the fear of being in a place or situation from which escape is difficult or impossible if something should go wrong (American Psychiatric Association, 2013). Furthermore, the anxiety is present in more than one situation. Someone is diagnosed with agoraphobia if they feel anxiety in at least two of five possible situations such as using public transportation like a bus or plane, being out in an open space such as on a bridge or in a parking lot, being in an enclosed space such as a grocery store or movie theatre, standing in line or being in a crowd like at a concert, or being out of the home alone (American Psychiatric Association, 2013).

If a person has agoraphobia, it might be difficult to even go to work or to the store, right?

Exactly. People with specific phobias can usually avoid the object or situation without too much difficulty and people with social phobias may simply avoid jobs and situations that involve meeting people face to face. But people with agoraphobia cannot avoid their phobia’s source because it is simply being outside in the real world. A severe case of agoraphobia can make a person’s home a prison, leaving the person trapped inside unable to go to work, shop, or engage in any kind of activity that requires going out of the home.

PANIC DISORDER

Fourteen-year-old Dariya was sitting in science class watching a film. All of a sudden, she started feeling really strange. Her ears seemed to be stuffed with cotton and her vision was very dim. She was cold, had broken out in a sweat, and felt extremely afraid for no good reason. Her heart was racing and she immediately became convinced that she was dying. A friend sitting behind her saw how pale she had become and tried to ask her what was wrong, but Dariya couldn’t speak. She was in a state of panic and couldn’t move.

Dariya’s symptoms are the classic symptoms of a **panic attack**, a sudden onset of extreme panic with various physical symptoms: racing heart, rapid breathing, a sensation of being “out of one’s body,” dulled hearing and vision, sweating, and dry mouth (Kumar & Oakley-Browne, 2002). Many people who have a panic attack think that they are having a heart attack and can experience pain as well as panic, but the symptoms are caused by the panic, not by any actual physical disorder. Psychologically, the person having a panic attack is in a state of terror, thinking that this is it, death is happening, and many

people may feel a need to escape. The attack happens without warning and quite suddenly. Although some panic attacks can last as long as half an hour, some last only a few minutes, with most attacks peaking within 10 to 15 minutes.

Having a panic attack is not that unusual, especially for adolescent girls and young adult women (Eaton et al., 1994; Hayward et al., 1989, 2000). Researchers have also found evidence that cigarette smoking greatly increases the risk of panic attacks in adolescents and young adults (Johnson, 2000; Zvolensky et al., 2003). Regardless, it is only when panic attacks occur more than once or repeatedly, and cause persistent worry or changes in behavior, that they become a **panic disorder**. Many people try to figure out what triggers a panic attack and then do their best to avoid the situation if possible. If driving a car sets off an attack, they don't drive. If being in a crowd sets off an attack, they don't go where crowds are.

GENERALIZED ANXIETY DISORDER



What about people who are just worriers? Can that become a disorder?

Remember free-floating anxiety? That's the kind of anxiety that has no known specific source and may be experienced by people with **generalized anxiety disorder**, in which excessive anxiety and worries (apprehensive expectations) occur more days than not for at least 6 months. People with this disorder may also experience anxiety about a number of events or activities (such as work or school performance). These feelings of anxiety have no particular source that can be pinpointed, nor can the person control the feelings even if an effort is made to do so. Watch the [Video](#), Anxiety and Worry: Sue Mineka, at [MyPsychLab](#)

People with this disorder are just plain worriers (Ruscio et al., 2001). They worry *excessively* about money, their children, their lives, their friends, the dog, as well as things no one else would see as a reason to worry. They feel tense, edgy, get tired easily, and may have trouble concentrating. They have muscle aches, they experience sleeping problems, and are often irritable—all signs of stress. Generalized anxiety disorder is often found occurring with other anxiety disorders and depression.

As discussed earlier, despite anxiety being a common symptom, the following disorders are no longer classified as anxiety disorders in the DSM-5. *Obsessive-compulsive disorder* now falls in the category of “Obsessive-Compulsive and Related Disorders” while *posttraumatic stress disorder* and *acute stress disorder* are found under “Trauma- and Stressor-Related Disorders” (American Psychiatric Association, 2013).

OBSESSIVE-COMPULSIVE DISORDER

Sometimes people get a thought running through their head that just won't go away, like when a song gets stuck in one's mind. If that particular thought causes a lot of anxiety, it can become the basis for an **obsessive-compulsive disorder**, or OCD. OCD is a disorder in which intruding* thoughts that occur again and again (obsessions, such as a fear that germs are on one's hands) are followed by some repetitive, ritualistic behavior or mental acts (compulsions, such as repeated hand washing, counting, etc.). The compulsions are meant to lower the anxiety caused by the thought (Soomro, 2001).

I knew someone who had just had a baby, and she spent the first few nights home with the baby checking it to see if it was breathing—is that an obsessive-compulsive disorder?

No, many parents check their baby's breathing often at first. Everyone has a little obsessive thinking on occasion or some small ritual that makes them feel better. The

*intruding: forcing one's way in; referring to something undesirable that enters awareness.

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After the BP oil spill in April of 2010, anywhere from 35 to 45 percent of people living around or near the Gulf of Mexico reported suffering symptoms of stress (Abramson et al., 2010).

difference is whether a person *likes* to perform the ritual (but doesn't *have to*) or feels *compelled* to perform the ritual and feels extreme anxiety if unable to do so. You may wash your hands a time or two after picking up garbage but it is entirely different if you *must* wash them a *thousand times* to prevent getting sick. The distress caused by a failure or an inability to successfully complete the compulsion is a defining feature of OCD.

ACUTE STRESS DISORDER (ASD) AND POSTTRAUMATIC STRESS DISORDER (PTSD)

Both general and specific stressors were discussed in Chapter Eleven: Stress and Health. Two trauma- and stressor-related disorders—*acute stress disorder* and *posttraumatic stress disorder*—are related to exposure to significant and traumatic stressors. The trauma, severe stress, and anxiety experienced by people after 9/11, Hurricane Katrina, the East Japan Earthquake, and the April 2013 Boston Marathon bombings can lead to **acute stress disorder (ASD)**. The symptoms of ASD often occur immediately after the traumatic event and include anxiety, dissociative symptoms (such as emotional numbness/lack of responsiveness, not being aware of surroundings, dissociative amnesia), recurring nightmares, sleep disturbances, problems in concentration, and moments in which people seem to “relive” the event in dreams and flashbacks for as long as 1 month following the event. One recently published study gathered survey information from Katrina evacuees at a major emergency shelter and found that 62 percent of those sampled met the criteria for having acute stress disorder (Mills et al., 2007).

When the symptoms associated with ASD last for more than 1 month, the disorder is then called **posttraumatic stress disorder (PTSD)**. In the same study (Mills et al., 2007), researchers concluded that it was likely that anywhere from 38 to 49 percent of all the evacuees sampled were at risk of developing PTSD that would still be present 2 years after the disaster. Furthermore, whereas the onset of ASD often occurs immediately after the traumatic event, the symptoms of PTSD may not occur until 6 months or later after the event (American Psychiatric Association, 2013). Treatment of these stress disorders may involve psychotherapy and the use of drugs to control anxiety. [LINK](#) to Learning Objective 15.8. The video, *In the Real World: The Memories We Don't Want*, describes PTSD in more detail.

Symptoms of PTSD

re-experiencing
avoidance
hypervigilance

Play button

[Watch the Video](#), *In the Real World: The Memories We Don't Want*, at [MyPsychLab](#)

Researchers have found that women have almost twice the risk of developing PTSD than do men and that the likelihood increases if the traumatic experience took place before the woman was 15 years old (Breslau et al., 1997, 1999). However, female and male veterans tend to have similar symptoms of PTSD, at least for military-related stressors (King et al., 2013). Children may also suffer different effects from stress than do adults. Severe PTSD has been linked to a decrease in the size of the hippocampus in children with the disorder (Carrion et al., 2007). The hippocampus is important in the formation of new long-term declarative memories ([LINK](#) to Learning Objectives 2.8, 6.5, 6.11), and this may have a detrimental effect on learning and the effectiveness of treatments for these children. One recent study of older veterans over a 7-year period (Yaffe et al., 2010) found that those with PTSD were more likely to develop dementia (10.6 percent risk) when compared to those without PTSD (only 6.6 percent risk). Some life experiences lend themselves to people experiencing traumatic events. For example, the rate of PTSD (self-reported) among combat-exposed military personnel has tripled since 2001 (Smith et al., 2008). Lastly, individuals with ASD and PTSD likely perceive the world around them differently. A recent study of assault and motor vehicle accident survivors treated in a South London, UK, emergency room suggested individuals with ASD or PTSD were more likely to identify trauma-related pictures than neutral pictures, as compared to trauma survivors not diagnosed with ASD or PTSD. Furthermore, such preferential processing of trauma-related information may be more strongly primed in individuals with PTSD (Kleim et al., 2012) and is supported by fMRI studies demonstrating heightened brain processing in areas associated with associative learning and priming in individuals with PTSD (Sartory et al., 2013). [LINK](#) to Learning Objectives 6.5.

CAUSES OF ANXIETY, TRAUMA, AND STRESS DISORDERS

Different perspectives on how personality develops offer different explanations for these disorders. For example, the psychodynamic model sees anxiety as a kind of danger signal that repressed urges or conflicts are threatening to surface (Freud, 1977). A phobia is seen as a kind of displacement, in which the phobic object is actually only a symbol of whatever the person has buried deep in his or her unconscious mind—the true source of the fear. A fear of knives might mean a fear of one's own aggressive tendencies, or a fear of heights may hide a suicidal desire to jump.

BEHAVIORAL AND COGNITIVE FACTORS Behaviorists believe that anxious behavioral reactions are learned. They see phobias, for example, as nothing more than classically conditioned fear responses, as was the case with “Little Albert” (Rachman, 1990; Watson & Rayner, 1920). [LINK](#) to Learning Objective 5.3. Cognitive psychologists see anxiety disorders as the result of illogical, irrational thought processes. One way in which people with anxiety disorders show irrational thinking (Beck, 1976, 1984) is through **magnification**, or the tendency to “make mountains out of molehills” by interpreting situations as being far more harmful, dangerous, or embarrassing than they actually are. In panic disorder, for example, a person might interpret a racing heartbeat as a sign of a heart attack instead of just a momentary arousal.

Cognitive-behavioral psychologists may see anxiety as related to another distorted thought process called **all-or-nothing thinking**, in which a person believes that his or her performance must be perfect or the result will be a total failure. **Overgeneralization** (a single negative event interpreted as a never-ending pattern of defeat), jumping to conclusions without facts to support that conclusion, and **minimization** (giving little or no emphasis to one's successes or positive events and traits) are other examples of irrational thinking.

BIOLOGICAL FACTORS Growing evidence exists that biological factors contribute to anxiety disorders. Several disorders, including generalized anxiety disorder, panic disorders, phobias, and OCD, tend to run in families, pointing to a genetic basis for these disorders. Furthermore, genetic factors in PTSD seem to influence both the risk of

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Anxiety disorders affect children as well as adults.

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developing the disorder and the likelihood individuals may be involved in potentially dangerous situations (Hyman & Cohen, 2013). Functional neuroimaging studies,  to Learning Objective 2.6, have revealed that the amygdala, an area of the limbic system, is more active in phobic people responding to pictures of spiders than in nonphobic people (LeDoux, 2003; Rauch et al., 2003) and also more active in individuals with PTSD and social anxiety disorder, suggesting excessive conditioning and exaggerated responses to stimuli that would typically elicit minimal fear-related responses (Hyman & Cohen, 2013).  to Learning Objectives 2.8, 6.11 and 9.7.

CULTURAL VARIATIONS Anxiety disorders are found around the world, although the particular form the disorder takes might be different in various cultures. For example, in some Latin American cultures anxiety can take the form of *ataque de nervios*, or “attack of nerves,” in which the person may have fits of crying, shout uncontrollably, experience sensations of heat, and become very aggressive, either verbally or physically. These attacks usually come after some stressful event such as the death of a loved one (American Psychiatric Association, 2013). Several syndromes that are essentially types of phobias are specific to certain cultures. For example, *koro*, found primarily in China and a few other South Asian and East Asian countries, involves a fear that one’s genitals are shrinking (Pfeiffer, 1982), and *taijin kyofusho* (TKS), found primarily in Japan, involves excessive fear and anxiety, but in this case it is the fear that one will do something in public that is socially inappropriate or embarrassing, such as blushing, staring, or having an offensive body odor (Kirmayer, 1991). Panic disorder occurs at similar rates in adolescents and adults in the United States and parts of Europe, but found less often in Asian, African, and Latin American countries. Within the United States, American Indians have significantly higher rates whereas Latinos, African Americans, Caribbean blacks, and Asian Americans have significantly lower rates as compared to non-Latino whites (American Psychiatric Association, 2013).

Disorders of Mood: The Effect of Affect

14.5 What are different disorders of mood and their causes?

In psychological terms, the word **affect** is used to mean “emotion” or “mood.” **Mood disorders** are disturbances in emotion and are also referred to as affective disorders. Although the range of human emotions runs from deep, intense sadness and despair to extreme happiness and elation, under normal circumstances people stay in between those extremes—neither too sad nor too happy, but content (see Figure 14.1). It is when stress or some other factor pushes a person to one extreme or the other that mood disorders can result. Mood disorders can be relatively mild or moderate (straying only a short distance from the “average”) or they can be extreme (existing at either end of the full range). Another major change in the DSM-5 was to separate disorders previously and collectively classified as “mood disorders” into different categories. As such, in the *DSM-5*, disorders of mood can be found under “Bipolar and Related Disorders” or “Depressive Disorders.” Given disordered mood is still a common feature, they will be examined together here.

MAJOR DEPRESSIVE DISORDER

When a deeply depressed mood comes on fairly suddenly and either seems to be too severe for the circumstances or exists without any external cause for sadness, it is called **major depressive disorder**. Major depression would fall at the far extreme of sadness on Figure 14.1. People suffering from major depressive disorder are depressed for most of

Figure 14.1 The Range of Emotions

Most people experience a range of emotions over the course of a day or several days, such as mild sadness, calm contentment, or mild elation and happiness. A person with a disorder of mood experiences emotions that are extreme and, therefore, abnormal.

Extreme sadness	Mild sadness	Normal emotions	Mild elation	Extreme elation
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every day, take little or no pleasure in any activities, feel tired, have trouble sleeping or sleep too much, experience changes in appetite and significant weight changes, experience excessive guilt or feelings of worthlessness, and have trouble concentrating. Some people with this disorder also suffer from delusional thinking and may experience hallucinations. Most of these symptoms occur on a daily basis, lasting for the better part of the day (American Psychiatric Association, 2013).

Some people with depression may have thoughts of death or suicide, including suicide attempts. Death by suicide is the most serious negative outcome for the person with depression. It is the third leading cause of death among young people from 15 to 24 years of age, and more than 90 percent of suicides are associated with a psychological disorder, with depression being the most likely cause (Hyman & Cohen, 2013; National Institute of Mental Health, 2008). If you or someone you know is thinking about suicide, confidential assistance is available from the National Suicide Prevention Lifeline, 1-800-273-TALK (8255).

Major depressive disorder is the most common of the diagnosed disorders of mood and is 1.5 to 3 times more likely in women as it is in men (American Psychiatric Association, 2013). This is true even across various cultures (Kessler et al., 2012; Seedat et al., 2009). Many possible explanations have been proposed for this gender difference, including the different hormonal structure of the female system (menstruation, hormonal changes during and after pregnancy, menopause, etc.) and different social roles played by women in the culture (Blehar & Oren, 1997). Research has found little support for hormonal influences in general, instead finding that the role of hormones and other biological factors in depression is unclear. Furthermore, studies have found that the degree of differences between male and female rates of depression is decreasing and is non-existent in college students and single adults, leading some to conclude that gender roles and social factors such as marital status, career type, and number of children may have more importance in creating the gender difference than biological differences (McGrath et al., 1992; Nolen-Hoeksema, 1990; Seedat et al., 2009; Weissman & Klerman, 1977). Women also tend to ruminate, or repeatedly focus more on negative emotions, more than men and this may also be a contributing factor for reported gender differences in prevalence rates for both depression and anxiety (Nolen-Hoeksema, 2012).  [Watch the Video](#), Speaking Out: Martha: Living with Major Depressive Disorder, at [MyPsychLab](#)

Some people find that they only get depressed at certain times of the year. In particular, depression seems to set in during the winter months and goes away with the coming of spring and summer. *Seasonal affective disorder (SAD)* is a mood disorder that is caused by the body's reaction to low levels of light present in the winter months (Partonen & Lonnqvist, 1998).

BIPOLAR DISORDERS

Major depressive disorder is sometimes referred to as a *unipolar disorder* because the emotional problem exists at only one end, or “pole,” of the emotional range. When a person experiences periods of mood that can range from severe depression to **manic** episodes (excessive excitement, energy, and elation), that person is said to suffer from a type of **bipolar disorder** (American Psychiatric Association, 2013). However, while an individual may experience periods of mood at the two extremes, in some instances the individual may only experience mood that spans from normal to manic, and may or may not experience episodes of depression, called *bipolar I disorder*. In the manic episodes, the person is extremely happy or euphoric * without any real cause to be so happy. Restlessness, irritability, an inability to sit still or remain inactive, and seemingly unlimited energy are also common. The person may seem silly to others and can become aggressive when not allowed to carry out the grand (and sometimes delusional) plans that may occur in mania. Speech may be rapid and jump from one topic to another. Oddly, people in the manic state are often very creative until their lack

*euphoric: having a feeling of vigor, well-being, or high spirits.

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of organization renders their attempts at being creative useless (Blumer, 2002; McDermott, 2001; Rothenberg, 2001). In *bipolar II disorder*, spans of normal mood are interspersed with episodes of major depression and episodes of *hypomania*, a level of mood that is elevated but at a level below or less severe than full mania (American Psychiatric Association, 2013).



That sounds almost like a description of an overactive child—can't sit still, can't concentrate—are the two disorders related?

The answer to that question is actually part of an ongoing controversy. There does seem to be a connection between attention-deficit/hyperactivity disorder (ADHD) and the onset of bipolar disorder in adolescence (Carlson et al., 1998), but only a small percentage of children with ADHD go on to develop bipolar disorder. Recent evidence has found significantly higher rates of ADHD among relatives of individuals with bipolar disorder, and a higher prevalence of bipolar disorder among relatives of individuals with ADHD (Faraone et al., 2012). The symptoms of bipolar disorder include irrational thinking and other manic symptoms that are not present in ADHD (Geller et al., 1998). Confusion between the two disorders arises because hyperactivity (excessive movement and an inability to concentrate) is a symptom of both disorders. In one study, researchers compared children diagnosed with both bipolar disorder and ADHD to children diagnosed with ADHD only on measures of academic performance and a series of neurological tests (Henin et al., 2007). They found that the two groups responded in very similar ways, showing the same deficits in information-processing abilities, with only one exception: The children with both disorders performed more poorly on one measure of processing speed when compared to children with only ADHD. The researchers concluded that the neurological deficits often observed in children with bipolar disorder are more likely to be due to the ADHD rather than the bipolar disorder itself. Children with bipolar disorder also seem to suffer from far more severe emotional and behavioral problems than those with ADHD (Ferguson-Noyes, 2005; McDougall, 2009).

CAUSES OF DISORDERED MOOD

Explanations of depression and other disorders of mood today come from the perspectives of behavioral, social cognitive, and biological theories as well as genetics.

Behavioral theorists link depression to learned helplessness (Seligman, 1975, 1989), whereas social cognitive theorists point to distortions of thinking such as blowing negative events out of proportion and minimizing positive, good events (Beck, 1976, 1984). In the social cognitive view, depressed people continually have negative, self-defeating thoughts about themselves, which depress them further in a downward spiral of despair. Learned helplessness has been linked to an increase in such self-defeating thinking and depression in studies with people who have experienced uncontrollable, painful events (Abramson et al., 1978, 1980). This link does not necessarily mean that negative thoughts *cause* depression; it may be that depression increases the likelihood of negative thoughts (Gotlib et al., 2001). One study found that when comparing adolescents who were depressed to those who were not, the depressed group faced risk factors specifically associated with the social cognitive environment, such as being female or a member of an ethnic minority, living in poverty, regular use of drugs (including tobacco and alcohol), and engaging in delinquent behavior (Costello et al., 2008). In contrast, those in the nondepressed group of adolescents were more likely to come from two-parent households; had higher self-esteem; and felt connected to parents, peers, and school. Clearly, learned helplessness in the face of discrimination, prejudice, and poverty may be associated with depression in these adolescents. A recent study has also found that when therapists focus on helping clients to change their way of thinking, depression improves significantly when compared to therapy that focuses only on changing behavior; these results lend support to the cognitive explanation of distorted thinking as the source of depression (Strunk et al., 2010).

Biological explanations of disordered mood focus on the effects of brain chemicals such as serotonin, norepinephrine, and dopamine; drugs used to treat depression and



Depression may be caused by conflicts with others, learned reactions, illogical thought patterns, or brain dysfunction—or some combination of all of these factors.

mania typically affect the levels of these three neurotransmitters, either alone or in combination (Cohen, 1997; Cummings & Coffey, 1994; Ruhe et al., 2007).

Genes also play a part in these disorders. The fact that the more severe mood disorders are not a reaction to some outside source of stress or anxiety but rather seem to come from within the person's own body, together with the tendency of mood disorders to appear in genetically related individuals at a higher rate, suggests rather strongly that inheritance may play a significant part in these disorders (Barondes, 1998; Farmer, 1996). It is possible that some mood disorders share a common gene, but actual rates vary. For example, genetic risks are higher in bipolar disorder as compared to unipolar depression (Hyman & Cohen, 2013; McMahon et al., 2010). More than 65 percent of people with bipolar disorder have at least one close relative with either bipolar disorder or major depression (Craddock et al., 2005; National Institute of Mental Health Genetics Workgroup, 1998; Sullivan et al., 2000). Twin studies have shown that if one identical twin has either major depression or bipolar disorder, the chances that the other twin will also develop a mood disorder are about 40 to 70 percent (Muller-Oerlinghausen et al., 2002).

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 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP

- **anxiety, OCD, trauma and stress disorders**

most dominant symptom is excessive or unrealistic anxiety, or related to traumatic stress

- anxiety can be free-floating (nonspecific, anxious in general) or more specific, as in the case of phobias
- **panic disorder** consists of an individual having recurrent panic attacks that cause ongoing worry and concern
- **generalized anxiety disorder** involves excessive worry about lots of things and occurs more days than not
- **obsessive-compulsive disorder (OCD)** consists of recurring anxiety-provoking thoughts or obsessions that are only relieved through ritualistic or repetitive behaviors or mental events
- **acute stress disorder (ASD)**
- **posttraumatic stress disorder (PTSD)**
- causes
 - **behavioral:** anxious behavioral reactions are learned
 - **cognitive:** anxiety is result of illogical, irrational thought processes
 - **biological:** anxiety is due to dysfunction in several neurotransmitter systems (e.g., serotonin, GABA) and/or difference in brain activation; panic disorder is also hereditary
 - **cultural:** anxiety disorders found around the world but particular forms vary across cultures
- caused by significant and traumatic stressors; diagnosis differs according to duration and onset of symptoms, including dissociation, nightmares, and reliving the event.

- social anxiety disorder (social phobia)
- specific phobias (e.g., **claustrophobia, acrophobia**)
- **agoraphobia**

- **magnification**
- **all-or-none thinking**
- **overgeneralization**
- **minimization**

Disorders of Anxiety, Trauma, Stress, and Mood

- **mood disorders**

involve a disturbance in mood or emotion; can be mild or severe

- **major depressive disorder:** deeply depressed mood; most commonly diagnosed mood disorder, twice as common in women
- **bipolar disorders:** experience of mood from normal to manic, possibly with episodes of depression, or the experience of normal mood interrupted by episodes of depression and hypomania
- causes
 - **psychodynamic:** depression is repressed anger originally aimed at parents or other authority figures
 - **behavioral:** depression is linked to learned helplessness
 - **social cognitive:** distorted thinking and negative, self-defeating thoughts
 - **biological:** variation in neurotransmitter systems (e.g., serotonin, norepinephrine, dopamine) or specific brain activity; genes and heritability also play a part

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PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Who is most likely to be diagnosed with a phobic disorder?
 - a. Brianne, who is afraid of snakes after nearly being bitten while running
 - b. Calista, who is afraid of snakes after watching a documentary on poisonous snakes found in her region
 - c. Jennifer, who is morbidly afraid of snakes and refuses to even look a picture of a snake
 - d. Both Calista and Jennifer's behavior would qualify as a phobic disorder.
 2. Amelia has recently given birth to her first child. She mentions that she often goes into her baby's bedroom to check if he is still breathing. Would this qualify as an obsessive-compulsive disorder (OCD)?
 - a. If Amelia continues to carry out this behavior for more than one or two days, this would qualify as an OCD.
 - b. If Amelia and her husband both carry out this behavior, then it would qualify as an OCD.
 - c. If Amelia enjoys frequently checking to see that her baby is breathing, then this would qualify as an OCD.
 - d. As long as Amelia is not compelled to check on her baby and does not suffer from severe anxiety if she is unable to do so, then this is not an OCD.
 3. Sandy took part in the April 2013 Boston Marathon, where two bombs were detonated near the finish line killing three spectators. For approximately two weeks after the marathon, Sandy was unable to sleep or concentrate and often found herself reliving the moment she heard the bombs explode. What disorder might Sandy be diagnosed with?
- a. acute stress disorder
 - b. posttraumatic stress disorder
 - c. phobic disorder
 - d. panic disorder
4. Jorge finds himself feeling depressed most of the day. He is constantly tired yet he sleeps very little. He has feelings of worthlessness that have come on suddenly and seemingly have no basis in reality. What might Jorge be diagnosed with?
 - a. seasonal affective disorder
 - b. acute depressive disorder
 - c. major depressive disorder
 - d. bipolar disorder
 5. Studies have suggested the increased rates of major depressive disorder in women may have a basis in _____.
 - a. gender roles, social factors, and emotional processing.
 - b. hormonal differences.
 - c. biological differences.
 - d. heredity.
 6. What disorder seems to hold an association with bipolar disorder?
 - a. dysthymia
 - b. cyclothymia
 - c. phobic disorder
 - d. ADHD



This young model is not merely thin; by medical standards she is probably at a weight that would allow her to be labeled as having anorexia. The "thin is in" mentality that dominates the field of fashion design models is a major contributor to the Western cultural concept of very thin women as beautiful and desirable. The model pictured here is a far cry from the days of sex symbol Marilyn Monroe, who was rumored to be a size 12.

Eating Disorders

What are different types of eating disorders, how do they differ, and who are they most likely to affect?

There are a variety of disorders that relate to the intake of food, or in some cases non-nutritive substances, or in the elimination of bodily waste. These are found in the *DSM-5* under "Feeding and Eating Disorders." We will specifically examine three eating disorders: *anorexia nervosa*, *bulimia nervosa*, and *binge-eating disorder*.  Watch the [Video](#), [In the Real World: Eating Disorders](#), at [MyPsychLab](#)

ANOREXIA NERVOSA

Anorexia nervosa, often called **anorexia**, is a condition in which a person (typically young and female) reduces eating to the point that their body weight is significantly low, or less than minimally expected. For adults, this is likely a body mass index (BMI; weight in kilograms/height in meters²) less than 18.5 (American Psychiatric Association, 2013). Hormone secretion becomes abnormal, especially in the thyroid and adrenal glands. The heart muscles become weak and heart rhythms may alter. Other physical effects of anorexia may include diarrhea, loss of muscle tissue, loss of sleep, low blood pressure, and lack of menstruation in females.

Some individuals with anorexia will eat in front of others (whereas individuals with bulimia tend to binge eat as secretly as possible) but then force themselves to throw up or take large doses of laxatives. They are often obsessed with exercising and with food—cooking elaborate meals for others while eating nothing themselves. They have extremely distorted body images, seeing fat where others see only skin and bones.

What can be done to treat anorexia? If the weight loss due to anorexia is severe (40 percent or more below expected normal weight), dehydration, severe chemical imbalances, and possibly organ damage may result. Hospitalization should occur before this dangerous point is reached. In the hospital the individual's physical needs will be treated, even to the point of force-feeding in extreme cases. Psychological counseling will also be part of the hospital treatment, which may last from 2 to 4 months. Those individuals with anorexia who are not so severely malnourished as to be in immediate danger can be treated outside of the hospital setting. Psychological treatment strategies might include supportive clinical management, interpersonal therapy, cognitive-behavioral therapy, group therapy, or family-based therapy (Hay, 2013). [LINK](#) to Learning Objective 15.6. The prognosis for full recovery is not as hopeful as it should be; only 40 to 60 percent of all individuals with anorexia who receive treatment will make a recovery. For some individuals with anorexia who do gain weight, the damage already done to the heart and other body systems may still be so great that an early death is a possibility (Neumarker, 1997). Overall, the estimated mortality rate in anorexia is highest among all of the eating disorders, and much higher than any other psychological disorder (Arcelus et al., 2011).

BULIMIA NERVOSA

Bulimia nervosa, often called **bulimia**, is a condition in which a person develops a cycle of “binging,” or overeating enormous amounts of food at one sitting, and then using inappropriate methods for avoiding weight gain (American Psychiatric Association, 2013). Most individuals with bulimia engage in “purging” behaviors, such as deliberately vomiting after the binge or misuse of laxatives, but some may not, using other inappropriate methods to avoid weight gain such as fasting the day or two after the binge or engaging in excessive exercise (American Psychiatric Association, 2013). There are some similarities to anorexia: The victims are usually female, are obsessed with their appearance, diet excessively, and believe themselves to be fat even when they are quite obviously not fat. But individuals with bulimia are typically a little older than individuals with anorexia at the onset of the disorder—early 20s rather than early puberty. Individuals with bulimia often maintain a normal weight, making the disorder difficult to detect. The most obvious difference between the two conditions is that the individual with bulimia will eat, and eat to excess, binging on huge amounts of food—an average of 3,500 calories in a single binge and as much as 50,000 calories in one day (Humphries, 1987; Mitchell et al., 1981; Oster, 1987). A typical binge may include a gallon of ice cream, a package of cookies, and a gallon of milk—all consumed as quickly as possible.



 But wait a minute—if individuals with bulimia are so concerned about gaining weight, why do they binge at all?

The binge itself may be prompted by an anxious or depressed mood, social stressors, feelings about body weight or image, or intense hunger after attempts to diet. The binge continues due to a lack of, or impairment in, self-control once the binge begins. The individual is unable to control when to stop eating or how much to eat. Eating one cookie while trying to control weight can lead to a binge—after all, since the diet is completely blown, why not go all out? This kind of thought process is another example of the cognitive distortion of all-or-nothing thinking.

One might think that bulimia is not as damaging to the health as anorexia. After all, the individual with bulimia is in no danger of starving to death. But bulimia comes with many serious health consequences: severe tooth decay and erosion of the lining of the esophagus from the acidity of the vomiting, enlarged salivary glands, potassium, calcium, and sodium imbalances that can be very dangerous, damage to the intestinal tract from overuse of laxatives, heart problems, fatigue, and seizures (Berg, 1999).

Treatment of bulimia can involve many of the same measures taken to treat anorexia. In addition, the use of antidepressant medication can be helpful, especially those

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that affect serotonin levels such as the SSRIs (Mitchell et al., 2013). The prognosis for recovery of the individual with bulimia is somewhat more hopeful than that of anorexia. Therapist-led cognitive-behavioral therapy is the best empirically supported therapy and there is developing evidence for some guided self-help approaches (Hay, 2013). A cognitive therapist is very direct, forcing clients to see how their beliefs do not stand up when considered in “the light of day” and helping them form new, more constructive ways of thinking about themselves and their behavior.  [LINK](#) to Learning Objective 15.5.

BINGE-EATING DISORDER

Binge-eating disorder also involves uncontrolled binge eating but differs from bulimia primarily in that individuals with binge-eating disorder do not purge or use other inappropriate methods for avoiding weight gain (American Psychiatric Association, 2013). Treatment of binge-eating disorder may use some of the same strategies used for anorexia and bulimia, with the added issue of weight loss management in those with obesity.

CAUSES OF EATING DISORDERS

The causes of anorexia, bulimia, and binge-eating disorder are not yet fully understood, but the greatest risk factor appears to be someone being an adolescent or young adult female (Keel & Forney, 2013). Increased sensitivity to food and its reward value may play a role in bulimia and binge-eating disorder while fear and anxiety may become associated with food in anorexia nervosa, with altered activity or functioning of associated brain structures in each (Friedrich et al., 2013; Kaye et al., 2009; Kaye et al., 2013). Research continues to investigate genetic components for eating disorders, as they account for 40 to 60 percent of the risk for anorexia, bulimia, and binge-eating disorder, and although several genes have been implicated, the exact ones to focus on have not yet been identified (Trace et al., 2013; Wade et al., 2013).

CULTURE AND EATING DISORDERS

Although many researchers have believed eating disorders, especially anorexia, are cultural syndromes that only show up in cultures obsessed with being thin (as many Western cultures are), eating disorders are also found in non-Western cultures (Miller & Pumariega, 1999). What differs between Western and non-Western cultures is the rate at which such disorders appear. For example, Chinese and Chinese American women are far less likely to suffer from eating disorders than are non-Hispanic White women (Pan, 2000). Why wouldn't Chinese American women be more likely to have eating disorders after being exposed to the Western cultural obsession with thinness? Pan (2000) assumes that whatever Chinese cultural factors “protect” Chinese women from developing eating disorders may also still have a powerful influence on Chinese American women.

One problem with studying anorexia and bulimia in other cultures is that the behavior of starving oneself may be seen in other cultures as having an entirely different purpose than in Western cultures. One key component of anorexia, for example, is a fear of being fat, a fear that is missing in many other cultures. Yet women in those cultures have starved themselves for other socially recognized reasons: religious fasting or unusual ideas about nutrition (Castillo, 1997).

Anorexia and bulimia have also been thought to occur only rarely in African American women, but that characterization seems to be changing. Researchers are seeing an increase in anorexia and bulimia among young African American women of all socioeconomic levels (Crago et al., 1996; Mintz & Betz, 1998; Pumariega & Gustavson, 1994). If clinicians and doctors are not aware that these disorders can affect more than the typical White, young, middle-class to upper-middle-class woman, important signs and symptoms of eating disorders in non-White or non-Western people may allow these disorders to go untreated until it is too late.

Dissociative Disorders: Altered Identities

How do the various dissociative disorders differ, and how do they develop?

Dissociative disorders involve a break, or dissociation, in consciousness, memory, or a person's sense of identity. This "split" is easier to understand when thinking about how people sometimes drive somewhere and then wonder how they got there—they don't remember the trip at all. This sort of "automatic pilot" driving happens when the route is familiar and frequently traveled. One part of the conscious mind was thinking about work, school, or whatever was uppermost in the mind while lower centers of consciousness were driving the car, stopping at signs and lights, and turning when needed. This split in conscious attention is very similar to what happens in dissociative disorders. The difference is that in these disorders the dissociation is much more pronounced and involuntary.

DISSOCIATIVE AMNESIA AND FUGUE: WHO AM I AND HOW DID I GET HERE?

In *dissociative amnesia*, the individual cannot remember personal information such as one's own name or specific personal events—the kind of information contained in episodic long-term memory.  [LINK](#) to Learning Objective 6.5. Dissociative amnesia may sound like retrograde amnesia, but it differs in its cause. In retrograde amnesia, the memory loss is typically caused by a physical injury, such as a blow to the head. In dissociative amnesia, the cause is psychological rather than physical. The "blow" is a mental one, not a physical one. The reported memory loss is usually associated with a stressful or emotionally traumatic experience, such as rape or childhood abuse (Chu et al., 1999; Kirby et al., 1993), and cannot be easily explained by simple forgetfulness. It can be a loss of memory for only one small segment of time, or it can involve a total loss of one's past personal memories. For example, a soldier might be able to remember being in combat but cannot remember witnessing a friend get killed, or a person might forget his or her entire life. These memories usually resurface, sometimes quickly, and sometimes after a long delay. Dissociative amnesia can occur with or without *fugue*. The Latin word *fugere* means "flight" and is the word from which the term *fugue* is taken. A *dissociative fugue* occurs when a person suddenly travels away from home (the flight) and afterwards cannot remember the trip or even personal information such as identity. The individual may become confused about identity, sometimes even taking on a whole new identity in the new place (Nijenhuis, 2000). Such flights usually take place after an emotional trauma and are more common in times of disasters or war.

DISSOCIATIVE IDENTITY DISORDER: HOW MANY AM I?

Perhaps the most controversial dissociative disorder is **dissociative identity disorder (DID)**, formerly known as multiple personality disorder. In this disorder, a person seems to experience at least two or more distinct personalities existing in one body. There may be a "core" personality, who usually knows nothing about the other personalities and is the one who experiences "blackouts" or losses of memory and time. Fugues are common in dissociative identity disorder, with the core personality experiencing unsettling moments of "awakening" in an unfamiliar place or with people who call the person by another name (Kluft, 1984).

With the publication of several famous books and movies made from those books, dissociative identity disorder became well known to the public. Throughout the 1980s, psychological professionals began to diagnose this condition at an alarming

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rate—“multiple personality,” as it was then known, had become the “fad” disorder of the late twentieth century, according to some researchers (Aldridge-Morris, 1989; Boor, 1982; Cormier & Thelen, 1998; Showalter, 1997). In the last decade, the diagnosis of dissociative identity disorder has come under scrutiny, with many (but not all) professionals now doubting the validity of previous diagnoses.

CAUSES OF DISSOCIATIVE DISORDERS

Psychodynamic theory sees the repression of threatening or unacceptable thoughts and behavior as a defense mechanism at the heart of all disorders, and the dissociative disorders in particular seem to have a large element of repression—motivated forgetting—in them. In the psychodynamic view, loss of memory or disconnecting one’s awareness from a stressful or traumatic event is adaptive in that it reduces the emotional pain (Dorahy, 2001).

Cognitive and behavioral explanations for dissociative disorders are connected: The person may feel guilt, shame, or anxiety when thinking about disturbing experiences or thoughts and start to avoid thinking about them. This “thought avoidance” is negatively reinforced by the reduction of the anxiety and unpleasant feelings and eventually will become a habit of “not thinking about” these things. This is similar to what many people do when faced with something unpleasant, such as an injection or a painful procedure such as having a root canal. They “think about something else.” In doing that, they are deliberately not thinking about what is happening to them at the moment and the experience of pain is decreased. People with dissociative disorders may simply be better at doing this sort of “not thinking” than other people are.

Also, consider the positive reinforcement possibilities for a person with a dissociative disorder: attention from others and help from professionals. Shaping may also play a role in the development of some cases of dissociative identity disorder. The therapist may unintentionally pay more attention to a client who talks about “feeling like someone else,” which may encourage the client to report more such feelings and even elaborate on them.

There are some possible biological sources for dissociations, as well. Researchers have found that people with *depersonalization/derealization disorder* (a dissociative disorder in which people feel detached and disconnected from themselves, their bodies, and their surroundings) have lower brain activity in the areas responsible for their sense of body awareness than do people without the disorder (Simeon et al., 2000). Others have found evidence that people with dissociative identity disorders show significant differences in PET scan activity taken when different “personalities” are present (Reinders et al., 2001; Tsai et al., 1999). It is also possible individuals with DID may be more elaborative when forming memories and are better at memory recall as a result (García-Campayo et al., 2009).

Dissociative symptoms and features can also be found in other cultures. The trance-like state known as *amok* in which a person suddenly becomes highly agitated and violent (found in Southeast Asia and Pacific Island cultures) is usually associated with no memory for the period during which the “trance” lasts (Suryani & Jensen, 1993). But a study that reviewed historical literature throughout the centuries found no mention or tales of what would be labeled as dissociative amnesia in the stories or nonfiction writings of any culture prior to the 1800s (Pope et al., 2007). The authors concluded that dissociative amnesia may be more of a nineteenth-century cultural phenomenon than a neuropsychological one.

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 Explore the Concept at [MyPsychLab](#)

eating disorders

- **anorexia nervosa** is disordered eating that results in significantly low body weight
- **bulimia nervosa** involves cycles of binging and use of unhealthy methods to avoid weight gain; unlike anorexia, those with bulimia will tend to maintain a normal body weight
- **binge-eating disorder** involves binge-eating similar to bulimia but individuals do not purge afterwards; weight gain and related issues may result
- social influences on "thinness" and fear of being fat impacts prevalence rates across various cultures

CONCEPT MAP

typically female, obsessed with appearance, diet excessively, and have distorted body images; biological, psychological, and cultural factors are likely

Eating and Dissociative Disorders

dissociative disorders

involve a dissociation in consciousness, memory, or sense of identity, often associated with extreme stress or trauma

- **dissociative amnesia:** one cannot remember personal information; may involve a dissociative fugue in that the person takes a sudden trip and also cannot remember the trip
- **dissociative identity disorder:** person seems to experience at least two or more distinct personalities; validity of actual disorder has been topic of debate
- causes
 - **psychodynamic:** repressed thoughts and behavior is primary defense mechanism and reduces emotional pain
 - **cognitive and behavioral:** trauma-related thought avoidance is negatively reinforced by reduction in anxiety and emotional pain
 - **biological:** support for brain activity differences in body awareness has been found in individuals with depersonalization/derealization disorder

PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Olivia is a teenager who has been diagnosed with anorexia nervosa. What percentage of individuals with anorexia that receive treatment make a recovery?
 - a. 40 to 60 percent
 - b. 70 to 80 percent
 - c. 80 to 90 percent
 - d. approximately 95 percent
2. Which of the following characteristics best describes differences between bulimia nervosa and anorexia nervosa?
 - a. Individuals with anorexia do not have as severe health risks that individual with bulimia have.
 - b. Individuals with bulimia may have a normal body weight whereas those with anorexia tend to be severely under their expected body weight.
 - c. Individuals with anorexia have been known to binge like those with bulimia on occasion.
 - d. Anorexia tends to occur in early adulthood while bulimia often starts in early adolescence.
3. Researchers believe that 40 to 60 percent of the risk for anorexia, bulimia, and binge-eating disorder are due to
 - a. genetic factors
 - b. hormonal factors
 - c. environmental factors
 - d. psychological factors.
4. What is the major difference between dissociative amnesia and retrograde amnesia?
 - a. Retrograde amnesia patients often suffer from some form of physical brain trauma.
5. Individuals suffering from dissociative amnesia often have a history of memory loss that seems to be hereditary.
6. Those suffering from dissociative amnesia have prior damage to the brain, which in turn causes memory loss.
7. Retrograde amnesia patients often have suffered from painful psychological trauma.
8. Franklin wakes up on a cot in a homeless shelter in another town. He doesn't know where he is or how he got there, and he's confused when people say he has been calling himself Anthony. This is most likely an episode of dissociative
 - a. amnesia.
 - b. amnesia with fugue.
 - c. identity disorder.
 - d. multiple personality.
9. Dr. Cowden believes that Jamison's dissociation disorder may be due to his apparent enhanced ability to think about things other than those associated with his traumatic childhood. What psychological perspective is Dr. Cowden applying?
 - a. psychodynamic perspective
 - b. biological perspective
 - c. cognitive/behavioral perspective
 - d. evolutionary perspective

THINKING CRITICALLY:

How might the proliferation of various media and the Internet affect the development of eating disorders in cultures not previously impacted by them?

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Schizophrenia: Altered Reality

14.8 What are the main symptoms and causes of schizophrenia?

Once known as *dementia praecox*, a Latin-based term meaning “out of one’s mind before one’s time,” **schizophrenia** was renamed by Eugen Bleuler, a Swiss psychiatrist, to better illustrate the division (*schizo-*) within the brain (*phren*) among thoughts, feelings, and behavior that seems to take place in people with this disorder (Bleuler, 1911; Möller & Hell, 2002). Because the term literally means “split mind,” it has often been confused with dissociative identity disorder, which was at one time called “split personality.” A more modern definition of schizophrenia describes it as a long-lasting **psychotic** disorder (involving a severe break with reality), in which there is an inability to distinguish what is real from fantasy as well as disturbances in thinking, emotions, behavior, and perception. The disorder typically arises in the late teens or early twenties, affects both males and females, and is consistent across cultures.

SYMPTOMS

Schizophrenia includes several different kinds of symptoms. Disorders in thinking are a common symptom and are called **delusions**. Although delusions are not prominent in everyone with schizophrenia, they are the symptom that most people associate with this disorder. Delusions are false beliefs about the world that the person holds and that tend to remain fixed and unshakable even in the face of evidence that disproves the delusions. Common schizophrenic delusions include *delusions of persecution*, in which people believe that others are trying to hurt them in some way; *delusions of reference*, in which people believe that other people, television characters, and even books are specifically talking to them; *delusions of influence*, in which people believe that they are being controlled by external forces, such as the devil, aliens, or cosmic forces; and *delusions of grandeur* (or *grandiose delusions*), in which people are convinced that they are powerful people who can save the world or have a special mission (American Psychiatric Association, 2013).



Dr. John Nash is a famous mathematician who won the Nobel Prize for mathematics in 1994. His fame, however, is more due to the fact that Nash once suffered from a form of schizophrenia in which he experienced delusions of persecution. He at one time believed that aliens were trying to contact him through the newspaper (delusions of reference). His life story and remarkable recovery from schizophrenia are portrayed in the 2001 movie *A Beautiful Mind*, which starred Russell Crowe as Nash.

Watch the [Video](#), Schizophrenia: The Case of Georgina, at [MyPsychLab](#)

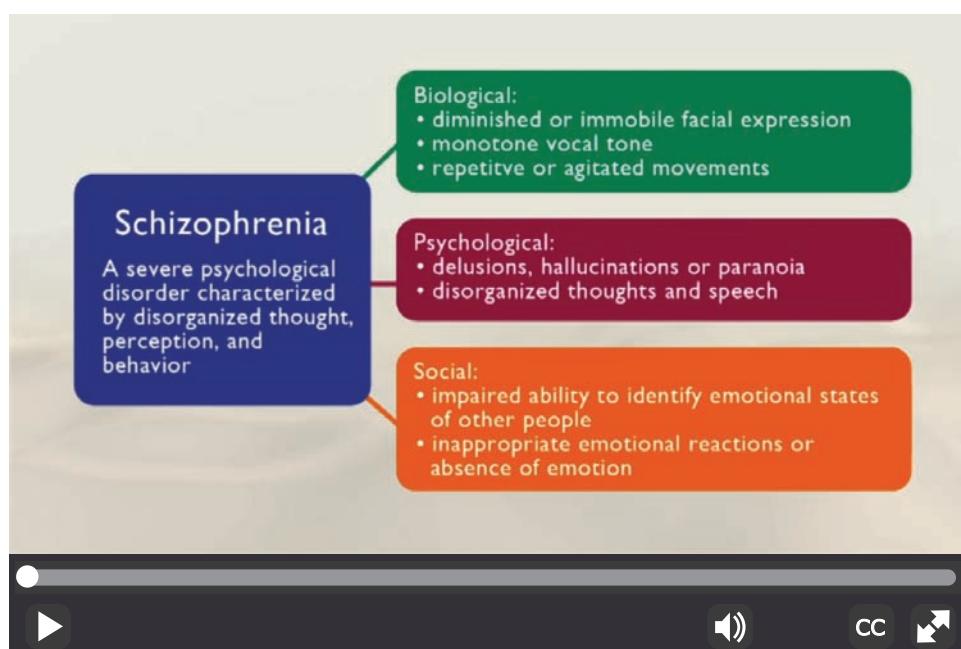
Delusional thinking alone is not enough to merit a diagnosis of schizophrenia, as other symptoms must be present (American Psychiatric Association, 2013). Speech

disturbances are common: People with schizophrenia will make up words, repeat words or sentences persistently, string words together on the basis of sounds (called *clang*ing, such as “come into house, louse, mouse, mouse and cheese, please, sneeze”), and experience sudden interruptions in speech or thought. Thoughts are significantly disturbed as well, with individuals with schizophrenia having a hard time linking their thoughts together in a logical fashion, and in advanced schizophrenia, may express themselves in a meaningless and jumbled mixture of words and phrases sometimes referred to as a *word salad*. Attention is

also a problem for many people with schizophrenia. They seem to have trouble “screening out” information and stimulation that they don’t really need, causing them to be unable to focus on information that is relevant (Asarnow et al., 1991; Luck & Gold, 2008).

People with schizophrenia may also have **hallucinations**, in which they hear voices or see things or people that are not really there. Hearing voices is actually more common and one of the key symptoms in making a diagnosis of schizophrenia (Kuhn & Nasar, 2001; Nasar, 1998). Hallucinations involving touch, smell, and taste are less common but also possible. Emotional disturbances are also a key feature of schizophrenia. **Flat affect** is a condition in which the person shows little or no emotion. Emotions can also be excessive and/or inappropriate—a person might laugh when it would be more appropriate to cry or show sorrow, for example. The person’s behavior may also become disorganized and extremely odd. The person may not respond to the outside world and either doesn’t move at all, maintaining often odd-looking postures for hours on end or moves about wildly in great agitation. Both extremes, either wildly excessive movement or total lack thereof are referred to as **catatonia**.

Another way of describing symptoms in schizophrenia is to group them by the way they relate to normal functioning. **Positive symptoms** appear to reflect an excess or distortion of normal functions, such as hallucinations and delusions. **Negative symptoms** appear to reflect a decrease of normal functions, such as poor attention or lack of affect (American Psychiatric Association, 2013). According to the American Psychiatric Association (2013), at least two or more of the following symptoms must be present frequently for at least 1 month to diagnose schizophrenia: delusions, hallucinations, disorganized speech, negative symptoms, and grossly disorganized or catatonic behavior, and at least one of the two symptoms has to be delusions, hallucinations, or disorganized speech. The video, *The Basics: Living with a Disorder: Schizophrenia*, summarizes the key biological, psychological, and social components of the disorder.



[Watch the Video](#), *The Basics: Living with a Disorder: Schizophrenia*, at [MyPsychLab](#)

CAUSES OF SCHIZOPHRENIA

When trying to explain the cause or causes of schizophrenia, biological models and theories prevail, as it appears to be most likely caused by a combination of genetic and environmental factors. This is captured by the neurodevelopmental model, or neurodevelopmental hypothesis, of schizophrenia (Rapoport et al., 2005; Rapoport et al., 2012). Biological explanations of schizophrenia have generated a significant amount of research pointing to genetic origins, prenatal influences such as the mother experiencing viral infections during

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Nathaniel Ayers, a homeless musician, is pictured in 2003 in front of the Midnight Mission shelter in Los Angeles, California. Mr. Ayers's life is the subject of the 2009 movie *The Soloist* starring Jamie Foxx. Mr. Ayers was a Julliard-trained musician who developed schizophrenia.

pregnancy, inflammation in the brain, chemical influences (dopamine, GABA, glutamate, and other neurotransmitters), and brain structural defects (frontal lobe defects, deterioration of neurons, and reduction in white matter integrity) as the causes of schizophrenia (Brown & Derkits, 2010; Cardno & Gottesman, 2000; Gottesman & Shields, 1982; Harrison, 1999; Kety et al., 1994; Nestor et al., 2008; Rijsdijk et al., 2011; Söderlund et al., 2009). Dopamine was first suspected when amphetamine users began to show schizophrenia-like psychotic symptoms. One of the side effects of amphetamine usage is to increase the release of dopamine in the brain. Drugs used to treat schizophrenia decrease the activity of dopamine in areas of the brain responsible for some of the positive symptoms. However, it is not that simple, the prefrontal cortex (an area of the brain involved in planning and organization of information) of people with schizophrenia has been shown to produce lower levels of dopamine than normal (Harrison, 1999), resulting in attention deficits (Luck & Gold, 2008) and poor organization of thought, negative symptoms of the disorder.

Further support for a biological explanation of schizophrenia comes from studies of the incidence of the disorder across different cultures. If schizophrenia were caused mainly by environmental factors, the expectation would be that rates of schizophrenia would vary widely from culture to culture. There is some variation for immigrants and children of immigrants, but about 7 to 8 individuals out of 1,000 will develop schizophrenia in their lifetime, regardless of the culture (Saha et al., 2005).

Family, twin, and adoption studies have provided strong evidence that genes are a major means of transmitting schizophrenia. The highest risk for developing schizophrenia if one has a blood relative with the disorder is faced by monozygotic (identical) twins, who share 100 percent of their genetic material, with a risk factor of about 50 percent (Cardno & Gottesman, 2000; Gottesman & Shields, 1976, 1982; Gottesman et al., 1987). Dizygotic twins, who share about 50 percent of their genetic material, have about a 17 percent risk, the same as a child with one parent with schizophrenia. As genetic relatedness decreases, so does the risk (see Figure 14.2). Twin studies are not perfect tools, however; identical twins share the same womb but are not necessarily exposed to the same exact prenatal or postnatal environments, causing some to urge caution in interpreting the 50 percent figure; and even twins reared apart are often raised in similar childhood environments (Davis et al., 1995).

Adoption studies also support the genetic basis of schizophrenia (Sullivan, 2005; Tienari et al., 2004). In one study, the biological and adoptive relatives of adoptees with schizophrenia were compared to a control group of adoptees without schizophrenia but from similar backgrounds and conditions (Kety et al., 1994). The adoptees with schizophrenia had relatives with schizophrenia but *only among their biological relatives*. When

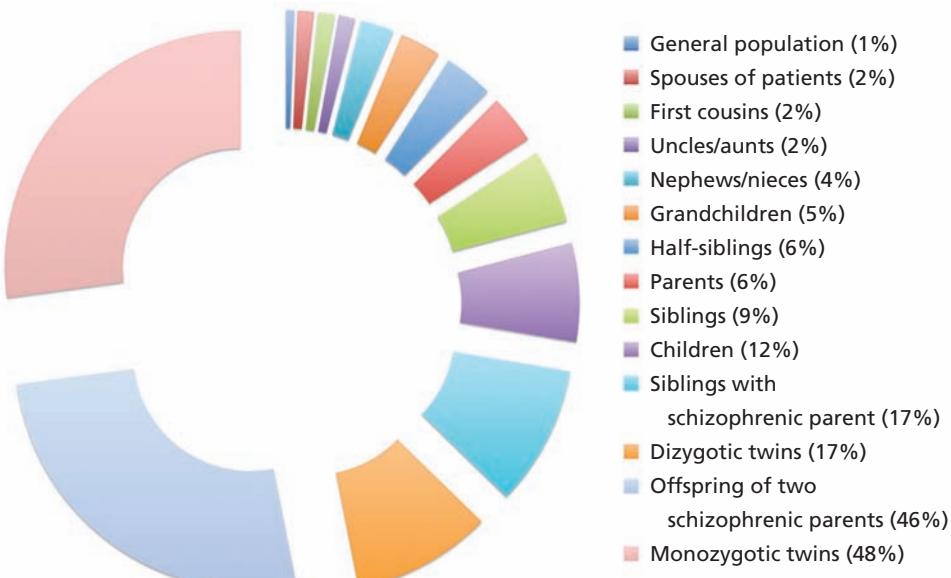


Figure 14.2 Genetics and Schizophrenia

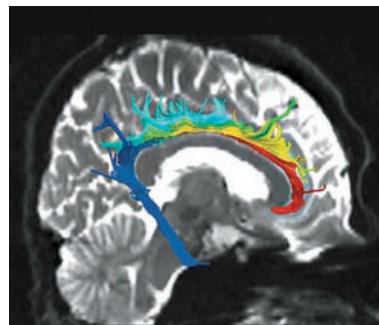
This chart shows a definite pattern: The greater the degree of genetic relatedness, the higher the risk of schizophrenia in individuals related to each other. The only individual to carry a risk even close to that of identical twins (who share 100 percent of their genes) is a person who is the child of two parents with schizophrenia. Based on Gottesman (1991).

the prevalence of schizophrenia was compared between the biological relatives of the adoptees with schizophrenia and the biological relatives of the control group, the rate of the disorder in the relatives of the group with schizophrenia was 10 times higher than in the control group (Kety et al., 1994).

 There's something I don't understand. If one identical twin has the gene and the disorder, shouldn't the other one always have it, too? Why is the rate only 50 percent?

If schizophrenia were entirely controlled by genes, identical twins would indeed both have the disorder at a risk of 100 percent, not merely 50 percent. Obviously, there is some influence of environment on the development of schizophrenia. One model that has been proposed is the **stress-vulnerability model**, which assumes that persons with the genetic "markers" for schizophrenia have a physical vulnerability to the disorder but will not develop schizophrenia unless they are exposed to environmental or emotional stress at critical times in development, such as puberty (Harrison, 1999; Weinberger, 1987). That would explain why only one twin out of a pair might develop the disorder when both carry the genetic markers for schizophrenia—the life stresses for the affected twin were different from those of the one who remained healthy. The immune system is activated during stress, and one recent study has found that in recent-onset schizophrenia (the early stages of the disorder) the brain's immune system secretes high levels of an inflammation-fighting substance, indicating a possible infection (Söderlund et al., 2009). This leads to the possibility that schizophrenia might one day be treatable with anti-inflammatory medications.

The development of brain-scanning techniques such as magnetic resonance imaging (MRI) and functional MRI (fMRI) has made studies of the structure as well as the functioning of the brains of those with schizophrenia possible. In one study, researchers using *diffusion tensor imaging* (DTI),  to Learning Objective 2.6, in addition to other neurological testing found that, when compared to healthy control participants, participants with schizophrenia showed structural differences in two particular areas of the brain (Nestor et al., 2008). Specifically, a white matter tract called the cingulum bundle (CB) that lies under the cingulate gyrus and links part of the limbic system, and another that links the frontal lobe to the temporal lobe, were found to have significantly less myelin coating on the axons of the neurons within the bundle. This makes these areas of the brain less efficient in sending neural messages to other cells, resulting in decreased memory and decision-making ability. The CB has been implicated in other studies of schizophrenia using DTI, which suggests that the less myelin and lower neural efficiency is partly responsible for attention problems in schizophrenia (Kubicki et al., 2009) and lower white matter integrity in areas of the frontal lobe might be associated with genetic predisposition to schizophrenia (Camchong et al., 2009). Measuring cortical thickness and tracking changes in the volume of gray matter and white matter is also providing valuable information about the abnormal patterns of brain development in schizophrenia and other disorders (Gogtay et al., 2008; Gogtay & Thompson, 2010; Goldman et al., 2009).



Nestor et al. (2008) used diffusion tensor imaging to investigate schizophrenia. Two of the brain areas examined were the cingulum bundle (CB, consisting of fibers underlying the cingulate gyrus linking parts of the limbic system) and the uncinate fasciculus (UF, neural fibers linking the frontal lobe to the temporal lobe). The cingulum bundle is depicted in the image above. For individuals with schizophrenia, both the CB and UF fiber pathways were found to have neurons with significantly less myelin, making them less efficient in information transfer, and resulting in decreased memory and decision-making ability. Image courtesy of Dr. Paul Nestor.

Personality Disorders: I'm Okay, It's Everyone Else Who's Weird

 How do various personality disorders differ, and what is thought to be the cause of personality disorders?

Personality disorders are a little different from other psychological disorders in that the disorder does not affect merely one aspect of the person's life, such as a higher than normal level of anxiety or a set of distorted beliefs, but instead affects the entire life

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adjustment of the person. The disorder is the personality itself, not one aspect of it. In personality disorder, a person has an excessively rigid, maladaptive pattern of behavior and ways of relating to others (American Psychiatric Association, 2013). This rigidity and the inability to adapt to social demands and life changes make it very difficult for the individual with a personality disorder to fit in with others or have relatively normal social relationships. The *DSM-5* lists ten primary types of personality disorder across three basic categories (American Psychiatric Association, 2013): those in which the people are seen as odd or eccentric by others (Paranoid, Schizoid, Schizotypal), those in which the behavior of the person is very dramatic, emotional, or erratic (Antisocial, Borderline, Histrionic, Narcissistic), and those in which the main emotion is anxiety or fearfulness (Avoidant, Dependent, Obsessive-Compulsive). These categories are labeled Cluster A, Cluster B, and Cluster C, respectively.

ANTISOCIAL PERSONALITY DISORDER

One of the most well researched of the personality disorders is **antisocial personality disorder (ASPD)**. People with ASPD are literally “against society.” The antisocial person may habitually break the law, disobey rules, tell lies, and use other people without worrying about their rights or feelings. The person with ASPD may be irritable or aggressive. These individuals may not keep promises or other obligations and are consistently irresponsible. They may also seem indifferent, or able to rationalize taking advantage of or hurting others. Typically they borrow money or belongings and don’t bother to repay the debt or return the items, they are impulsive, they don’t keep their commitments either socially or in their jobs, and they tend to be very selfish, self-centered, and manipulative. There is a definite gender difference in ASPD with many more males diagnosed with this disorder than females (American Psychiatric Association, 2013). The habitual disregard for both the law and rights of others may be confused with the terms *sociopath* or *psychopath*. Although some people with psychopathic personality may be diagnosed with ASPD, the majority of individuals with ASPD are not psychopathic.

BORDERLINE PERSONALITY DISORDER

People with **borderline personality disorder (BPD)** have relationships with other people that are intense and relatively unstable. They are impulsive, have an unstable sense of self, and are intensely fearful of abandonment. Life goals, career choices, friendships, and even sexual behavior may change quickly and dramatically. Close personal and romantic relationships are marked by extreme swings from idealization to demonization. Periods of depression are not unusual, and some may engage in excessive spending, drug abuse, or suicidal behavior (suicide attempts may be part of the manipulation used against others in a relationship). Emotions are often inappropriate and excessive, leading to confusion with *histrionic personality disorder*. What makes the individual with BPD different is the pattern of self-destructiveness, chronic loneliness, and disruptive anger in close relationships (American Psychiatric Association, 2013). The frequency of this disorder in women is nearly three times greater than in men (American Psychiatric Association, 2013).

CAUSES OF PERSONALITY DISORDERS

Cognitive-behavioral theorists talk about how specific behavior can be learned over time through the processes of reinforcement, shaping, and modeling. More cognitive explanations involve the belief systems formed by the personality disordered persons, such as the paranoia, extreme self-importance, and fear of being unable to cope by oneself of the paranoid, narcissistic, and dependent personalities, for example.

There is some evidence of genetic factors in personality disorders (Reichborn-Kjennerud, 2008). Close biological relatives of people with disorders such as antisocial, schizotypal, and borderline are more likely to have these disorders than those who are not related (American Psychiatric Association, 2013; Kendler et al., 2006; Reichborn-Kjennerud et al., 2007; Torgersen et al., 2008). Adoption studies of children whose

biological parents had antisocial personality disorder show an increased risk for that disorder in those children, even though raised in a different environment by different people (American Psychiatric Association, 2013). A longitudinal study has linked the temperaments of children at age 3 to antisocial tendencies in adulthood, finding that those children with lower fearfulness and inhibitions were more likely to show antisocial personality characteristics in a follow-up study at age 28 (Glenn et al., 2007).

Other causes of personality disorders have been suggested. Antisocial personalities are emotionally unresponsive to stressful or threatening situations when compared to others, which may be one reason that they are not afraid of getting caught (Arnett et al., 1997; Blair et al., 1995; Lykken, 1995). This unresponsiveness seems to be linked to lower than normal levels of stress hormones in antisocial persons (Fairchild et al., 2008; Lykken, 1995).

Disturbances in family relationships and communication have also been linked to personality disorders and, in particular, to antisocial personality disorder (Benjamin, 1996; Livesley, 1995). Childhood abuse, neglect, overly strict parenting, overprotective parenting, and parental rejection have all been put forth as possible causes, making the picture of the development of personality disorders a complicated one. It is safe to say that many of the same factors (genetics, social relationships, and parenting) that help to create ordinary personalities also create disordered personalities.

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 Explore the Concept at [MyPsychLab](#)

CONCEPT MAP

schizophrenia
psychotic disorder involving a break with reality and disturbances in thinking, emotions, behavior, and perceptions

- primary symptoms are often classified as positive (in excess or in addition to normal functions) or negative (absence or decrease in normal functions)

causes

- delusions:** false beliefs about the world (e.g., delusions of persecution, delusions of grandeur, delusions of reference)
- disturbed or disorganized thoughts:** often lacking structure or relevance, most often displayed through disorganized speech
- hallucinations:** can occur in any sensory modality but auditory hallucinations are most common
- changes in mood:** including flat affect (displaying little or no emotion)
- disorganized or odd behavior:** ranging from periods of immobility to odd gesturing or facial grimaces; wildly excessive movement or total lack thereof is called catatonia

Schizophrenia and Personality Disorders

personality disorders
involve excessively rigid and maladaptive patterns of behavior and ways of relating to others

- antisocial personality disorder:** minimal to no regard for value of others' rights or feelings; more common in men
- borderline personality disorder:** relationships with others that are intense and unstable; often moody, manipulative, and untrusting of others; more common in women

causes

- psychodynamic:** inadequate resolution of Oedipus complex
- cognitive-behavioral:** specific behaviors learned over time, associated with maladaptive belief systems
- genetic factors play a role, with many showing increased rates of heritability
- variances in stress tolerance and disturbances in family relationships and communication have also been linked to personality disorders

(continued)

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PRACTICE QUIZ How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. David believes that characters in a popular science fiction show are secretly sending him messages. This would be an example of a delusion of
 - a. persecution.
 - b. reference.
 - c. influence.
 - d. grandeur.
2. Dr. Haldol has several patients with schizophrenia who appear to exhibit excessive or distorted characteristics in relation to what one might consider normal functioning. Specific symptoms include varied hallucinations and multiple delusions. According to the *DSM-5*, these are referred to as
 - a. flat affect.
 - b. positive symptoms.
 - c. negative symptoms.
 - d. catatonia.
3. Which of the following is not an accurate portrayal of antisocial personality disorder?
 - a. Most people with this disorder are female.
 - b. Most people with this disorder are male.
 - c. People with this disorder suffer little or no guilt for their criminal acts.
 - d. People with this disorder are consistently irresponsible and don't keep commitments.
4. Studies show that _____ personality disorders occur more frequently in women while _____ personality disorders happen more often in men.
 - a. antisocial; borderline
 - b. borderline; schizotypal
 - c. schizotypal; antisocial
 - d. borderline; antisocial

Applying Psychology to Everyday Life: Taking the Worry Out of Exams

14.10 What are some ways to overcome test anxiety?

Imagine this scenario: You sit down to take your midterm exam, feeling that you are prepared and ready. Once you get the test in front of you, well, maybe you start to feel just a bit more nervous, your hands get sweaty, your stomach may ache; and when you look at the first question—your mind becomes a complete blank!

These are a few of the common symptoms of *test anxiety*, the personal experience of possible negative consequences or poor outcomes on an exam or evaluation, accompanied by a cluster of cognitive, affective, and behavioral symptoms (Zeidner & Matthews, 2005). Cognitive symptoms may consist of worrying excessively about an exam, expecting to do poorly no matter how hard you study, or even finding it hard to start studying in the first place. Then, while taking the test, you might find you do not understand certain directions or questions, “go blank” when looking at the items, or feel like you cannot concentrate on the exam in front of you because your mind keeps wandering. *Affective* or emotional symptoms may include body tension and heightened physiological arousal including sweaty palms, upset stomach, difficulty breathing, and the like, prior to and/or during the exam. *Behavioral* aspects may include procrastination, deficient study skills, or avoiding studying altogether.

While not yet recognized as a clinical disorder in the *DSM-5*, test anxiety has caused countless students considerable stress and agony over the years. Remember “psychology student’s syndrome”? You may not really have any of the psychological disorders we’ve discussed in this chapter, but chances are good that you *have* experienced test anxiety a time or two. One way to make the development of a true anxiety disorder less likely is to deal realistically with milder forms of anxiety *before* they escalate, and the main intent of this section is to help you achieve that.

So, what can you do if you experience test anxiety and want to get your worrying under control? First, determine why you want to do well on the test in the first place. Do you really want to demonstrate your understanding of the material or are you hoping just to pass? Try to find an internal motivation to do well on the exam rather than simply

relying on extrinsic reasons. Even if you are taking a test in a subject you don't necessarily enjoy, try to identify something you want to accomplish, and get your focus off the goal of simply earning a passing grade.

Second, develop some type of strategy for controlling both your cognitive state and behavior, before and during the exam. Review the study tips we presented in the Psychology in Action section of this book.  to Learning Objective PIA.5. As mentioned there, if you are well prepared, you are less likely to worry. Avoid cramming and take advantage of the additive effects of distributed practice. Refer back to that information and review suggestions that will help you manage your tasks and your time. Schedule regular study sessions and avoid or limit distractions (email, phone, text messages, television, noisy roommates, and the like may seem to provide welcome escapes from studying, but they will only keep you from your intended goal). You've read the chapter on Memory (or at least you should have!) and now know that spacing out your study and using meaningful, elaborative rehearsal over multiple study periods is going to yield much better results than an all-out cramming marathon the night before an exam.  to Learning Objective 6.4 and 6.10.

The way you approach an exam can have a significant impact on the testing experience and how you manage yourself during that exam (Davis et al., 2008). Instead of focusing on how nervous you are and how sure you are that you aren't going to be able to remember anything, turn that thinking around and recognize how much energy you have going into the exam (Dundas et al., 2009). Positive self-talk can be very valuable in this kind of situation (and is a good example of cognitive therapy at work). A recent study demonstrated that competence-priming (imagining a person who is successful at a related task) lowered the relationship between test anxiety and test performance (Lang & Lang, 2010). Additionally, instead of focusing on the whole exam, take control and address one question at a time, first answering the questions you know—that will build your confidence and help you progress through the test. Also control your body; try to stay relaxed and breathe normally. If you get distracted, consciously redirect yourself back to the next question. Before you know it, you will have completed the entire exam—whew!

Questions for Further Discussion:

1. Have you ever experienced test anxiety? What methods did you use to get your worrying under control?
2. What factors, other than the ones listed here, might influence the anxiety one feels when taking an exam?

Writing Prompt

- ▼ Why do most researchers consider schizophrenia a brain disorder? What evidence suggests that schizophrenia could begin in the womb?

Words: 0

Print

Feedback

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chapter summary

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What Is Abnormality?

14.1 How has mental illness been explained in the past and how is abnormal behavior and thinking defined today?

- Psychopathology is the study of abnormal behavior and psychological dysfunction.
- In ancient times holes were cut in an ill person's head to let out evil spirits in a process called trephining. Hippocrates believed that mental illness came from an imbalance in the body's four humors, whereas in the early Renaissance period the mentally ill were labeled as witches.
- Abnormality can be characterized as thinking or behavior that is statistically rare, deviant from social norms, causes subjective discomfort, does not allow day-to-day functioning, or causes a person to be dangerous to self or others.
- In the United States, *insanity* is a legal term, not a psychological term.

14.2 What are some of the models used to explain psychological disorders?

- In biological models of abnormality, the assumption is that mental illnesses are caused by chemical or structural malfunctions in the nervous system.
- Psychodynamic theorists assume that abnormal thinking and behavior stems from repressed conflicts and urges that are fighting to become conscious.
- Behaviorists see abnormal behavior or thinking as learned.
- Cognitive theorists see abnormal behavior as coming from irrational beliefs and illogical patterns of thought.
- The sociocultural perspective conceptualizes all thinking and behavior as the product of learning and shaping of behavior within the context of family, social group, and culture.
- Cultural relativity refers to the need to consider the norms and customs of another culture when diagnosing a person from that culture with a disorder.
- The biopsychosocial model views abnormal thinking and behavior as the sum result of biological, psychological, social, and cultural influences

Diagnosing and Classifying Disorders

14.3 What are the different types of psychological disorders, and how common are they?

- *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* is a manual of psychological disorders and their symptoms.
- Over one fifth of all adults over age 18 suffer from a mental disorder in any given year.

Disorders of Anxiety, Trauma, and Stress: What, Me Worry?

14.4 What are different types of anxiety disorders, obsessive-compulsive disorder, and stress-related disorders, and what are their symptoms and causes?

- Anxiety disorders are all disorders in which the most dominant symptom is excessive and unrealistic anxiety.
- Phobias are irrational, persistent fears. Three types of phobias are social anxiety disorder (social phobia), specific phobias, and agoraphobia.
- Panic disorder is the sudden and recurrent onset of intense panic for no reason, with all the physical symptoms that can occur in sympathetic nervous system arousal.
- Generalized anxiety disorder is a condition of intense and unrealistic anxiety that lasts 6 months or more.
- Obsessive-compulsive disorder consists of an obsessive, recurring thought that creates anxiety and a compulsive, ritualistic, and repetitive behavior or mental action that reduces that anxiety.
- Significant and traumatic stressors can lead to acute stress disorder or posttraumatic stress disorder. The diagnosis differs according to duration and onset but includes symptoms of anxiety, dissociation, nightmares, and reliving the event.
- Psychodynamic explanations of anxiety and related disorders point to repressed urges and desires that are trying to come into consciousness, creating anxiety that is controlled by the abnormal behavior.
- Behaviorists state that disordered behavior is learned through both operant conditioning and classical conditioning techniques.
- Cognitive psychologists believe that excessive anxiety comes from illogical, irrational thought processes.
- Biological explanations of anxiety-related disorders include chemical imbalances in the nervous system, in particular serotonin and GABA systems.
- Genetic transmission may be responsible for anxiety-related disorders among related persons.

Disorders of Mood: The Effect of Affect

14.5 What are different disorders of mood and their causes?

- Mood disorders, also called affective disorders, are severe disturbances in emotion.
- Major depressive disorder has a fairly sudden onset and is extreme sadness and despair, typically with no obvious external cause. It is the most common of the mood disorders and is more common in women than in men.

- Bipolar disorders are characterized by shifts in mood that may range from normal to manic, with or without episodes of depression (bipolar I disorder), or spans of normal mood interspersed with episodes of major depression and hypomania (bipolar II disorder).
- Learning theories link depression to learned helplessness.
- Cognitive theories see depression as the result of distorted, illogical thinking.
- Biological explanations of mood disorders look at the function of serotonin, norepinephrine, and dopamine systems in the brain.
- Mood disorders are more likely to appear in genetically related people, with higher rates of risk for closer genetic relatives.

Eating Disorders

14.6 What are different types of eating disorders, how do they differ, and who are they most likely to affect?

- Maladaptive eating problems include anorexia nervosa, bulimia nervosa, and binge-eating disorder.
- Genetics, increased sensitivity to the rewarding value of food, or food-related anxiety, altered brain function, and being female contribute to risk of being diagnosed with an eating disorder.

Dissociative Disorders: Altered Identities

14.7 How do the various dissociative disorders differ, and how do they develop?

- Dissociative disorders involve a break in consciousness, memory, or both. These disorders include dissociative amnesia, with or without fugue, and dissociative identity disorder.
- Psychodynamic explanations point to repression of memories, seeing dissociation as a defense mechanism against anxiety.
- Cognitive and behavioral explanations see dissociative disorders as a kind of avoidance learning.
- Biological explanations point to lower than normal activity levels in the areas responsible for body awareness in people with dissociative disorders.

Schizophrenia: Altered Reality

14.8 What are the main symptoms and causes of schizophrenia?

- Schizophrenia is a split between thoughts, emotions, and behavior. It is a long-lasting psychotic disorder in which reality and fantasy become confused.
- Symptoms of schizophrenia include delusions (false beliefs about the world), hallucinations, emotional disturbances, attentional difficulties, disturbed speech, and disordered thinking.

- Positive symptoms are excesses of behavior associated with increased dopamine activity in some parts of the brain, whereas negative symptoms are deficits in behavior associated with decreased dopamine activity in other parts of the brain.
- Biological explanations for schizophrenia focus on dopamine, structural defects in the brain, and genetic influences. Rates of risk of developing schizophrenia increase drastically as genetic relatedness increases, with the highest risk faced by an identical twin whose twin sibling has schizophrenia.

Personality Disorders: I'm Okay, It's Everyone Else Who's Weird

14.9 How do various personality disorders differ, and what is thought to be the cause of personality disorders?

- Personality disorders are extremely rigid, maladaptive patterns of behavior that prevent a person from normal social interactions and relationships.
- In antisocial personality disorder a person consistently violates the rights of others.
- In borderline personality disorder a person is clingy, moody, unstable in relationships, and suffers from problems with identity.
- Cognitive-learning theorists see personality disorders as a set of learned behavior that has become maladaptive—bad habits learned early on in life. Belief systems of the personality disordered person are seen as illogical.
- Biological relatives of people with personality disorders are more likely to develop similar disorders, supporting a genetic basis for such disorders.
- Biological explanations look at the lower than normal stress hormones in antisocial personality disordered persons as responsible for their low responsiveness to threatening stimuli.
- Other possible causes of personality disorders may include disturbances in family communications and relationships, childhood abuse, neglect, overly strict parenting, overprotective parenting, and parental rejection.

Applying Psychology to Everyday Life: Taking the Worry Out of Exams

14.10 What are some ways to overcome test anxiety?

- Test anxiety is the personal experience of possible negative consequences or poor outcomes on an exam or evaluation.
- Some ways to deal with test anxiety are to find an internal motivation, develop strategies for studying and controlling your emotional reactions, and focusing on the positive rather than the negative.

test YOURSELF

ANSWERS AVAILABLE IN ANSWER KEY.

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Pick the best answer.

1. What was the most likely reason that someone would perform an exorcism?
 - a. to relieve fluid pressure on the brain
 - b. to look into the brain to see what was wrong
 - c. to release evil spirits
 - d. to restore balance to the body's humors
2. In 1972, a jet carrying a rugby team from Peru crashed high in the snow-covered Andes Mountains. Many of the players survived for over 2 months by eating the remains of those who died. Psychologists justified their cannibalism because that was the only way they could have survived so long without food. By what definition might their behavior best be classified?
 - a. statistical
 - b. subjective discomfort
 - c. maladaptive
 - d. situational context
3. Which of the following is an example of cultural relativity?
 - a. Dr. Han believes that the voices his patient is hearing stem from a biological instead of a psychological cause.
 - b. While Dr. Howard believes that hypnosis is the best way to understand all disorders, his approach is not shared by his colleagues.
 - c. While Dr. Akido knows that his patient, Aki, believes her anxiety has a biological explanation, in learning more about her family of origin, he suspects it has a psychological cause.
 - d. Dr. Roland uses a behavioral approach to treat all his clients who are younger than age 10.
4. How many axes does the *DSM-5* use to aid mental health professionals in making a diagnosis?
 - a. one
 - b. two
 - c. four
 - d. five
5. Trypanophobia, also known as a fear of receiving an injection, is an example of
 - a. obsession.
 - b. social phobia.
 - c. anxiety attack.
 - d. specific phobia.
6. Aaron hates to go to restaurants for fear that he will be seated in the far back of the restaurant and be unable to get out in case of an emergency. This may be a symptom of
 - a. social phobia.
 - b. specific phobia.
 - c. agoraphobia.
 - d. claustrophobia.
7. Ria experienced a sudden attack of intense fear when she was boarding a plane with her friends to fly to Mexico for spring break. Ria's heart raced, she became dizzy, and she was certain she would die in a plane crash if she boarded the plane. Subsequently she did not go on her trip, and the plane arrived safely in Mexico 3 hours later. Ria experienced
 - a. a depressive episode.
 - b. a panic attack.
 - c. panic disorder.
 - d. agoraphobia.
8. Dr. Kirby has been meeting with 9-year-old Loren, whose family lost everything in a tornado. In her initial visit, Loren was diagnosed with acute stress disorder. During a 2-month follow-up with Dr. Kirby, Loren is still exhibiting many of the same symptoms. What should Dr. Kirby do?
 - a. Dr. Kirby will revise Loren's diagnosis from ASD to posttraumatic stress disorder.
 - b. Dr. Kirby will revise Loren's diagnosis from ASD to generalized anxiety disorder.
 - c. Dr. Kirby will continue treatment for acute stress disorder for at least 6 months.
 - d. Dr. Kirby should tell Loren she is cured so as to speed her recovery.
9. Survivors of natural disasters like Hurricane Sandy in 2012 may experience higher incidences of
 - a. depression.
 - b. posttraumatic stress disorder.
 - c. anxiety disorders.
 - d. schizophrenia.
10. Calvin is terribly worried that his college education was wasted when he didn't get his dream job. Furthermore, Calvin believes he ruined his future when he did poorly in his job interview. Calvin explains, "I had to ace the interview. It had to be perfect, and it wasn't!" How might a cognitive-behavioral psychologist classify this distorted thought process?
 - a. magnification
 - b. overgeneralization
 - c. all-or-nothing thinking
 - d. minimization
11. Which type of depression is the most common type of mood disorder?
 - a. bipolar disorder
 - b. mania
 - c. seasonal affective disorder
 - d. major depressive disorder
12. Behavioral theorists link depression to _____, whereas social cognitive theorists point to _____.
 - a. distortions in thinking; learned helplessness
 - b. biological abnormalities; distortions in thinking
 - c. unconscious forces; learned helplessness
 - d. learned helplessness; distortions in thinking
13. Individuals with bulimia often rationalize that since they have had a single treat, their diet is ruined and therefore they might as well go ahead and eat excessively. Such irrational thinking is an example of the cognitive distortion known as
 - a. overgeneralization.
 - b. all or nothing thinking.
 - c. magnification.
 - d. minimization.
14. Binge-eating disorder is different from bulimia in that individuals with binge-eating disorder
 - a. typically eat much smaller portions before purging the food.
 - b. do not typically purge the food they eat.
 - c. only purge their food after several binge sessions.
 - d. often resort to anorexic methods to rid themselves of the food they have eaten.

15. Dissociative amnesia is different from retrograde amnesia because
- dissociative amnesia is typically psychological in origin.
 - retrograde amnesia has been shown to not actually exist.
 - dissociative amnesia is caused by a physical blow to the head.
 - retrograde amnesia is caused by psychological trauma.
16. Depersonalization/derealization disorder is a type of dissociative disorder that has been found to have possible _____ foundations for the experience of detachment.
- biological
 - psychodynamic
 - behavioral
 - cognitive
17. On your first call as a paramedic, you enter the house of a man who has covered his walls and ceiling in aluminum foil to protect his brain from the thought-controlling rays of the government. This is an example of a _____ delusion.
- persecution
 - reference
 - influence
 - grandeur
18. Rodney has been diagnosed with schizophrenia. He rarely smiles and often shows little emotion to any situation. Psychologists refer to this characteristic as
- catatonia.
 - flat affect.
 - positive symptoms.
 - negative symptoms.
19. What neurotransmitter was first believed to be the cause of schizophrenia?
- GABA
 - serotonin
 - epinephrine
 - dopamine
20. Colleen found herself attracted to her psychology instructor. She would frequently go by his office just to be near him. When he didn't respond to her advances, Colleen eventually told him that she had thoughts of killing herself so that he would spend time trying to counsel her. What personality disorder best describes Colleen's thinking and behavior?
- borderline personality disorder
 - schizoid personality disorder
 - schizotypal personality disorder
 - antisocial personality disorder

15

psychological therapies

A set of films were made in the mid-1960s, "Three Approaches to Psychotherapy," that focused on three pioneering therapists working with a single client, "Gloria." Often referred to as the "Gloria tapes" or "Gloria films," this collection provided many students of psychology and professionals in training, their first look into what actually may occur during a therapy session.

Each of the therapists worked with Gloria to address concerns she was experiencing as a recently divorced mother. In doing so, each demonstrated aspects of their respective techniques and theories. The therapists were none other than Carl Rogers demonstrating his *person-centered therapy*, Fritz Perls demonstrating his *Gestalt therapy*, and Albert Ellis demonstrating his *rational therapy* or *rational emotive therapy* (later developed into *rational emotive behavior therapy*).

The field of psychology has grown a great deal since the Gloria films were made, and potential clients now have many more sources of information available to them regarding therapy options.

What information might be most useful for someone interested in pursuing a particular therapy or treatment for a psychological disorder?

Watch the Video at [MyPsychLab.com](#)

Why study therapies for psychological disorders?

There are almost as many therapy methods as there are disorders. Correctly matching the type of therapy to the disorder can mean the difference between a cure or a crisis. It is important to know the choices available for treatment and how they relate to the different kinds of disorders so that an informed decision can be made and the best possible outcome can be achieved for mental health and wellness.

Learning objectives

15.1

How have psychological disorders been treated throughout history, and what are two modern ways they are treated today?

15.2

What were the basic elements of Freud's psychoanalysis, and how do psychodynamic approaches differ today?

15.3

What are the basic elements of the humanistic therapies known as person-centered therapy and Gestalt therapy?

15.4

How do behavior therapists use classical and operant conditioning to treat disordered behavior, and how successful are these therapies?

15.5

What are the goals and basic elements of cognitive therapies such as cognitive-behavioral therapy and rational emotive behavior therapy?

15.6

What are the various types of group therapies and the advantages and disadvantages of group therapy?

15.7

How effective is psychotherapy, and what factors influence its effectiveness?

15.8

What are the various types of drugs used to treat psychological disorders?

15.9

How are electroconvulsive therapy and psychosurgery used to treat psychological disorders today?

15.10

How might computers be used in psychotherapy?



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Treatment of Psychological Disorders: Past to Present

How have psychological disorders been treated throughout history, and what are two modern ways they are treated today?

As discussed in Chapter Fourteen, although psychological or social causes might have been identified for some disorders, until the late 1700s, people suffering severe mental illnesses were sometimes thought to be possessed by demons or evil spirits, and the “treatments” to rid the person of these spirits were severe and deadly. Even within the last 200 years, a period of supposedly more “enlightened” awareness, the mentally ill did not always receive humane* treatment Watch the Video, Thinking Like a Psychologist: Assessing Treatment Effectiveness: History of Treatments, at [MyPsychLab](#).

EARLY TREATMENT OF THE MENTALLY ILL

I've seen movies about mental hospitals, and they didn't look like great places to be in even now—how bad was it back then? What did people do with relatives who were ill that way?

The first truly organized effort to do something with mentally ill persons began in England in the middle of the sixteenth century. Bethlehem Hospital in London (later known as “Bedlam”) was converted into an asylum (a word meaning “place of safety”) for the mentally ill. In reality, the first asylums were little more than prisons where the mentally ill were chained to their beds. “Treatments” consisted of bloodletting (which more often than not led to death or the need for lifelong care for the patient), beatings, ice baths in which the person was submerged until passing out or suffering a seizure, and induced vomiting in a kind of spiritual cleansing (Hunt, 1993). This cleansing or purging was meant to rid the body of physical impurities so that the person's mind and soul could function more perfectly.

It was not until 1793 that efforts were made to treat the mentally ill with kindness and guidance—known as “moral treatment”—rather than beating them or subjecting them to the harsh physical purging that had been commonplace. It was at this time that Philippe Pinel personally unchained the inmates at La Bicêtre Asylum in Paris, France, beginning the movement of humane treatment of the mentally ill (Brigham, 1844; Curtis, 1993).

CURRENT TREATMENTS: TWO KINDS OF THERAPY

Today, we can group the primary approaches to **therapy** (treatment methods aimed at making people feel better and function more effectively) into two broad categories. One category is based primarily in psychological theory and techniques; people tell the therapist about their problems, and the therapist listens and tries to help them understand those problems or assists them in changing the behaviors related to the problem. The other category uses medical interventions to bring the symptoms under control. Although we can separate treatments into these two larger categories, in actual practice, many effective treatment strategies or treatment plans combine facets of both. Just as there is no one single “cause” of a disorder (Maxmen et al., 2009), different psychological treatments are often used in tandem or combined with biomedical interventions. Furthermore, many psychology professionals do not limit themselves to a single technique and are **eclectic**, using more than one treatment approach or technique to best meet the needs of the people they are working with. The fields of clinical psychology and counseling psychology are diverse, and professionals have a wide variety of educational and training experiences. LINK to Learning Objective B.5. Before we discuss the various types of therapy in more detail, take a moment to evaluate your own views and experiences with therapy in the experiment, *How Do You Take Care of Your Mental Health?*

*humane: marked by compassion, sympathy, or consideration for humans (and animals).



In this famous painting by French artist Robert Fleury, French psychiatrist Dr. Philippe Pinel orders the chains removed from patients at a Paris asylum for insane women. Pinel was one of the first psychiatrists to recommend humane treatment of the mentally ill.

Simulation

How Do You Take Care of Your Mental Health?

This survey asks you about your attitudes towards and experiences with taking care of your mental health.

[Go to the Experiment ▶](#)

Thinking of your overall experiences with psychological therapy or counseling, please indicate the extent of your agreement with the statement below. (Mark N/A if you have never participated in therapy/counseling).

Therapy helped me learn more effective ways of interacting with others.

- Strongly Disagree
- Moderately Disagree
- Neither Agree nor Disagree
- Moderately Agree
- Strongly Agree
- N/A

Simulate the Experiment, *How Do You Take Care of Your Mental Health?*, on [MyPsychLab](#)

PSYCHOTHERAPY **Psychotherapy** typically involves an individual, couple, or small group of individuals working directly with a therapist and discussing their concerns or problems. The goal of most psychotherapy is to help both mentally healthy and psychologically disordered persons understand themselves better (Goin, 2005; Wolberg, 1977). Because understanding of one's motives and actions is called *insight*, therapies aimed mainly at this goal are called **insight therapies**. A therapy that is directed more at changing behavior than providing insights into the reasons for that behavior is called **action therapy**. Many psychological professionals use a combination of insight and action therapeutic* methods.

BIOMEDICAL THERAPY The other main type of therapy uses some biological treatment in the form of a medical procedure to bring about changes in the person's disordered behavior. **Biomedical therapies** include the use of drugs, surgical methods, electric shock treatments, and noninvasive stimulation techniques. It is important to understand that biomedical therapy often eliminates or alleviates the symptoms of a disorder, while psychotherapy addresses issues associated with the disorder, and when used together, these two types of therapy facilitate** each other (Maxmen et al., 2009). For example, when medications are needed, individuals taking the proper medications are going to benefit more from psychotherapy, as their symptoms will be better controlled. Furthermore, psychotherapy, not medication, is going to help them better understand what the symptoms of their disorder are and facilitate adjustment, other coping strategies, and proactive ways of addressing the disorder or its related outcomes (Maxmen et al., 2009).

Psychotherapy Begins

What were the basic elements of Freud's psychoanalysis, and how do psychodynamic approaches differ today?



So what exactly happens in psychoanalysis? I've heard lots of stories about it, but what's it really like?

In a sense, Freud took the sixteenth-century method of physical cleansing to a different level. Instead of a physical purge, cleansing for Freud meant removing all the "impurities"

*therapeutic: providing or assisting in a cure.

**facilitate: to assist, make possible, or make easier.

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"Why do you think you cross the road?"

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of the unconscious mind that he believed were responsible for his patients' psychological and nervous disorders. (Freud was a medical doctor and referred to the people who came to him for help as "patients.") The impurities of the unconscious mind were considered to be disturbing thoughts, socially unacceptable desires, and immoral urges that originated in the id, the part of the personality that is itself unconscious and driven by basic needs for survival and pleasure. [LINK](#) to Learning Objective 13.2.

PSYCHOANALYSIS

Freud believed that his patients used these unconscious thoughts to prevent anxiety, and as such, the thoughts would not be easily brought into conscious awareness. Freud designed a therapy technique to help his patients feel more relaxed, open, and able to explore their innermost feelings without fear of embarrassment or rejection. This method was called **psychoanalysis**, and it is an insight therapy that emphasizes revealing the unconscious conflicts, urges, and desires that are assumed to cause disordered emotions and behavior (Freud, 1904; Mitchell & Black, 1996). This is the original reason for the couch in Freud's version of psychoanalysis; people lying on the couch were more relaxed and would, Freud thought, feel more dependent and childlike, making it easier for them to "get at" those early childhood memories. An additional plus was that he could sit behind the patients at the head of the couch and take notes. Without the patients being able to see his reactions to what they said, they remained unaffected by his reactions.

Freud also made use of two techniques to try to reveal the repressed information in his patients' unconscious minds. These techniques were the interpretation of dreams and allowing patients to talk freely about anything that came to mind.

DREAM INTERPRETATION *Dream interpretation*, or the analysis of the elements within a patient's reported dream, formed a large part of Freud's psychoanalytic method. [LINK](#) to Learning Objective 4.5. Freud believed that repressed material often surfaced in dreams, although in symbolic form. The *manifest content* of the dream was the actual dream and its events, but the **latent content** was the hidden, symbolic meaning of those events that would, if correctly interpreted, reveal the unconscious conflicts that were creating the nervous disorder (Freud, 1900).

FREE ASSOCIATION The other technique for revealing the unconscious mind was a method originally devised by Freud's coworker, Josef Breuer (Breuer & Freud, 1895). Breuer encouraged his patients to freely say whatever came into their minds without fear of being negatively evaluated or condemned. As the patients talked, they began to reveal things that were loosely associated with their flow of ideas, often revealing what Breuer felt were hidden, unconscious concerns. Freud adopted this method of **free association**, believing that repressed impulses and other material were trying to "break free" into consciousness and would eventually surface using this technique.

RESISTANCE AND TRANSFERENCE Other components of Freud's original psychoanalytic method were **resistance** (the point at which the patient becomes unwilling to talk about certain topics) and **transference** (when the therapist becomes a symbol of a parental authority figure from the past). Therapists can also experience *countertransference*, in which the therapist has a transference reaction to the patient. This reaction might not always be to the benefit of the patient. As in all of the therapeutic approaches, peer and professional supervision helps therapists recognize potential issues in providing effective therapy.

EVALUATION OF PSYCHOANALYSIS AND PSYCHODYNAMIC APPROACHES

Freud's original theory, on which he based his interpretations of his patients' revelations, has been criticized as having several flaws, which were discussed in Chapter Thirteen. These included the lack of scientific research to support his claims, his unwillingness to believe some of the things revealed by his patients when those revelations did not fit into his view of the world, and his almost obsessive need to assume that problems with sex and sexuality were at the heart of nearly every nervous disorder.

Few psychoanalysts today still use Freud's original methods, which could take years to produce results. The couch is gone, and the *client* (a term used to support the active role of the person seeking help and to avoid implying "sickness," as might result when using the term *patient*) may sit face-to-face with the therapist. The client may also stand or walk about. Rather than remaining quiet until the client says something revealing, the modern psychoanalyst is far more **directive**, asking questions, suggesting helpful behavior, and giving opinions and interpretations earlier in the relationship, which helps speed up the therapeutic process. Today's psychoanalysts also focus less on the id as the motivator of behavior, instead looking more at the ego or sense of self as the motivating force behind all actions (Prochaska & Norcross, 2003). Some psychoanalysts also focus on the process of transference more than on other typical aspects of traditional psychoanalysis, leading to the more general method called **psychodynamic therapy**. Psychodynamic therapy is typically shorter in duration than traditional psychoanalysis.

 [Watch the Video, *The Basics: Therapies in Action: Psychoanalysis*, at MyPsychLab](#)

Even so, all of the psychodynamic techniques require the client to be fairly intelligent and verbally able to express his or her ideas, feelings, and thoughts effectively. People who are extremely withdrawn or who suffer from the more severe psychotic disorders are not good candidates for this form of psychotherapy. People who have nonpsychotic adjustment disorders, such as anxiety, somatoform, or dissociative disorders, are more likely to benefit from psychodynamic therapy.

INTERPERSONAL PSYCHOTHERAPY

Interpersonal psychotherapy (IPT) is a psychotherapy developed to address depression. It is an insight therapy focusing on relationships of the individual with others and the interplay between mood and the events of everyday life (Bleiberg & Markowitz, 2008). It is based on the interpersonal theories of Adolph Meyer and Harry Stack Sullivan along with the attachment theory of John Bowlby, and focuses on interpersonal relationships and functioning (Bleiberg & Markowitz, 2008). It is one of the few theories derived from psychodynamic thinking that does have some research support for its effectiveness in treating depression, particularly when combined with medication (Mufson et al., 2004; Reynolds et al., 1999). Despite its origins, IPT is not considered to be a psychodynamic therapy as it combines aspects of humanistic and cognitive-behavioral therapies, making it truly eclectic.

Humanistic Therapy: To Err Is Human

What are the basic elements of the humanistic therapies known as person-centered therapy and Gestalt therapy?

Unlike psychodynamic therapists, humanistic theorists do not focus on unconscious, hidden conflicts. Instead, humanists focus on conscious, subjective experiences of emotion and people's sense of self, as well as the more immediate experiences in their daily



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lives rather than early childhood experiences of the distant past (Cain & Seeman, 2001; Rowan, 2001; Schneider et al., 2001).  [Learning Objective 1.4](#). Humanistic therapy emphasizes the importance of the choices made by individuals and the potential to change one's behavior. The two most common therapy styles based on humanistic theory are Carl Rogers's person-centered therapy and Fritz Perls's Gestalt therapy; both are primarily insight therapies.

TELL ME MORE: ROGERS'S PERSON-CENTERED THERAPY

Chapter Thirteen discussed the basic elements of Rogers's theory of personality, which emphasizes the sense of self (Rogers, 1961). To sum it up quickly, Rogers proposed that everyone has a *real self* (how people see their actual traits and abilities) and an *ideal self* (how people think they should be). The closer the real and ideal selves match up, the happier and more well adjusted the person. To have these two self-concepts match, people need to receive *unconditional positive regard*, which is love, warmth, respect, and affection without any conditions attached. If people think that there are conditions put on the love and affection they receive, their ideal selves will be determined by those conditions and become more difficult to achieve, resulting in a mismatch of selves and unhappiness.



 So the key to getting over unhappiness would be to get the real and ideal selves closer together? How does a therapist do that?

Rogers believed that the goal of the therapist should be to provide the unconditional positive regard that has been absent from the troubled person's life and to help the person recognize the discrepancies between the real and ideal selves. He also believed that the person would actually have to do most of the work, talking out problems and concerns in an atmosphere of warmth and acceptance from the therapist, so he originally called the people in this therapy relationship "clients" instead of "patients," to put the therapeutic relationship on a more equal footing. As a result, Rogers's therapy is very **nondirective** because the person actually does all the real work, with the therapist merely acting as a sounding board. However, therapists may help individuals redirect or reallocate their attention to focus on feelings not fully processed previously (Prochaska & Norcross, 2009). Later, the term *client* was changed to the even more neutral term *person*. His therapy is now called **person-centered therapy** because the person is truly the center of the process.

 [Watch the Video, The Basics: Therapies in Action: Humanistic Therapy, at MyPsychLab.](#)

BASIC ELEMENTS Rogers (1961) saw three key elements as being necessary in any successful person–therapist relationship.

Authenticity The therapist must show **authenticity** in a genuine, open, and honest response to the individual. It is easier for some professionals to "hide" behind the role of the therapist, as was often the case in psychoanalysis. In person-centered therapy, the therapist has to be able to tolerate a person's differences without being judgmental.

Unconditional Positive Regard Another key element of person-centered therapy is the warm, accepting, completely uncritical atmosphere that the therapist must create for the people they work with. Having respect for an individual and their feelings, values, and goals, even if they are different from those of the therapist, is called **unconditional positive regard**.

Empathy Lastly, the therapist needs to be able to see the world through the eyes of the person they are working with. The therapist has to be able to acknowledge what people are feeling and experiencing by using a kind of understanding called **empathy**. This involves listening carefully and closely to what individuals are saying and trying to feel what they feel. Therapists must also avoid getting their own feelings mixed up



A Rogerian person-centered therapist listens with calm acceptance to anything the client says. A sense of empathy with the client's feelings is also important.

with their clients' feelings (e.g., countertransference).  **Watch the Video**, *Classic Footage of Carl Rogers on the Role of a Therapist*, at **MyPsychLab**.

A person-centered therapist typically responds in a way that seeks clarification and demonstrates attempts to understand the experience of the individual. **Reflection** refers to a technique therapists use to allow clients to continue to talk and have insights without the interference of the therapist's interpretations and possible biases. Reflection is literally a kind of mirroring of clients' statements. Here's an example from one of Rogers's own therapy sessions with a client (Meador & Rogers, 1984, p. 143):

CLIENT: I just ain't no good to nobody, never was, and never will be.

ROGERS: Feeling that now, hm? That you're just no good to yourself, no good to anybody. Never will be any good to anybody. Just that you're completely worthless, huh?—Those really are lousy feelings. Just feel that you're no good at all, hm?

CLIENT: Yeah.

MOTIVATIONAL INTERVIEWING A variation of person-centered therapy is *motivational interviewing*, or MI (Miller & Rollnick, 2002), which has been described by Hal Arkowitz and William R. Miller as "client-centered therapy with a twist" (p. 4). In contrast to person-centered, MI has specific goals, to reduce ambivalence about change and to increase intrinsic motivation to bring that change about (Arkowitz & Miller, 2008). For a therapist, the four principles of MI are express empathy, develop discrepancy between the client's present behaviors and values, roll with resistance, and support the client's self-efficacy (Miller & Rollnick, 2002). Beyond assisting the individual with self-understanding, MI incorporates therapist goals and specific strategies for helping the individual achieve self-directed behavior change (Prochaska & Norcross, 2009). Although it was originally developed and validated as effective for addictive disorders, it has also been useful in the treatment of anxiety and mood disorders (Arkowitz & Miller, 2008; Barlow et al., 2013).

GESTALT THERAPY

Another therapy based on humanistic ideas is called **Gestalt therapy**. The founder of this therapeutic method is Fritz Perls, who believed that people's problems often stemmed from hiding important parts of their feelings from themselves. If some part of a person's personality, for example, is in conflict with what society says is acceptable, the person might hide that aspect behind a false "mask" of socially acceptable behavior. As happens in Rogers's theory when the real and ideal selves do not match, in Gestalt theory the person experiences unhappiness and maladjustment when the inner self does not match the mask (Perls, 1951, 1969).

 That sounds pretty much like the same thing, only with slightly different words. How is Gestalt therapy different from person-centered therapy?

The two therapy types are similar because they are both based in humanism. But whereas person-centered therapy is nondirective, allowing the client to talk out concerns and eventually come to insights with only minimal guidance from the therapist, Gestalt therapists are very directive, often confronting clients about the statements they have made. This means that a Gestalt therapist does more than simply reflect back clients' statements; instead, a Gestalt therapist actually leads clients through a number of planned experiences, with the goal of helping clients to become more aware of their own feelings and take responsibility for their own choices in life, both now and in the past. These experiences might include a dialogue that clients have with their own conflicting feelings in which clients actually argue both sides of those feelings. Clients may talk with an empty

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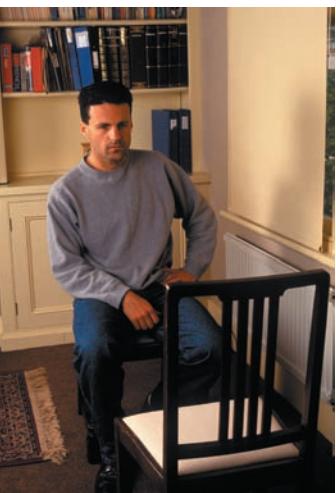
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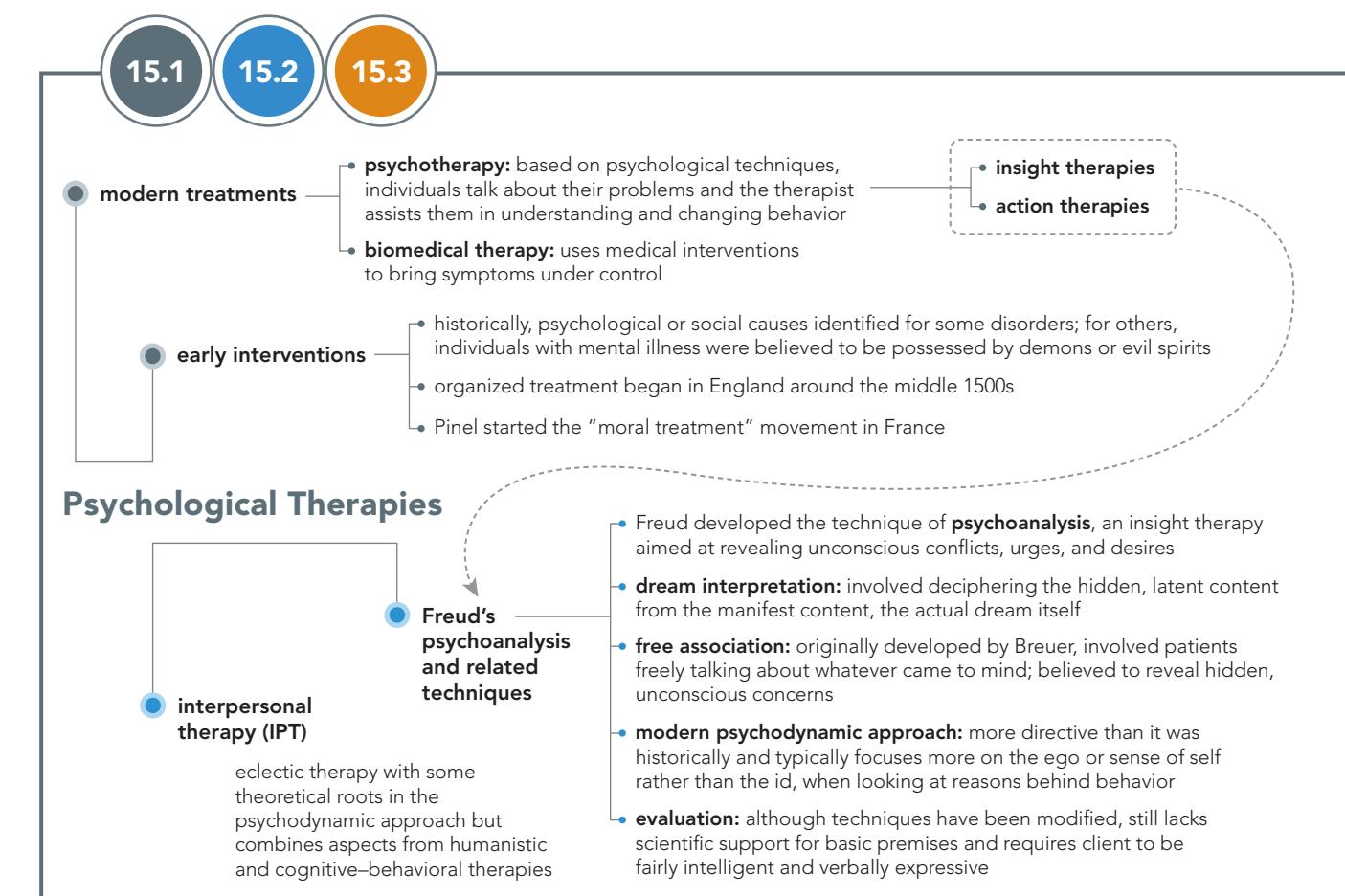
chair to reveal their true feelings toward the person represented by the chair or take on the role of a parent or other person with whom they have a conflict so that the clients can see things from the other person's point of view. The Gestalt therapist pays attention to body language as well as to the events going on in the client's life at the time of therapy. Unlike psychoanalysis, which focuses on the *hidden past*, Gestalt therapy focuses on the *denied past*. Gestalt therapists do not talk about the unconscious mind. They believe everything is conscious but that it is possible for some people to simply refuse to "own up" to having certain feelings or to deal with past issues. By looking at the body language, feelings both stated and unstated, and the events in the life of the client, the therapist gets a *gestalt*—a whole picture—of the client.

EVALUATION OF THE HUMANISTIC THERAPIES

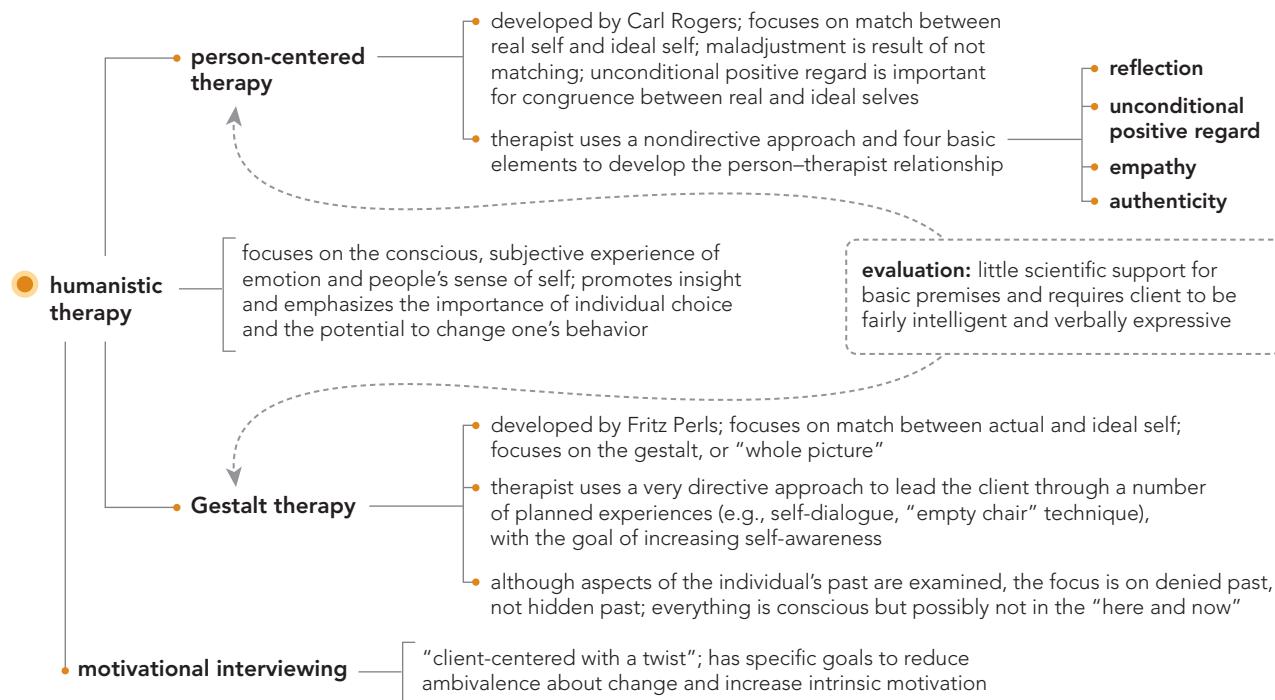
Humanistic therapies have been used to treat psychological disorders, help people make career choices, deal with workplace problems, and counsel married couples. Person-centered therapy in particular can be a very "hands-off" form of therapy because it is so nondirective: Most often, there's nothing that the therapist says that the client has not already said, so the therapist runs a lower risk of misinterpretation. However, omission or not reflecting some things back might be a source of error.

Unfortunately, humanistic therapies have several of the same drawbacks as Freudian psychoanalysis and other forms of modern psychodynamic therapy. There is little experimental research to support the basic ideas on which this type of therapy is founded, but humanists have always preferred to use case studies to build their theories. People must be intelligent, verbal, and able to express their thoughts, feelings, and experiences in a logical manner, which makes humanistic therapies a somewhat less practical choice for treating the more serious mental disorders such as schizophrenia.

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Psychological Therapies (continued)



PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

- One of the first therapists to begin a movement towards the humane treatment of patients was
 - Robert Fleury.
 - Philippe Pinel.
 - Sigmund Freud.
 - Josef Breuer.
- Psychotherapies that attempt to increase the understanding of a client's motives are known as _____ therapies.
 - insight
 - action
 - biomedical
 - psychoanalytic
- Although the term may apply to many therapies, transfer- ence is typically associated with _____ therapies.
 - behavioral
 - humanistic
 - biomedical
 - psychodynamic
- Motivational interviewing is an alternative therapy to what therapeutic approach?
 - psychodynamic therapy
 - Gestalt therapy
 - humanistic therapy
 - group therapy
- Dr. Ellington is directive in his approach with clients. He pays close attention to body language and often focuses on a client's denied past. What type of therapeutic ap- proach is Dr. Ellington using?
 - humanistic approach
 - Gestalt approach
 - group approach
 - behavioral approach
- Which of the following cases would a humanistic approach probably be LEAST effective in treating?
 - Leilani, a university professor who has feelings of inadequacy
 - Kayla, a professional musician who feels worthless and suffers from depression
 - Miranda, a corporate executive who suffers from marked delusions and active auditory hallucinations
 - Felicia, a homemaker who suffers from the traumatic memories of her abusive childhood

THINKING CRITICALLY:

Which of the forms of psychotherapy discussed so far would probably work best for a client who has commitment issues in relationships? Why?

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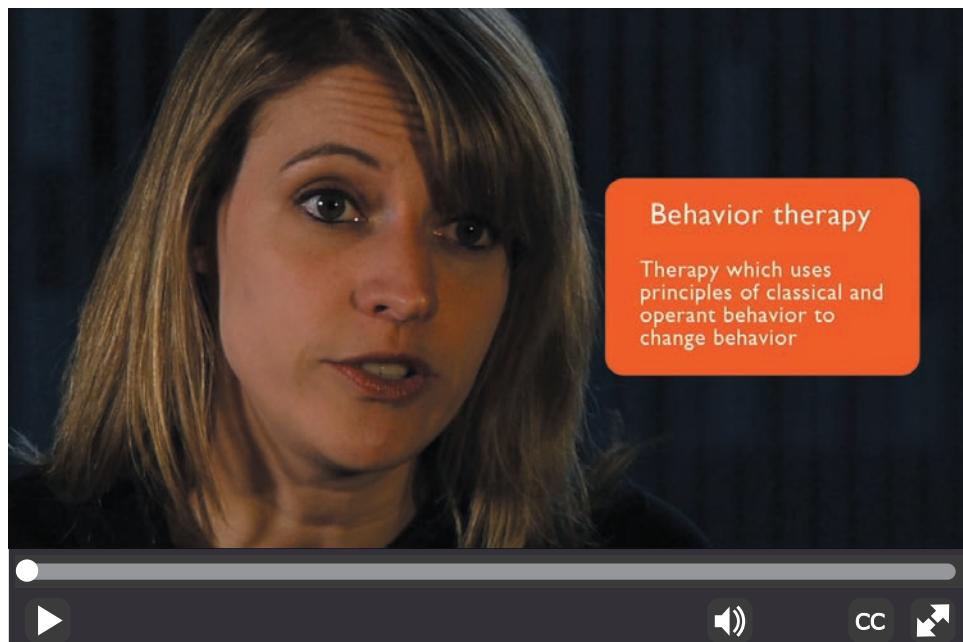
"Freudian - What's the nature of the trouble, and when did it begin?
 Behavior Therapist - Let's drive it around and see what happens"
 Sidney Harris/Sciencecartoonsplus.com

Behavior Therapies: Learning One's Way to Better Behavior

How do behavior therapists use classical and operant conditioning to treat disordered behavior, and how successful are these therapies?

The last chapter talked about how behaviorists have a very different way of looking at abnormality—it's all learned. So do behaviorists do any kind of therapy?

That's right—the basic concept behind behaviorism is that all behavior, whether “normal” or “abnormal,” is learned through the same processes of classical and operant conditioning. Unlike the psychodynamic and humanistic therapies, **behavior therapies** are action based rather than insight based. Their aim is to change behavior through the use of the same kinds of learning techniques that people (and animals) use to learn any new responses. The abnormal or undesirable behavior is not seen as a symptom of anything else but rather is the problem itself. Learning created the problem, and new learning can correct it (Onken et al., 1997; Skinner, 1974; Sloan & Mizes, 1999). The video *The Basics: Therapies in Action: Behavioral Therapy* provides an overview of these therapies.



Watch the Video, *The Basics: Therapies in Action: Behavioral Therapy*, at [MyPsychLab](#)

THERAPIES BASED ON CLASSICAL CONDITIONING

Classical conditioning is the learning of involuntary responses by pairing a stimulus that normally causes a particular response with a new, neutral stimulus. After enough pairings, the new stimulus will also cause the response to occur. [LINK](#) to Learning Objectives 5.2 and 5.3. Through classical conditioning, old and undesirable automatic responses can be replaced by desirable ones. There are several techniques that have been developed using this type of learning to treat disorders such as phobias, anxiety disorders, and obsessive-compulsive disorder.

Using learning techniques to change undesirable behavior and increase desirable behavior has a long history (Hughes, 1993; Lovaas, 1987; Lovaas et al., 1966). Originally

called **behavior modification**, the more recent adaptation of these techniques is **applied behavior analysis**. The newer term better highlights the need for a functional analysis of the behavior to be modified, which is then followed by the use of conditioning techniques to modify the behavior.

SYSTEMATIC DESENSITIZATION **Systematic desensitization**, in which a therapist guides the client through a series of steps meant to reduce fear and anxiety, is normally used to treat phobic disorders and consists of a three-step process. First, the client must learn to relax through deep muscle relaxation training. Next, the client and the therapist construct a list, beginning with the object or situation that causes the least fear to the client, eventually working up to the object or situation that produces the greatest degree of fear. Finally, under the guidance of the therapist the client begins at the first item on the list that causes minimal fear and looks at it, thinks about it, or actually confronts it, all while remaining in a relaxed state. By pairing the old conditioned stimulus (the fear object) with a new relaxation response that is incompatible* with the emotions and physical arousal associated with fear, the person's fear is reduced and relieved. The person then proceeds to the next item on the list of fears (called a *hierarchy of fears*) until the phobia is gone (see **Table 15.1**). It is even possible to use a computer-generated virtual reality technique for desensitization (Rothbaum et al., 1995).

AVERSION THERAPY Another way to use classical conditioning is to reduce the frequency of undesirable behaviors, such as smoking or overeating, by teaching the client to pair an aversive (unpleasant) stimulus with the stimulus that results in the undesirable response, in a process called **aversion therapy**. For example, someone who wants to stop smoking might go to a therapist who uses a *rapid-smoking* technique, in which the client is allowed to smoke but must take a puff on the cigarette every 5 or 6 seconds. As nicotine is a poison, such rapid smoking produces nausea and dizziness, both unpleasant effects.



Could you use aversion therapy to help someone with a phobia?

Because phobias are already very unpleasant, aversive conditioning is not the most useful method of therapy. But although desensitization remains one of the more common therapies for phobias, it does not always bring quick results.

Table 15.1

Fear Hierarchy

SITUATION	FEAR LEVEL
Being bitten by a rabbit	100
Petting a rabbit on the head	90
Petting a rabbit on the back	80
Holding a rabbit	70
Touching a rabbit held by someone else	60
Seeing someone I trust hold a rabbit	50
Being in a room with a rabbit	40
Thinking about petting a rabbit	30
Looking at pictures of rabbits	20
Watching the movie "Hop"	10

Items are ranked by level of fear from most fearful, Fear = 100, to least fearful, Fear = 0.

*incompatible: referring to two or more things that cannot exist together or at the same time.

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EXPOSURE THERAPIES Behavioral techniques that introduce the client to situations, under carefully controlled conditions, which are related to their anxieties or fears are called **exposure therapies**. Exposure can be accomplished through a variety of routes and is intended to promote new learning. It can be *in vivo* (“in life”), where the client is exposed to the actual anxiety-related stimulus; *imaginal*, where the client visualizes or imagines the stimulus; and even *virtual*, where virtual reality (VR) technology is used (Najavits, 2007). (For more on virtual reality in psychology, see the Applying Psychology to Everyday Life section at the end of this chapter.)

For example, if Chang-sun has social anxiety disorder (fairly rare for Korean males, at a lifetime prevalence of only about 0.1 percent) (Sadock et al., 2007), for *in vivo* exposure he might have to attend a social event; for *imaginal* exposure he might be asked to visualize himself attending a social event; and for *virtual* exposure, Chang-sun might experience a social event, such as attending a dinner party, through VR technology.

Exposure methods can introduce the feared stimulus gradually, or quite suddenly. A gradual, or *graded*, exposure involves the client and therapist developing a fear hierarchy as in systematic desensitization: Exposure begins at the least feared event and progresses through to the most feared, similar to desensitization. If the exposure is rapid and intense, it begins with the most feared event and is called **flooding** (Gelder, 1976; Olsen, 1975). Flooding is used under very controlled conditions and, like graded exposure, produces extinction of the conditioned fear response by preventing an escape or avoidance response (e.g., Chang-sun would not be allowed to leave the party). Exposure therapy is sometimes called “exposure and response prevention” for that reason.

Eye-movement desensitization and reprocessing, or EMDR, is an exposure-based therapy, sometimes used in the treatment of posttraumatic stress disorder (PTSD). As originally formulated, it involves very brief and repeated *imaginal flooding*, cognitive reprocessing and desensitization of the fearful event, and rapid eye movements or other bilateral stimulation (Shapiro, 2001, 2012). It is also used with phobias and other anxiety-related disorders, although PTSD remains a primary disorder for which this therapy is most commonly used. It is a somewhat controversial therapy as it evolved from the founder’s personal observation, not psychological theory or modification of techniques for other disorders, and past research has suggested the eye movements or other bilateral stimulation serve little to no purpose (Resick et al., 2008). As a topic of ongoing investigation and debate, recent studies have suggested eye movements or other dual-attention tasks interfere with working memory processes and may decrease the vividness or emotional impact of negative memories (de Jongh et al., 2013; van den Hout et al., 2013).

THERAPIES BASED ON OPERANT CONDITIONING

Operant conditioning techniques include reinforcement, extinction, shaping, and modeling to change the frequency of voluntary behavior.  to Learning Objectives 5.9, 5.10, and 5.12. In the treatment of psychological disorders, the goal is to reduce the frequency of undesirable behavior and increase the frequency of desirable responses.

One of the advantages of using operant conditioning to treat a problem behavior is that results are usually quickly obtained rather than having to wait through years of more insight-oriented forms of therapy. When bringing the behavior under control (rather than finding out why it occurs in the first place) is the goal, operant and other behavioral techniques are very practical. There’s an old joke about a man whose fear of things hiding under his bed is cured by a behavioral therapist in one night. The therapist simply cut the legs off the bed.

MODELING **Modeling**, or learning through the observation and imitation of a model, is discussed in Chapter Five. The use of modeling as a therapy is based on the work of Albert Bandura, which states that a person with specific fears or someone who needs to develop social skills can learn to do so by watching someone else (the model) confront those fears or demonstrate the needed social skills (Bandura et al., 1969). In **participant modeling**, a model demonstrates the desired behavior in a step-by-step, gradual process.

The client is encouraged by the therapist to imitate the model in the same gradual, step-by-step manner (Bandura, 1986; Bandura et al., 1974). The model can be a person actually present in the same room with the client or someone viewed on video. For example, a model might first approach a dog, then touch the dog, then pet the dog, and finally hug the dog. A child (or adult) who fears dogs would watch this process and then be encouraged to repeat the steps that the model demonstrated.

Behavioral therapists can give parents or others advice and demonstrations on how to carry out behavioral techniques. Once a person knows what to do, modeling is a fairly easy technique. Modeling has been effective in helping children with dental fears (Klorman et al., 1980; Ollendick & King, 1998), social withdrawal (O'Connor, 1972), obsessive-compulsive disorder (Roper et al., 1975), and phobias (Hintze, 2002).

USING REINFORCEMENT *Reinforcement* is the strengthening of a response by following it with some pleasurable consequence (positive reinforcement) or the removal of an unpleasant stimulus (negative reinforcement). Reinforcement of both types can form the basis for treatment of people with behavioral problems.

Token Economies In a **token economy**, objects known as *tokens* can be traded for food, candy, treats, or special privileges. Clients earn tokens for behaving correctly or accomplishing behavioral goals and can later exchange those tokens for things that they want. They may also lose tokens for inappropriate behavior. This trading system is a token economy.  to Learning Objective 5.10. Token economies have also been used successfully in modifying the behavior of relatively disturbed persons in mental institutions, such as people with schizophrenia or depressed persons (Dickerson et al., 1994; Glynn, 1990; McMonagle & Sultana, 2002).

Contingency Contracting Another method based on the use of reinforcement involves making a **contingency contract** with the client (Salend, 1987). This contract is a formal agreement between therapist and client (or teacher and student, or parent and child) in which both parties' responsibilities and goals are clearly stated. Such contracts are useful in treating specific problems such as drug addiction (Talbott & Crosby, 2001), educational problems (Evans & Meyer, 1985; Evans et al., 1989), and eating disorders (Brubaker & Leddy, 2003). Because the stated tasks, penalties, and reinforcements are clearly stated and consistent, both parties are always aware of the consequences of acting or failing to act within the specifications of the contract, making this form of behavioral treatment fairly effective. Consistency is one of the most effective tools in using both rewards and punishments to mold behavior.  to Learning Objective 5.8.

USING EXTINCTION *Extinction* involves the removal of a reinforcer to reduce the frequency of a particular response. In modifying behavior, operant extinction often involves removing one's attention from the person when that person is engaging in an inappropriate or undesirable behavior. With children, this removal of attention may be a form of **time-out**, in which the child is removed from the situation that provides reinforcement (Kazdin, 1980). In adults, a simple refusal by the other persons in the room to acknowledge the behavior is often successful in reducing the frequency of that behavior.

EVALUATION OF BEHAVIOR THERAPIES

Behavior therapies may be more effective than other forms of therapy in treating specific behavioral problems, such as bed-wetting, overeating, drug addictions, and phobic reactions (Burgio, 1998; Wetherell, 2002). More serious psychological disorders, such as severe depression or schizophrenia, do not respond as well overall to behavioral treatments, although improvement of specific symptoms can be achieved (Glynn, 1990; McMonagle & Sultana, 2002). Bringing symptoms under control is an important step in allowing a person to function normally in the social world, and behavior therapies are a relatively quick and efficient way to eliminate or greatly reduce such symptoms. However, some behavioral paradigms are not simple to establish or continually implement, and steps

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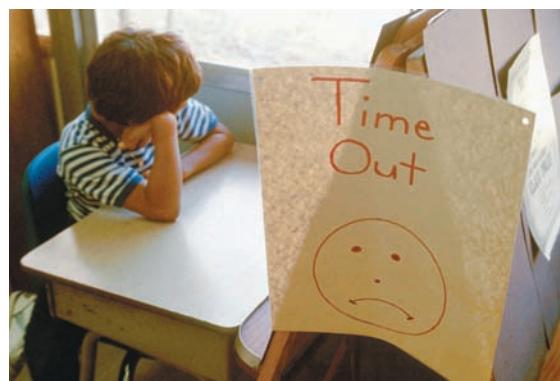
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This boy is sitting in the "time-out" corner at his school. By removing the attention that he found rewarding, the teacher is attempting to extinguish the behavior that earned the boy a time-out. Do you see anything in this time-out corner that might make it less effective?

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have to be taken so adaptive behaviors can be generalized to other situations and maintained in the future (Prochaska & Norcross, 2009).

Cognitive Therapies: Thinking Is Believing

What are the goals and basic elements of cognitive therapies such as cognitive-behavioral therapy and rational emotive behavior therapy?

Cognitive therapy (Beck, 1979; Freeman et al., 1989) was developed by Aaron T. Beck and is focused on helping people change their ways of thinking. Rather than focusing on the behavior itself, the cognitive therapist focuses on the distorted thinking and unrealistic beliefs that lead to maladaptive behavior (Hollon & Beck, 1994), especially those distortions relating to depression (Abela & D'Allesandro, 2002; McGinn, 2000). The goal is to help clients test, in a more objective, scientific way, the truth of their beliefs and assumptions, as well as their attributions concerning both their own behavior and the behavior of others in their lives.  to Learning Objective 12.7. Then they can recognize thoughts that are distorted and negative and replace them with more positive, helpful thoughts. Because the focus is on changing thoughts rather than gaining deep insights into their causes, this kind of therapy is primarily an action therapy.

BECK'S COGNITIVE THERAPY



What are these unrealistic beliefs?

Cognitive therapy focuses on the distortions of thinking.  to Learning Objective 13.4. Here are some of the more common distortions in thought that can create negative feelings and unrealistic beliefs in people:

- **Arbitrary inference:** This refers to “jumping to conclusions” without any evidence. Arbitrary means to decide something based on nothing more than personal whims. Example: “Suzy canceled our lunch date—I’ll bet she’s seeing someone else!”
- **Selective thinking:** In selective thinking, the person focuses only on one aspect of a situation, leaving out other relevant facts that might make things seem less negative. Example: Peter’s teacher praised his paper but made one comment about needing to check his punctuation. Peter assumes that his paper is lousy and that the teacher really didn’t like it, ignoring the other praise and positive comments.
- **Overgeneralization:** Here a person draws a sweeping conclusion from one incident and then assumes that the conclusion applies to areas of life that have nothing to do with the original event. Example: “I got yelled at by my boss. My boyfriend is going to break up with me and kick me out of the apartment—I’ll end up living in a van down by the river.”
- **Magnification and minimization:** Here a person blows bad things out of proportion while not emphasizing good things. Example: A student who has received good grades on every other exam believes that the C she got on the last quiz means she’s not going to succeed in college.
- **Personalization:** In personalization, an individual takes responsibility or blame for events that are not really connected to the individual. Example: When Sandy’s husband comes home in a bad mood because of something that happened at work, she immediately assumes that he is angry with her.

A cognitive therapist tries to get clients to look at their beliefs and test them to see how accurate they really are. The first step is to identify an illogical or unrealistic belief, which the therapist and client do in their initial talks. Then the client is guided by the

therapist through a process of asking questions about that belief, such as “When did this belief of mine begin?” or “What is the evidence for this belief?”

💬 Don’t those questions sound like critical thinking, which was discussed in Chapter One?

Cognitive therapy really is critical thinking applied to one’s own thoughts and beliefs. Just as cognitive psychology grew out of behaviorism, [LINK](#) to Learning Objectives 1.3 and 1.4, therapies using cognitive methods have behavioral elements within them as well, leading to the term **cognitive-behavioral therapy (CBT)**.

👁 Watch the **Video**, *The Basics: Therapies in Action: CBT*, at [MyPsychLab](#)

Cognitive-behavioral therapy, or CBT, focuses on the present rather than the past (like behaviorism) but also assumes that people interact with the world with more than simple, automatic reactions to external stimuli. People observe the world and the people in the world around them, make assumptions and inferences* based on those observations or cognitions, and then decide how to respond (Rachman & Hodgson, 1980). As a form of cognitive therapy, CBT also assumes that disorders come from illogical, irrational cognitions and that changing the thinking patterns to more rational, logical ones will relieve the symptoms of the disorder, making it an action therapy. CBT has three basic elements: cognitions affect behavior, cognitions can be changed, behavior change can result from cognitive change (Dobson & Block, 1988). Cognitive-behavioral therapists may also use any of the tools that behavioral therapists use to help clients alter their actions. The three basic goals of any cognitive-behavioral therapy follow. [👁 Watch the Video, In the Real World: Cognitive Behavioral Therapy](#), at [MyPsychLab](#).

1. Relieve the symptoms and help clients resolve the problems.
2. Help clients develop strategies that can be used to cope with future problems.
3. Help clients change the way they think from irrational, self-defeating thoughts to more rational, self-helping, positive thoughts.

ELLIS AND RATIONAL EMOTIVE BEHAVIOR THERAPY (REBT)

Albert Ellis proposed a version of CBT called **rational emotive behavior therapy (REBT)**, in which clients are taught a way to challenge their own irrational beliefs with more rational, helpful statements (Ellis, 1997, 1998). Here are some examples of irrational beliefs:

- Everyone should love and approve of me (if they don’t, I am awful and unlovable).
- When things do not go the way I wanted and planned, it is terrible and I am, of course, going to get very disturbed. I can’t stand it!



💬 But I’ve felt that way at times. Why are these statements so irrational?

Notice that these statements have one thing in common: It’s either all or nothing. Can a person really expect the love and affection of every single person? Is it realistic to expect things to work as planned every time? Rational emotive behavioral therapy is about challenging these types of “my way or nothing” statements, helping people to realize that life can be good without being “perfect.” In REBT, therapists take a very directive role, challenging the client when the client makes statements like those listed earlier, assigning homework, using behavioral techniques to modify behavior, and arguing with clients about the rationality of their statements.

EVALUATION OF COGNITIVE AND COGNITIVE-BEHAVIORAL THERAPIES

Cognitive and cognitive-behavioral therapies are less expensive than the typical insight therapy because they are comparatively short-term therapies. As in behavior therapy, clients do not have to dig too deep for the hidden sources of their problems. Instead,

*inferences: conclusions drawn from observations and facts.

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Table 15.2**Characteristics of Psychotherapies**

TYPE OF THERAPY (KEY PEOPLE)	GOAL	METHODS
Psychodynamic therapy (Freud)	Insight	Aims to reveal unconscious conflicts through dream interpretation, free association, resistance and transference
Humanistic therapy Person-centered therapy (Rogers) Gestalt therapy (Perls)	Insight	Non-directive therapy; client does most of the talking; key elements are authenticity, unconditional positive regard, and empathy. Directive therapy; therapist uses leading questions and role-playing to help client accept all parts of their feelings and experiences
Behavior therapy (Watson, Jones, Skinner, Bandura)	Action	Based on principles of classical and operant conditioning; aimed at changing behavior without concern for causes of behavior
Cognitive therapy (Beck) CBT (various professionals) REBT (Ellis)	Action	Aims to help clients overcome problems by learning to think more rationally and logically Clients are challenged in their irrational beliefs and helped to restructure their thinking

cognitive-based therapies get right to the problems themselves, helping clients deal with their symptoms more directly. In fact, one of the criticisms of these therapies as well as behavior therapies is that they treat the symptom, not the cause. However, it should be noted that in the cognitive viewpoint, the maladaptive thoughts are seen as the cause of the problems, not merely the symptoms. There is also an element of potential bias because of the therapist's opinions as to which thoughts are rational and which are not (Westen, 2005).

Nevertheless, cognitive and cognitive-behavioral therapies have considerable success in treating many types of disorders, including depression, stress disorders, eating disorders, anxiety disorders, personality disorders, and even—in addition to other forms of therapy—some types of schizophrenia (Barlow et al., 2007; Beck, 2007; Clark et al., 1989, 2009; DeRubeis et al., 1999; Holcomb, 1986; Jay & Elliot, 1990; Kendall, 1983; Kendall et al., 2008; McGinn, 2000; Meichenbaum, 1996; Mueser et al., 2008; Resick et al., 2008; Turk et al., 2008; Young et al., 2008). As an offshoot of behaviorism, the learning principles that are the basis of cognitive-behavioral therapies are considered empirically sound (Barlow et al., 2007; Masters et al., 1987). For a summary of the various types of psychotherapies discussed up to this point, see **Table 15.2**.

Group Therapies: Not Just for the Shy

What are the various types of group therapies and the advantages and disadvantages of group therapy?

An alternative to individual therapy, in which the client and the therapist have a private, one-on-one session, is **group therapy**, in which a group of clients with similar problems gather together to discuss their problems under the guidance of a single therapist (Yalom, 1995).

TYPES OF GROUP THERAPIES

Group therapy can be accomplished in several ways. The therapist may use either an insight or cognitive-behavioral style, although person-centered, Gestalt, and behavior therapies seem to work better in group settings than psychodynamic and cognitive-behavioral therapies (Andrews, 1989).

In addition to the variations in the style of therapy, the group structure can also vary. There may be small groups formed of related persons or other groups of unrelated persons that meet without the benefit of a therapist. Their goal is to share their problems and provide social and emotional support for each other.



In group therapy, several people who share similar problems gather with a therapist to discuss their feelings and concerns. The presence of others who are going through the same kind of emotional difficulties can be comforting as well as provide the opportunity for insights into one's own problems by hearing about the problems of others.

FAMILY COUNSELING One form of group therapy is **family counseling** or **family therapy**, in which all of the members of a family who are experiencing some type of problem—marital problems, problems in child discipline, or sibling rivalry, for example—are seen by the therapist as a group. The therapist may also meet with one or more family members individually at times, but the real work in opening the lines of communication among family members is accomplished in the group setting (Frankel & Piercy, 1990; Pinsoff & Wynne, 1995). The family members may include grandparents, aunts and uncles, and in-laws as well as the core family. This is because family therapy focuses on the family as a whole unit or system of interacting “parts.” No one person is seen as “the problem” because all members of the family system are part of the problem: They are experiencing it, rewarding it, or by their actions or inactions causing it to occur in the first place.

The goal in family therapy, then, is to discover the unhealthy ways in which family members interact and communicate with one another and change those ways to healthier, more productive means of interaction. Family therapists work not only with families but also with couples who are in a committed relationship, with the goal of improving communication, helping the couple to learn better ways of solving their problems and disagreements, and increasing feelings of intimacy and emotional closeness (Christensen et al., 1995; Heavey et al., 1993).

SELF-HELP GROUPS Many people may feel that a therapist who has never had, for example, a drug problem would be unable to truly understand their situation; and they may also feel that someone who has experienced addiction and beaten it is more capable of providing real help. Therapists are also often in short supply, and they charge a fee for leading group-therapy sessions. These are reasons some people choose to meet with others who have problems similar to their own, with no therapist in charge. Called **self-help groups** or **support groups**, these groups are usually formed around a particular problem. Some examples of self-help groups are Alcoholics Anonymous, Overeaters Anonymous, and Narcotics Anonymous, all of which have groups meeting all over the country at almost any time of the day or night. There are countless smaller support groups for nearly every condition imaginable, including anxiety, phobias, having a parent with dementia, having difficult children, depression, and dealing with stress—to name just a few. The advantages of self-help groups are that they are free and provide the social and emotional support that a group session can provide (Bussa & Kaufman, 2000). Self-help groups do not have leaders but instead have people who volunteer monthly or weekly to lead individual meetings. So the person who is in charge of organizing the meetings is also a member of the group, with the same problem as all the other members.

EVALUATION OF GROUP THERAPY

Group therapy can provide help to people who might be unable to afford individual psychotherapy. Because the therapist can see several clients at one time, this type of therapy is usually less expensive than individual therapy. It also allows an opportunity for both the therapist and the person to see how that person interacts with others.

Another advantage of group therapy is that it offers social and emotional support from people who have problems that are similar or nearly identical to one's own. This advantage is an important one; studies have shown that breast cancer patients who were part of a group-therapy process had much higher survival and recovery rates than those who received only individual therapy or no psychotherapy (Fawzy et al., 1993; Spiegel et al., 1989). Another study found that adolescent girls in Africa, suffering from depression due to the stresses of the war in Uganda, experienced significant reductions in depression when treated with group therapy (Bolton et al., 2007).

Group therapy is not appropriate for all situations, and there can be disadvantages. Clients must share the therapist's time during the session. People who are not comfortable in social situations or who have trouble speaking in front of others may not find group therapy as helpful as those who are more verbal and social by nature. In addition, since the therapist is no longer the only person to whom secrets and fears are revealed,



In self-help groups, the person or persons leading a group are not specialists or therapists but just members of the group. They often have the same problem as all of the other people in the room, which is the strength of this type of program—people may be more likely to trust and open up to someone who has struggled as they have.

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PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Behavior-based therapies are _____ based while psychodynamic and humanistic therapies are _____ based.
 - a. insight; action
 - b. action; insight
 - c. rationale; medically
 - d. medically; action
2. Dr. Kali works with clients to help them learn deep relaxation. Next, he has them list their fears from least to most anxiety provoking. Finally, Dr. Kali slowly exposes his clients to each of their fears and assists them in gaining control of their anxiety. His approach is best known as
 - a. aversion therapy.
 - b. systematic desensitization.
 - c. flooding.
 - d. fear therapy.
3. Dr. Williams uses exposure-based therapies to treat many of her patients. Client A is actually confronted with the situation that causes her anxiety while Client B is asked to think about and visualize the frightening situation. Client A's treatment method would be described as _____ while client B's treatment method is _____.
 - a. virtual; in vivo
 - b. imaginal; virtual
 - c. in vivo; imaginal
 - d. virtual; in vivo
4. Which of the following therapies has been successful across multiple settings in the establishment of desirable behaviors and modification of problem behaviors?
 - a. token economies
 - b. aversion therapy
 - c. systematic desensitization
 - d. flooding
5. Nicole's therapist tells her that she is applying arbitrary inference to her thinking, which ultimately is causing her to be depressed. Which of the following is an example of Nicole's arbitrary inference?
 - a. Nicole maximizes the bad things she experiences while minimizing the good aspects of life.
 - b. Nicole tends to jump to conclusions with little or no evidence to support her beliefs.
 - c. Nicole focuses strictly on a single negative event while ignoring less negative aspects.
 - d. Nicole tends to overgeneralize a single bad event and assume all things about her life are failing.
6. Which of the following may be an effective option for some concerns if there isn't a therapist available in your local community?
 - a. family therapy
 - b. group therapy
 - c. self-help group
 - d. psychodynamic therapy

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Does Psychotherapy Really Work?

How effective is psychotherapy, and what factors influence its effectiveness?

There sure are a lot of psychotherapies, but do any of them really work?

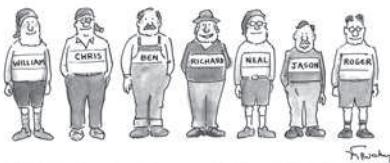
In the 1950s, Hans Eysenck did one of the earliest studies of the effectiveness of therapy. His conclusion—that the people receiving psychotherapy did not recover at any higher rate than those who had no psychotherapy and that the passage of time alone could account for all recovery.

STUDIES OF EFFECTIVENESS

Eysenck's classic survey created a major controversy within the world of clinical and counseling psychology. Other researchers began their own studies to find evidence that would contradict Eysenck's findings. One such effort reviewed studies that the researchers considered to be well controlled and concluded that the psychotherapies did not differ from one another in effectiveness (Luborsky et al., 1975). Of course, that can mean either that the psychotherapies were all equally effective or that they were all equally ineffective. (Reminder—many psychological professionals take an eclectic approach, using more than one psychotherapy technique.)

There are numerous problems with studying the effectiveness of psychotherapy. Controlled studies can be done using an experimental group of people who receive a particular psychotherapy and a control group of people who are put on a waiting list, but this is less than ideal. The control group is not getting the attention from the therapist, for one thing, and so there would be no placebo-effect expectations about getting better because of therapy (Shapiro & Shapiro, 1997). Also, not all therapies take the same amount of time to be effective. For example, psychoanalysis, even in its short form, takes longer than a behavioral therapy. In a short-term study, behavioral therapy would obviously look more

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THE SEVEN DWARFS AFTER THERAPY

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"William, Chris, Ben, Richard, Neal, Jason, Roger"
 ©The New Yorker Collection 1991 Mike Twohy from cartoonbank.com. All Rights Reserved.

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effective. Action therapies such as behavior therapy measure the success of the therapy differently than do insight therapies; in a behavioral therapy the reduction of the undesired behavior is easy to objectively measure, but gaining insights and feelings of control, self-worth, self-esteem, and so on are not as easily evaluated (Shadish et al., 2002).

Studies that do not use empirical* procedures but instead try to determine if the clients who have been helped by the therapy in general are plagued by problems such as experimenter bias (the therapist expects the therapy to work and is also the one assessing the progress of the client), the inaccuracies of self-report information, and the same placebo-effect expectations cited by Shapiro and Shapiro (Seligman, 1995; Wampold, 1997). [LINK](#) to Learning Objective 1.11.

Nevertheless, more recent surveys have shown that people who have received psychotherapy believe that they have been helped more often than not (*Consumer Reports*, 1995; Kotkin et al., 1996). The *Consumer Reports* research was a survey of the magazine's readers in which those who had been or were currently clients in psychotherapy rated the effectiveness of the therapy they received. Here are the findings from a summary of this and several other similar surveys (Lambert & Ogles, 2004; Seligman, 1995; Thase, 1999):

- An estimated 75–90 percent of people feel that psychotherapy has helped them.
- The longer a person stays in therapy, the greater the improvement.

Other studies have found that some psychotherapies are more effective for certain types of disorders (Clarkin et al., 2007; Hollon et al., 2002) but that no one psychotherapy is the most effective or works for every type of problem.

CHARACTERISTICS OF EFFECTIVE THERAPY

 So how does a person with a problem know what kind of therapist to go to? How do you pick a good one?

As the Psychology in the News feature that follows describes, an increasing number of college students are seeking help for psychological disorders. It can sometimes be hard to determine if you or someone you know needs professional help and, if so, where to find it. The video, *What's In It For Me?: Finding a Therapist if You Need One: Resources for Students*, offers some advice.



 [Watch the Video](#), *What's In It For Me?: Finding a Therapist if You Need One: Resources for Students*, at [MyPsychLab](#)

*empirical: capable of being verified or disproved by observation or experiment.

As discussed before, many psychological professionals today take an eclectic view of psychotherapy, using a combination of methods or switching methods to fit the particular client's needs or specific problems.

The *common factors approach* in psychotherapy is a modern approach to eclecticism and focuses on those factors common to successful outcomes from different forms of therapy (Norcross, 2005). These factors are seen as the source of the success rather than specific differences among therapies. The most important common factor of a successful psychotherapy may be the relationship between the client and the therapist, known as the **therapeutic alliance**. This relationship should be caring, warm, and accepting, and be characterized by empathy, mutual respect, and understanding. Therapy should also offer clients a *protected setting* in which to release emotions and reveal private thoughts and concerns and should help clients understand why they feel the way they do and provide them with ways to feel better. Other common factors in therapy effectiveness are *opportunity for catharsis* (relieving pent-up emotions), *learning and practice of new behaviors*, and *positive experiences* for the client (Norcross, 2005).

An ongoing area of research in psychology is related to identifying those treatments and other aspects of treatment that work best for specific disorders. Some treatments may not only be ineffective for certain disorders, some treatments or alternative therapies may even prove to be dangerous or harmful. Especially in light of managed health care and tight budgets, clients benefit through *evidence-based practice*. Empirically supported or **evidence-based treatment** (EBT) refers to techniques or interventions that have produced desired outcomes, or therapeutic change in controlled studies (Barlow et al., 2013; Kazdin, 2008). Evidence-based practice includes systematic reviews of relevant and valid information that ranges from assessment to intervention (American Psychological Association, 2005; Hunsley & Mash, 2008; Kazdin, 2008; Nathan & Gorman, 2007). Some examples of evidence-based, or empirically supported, treatments are exposure therapies, cognitive-behavioral, and cognitive processing for PTSD (Ehlers et al., 2010; Najavits, 2007; Resick et al., 2008), cognitive-behavioral treatment for panic disorder with agoraphobia (Barlow et al., 2007; Craske & Barlow, 2008), cognitive-behavioral group therapy for social anxiety disorder (Turk et al., 2008), cognitive therapy for depression (Young et al., 2008), antipsychotic drugs for schizophrenia (Sharif et al., 2007), and interpersonal psychotherapy for depression (Bleiberg & Markowitz, 2008).  **Simulate** the **Experiment**, *Ineffective Therapies*, on **MyPsychLab**



"I like to think that each generation will need a little less therapy than the generation before."

"I like to think that each generation will need a little less therapy than the generation before"

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psychology in the news

Mental Health on Campus



The college experience is supposed to be one of intellectual and social development, but it is also a time of strife and stress for many. From exams to living conditions (commuting, new roommates, living in a dorm), relationship issues (immediate family, significant others), and adjustment in general, college life can be quite stressful. The shootings and other campus crises over the past few years are just one indicator of the level of psychological dysfunction that can occur in extreme circumstances.

These circumstances can make preexisting conditions worse or prompt the development of new psychological disorders. According to the American College Counseling Association's 2009 National Survey of Counseling Center Directors, of the 2.6 million students represented in the survey, approximately 270,000 sought counseling (Gallagher, 2009). Of those students receiving services in college counseling centers, 16 percent are referred for psychiatric evaluation and 25 percent are on psychiatric medication. The majority of counseling center directors believe there is an increase in the number of students coming to campus already on psychiatric medication, and there is a trend toward a greater number of students on campus recognized with severe psychological problems. Increases are being noted in medication

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management, crisis intervention, learning disabilities, self-injury (e.g., self-cutting), illicit drug use, alcohol abuse, eating disorders, and sexual assault concerns or problems related to earlier sexual abuse (Gallagher, 2009).

As revealed by the 2009–2010 Community College Counselors Survey, these increases are especially troublesome given the added stress of the ongoing economic situation in the United States. Consequences of economic stressors include increases in enrollment, more signs of anxiety and depression in both students and college employees, and an increased need for mental health services (American College Counseling Association's Community College Task Force, 2010). The top four presenting problems were stress, depression, anxiety disorders, and academic problems.

So what can you do with this information? First, if you are not familiar with your college's counseling resources, learn more about what is offered. Even if you do not have a serious psychological disorder, counselors can assist you in identifying and developing effective coping strategies. Second, take care of yourself, get enough sleep, eat healthy foods (not just instant noodles or macaroni and cheese), exercise, and take time for yourself to relax. Finally, know that you are not alone if you do experience difficulties and that a variety of resources are likely available to help you along the path to your college degree.

Questions for Further Discussion

1. Do you know any of your fellow students who have used your college's counseling center? If so, what was their experience like?
 2. What do you believe to be the greatest stressor in college life today?
-

CULTURAL, ETHNIC, AND GENDER CONCERN IN PSYCHOTHERAPY

Consider the following situation (adapted from Wedding, 2004).

K. is a 24-year-old Korean American. She lived with her parents, who were both born and reared in Korea before moving to the United States as adults. She came to a therapist because she was depressed and unhappy with her lack of independence. Her father was angry about her plans to marry a non-Korean. Her therapist immediately began assertiveness training and role-playing to prepare K. to deal with her father. The therapist was disappointed when K. failed to keep her second appointment.

This example of an actual case demonstrates a problem that exists in the therapist-client relationship for many clients when the ethnicity or culture of the client is different from that of the therapist. This cultural difference makes it difficult for therapists to understand the exact nature of their clients' problems and for clients to benefit from therapies that do not match their needs (Matsumoto, 1994; Moffic, 2003; Wedding, 2004). The values of different cultures and ethnic groups are not universally the same. How, for example, could a female therapist who is White, from an upper-middle-class family, and well educated understand the problems of a Hispanic adolescent boy from a poor family living in substandard housing if she did not acknowledge the differences between them? In this case, gender, ethnicity, and economic background of client and therapist are all vastly different.

In the case of K., for example, the therapist mistakenly assumed that the key to improving K.'s situation was to make her more assertive and independent from her family, particularly her father. This Western idea runs counter to Korean cultural values. Korean culture stresses interdependence, not independence. The family comes first, obedience to one's elders is highly valued, and "doing one's own thing" is not acceptable. K.'s real problem may have been her feelings of guilt about her situation and her father's anger. She may have wanted help in dealing with her family situation and her feelings about that situation, not help in becoming more independent.

For therapy to be effective, the client must continue in treatment until a successful outcome is reached. K. never came back after the first session. One of the problems that can occur when the culture or ethnic backgrounds of the client and therapist are mismatched, as in K.'s case, is that the therapist may project his or her values onto the client, failing to achieve true empathy with the client's feelings or even to realize what the client's true feelings are, thus causing the client to drop out of therapy. Studies of such situations have found that members of minority racial or ethnic groups drop out of therapy at a significantly higher rate than the majority group clients (Brown et al., 2003; Cooper et al., 2003; Flaherty & Adams, 1998; Fortuna et al., 2010; Sue, 1977, 1992; Sue et al., 1994; Vail, 1976; Vernon & Roberts, 1982).

Traditional forms of psychotherapy, developed mainly in Western, individualistic cultures, may need to be modified to fit the more collectivistic, interdependent cultures. For example, Japanese psychologist Dr. Shigeru Iwakabe has pointed out that the typical "talking cure" practiced by many psychotherapists—including psychodynamic and humanistic therapists—may have to be altered to a nontalking cure and the use of nonverbal tasks (like drawing) due to the reluctance of many traditional Japanese people to talk openly about private concerns (Iwakabe, 2008).



Are differences in gender that important? For example, do women prefer female therapists, but men would rather talk to another man?

Research on gender and therapist-client relationships varies. When talking about White, middle-class clients, it seems that both men and women prefer a female therapist (Jones et al., 1987). But African American clients were more likely to drop out of therapy if the therapist was the *same sex* as the client (Vail, 1976); male Asian clients seemed to prefer a male therapist; and female Asian clients stayed in therapy equally long with either male or female therapists (Flaherty & Adams, 1998; Flaskerud, 1991).

Four barriers to effective psychotherapy exist when the culture or ethnic backgrounds of client and therapist are different (Sue & Sue, 2008):

1. **Culture-bound values.** Including individual centered versus other (or others) centered, verbal/emotional/behavioral expressiveness, communication patterns from client to counselor, nuclear family, and so forth (Sue & Sue, 2008). Differing cultural values can cause therapists to fail at forming an empathetic relationship (Sattler, 1977; Wedding, 2004).
2. **Class-bound values.** Adherence to time schedules, ambiguous approach to problems, looking for long-range goals (Sue & Sue, 2008). Clients from impoverished backgrounds may have values and experiences that the therapist cannot understand (Wedding, 2004).
3. **Language.** Use of Standard English, emphasis on verbal communication (Sue & Sue, 2008). Speaking different languages becomes a problem in understanding what both client and therapist are saying and in psychological testing (Betancourt & Jacobs, 2000; Lewis, 1996).
4. **Nonverbal communication.** Body language, or nonverbal communication, can also differ between cultures and ethnicities. The physical distance between the client and therapist, the use of gestures, and eye contact, for example, can cause misunderstandings during the session and in interpretation of the client's moods and intentions (Galanti, 1997; Like et al., 1996). People in some cultures are content with long periods of silence whereas others are not, direct eye contact is desirable in some cultures and offensive in others, and even facial expressions of emotion vary

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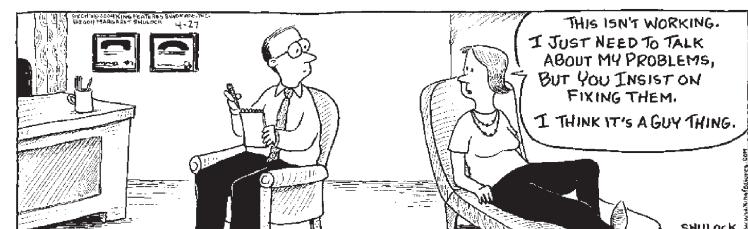
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from very expressive (as with many Hispanic people) to nonexpressive (as with many Asian people).

The American Psychiatric Association (2013) has included information for psychology professionals concerning cultural issues and culture syndromes.  to Learning Objective 14.2. All therapists need to make an effort to become aware of cultural differences, syndromes, and possible gender issues. Sociopolitical issues should also be examined (Sue & Sue, 2008).

CYBERTHERAPY: THERAPY IN THE COMPUTER AGE

Although psychotherapy is usually accomplished by the client or clients speaking face-to-face with the therapist, a new type of therapy is now available to people in need who own a computer. **Cybertherapy** refers to psychotherapy that is offered on the Internet, and the people who practice it are called *cybertherapists*. Although this method of delivery may have the advantages of lower or no cost, availability of therapy opportunities for those unable to get to a therapist easily (such as people living in a remote or rural area), access to support groups online, and relative anonymity, there are dangers. There is no guarantee that the cybertherapist has any credentials or training in psychotherapy. Although some therapists use voice or video conferencing, some only use text-based chat. When there is no face-to-face or voice-to-voice contact, the therapist has no access to body language or vocal tones in trying to assess a client's emotional and psychological state. For further information on this subject, an excellent list of the various forms that cybertherapy can take and the strengths and weaknesses of each has been developed by Dr. Azy Barak, a psychologist at the University of Haifa in Israel and an expert in Internet psychotherapy (Barak, 1999; Barak & Hen, 2008; Barak & Suler, 2008). (For more on the application of computers in psychology, see the Applying Psychology to Everyday Life section.)

A group of researchers in Germany found that people who were treated as inpatients and then allowed to "meet" with a group therapist in an Internet chat room showed a significantly lower risk of negative changes in their mental status than a control group (Golkaramnay et al., 2007). The dropout rate from the Internet group was very low, and most patients "attended" the chat room sessions, which suggests that the ease of using a computer to connect to a group-therapy session may make it a viable option for some people needing continued therapy opportunities.

Biomedical Therapies

Just as a therapist trained in psychoanalysis is more likely to use that technique, a therapist whose perspective on personality and behavior is biological will most likely turn to medical techniques to manage disordered behavior. Even psychotherapists who are not primarily biological in orientation may combine psychotherapy with medical treatments that are supervised by a medical doctor working with the psychologist. As medical doctors, psychiatrists are almost inevitably biological in perspective and, thus, use **biomedical therapies** (directly affecting the biological functioning of the body and brain) in addition to any psychotherapy technique they may favor. The biomedical therapies fall into several approaches and may consist of drug therapy, shock therapy, surgical treatments, or noninvasive stimulation techniques.

PSYCHOPHARMACOLOGY

15.8 What are the various types of drugs used to treat psychological disorders?

The use of drugs to control or relieve the symptoms of a psychological disorder is called **psychopharmacology**. Although these drugs are sometimes used alone, they are more often combined with some form of psychotherapy and are more effective as a result

(Kearney & Silverman, 1998; Keller et al., 2000). There are four basic categories of drugs used to treat psychotic disorders, anxiety disorders, the manic phase of mood disorders, and depression.  [Watch the Video, The Basics: Therapies in Action: Biomedical Therapies, at MyPsychLab](#)

ANTIPSYCHOTIC DRUGS Drugs used to treat psychotic symptoms, such as hallucinations, delusions, and bizarre behavior, are called **antipsychotic drugs**. These drugs can be classified into two categories, the classical, or *typical antipsychotics*, and newer *atypical antipsychotics*. The first of the typical antipsychotics to be developed was *chlorpromazine*. The first-generation antipsychotics caused “neurolepsis,” or psychomotor slowing and reduced emotionality, and thus were referred to as *neuroleptics*, due to the neurological side effects they produced (Julien et al., 2011; Preston et al., 2008; Stahl, 2013). **Table 15.3** lists several typical and atypical antipsychotic drugs and their side effects.

Typical antipsychotic drugs work by blocking certain dopamine receptors in the brain, namely the D2 receptor, thereby reducing the effect of dopamine in synaptic transmission (Julien et al., 2011; Preston et al., 2008; Stahl, 2013). However, because they block more pathways in the dopamine system than are involved in psychosis, with prolonged use they tend to cause problems. Such problems include movement disorders similar to those in Parkinson’s disease, sometimes called *extrapyramidal symptoms*, and others such as *tardive dyskinesia*. Tardive dyskinesia is a syndrome caused by long-term treatment and can even persist when typical antipsychotic medications are no longer being used. The syndrome is characterized by the person making facial and tongue movements such as repeatedly sticking their tongue out, grimacing, or constant chewing, or causing repetitive involuntary jerks or dance-like movements of the arms and legs (Julien et al., 2011; Preston et al., 2008; Stahl, 2013).

The atypical antipsychotics may also suppress dopamine but to a much greater degree in the one dopamine pathway that seems to cause psychotic problems. These drugs also block or partially block certain serotonin receptors, resulting in fewer negative side effects and occasionally some improvement in the negative symptoms of schizophrenia (Julien et al., 2011; Preston et al., 2008; Stahl, 2013). Despite their effectiveness, the atypical antipsychotics may also have unwanted side effects, such as weight gain, diabetes, blood lipid level changes, or changes in the electrical rhythms of the heart (Julien et al.,

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Table 15.3**Types of Drugs Used in Psychopharmacology**

CLASSIFICATION	TREATMENT AREAS	SIDE EFFECTS	EXAMPLES
Antipsychotic: Typical antipsychotic	Positive (excessive) symptoms such as delusions or hallucinations	Motor problems, tardive dyskinesia	chlorpromazine, droperidol, haloperidol
Antipsychotic: Atypical antipsychotic	Positive and some negative symptoms of psychoses	Fewer than typical antipsychotic; clozapine may cause serious blood disorder	risperidone, clozapine, aripiprazole
Antianxiety: Minor Tranquilizers	Symptoms of anxiety and phobic reactions	Slight sedative effect; potential for physical dependence	alprazolam, lorazepam, diazepam
Antimanic	Manic behavior	Potential for toxic buildup	lithium, anticonvulsant drugs
Antidepressants: MAOIs	Depression	Weight gain, constipation, dry mouth, dizziness, headache, drowsiness, insomnia, some sexual arousal disorders	iproniazid, isocarboxazid, phenelzine sulfate, tranylcypromine sulfate
Antidepressants: Tricyclics	Depression	Skin rashes, blurred vision, lowered blood pressure, weight loss	imipramine, desipramine, amitriptyline, doxepin
Antidepressants: SSRIs	Depression	Nausea, nervousness, insomnia, diarrhea, rash, agitation, some sexual arousal problems	fluoxetine, sertraline, paroxetine

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2011). One of these, clozapine, can cause a potentially fatal reduction in the white blood cells of the body's immune system in a very small percentage of people. For this reason, the blood of patients on clozapine is closely monitored, and it is not considered to be a "first choice" when selecting treatment options but used more often when other antipsychotic drugs are ineffective (Stahl, 2013).

Newer classes of atypical antipsychotics include *partial dopamine agonists* that affect the release of dopamine rather than blocking its receptors in the brain, and other agents that have agonistic or antagonistic properties for dopamine and serotonin (Stahl, 2013). (An *agonist* facilitates whereas an *antagonist* blocks or reduces effects.) Drugs are also being investigated that are linked to the actions of *glutamate*.  [LINK](#) to Learning Objective 2.2.



 How long do people generally have to take these antipsychotic medications?

In some cases, a person might have a psychotic episode that lasts only a few months or a few years and may need drug treatment only for that time. But in most cases, especially in schizophrenia that starts in adolescence or young adulthood, the medication must be taken for the rest of the person's life. Long-term use of antipsychotics, particularly the older typical drugs, has been associated with a decrease in cognitive functioning such as impaired memory and sedation, possibly due to the chemical actions of the drugs themselves. The hope for newer atypical antipsychotics is that they will not only produce fewer negative side effects but also have less impact on the cognitive processes of those persons taking these drugs (Julien et al., 2011; Stahl, 2013).

ANTIANXIETY DRUGS The traditional **antianxiety drugs** are the minor tranquilizers or *benzodiazepines* such as Xanax, Ativan, and Valium. All of these drugs have a sedative effect and in the right dose can start to relieve symptoms of anxiety within 20 to 30 minutes of taking the drug by mouth (Preston et al., 2008). Although many side effects are possible, the main concern in using these drugs is their potential for addiction as well as abuse in the form of taking larger doses to "escape" (National Institute on Drug Abuse [NIDA], 2002).

MOOD-STABILIZING DRUGS For many years, the treatment of choice for bipolar disorder and episodes of mania has been *lithium*, a metallic chemical element that in its salt form (lithium carbonate) evens out both the highs and the lows of bipolar disorder. It is generally recommended that treatment with lithium continue at maintenance levels in people with recurring bipolar disorder. Lithium affects the way sodium ions in neuron and muscle cells are transported, although it is not clear exactly how this affects mood. Side effects typically disappear quickly, although the use of lithium has been associated with weight gain. Diet needs to be controlled when taking lithium because lowered levels of sodium in the diet can cause lithium to build up to toxic levels, as can any substance that removes water from the body such as the caffeine in sodas, tea, and coffee.

Anticonvulsant drugs, normally used to treat seizure disorders, have also been used to treat mania. Examples are carbamazepine, valproic acid (Depakote), and lamotrigine. These drugs can be as effective in controlling mood swings as lithium and can also be used in combination with lithium treatments (Bowden et al., 2000; Thase & Sachs, 2000). Some atypical antipsychotics work as mood stabilizers and may be used alone or in conjunction with anticonvulsant medications (Julien et al., 2011; Preston et al., 2008; Stahl, 2013).

ANTIDEPRESSANT DRUGS As is so often the case in scientific discoveries, the first types of drugs used in the treatment of depression were originally developed to treat other disorders. Iproniazid, for example, was used to treat tuberculosis symptoms in the early 1950s and was found to have a positive effect on mood, becoming the first modern

antidepressant (Trujillo & Chinn, 1996). This drug became the first of the *monoamine oxidase inhibitors* (MAOIs), a class of antidepressants that blocks the activity of an enzyme called monoamine oxidase. Monoamine oxidase is the brain's "cleanup worker" because its primary function is to break down the neurotransmitters norepinephrine, serotonin, and dopamine—the three neurotransmitters most involved in control of mood. Under normal circumstances, the excess neurotransmitters are broken down *after* they have done their "job" in mood control. In depression, these neurotransmitters need more time to do their job, and the MAOIs allow them that time by inhibiting the enzyme's action.

Some common MAOIs in use today are isocarboxazid (Marplan), phenelzine sulfate (Nardil), and tranylcypromine sulfate (Parnate). These drugs can produce some unwanted side effects, although in most cases the side effects decrease or disappear with continued treatment: weight gain, constipation, dry mouth, dizziness, headache, drowsiness or insomnia, and sexual arousal disorders are possible. People taking MAOIs in general should also be careful about eating certain smoked, fermented, or pickled foods, drinking certain beverages, or taking some other medications due to a risk of severe high blood pressure in combination with consumption of these items, although there are a couple of MAOIs that do not require any dietary restrictions (Stahl, 2013). And while these precautions are very important, certain drug-drug interactions may be more common and sometimes even lethal, so individuals taking MAOIs should work closely with their health-care professionals to monitor adverse drug interactions (Julien et al., 2011; Preston et al., 2008; Stahl, 2013).

The second category of antidepressant drug to be developed is called the *tricyclic antidepressants*. These drugs were discovered in the course of developing treatments for schizophrenia (Trujillo & Chinn, 1996). Tricyclics, so called because of their molecular structure consisting of three rings (cycles), increase the activity of serotonin and norepinephrine in the nervous system by inhibiting their reuptake into the synaptic vesicles of the neurons.  [Learning Objective 2.2](#). Some common tricyclics are imipramine (Tofranil), desipramine (Norpramin, Pertofrane), amitriptyline (Elavil), and doxepin (Sinequan, Adapin). Side effects of these drugs, which may also decrease over the course of treatment, are very similar to those of the MAOIs but can also include skin rashes, blurred vision, lowered blood pressure, and weight gain (Julien et al., 2011; Preston et al., 2008; Stahl, 2013).

The effect of the MAOIs and the tricyclics on the action of the three critical neurotransmitters led researchers to try to develop drugs that would more specifically target the critical neural activity involved in depression with fewer negative side effects. This led to the development of the *selective serotonin reuptake inhibitors* (SSRIs), drugs that inhibit the reuptake process of only serotonin. This causes fewer side effects while still providing effective antidepressant action, making these drugs relatively safe when compared to the older antidepressants. But like the other two classes of antidepressants, the SSRIs may take from 2 to 6 weeks to produce effects. Some of the better-known SSRIs are fluoxetine (Prozac), sertraline (Zoloft), and paroxetine (Paxil). Other classes of antidepressants have been or are being investigated, including *serotonin-norepinephrine reuptake inhibitors* (SNRIs), *serotonin partial agonist/reuptake inhibitors* (SPARIs), *norepinephrine-dopamine reuptake inhibitors* (NDRIs), *selective norepinephrine reuptake inhibitors* (NRIs), and *serotonin antagonist/reuptake inhibitors* (SARIs).

There is also research examining the potential use of subanesthetic doses of *ketamine* as an antidepressant due to its apparent ability to have immediate antidepressant effects and reduction of suicidal thoughts (Stahl, 2013). The effects are not permanent, but its effects can come on within a few hours and last for several days, and up to a week in some individuals (DiazGranados, Ibrahim, Brutsche, Newberg, et al., 2010; DiazGranados, Ibrahim, Brutsche, Ameli, et al., 2010; Zarate et al., 2012; Zarate et al., 2006). In addition to rapid effects, it appears to also facilitate synaptogenesis and reverse some of the neuronal effects of chronic stress (Duman & Aghajanian, 2012). Drugs that act like ketamine are being investigated for potential use as antidepressants. Ketamine itself is

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an anesthetic, sometimes abused due to its dissociative and hallucinogenic effects (e.g., “Special K” or “K”), or used in cases of sexual assault.

Concerns have arisen that children and teenagers taking newer antidepressant medications may have an increased risk of suicide versus those not receiving treatment. Recent meta-analyses have provided conflicting information, with some data suggesting an increased risk for suicide while other data does not support an increased risk (Gibbons et al., 2012; Hetrick et al., 2012). Where there is an increased risk, it is possible depressive symptoms are being addressed while suicidal thoughts and behavior are not reduced. Regardless, caution is urged, especially in children and teens being treated with newer antidepressant medications.

With regard to other uses for antidepressant medication, in the last several years the use of the benzodiazepines to treat anxiety has declined, and physicians and therapists have begun to prescribe antidepressant drugs to treat anxiety and related disorders such as panic disorder, obsessive-compulsive disorder, and posttraumatic stress disorder. Although the antidepressants take from 3 to 5 weeks to show any effect, they are not as subject to abuse as the minor tranquilizers and have fewer of the same side effects.

Overall, many psychological professionals today believe that combining psychotherapy with medical therapies—particularly drug therapy—is a more effective approach to treating many disorders. A person dealing with depression may be given an antidepressant drug to alleviate symptoms but may also still need to talk about what it’s like to deal with depression and with needing the medication. Cognitive–behavioral therapy in combination with drug therapy has been shown to be particularly effective in treating depression (Dew et al., 2007; Frank et al., 2007; Rohde et al., 2008). Another study has found that women with recurrent depression benefit from a combination of treatment with antidepressants and monthly maintenance psychotherapy (Frank et al., 2007). Even individuals with such disorders as schizophrenia benefit from psychotherapy, with strategies ranging from family and community support-based programs to individual or group-based cognitive–behavioral therapy proving to be valuable conjunctive therapies to psychopharmacological treatment (Stahl, 2013).  [Watch the Video, Types of Treatment People Use, at MyPsychLab](#)

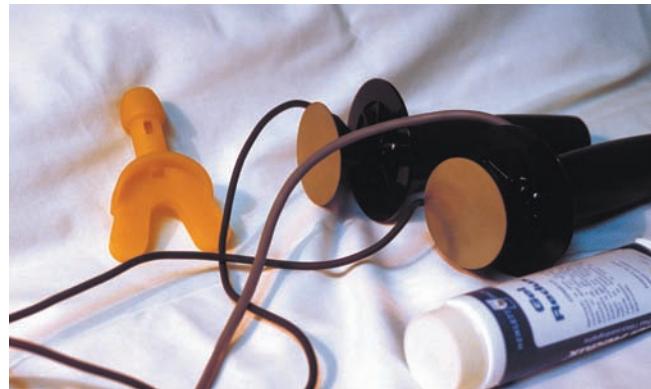
ELECTROCONVULSIVE THERAPY

How are electroconvulsive therapy and psychosurgery used to treat psychological disorders today?

Many people are—well—shocked to discover that **electroconvulsive therapy (ECT)** is still in use to treat cases of severe depression. ECT involves the delivery of an electric shock to either one side or both sides of a person’s head, resulting in a seizure or convulsion of the body and the release of a flood of neurotransmitters in the brain (American Psychiatric Association [APA] Committee on Electroconvulsive Therapy, 2001). The result is an almost immediate improvement in mood, and ECT is used not only in severe cases of depression that have not responded to drug treatments or psychotherapy, or where the side effects of medication are not acceptable, but also in the treatment of several other severe disorders, such as schizophrenia and severe mania, that are not responding to alternate treatments (APA Committee on Electroconvulsive Therapy, 2001; Pompili et al., 2013).

In the 1930s, doctors actually were researching the possible uses of inducing seizures in treating schizophrenia, although the seizures were induced through means of a drug (camphor) in those early experiments. It was Italian researchers Cerletti and Bini who first used electricity to induce a seizure in a man with schizophrenia, who fully recovered after only 11 such treatments (Endler, 1988; Fink, 1984; Shorter, 1997). Soon doctors were using ECT on every kind of severe mental disorder. In those early days, no anesthesia was used because the shock was severe enough to result in a loss of consciousness (most of the time). Broken bones, bitten tongues, and fractured teeth were not untypical “side effects.”

Today's ECT is far more controlled and humane. It is only used to treat severe disorders and written and informed consent is required in most states. ECT has been found to be most useful for severe depression that has not responded to medications or psychotherapy and in cases where suicide is a real possibility or has already been attempted. ECT works more quickly than antidepressant medications, so it can play an important role in helping to prevent suicide attempts (APA Committee on Electroconvulsive Therapy, 2001). However, ECT should not be considered a "cure." It is a way to get a person suffering from severe depression into a state of mind that is more receptive to other forms of therapy or psychotherapy. Relapse is very possible in individuals receiving ECT, and maintenance or continuation therapies are an important treatment strategy to pursue (Nordenskjold et al., 2011; Petrides et al., 2011).



Electroconvulsive therapy consists of applying an electric shock to one or both sides of the head. The result is rapid improvement in mood. It has been shown to be most effective in treating severe depression that has not responded to medication or where medication side effects cannot be tolerated.

ECT does have several negative side effects, some of which last longer than others. Memory is definitely affected, as ECT disrupts the consolidation process and prevents the formation of long-term memories. [LINK](#) to Learning Objective 6.12. This causes both retrograde amnesia, the loss of memories for events that happen close to the time of the treatment, and anterograde amnesia, the rapid forgetting of new material (APA Committee on Electroconvulsive Therapy, 2001; Lisanby et al., 2000; Weiner, 2000). The retrograde effects can extend to several months before and a few weeks after treatment and the older memories may return with time, whereas the anterograde amnesia is more temporary, clearing up in a few weeks after treatment. Only a very few patients suffer more severe and long-lasting cognitive difficulties, and it is not easy to determine whether these difficulties originate with the treatment or the disorder the person exhibits (Smith, 2001). When ECT is used today, an effort is made to reduce as many side effects as possible. The modern patient is given muscle relaxants to reduce the effects of the convulsion as well as a very short-term anesthetic. Despite its efficacy, the utilization of ECT in general is not uniform. In the United States, racial differences in the use of ECT appear to be present, with Black Americans with depression less likely to pursue or receive ECT treatment as compared to White Americans, and the overall use of ECT in general appears to be declining (Case et al., 2013; Case et al., 2012).

What are some of the side effects? Wasn't there something from an earlier chapter about this therapy affecting memory?

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PSYCHOSURGERY

Just as surgery involves cutting into the body, **psychosurgery** involves cutting into the brain to remove or destroy brain tissue for the purpose of relieving symptoms of mental disorders. One of the earliest and best-known psychosurgical techniques is the **prefrontal lobotomy**, in which the connections of the prefrontal cortex to other areas of the brain are severed. The lobotomy was developed in 1935 by Portuguese neurologist

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The woman on the left is Rosemary Kennedy, sister of President John F. Kennedy. The man on the right is her father, U.S. Ambassador to Great Britain Joseph Kennedy. About 6 years after this photograph was taken, Rosemary, who had mild intellectual disability and whose behavior had become difficult to control, was subjected to a transorbital lobotomy. The results were disastrous, and she remained institutionalized until her death on January 7, 2005.



Repetitive transcranial magnetic stimulation (rTMS) uses a pulsating magnetic field to activate specific parts of the brain's surface. As seen above, by placing an electromagnet on the scalp, rTMS can be used to stimulate small areas of the cortex and is being evaluated as a way to control some psychological symptoms, such as those related to depression and PTSD.

Dr. Antonio Egas Moniz, who was awarded the Nobel Prize in medicine for his contribution to psychosurgery (Cosgrove & Rauch, 1995; Freeman & Watts, 1937). Walter Freeman and James W. Watts modified Moniz's technique and developed a procedure called the *transorbital lobotomy*, during which an instrument resembling an ice pick, called a leucotome, was inserted through the back of the eye socket and into the brain to sever the brain fibers. It was this technique that became widely used, and unfortunately sometimes overused, in the pursuit of relief for so many people suffering from mental illness.

But I thought lobotomies left most people worse off than before—didn't it take away their emotions or something?

Although it is true that some of the early lobotomy patients did seem less agitated, anxious, and delusional, it is also true that some early patients did not survive the surgery (about 6 percent died, in fact) and others were left with negative changes in personality: apathy, lack of emotional response, intellectual dullness, and childishness, to name a few. Fortunately, the development of antipsychotic drugs, beginning with chlorpromazine, together with the results of long-term studies that highlighted serious side effects of lobotomies, led to the discontinuation of lobotomies as a psychosurgical technique (Cosgrove & Rauch, 1995; Swayze, 1995). Some famous recipients of the last decades of lobotomies (and the disorders for which the procedure was performed) were Rosemary Kennedy, sister of John F. Kennedy (mild intellectual disability), and Rose Williams, sister of playwright Tennessee Williams (schizophrenia).

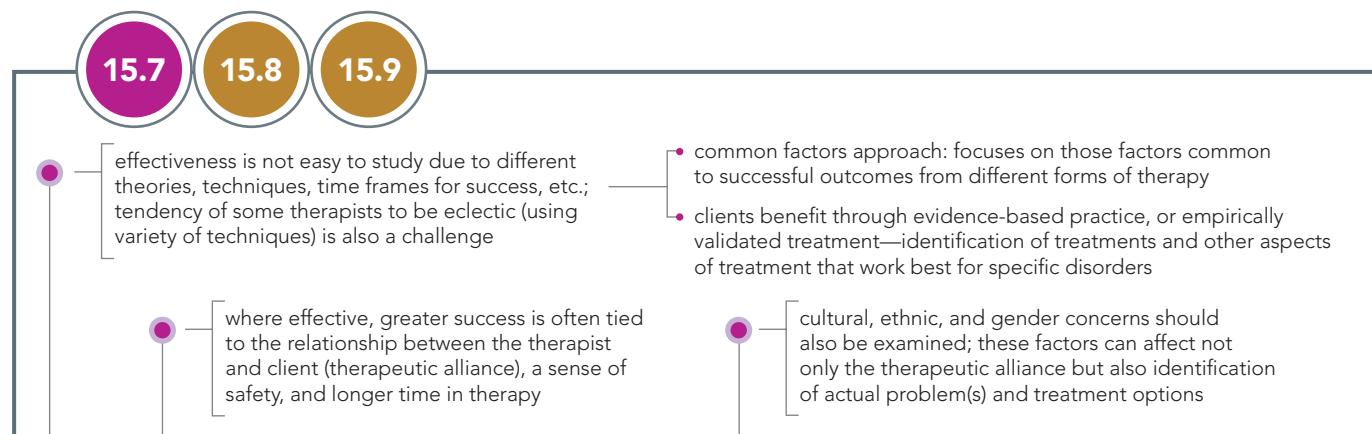
Are there any psychosurgical techniques in use today since the lobotomy is no longer used?

The lobotomy is gone, but there is a different and more modern technique called **bilateral anterior cingulotomy**, in which magnetic resonance imaging, to Learning Objective 2.6, is used to guide an electrode to a specific area of the brain called the cingulate gyrus. This area connects the frontal lobes to the limbic system, which controls emotional reactions. By running a current through the electrode, a very small and specific area of brain cells can be destroyed. This process is called *lesioning*. to Learning Objective 2.6. Cingulotomies have been shown to be effective in about one third to one half of cases of major depression, bipolar disorder, and certain forms of obsessive-compulsive disorder that have not responded to any other therapy techniques (Dougherty et al., 2002; Kuhn et al., 2010; Spangler et al., 1996). Because this is deliberate brain damage and quite permanent, all other possible treatments must be exhausted before a bilateral cingulotomy will be performed and, unlike the early days of lobotomies, it can be performed only with the patient's full and informed consent (Rodgers, 1992; Spangler et al., 1996). In fact, because of the ethical, social, and legal implications of psychosurgery in general, today only a very small number of such surgeries are carried out in a few medical centers across the world (Cosgrove & Rauch, 1995).

EMERGING TECHNIQUES

Some new noninvasive techniques for effecting changes in the brain were discussed in Chapter Two including repetitive transcranial magnetic stimulation (rTMS), where magnetic pulses are applied to the cortex, and transcranial direct current stimulation (tDCS), which uses scalp electrodes to pass very low amplitude direct currents to the brain. These new and exciting strategies are being evaluated as possible treatment options for a variety of psychological disorders or in assisting researchers to better understand the brain mechanisms underlying them, including PTSD, depression, stroke, spinal cord injuries, and ADHD, along with many others (Adeyemo et al., 2012; Benito et al., 2012; Boggio et al., 2009; Cristancho et al., 2013; Helfrich et al., 2012; Nitsche et al., 2009). Another technique highlighted in Chapter Two is deep brain stimulation (DBS), and it is being evaluated as a treatment modality for both depression and OCD (Harvard Mental Health

Letter, 2010; Huff et al., 2010). Exciting research is also investigating the use of DBS for individuals with chronic anorexia nervosa who have not responded well to other treatments, with initial results suggesting some individuals have improved body mass index (BMI), mood, and anxiety symptoms after DBS treatment (Lipsman et al., 2013).

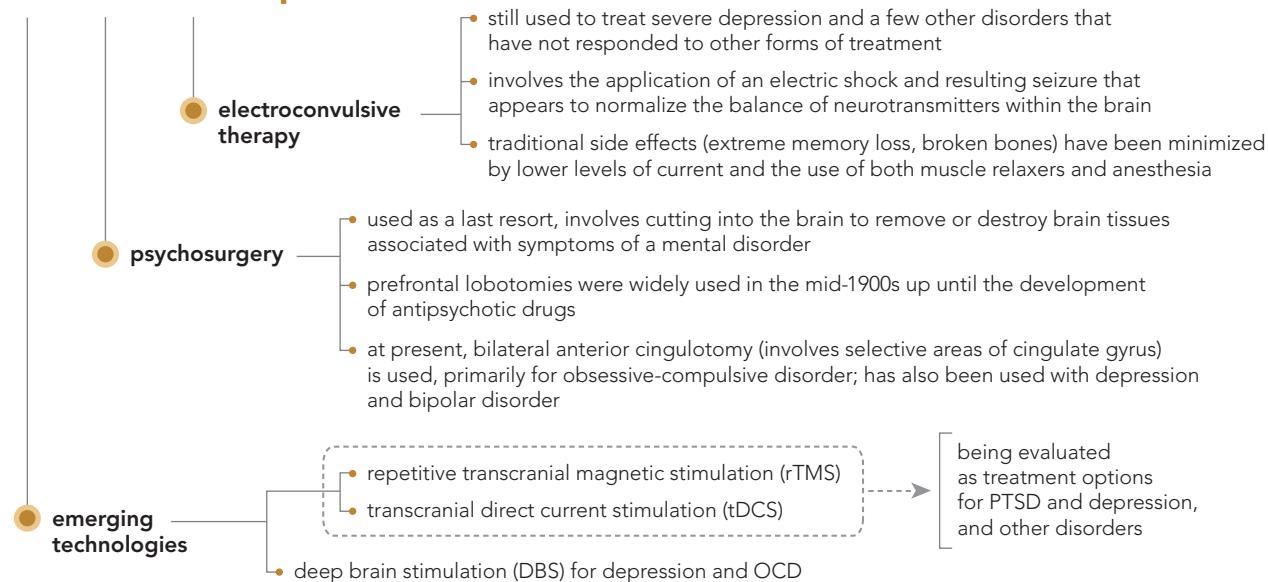


Does Psychotherapy Work?

psychopharmacology
the use of drugs to control or relieve the symptoms of a psychological disorder; may be used alone or in combination with other therapies (see Table 15.3)

- antipsychotic drugs:** treat psychotic symptoms such as hallucinations, delusions, and bizarre behavior; include the typical antipsychotics, atypical antipsychotics, and partial dopamine agonists; work by blocking certain dopamine receptors in the brain; long-term use has variety of risks, both behavioral and cognitive
- antianxiety drugs:** address anxiety and related disorders; include the minor tranquilizers (benzodiazepines) that have a sedative effect—also have potential for addiction and abuse; antidepressant drugs also used to treat anxiety disorders
- antimanic drugs:** address the manic episodes associated with bipolar disorder; most common is lithium; may also include anticonvulsants and antidepressants
- antidepressant drugs:** are used to treat symptoms of depression and include monoamine oxidase inhibitors (MAOIs), tricyclic antidepressants, and selective serotonin reuptake inhibitors (SSRIs)

Biomedical Therapies



(continued)

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PRACTICE quiz How Much Do You Remember?

ANSWERS AVAILABLE IN ANSWER KEY.

Pick the best answer.

1. Dr. Cavendish is trying to establish what is known as a therapeutic alliance with her clients. What specifically should she do to accomplish this goal?
 - a. She should work to better understand the disorder that she is treating.
 - b. She should be more confrontational in her approach so as to make clients aware of their difficulties.
 - c. She should be more empathetic and caring when working with her clients.
 - d. She should openly consult with others on all cases to ensure quality therapeutic treatment.
 2. Research shows that African American clients prefer a therapist _____ while Asian men prefer a _____ therapist.
 - a. of the opposite sex; male
 - b. of the same sex; female
 - c. of the same culture; Hispanic
 - d. who is female; White
 3. What do studies show about the overall effectiveness of cybertherapy?
 - a. It is a fad, and studies indicate that cybertherapy is relatively ineffective.
 - b. Cybertherapy can be effective for people who otherwise might be unable to get to a therapist.
 - c. Studies indicate that many clients who use chat rooms as part of their cybertherapy often stop showing up after 1–2 sessions.
 - d. There currently are not enough studies to indicate whether cybertherapy is or is not effective.
4. Why are antidepressants taking the place of many antianxiety drugs in the treatment of anxiety disorders?
 - a. Antidepressants are more cost effective.
 - b. Antianxiety drugs may be addictive and have more side effects.
 - c. Antianxiety drugs are becoming less effective.
 - d. Antianxiety drugs are actually no longer available.
 5. Today's electroconvulsive shock therapy is often quite useful in the treatment of
 - a. dissociative identity disorder.
 - b. schizophrenia.
 - c. mild anxiety.
 - d. severe depression.
 6. A new therapeutic technique known as deep brain stimulation (DBS) is showing promise in the treatment of
 - a. anorexia nervosa where other treatments have failed.
 - b. phobias.
 - c. personality disorders.
 - d. mania.

THINKING CRITICALLY:

At what age do you think children and/or teenagers should be able to decide if they will take medications to treat abnormal psychological functioning or behavior?



Virtual reality can be used to expose patients to phobic objects and situations. Dr. JoAnn Difede, director of the Anxiety and Traumatic Stress Studies Program at Weill Cornell Medical College, left, has adapted virtual reality therapy to treat World Trade Center survivors.

Applying Psychology to Everyday Life: Virtual Reality Therapies

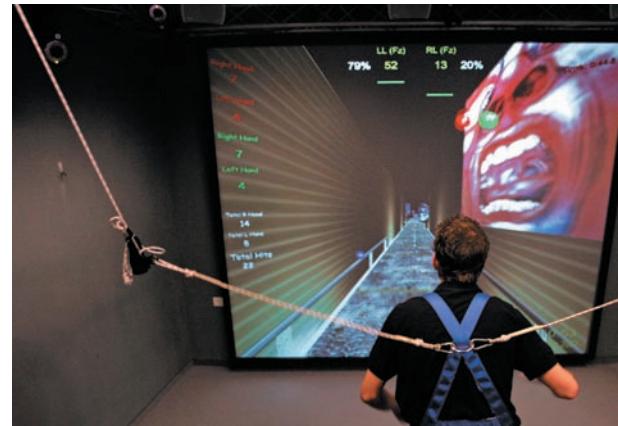
How might computers be used in psychotherapy?

Virtual reality is a software-generated three-dimensional simulated environment. Imagine yourself playing a video game, but instead of viewing your character on the screen in front of you, you are immersed in the visual and auditory world created by the game designers, seeing and hearing through the eyes and ears of your character. While playing a video game in this manner might be a lot of fun, there are some very practical uses of virtual reality (VR) for treating psychological disorders.

One of the main uses of VR as a therapy incorporates exposure therapy of some form. Exposure therapy involves preventing a person with a phobia, for example, from avoiding the presentation of the phobic object—preventing the typical avoidance response and eventually resulting in extinction of the conditioned fear. Using VR ensures that the person being treated cannot avoid exposure, as the sight and sound of the animal, open spaces, or whatever the phobia involves is always right in front of him or her. A study that was conducted at the University of Manchester, England, and led by Professor

Nick Tarrier focused on helping people with phobias about driving cars by having them wear sophisticated goggles that allowed them to experience a virtual driving environment (University of Manchester, 2009). Special sensors on chest and fingers measured anxiety levels. The real advantage of VR psychotherapy was that there was no physical risk to the phobic driver, therapist, or other drivers on a real road.

Posttraumatic stress disorder (PTSD) is another mental health issue benefiting from the use of VR psychotherapy. Cases of this disorder are rising (and with the BP oil spill disaster discussed in Chapter Fourteen and other such stressors, psychologists expect the number of PTSD cases to continue to rise), and traditional treatments are not always effective. Although still a relatively new area of research, evidence suggests virtual reality psychotherapy may be as effective as traditional exposure methods in the treatment of PTSD and may especially be appealing for clients that do not want to pursue traditional exposure methods or techniques (Goncalves et al., 2012; Motraghi et al., 2013). Another advantage is the more vivid and realistic imagery possible with VR, especially for patients who are asked to “imagine” the scenarios that disturb them who may not be highly skilled in visualization. Think also of the portability of VR: There are currently handheld VR devices that eventually could be used to deliver therapy for PTSD, for example, to survivors of earthquakes, tsunamis, hurricanes, and other massive disasters around the world.



A soldier injured in the Lebanon war undergoes therapy with an Israeli-developed virtual reality “Computer Assisted Rehabilitation Environment” (CAREN) system.

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Questions for Further Discussion

1. What other disorders can you think of that might benefit from virtual reality psychotherapy?
2. Can you think of any disadvantages to this method of therapy?

Writing Prompt

- ▼ Compare and contrast the following forms of psychotherapy: cognitive, humanistic, and behavioral. Identify the focus of each approach as well as areas of agreement and difference.

|

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chapter summary

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Treatment of Psychological Disorders: Past to Present

15.1 How have psychological disorders been treated throughout history, and what are two modern ways they are treated today?

- Mentally ill people began to be confined to institutions called asylums in the mid-1500s. Treatments were harsh and often damaging.
- Philippe Pinel became famous for demanding that the mentally ill be treated with kindness, personally unlocking the chains of inmates at Bicêtre Asylum in Paris, France.
- Psychotherapy involves a person talking to a psychological professional about the person's problems.
- Psychotherapy for the purpose of gaining understanding into one's motives and actions is called insight therapy, whereas psychotherapy aimed at changing disordered behavior directly is called action therapy.
- Biomedical therapy uses a medical procedure to bring about changes in behavior.

Psychotherapy Begins

15.2 What were the basic elements of Freud's psychoanalysis, and how do psychodynamic approaches differ today?

- Sigmund Freud developed a treatment called psychoanalysis that focused on releasing a person's hidden, repressed urges and concerns from the unconscious mind.
- Psychoanalysis uses interpretation of dreams, free association, positive and negative transference, and resistance to help patients reveal their unconscious concerns.
- Freud's original therapy technique is criticized for its lack of scientific research and his own personal biases that caused him to misinterpret much of what his patients revealed.
- Modern psychodynamic therapists have modified the technique so that it takes less time and is much more direct, and they do not focus on the id and sexuality as Freud did.

Humanistic Therapy: To Err Is Human

15.3 What are the basic elements of the humanistic therapies known as person-centered therapy and Gestalt therapy?

- Humanistic therapies focus on the conscious mind and subjective experiences to help clients gain insights.
- Person-centered therapy is very nondirective, allowing the client to talk through problems and concerns while the therapist provides a supportive background.
- The three basic elements of person-centered therapy are authenticity of the therapist in the client's perception, unconditional positive regard given to the client by the therapist, and the empathy of the therapist for the client.

- Gestalt therapy is more directive, helping clients to become aware of their feelings and to take responsibility for their choices in life.
- Gestalt therapists try to help clients deal with things in their past that they have denied and will use body language and other nonverbal cues to understand what clients are really saying.
- Humanistic therapies are also not based in experimental research and work best with intelligent, highly verbal persons.

Behavior Therapies: Learning One's Way to Better Behavior

15.4 How do behavior therapists use classical and operant conditioning to treat disordered behavior, and how successful are these therapies?

- Behavior therapies are action therapies that do not look at thought processes but instead focus on changing the abnormal or disordered behavior itself through classical or operant conditioning.
- Classical conditioning techniques for changing behavior include systematic desensitization, aversion therapy, and exposure therapy.
- Therapies based on operant conditioning include modeling, reinforcement and the use of token economies, and extinction.
- Behavior therapies can be effective in treating specific problems, such as bed-wetting, drug addictions, and phobias, and can help improve some of the more troubling behavioral symptoms associated with more severe disorders.

Cognitive Therapies: Thinking Is Believing

15.5 What are the goals and basic elements of cognitive therapies such as cognitive-behavioral therapy and rational emotive behavior therapy?

- Cognitive therapy is oriented toward teaching clients how their thinking may be distorted and helping clients to see how inaccurate some of their beliefs may be.
- Some of the cognitive distortions in thinking include arbitrary inference, selective thinking, overgeneralization, magnification and minimization, and personalization.
- Cognitive-behavioral therapies are action therapies that work at changing a person's illogical or distorted thinking.
- The three goals of cognitive-behavioral therapies are to relieve the symptoms and solve the problems, to develop strategies for solving future problems, and to help change irrational, distorted thinking.
- Rational emotive behavior therapy is a directive therapy in which the therapist challenges clients' irrational beliefs, often arguing with clients and even assigning them homework.
- Although CBT has seemed successful in treating depression, stress disorders, and anxiety, it is criticized for focusing on the symptoms and not the causes of disordered behavior.

Group Therapies: Not Just for the Shy

15.6 What are the various types of group therapies and the advantages and disadvantages of group therapy?

- Group therapy has the advantages of low cost, exposure to other people with similar problems, social interaction with others, and social and emotional support from people with similar disorders or problems. It has also been demonstrated to be very effective for people with social anxiety.
- Disadvantages of group therapy can include the need to share the therapist's time with others in the group, the lack of a private setting in which to reveal concerns, and the inability of people with severe disorders to tolerate being in a group.
- Group therapy can be accomplished using many styles of psychotherapy and may involve treating people who are all part of the same family, as in family counseling.
- Group therapy can also be accomplished without the aid of a trained therapist in the form of self-help or support groups composed of other people who have the same or similar problems.
- Group therapy is most useful to persons who cannot afford individual therapy and who may obtain a great deal of social and emotional support from other group members.

Does Psychotherapy Really Work?

15.7 How effective is psychotherapy, and what factors influence its effectiveness?

- Eysenck's early survey of client improvement seemed to suggest that clients would improve as time passed, with or without therapy.
- Surveys of people who have received therapy suggest that psychotherapy is more effective than no treatment at all.
- Surveys reveal that 75 to 90 percent of people who receive therapy report improvement, the longer a person stays in therapy the better the improvement, and psychotherapy works as well alone as with drugs.
- Some types of psychotherapy are more effective for certain types of problems, and no one psychotherapy method is effective for all problems.
- Effective therapy should be matched to the particular client and the particular problem, there should exist a therapeutic alliance between therapist and client, and a protected setting in which clients can release emotions and reveal private thoughts is essential.
- When the culture, ethnic group, or gender of the therapist and the client differs, misunderstandings and misinterpretations can occur due to differences in cultural/ethnic values, socioeconomic differences, gender roles, and beliefs.
- The four barriers to effective psychotherapy that exist when the backgrounds of client and therapist differ are language, cultural values, social class, and nonverbal communication.
- Cybertherapy is therapy that is offered on the Internet. Cybertherapists may or may not be trained in psychotherapy, but cybertherapy offers the advantages of anonymity and therapy for people who cannot otherwise get to a therapist.

Biomedical Therapies

15.8 What are the various types of drugs used to treat psychological disorders?

- Biomedical therapies include the use of drugs, induced convulsions, and surgery to relieve or control the symptoms of mental disorders.
- Antipsychotic drugs are used to control delusions, hallucinations, and bizarre behavior and include the typical antipsychotics, atypical antipsychotics, and partial dopamine agonists.
- Antianxiety drugs are used to treat anxiety and related disorders and include the benzodiazepines and certain antidepressant drugs.
- Antimanic drugs are used to treat bipolar disorder and include lithium and certain anticonvulsant drugs.
- Antidepressant drugs are used in the treatment of depression and include monoamine oxidase inhibitors (MAOIs), tricyclic antidepressants, and selective serotonin reuptake inhibitors (SSRIs).

15.9 How are electroconvulsive therapy and psychosurgery used to treat psychological disorders today?

- Electroconvulsive therapy, or ECT, is used to treat severe depression, bipolar disorder, and schizophrenia and involves the use of a muscle relaxant, a short-term anesthetic, and induction of a seizure under controlled conditions.
- One of the earliest psychosurgeries was the prefrontal lobotomy, in which the front part of the frontal lobe was cut away from the back part of the brain, producing effects ranging from a disappearance of symptoms to a lack of emotional response and dulling of mental functions.
- Modern psychosurgery includes the bilateral cingulotomy, used to treat major depression, bipolar disorders, and certain forms of obsessive-compulsive disorder that have not responded to other forms of treatment.
- Emerging technologies for treatment of psychological disorders include repetitive transcranial magnetic stimulation (rTMS), transcranial direct current stimulation (tDCS), and deep brain stimulation (DBS).

Applying Psychology to Everyday Life: Virtual Realities

15.10 How might computers be used in psychotherapy?

- Virtual reality therapy is a computer-based simulation of environments that can be used to treat disorders such as phobias and PTSD with less risk than that of actual exposure to anxiety-provoking stimuli.
- Virtual reality therapy is particularly useful as a delivery system for exposure therapy.

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Pick the best answer.

1. Clara is going to a therapist to gain a better understanding of why she has self-destructive relationships with all her friends. This type of therapy is known as _____ therapy.
 - a. insight
 - b. action
 - c. behavioral
 - d. biomedical
2. The hidden meaning of a dream is the _____ content, according to Freud.
 - a. repressed
 - b. latent
 - c. manifest
 - d. sexual
3. Through the use of _____, a person-centered therapist conveys they are trying to understand the experience of the person they are working with.
 - a. reflection
 - b. unconditional positive regard
 - c. empathy
 - d. authenticity
4. What differentiates motivational interviewing from person-centered therapy?
 - a. Motivational interviewing has specific goals of reducing ambivalence about change and increasing intrinsic motivation to bring changes about while traditional person-centered therapy does not.
 - b. Motivational interviewing focuses on unconscious motives while traditional person-centered therapy focuses on the self.
 - c. Motivational interviewing allows the client to talk about anything they wish while traditional person-centered therapy is more direct.
 - d. Motivational interviewing is a behavioral therapeutic technique while person-centered therapy is a biomedical therapy.
5. Which of the following clients would probably get the least benefit from a humanistic therapy?
 - a. Colin, who is bright but confused about self-image
 - b. Cole, who is very talkative and open in discussing feelings
 - c. Colleen, who enjoys exploring the inner workings of the mind
 - d. Cody, who has a hard time putting thoughts and feelings into words in a logical manner
6. To overcome her fear of balloons, because of the loud sound they might suddenly make should they pop, Bella must sit in a room filled with balloons while the therapist continuously pops each one. After a while, Bella realizes that her fear is unjustified and even begins to pop balloons herself. This technique is known as
 - a. systematic desensitization.
 - b. aversion therapy.
 - c. flooding.
 - d. extinction.
7. Megan's daughter Kayla was afraid of dogs. Megan took Kayla to a therapist to help her overcome her fear but was surprised when the therapist brought a dog into the room. At first Kayla was asked to watch from across the room as the therapist showed her how to approach and pet the dog and not grab its tail. Eventually, Kayla was asked to come over and mimic the behavior she had observed. After just a few sessions, Kayla was no longer fearful of dogs. What technique did the therapist use with Kayla?
 - a. virtual exposure
 - b. aversion therapy
 - c. flooding
 - d. participant modeling
8. Maria sat down with her daughter, Zoe, and together wrote out a list of things that Zoe was expected to do each day and the rewards she would get if she accomplished them, as well as the penalties she would face if she did not do them. This is most like which technique?
 - a. token economy
 - b. time-out
 - c. extinction
 - d. contingency contracting
9. For both children and adults, and for many undesirable behaviors, the use of _____ or some form of "time-out" can be quite effective.
 - a. arbitrary inference
 - b. extinction
 - c. positive reinforcement
 - d. negative reinforcement
10. Stephan gets a text message from his girlfriend saying that she will have to work overtime tonight. Stephan immediately assumes his girlfriend is seeing someone else at work. Beck would say that Stephan has engaged in what type of distorted thinking?
 - a. arbitrary inference
 - b. selective thinking
 - c. overgeneralization
 - d. personalization
11. Devin's wife comes home angry from her job, and he immediately assumes that he has done something wrong. Such irrational thinking is an example of
 - a. overgeneralization.
 - b. personalization.
 - c. arbitrary inference.
 - d. selective thinking.
12. Latanya tends to blow negative events out of proportion to their importance (magnification) while ignoring relevant positive events (minimization). What therapeutic technique may work best to help Latanya?
 - a. group therapy
 - b. virtual therapy
 - c. bilateral anterior cingulotomy
 - d. rational emotive behavior therapy (REBT)

13. Which therapy style requires the therapist to actively confront a client's irrational beliefs?
- person-centered
 - frontal lobotomy
 - rational emotive behavior therapy (REBT)
 - cognitive restructuring
14. Family therapy is a form of group therapy in which
- non-professionals lead a selected group of family members with similar concerns.
 - the entire family participates as no one person is seen as the problem.
 - family members meet to single out the individual that is causing problems in the family dynamic.
 - psychology professionals treat their own family members.
15. If Dr. Phelps uses an eclectic approach to her work as a therapist, what specifically is she doing?
- Dr. Phelps tends to rely on the unconscious as the source for all therapeutic treatments.
 - Dr. Phelps tends to rely on a behavioral approach in the treatment of her clients.
 - Dr. Phelps uses only the newest and most innovative approaches to treating her clients.
 - Dr. Phelps uses one, or a combination, of any number of therapeutic treatments depending on the situation.
16. With regard to treatment of psychological disorders, many psychological professionals believe medications work best in combination with
- electroconvulsive therapy.
 - psychotherapy.
 - psychosurgery.
 - deep brain stimulation.
17. Typical antipsychotic drugs work by blocking what neurotransmitter?
- norepinephrine
 - serotonin
 - dopamine
 - epinephrine
18. Bradley has been on an antipsychotic drug for many years to control his schizophrenia. He has developed repetitive, involuntary jerks and movements of the face, lips, legs, and body. These side effects make up a syndrome known as
- the "Thorazine shuffle."
 - neurolepsis.
 - tardive dyskinesia.
 - psychotic syndrome.
19. As part of the medical treatment trial she is participating in for severe and suicidal depression, Kierra was given _____, which is being investigated due to its seemingly immediate, although short-term, effects
- ketamine
 - lithium
 - valproic acid
 - paroxetine
20. In bilateral anterior cingulotomy,
- the front of the brain is cut away from the back.
 - a thin wire electrode is used to destroy a small area of brain tissue.
 - an electric shock is used to stimulate certain areas of the brain.
 - a drug is injected into the brain to destroy a large area of brain tissue.

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statistics in psychology

Why study statistics?

Psychology is a science, and scientists must have ways of describing, summarizing, and analyzing the numerical data gathered through systematic observation and experimentation. Statistics allow researchers to do all of these things in a meaningful, logical fashion.

A.1

Why are statistics important to psychologists and psychology majors?

A.2

What types of tables and graphs represent patterns in data?

A.3

What types of statistics examine central tendencies in data?

A.4

What types of statistics examine variations in data?

A.5

How can statistics be used to determine if differences in sets of data are large enough to be due to something other than chance variation?

A.6

How are statistics used to predict one score from another?

A.1

Why are statistics important to psychologists and psychology majors?

Many students in psychology wonder why the field uses such seemingly complicated mathematics. The answer is easy. Psychologists base their field on research findings. Data are collected and they have to be analyzed. *Statistics* is the field that gives us the tools to do that.

Psychologists have to be able to do two things with the data they collect. The first is to summarize the information from a study or experiment. The second is to make judgments and decisions about the data. We are interested if groups differ from each other. We are also interested in how one group of variables is related to another.

Statistical analysis is a way of trying to account for the error that exists in almost any body of data. Psychology is only one of many fields that use the following types of statistics.

In this appendix we will take a look at describing data—seeing if groups differ from each other and seeing if two variables are related to each other. Those are the basic ideas of psychological statistics. The more advanced techniques are just bigger and better versions of these ideas. Many psychology students sometimes panic at the thought of taking statistics. However, it is crucial to the field and not really that hard if you put your mind to it and don't freeze yourself up. Why is it so important? Even if you are not the kind of psychologist who uses statistics on a daily basis, all psychologists have to be able to read and understand the research others are doing, and understanding what the statistical analyses of that research is really saying is crucial. Here's a practical hint: Students with good research and statistical skills are much more employable and make more money than those who don't try to master research skills. It's nice to care about people, but you need all the skills you can get in today's world. Statistics and research design is one really profitable set of skills.

A.1

A.2

A.3

A.4

A.5

A.6

Statistics are calculated from a **sample**, a group of people selected, usually randomly, from a larger population of people. If you asked what the average height of teenage males was, and you calculated the average from just your high school, that average would be a statistic. **Statistics** is the branch of mathematics that is concerned with the collection and interpretation of data from samples (Agresti & Finlay, 1997; Aron et al., 2005).

Descriptive Statistics

Descriptive statistics are a way of organizing numbers and summarizing them so that they can be understood. There are two main types of descriptive statistics:

- **Measures of Central Tendency.** Measures of central tendency are used to summarize the data and give you one score that seems typical of your sample.
- **Measures of Variability.** Measures of variability are used to indicate how spread out the data are. Are they tightly packed or are they widely dispersed?

The actual descriptive statistics are best understood after we explain the concept of a frequency distribution.

One way psychologists get started in a research project is to look at their data, but just looking at a list of numbers wouldn't do much good. So we make a graph or chart. Then we can look for patterns.

FREQUENCY DISTRIBUTIONS

What types of tables and graphs represent patterns in data?

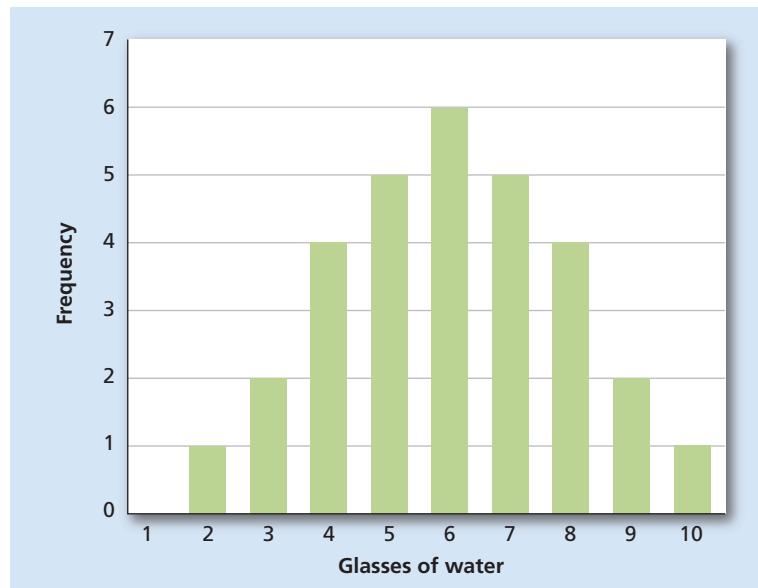
A **frequency distribution** is a table or graph that shows how often different numbers, or scores, appear in a particular set of scores. For example, let's say that you have a sample of 30 people, the size of some psychology classes. You ask them how many glasses of water they drink each day. You could represent the answers as shown in **Table A.1**. Just by looking at this table, it is clear that typical people drink between 4 and 8 glasses of water a day.

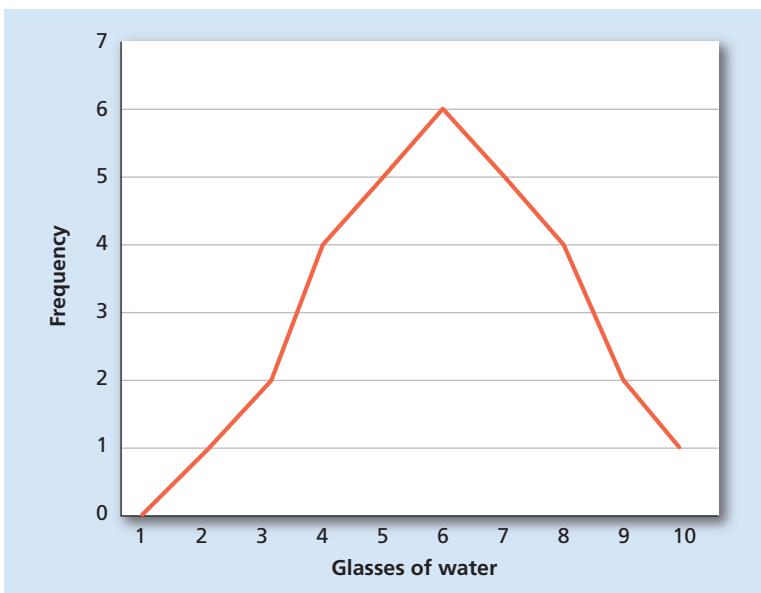
Tables can be useful, especially when dealing with small sets of data. Sometimes a more visual presentation gives a better "picture" of the patterns in a data set, and that is when researchers use graphs to plot the data from a frequency distribution. One common graph is a **histogram**, or a bar graph. **Figure A.1** shows how the same data from Table A.1 would look in a bar graph.

NUMBER OF GLASSES PER DAY	NUMBER OF PEOPLE OUT OF 30 (FREQUENCY)
1	0
2	1
3	2
4	4
5	5
6	6
7	5
8	4
9	2
10	1

Figure A.1 A Histogram

Histograms, or bar graphs, provide a visual way to look at data from frequency distributions. In this graph, for example, the height of the bars indicates that most people drink between 4 and 8 glasses of water (represented by the five highest bars in the middle of the graph).



**Figure A.2 A Polygon**

A polygon is a line graph that can represent the data in a frequency distribution in much the same way as a bar graph but allows the shape of the data set to be easily viewed.

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Another type of graph used in frequency distributions is the **polygon**, a line graph.

Figure A.2 shows the same data in a polygon graph.

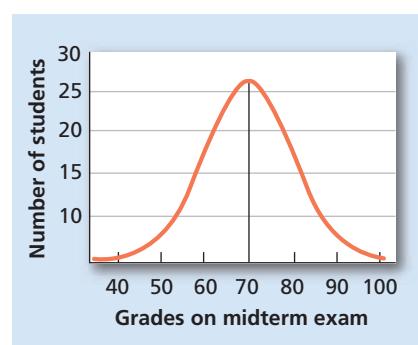
THE NORMAL CURVE

Frequency polygons allow researchers to see the shape of a set of data easily. For example, the number of people drinking glasses of water in Figure A.2 is easily seen to be centered about 6 glasses (central tendency) but drops off below 4 glasses and above 8 glasses a day (variability). Our frequency polygon has a high point and the frequency decreases on both sides.

A common frequency distribution of this type is called the **normal curve**. It has a very specific shape and is sometimes called the *bell curve*. Look at **Figure A.3**. This curve is almost a perfect normal curve, and many things in life are not that perfect. The normal curve is used as a model for many things that are measured, such as intelligence, height, or weight, but even those measures only come close to a perfect distribution (provided large numbers of people are measured). One of the reasons that the normal curve is so useful is that it has very specific relationships to measures of central tendency and a measurement of variability, known as the standard deviation.

OTHER DISTRIBUTION TYPES: SKEWED AND BIMODAL Distributions aren't always normal in shape. Some distributions are described as *skewed*. This occurs when the distribution is not even on both sides of a central score with the highest frequency (like in our example). Instead, the scores are concentrated toward one side of the distribution. For example, what if a study of people's water-drinking habits in a different class revealed that most people drank around 7 to 8 glasses of water daily, with no one drinking more than 8? The frequency polygon shown in **Figure A.4** on the next page reflects this very different distribution.

In this case, scores are piled up in the high end with most people drinking 7 or 8 glasses of water a day. The graphs in **Figure A.5** on the next page show a **skewed distribution**. Skewed distributions are called positively or negatively skewed, depending on where the scores are concentrated. A concentration in the high end would be called **negatively skewed**. A concentration in the low end would be called **positively skewed**. The direction of the extended tail determines whether it is positively (tail to right) or negatively (tail to left) skewed. Here's an example. What do you think about the distribution of

**Figure A.3 The Normal Curve**

The normal curve, also known as the bell curve because of its unique shape, is often the way in which certain characteristics such as intelligence or weight are represented in the population. The highest point on the curve typically represents the average score in any distribution.

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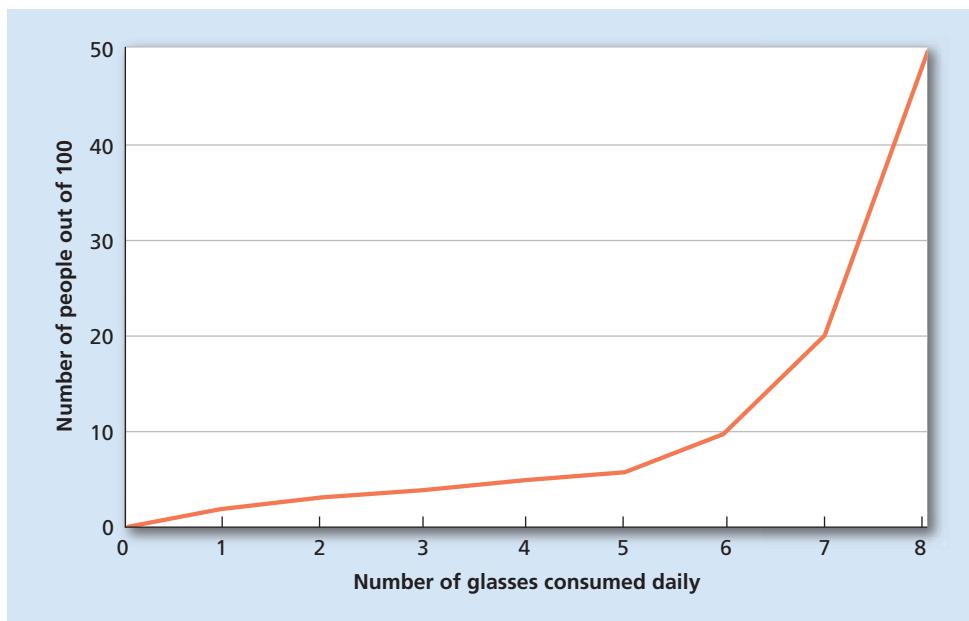
A.4

A.5

A.6

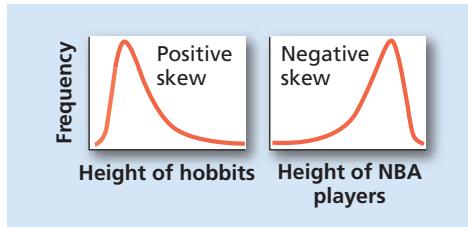
Figure A.4 A Frequency Polygon

Skewed distributions are those in which the most frequent scores occur at one end or the other of the distribution, as represented by this frequency polygon in which most people are seen to drink at least 7 to 8 glasses of water each day.

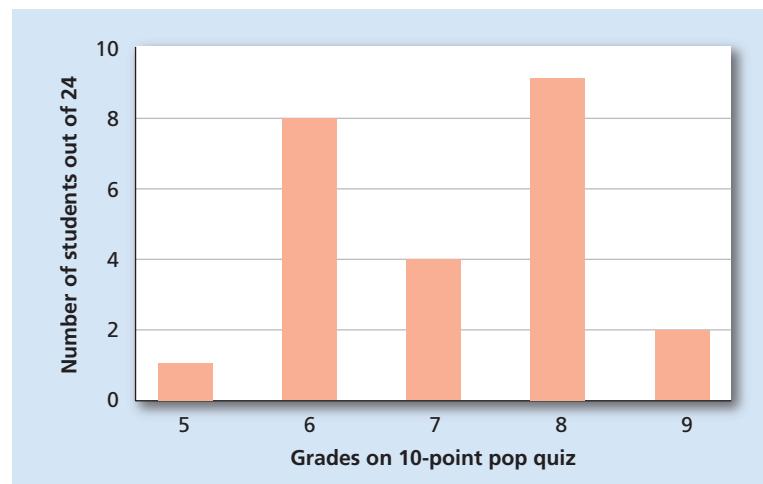


heights of hobbits (the little guys from *The Lord of the Rings*) and NBA basketball players (who are usually tall)? Might not these frequency distributions of height in Figure A.5 be appropriate?

Some frequency polygons show two high points rather than just one (see **Figure A.6**) and are called **bimodal distributions**. In this example, we have a distribution of scores from a 10-point pop quiz and we see that one group of students seemed to do well and one group didn't. Bimodal distributions usually indicate that you have two separate groups being graphed in one polygon. What would the distribution of height for men and women look like?

**Figure A.5 Skewed Distribution**

These frequency polygons show how distributions can be skewed in two different directions. The graph on the left represents the frequency of heights among hobbits (the little people from the fantasy *The Lord of the Rings*) and is positively skewed because the long "tail" goes to the right, or positive direction. The graph on the right shows the frequency of heights among NBA basketball players and is negatively skewed—the tail points to the left.

**Figure A.6 A Bimodal Distribution**

When a distribution is bimodal, it means that there are two high points instead of just one. For example, in the pop-quiz scores represented on this graph there are two "most frequent" scores—6 and 8. This most likely represents two groups of students, with one group being less successful than the other.

MEASURES OF CENTRAL TENDENCY

What types of statistics examine central tendencies in data?

A frequency distribution is a good way to look at a set of numbers, but there's still a lot to look at—isn't there some way to sum it all up? One way to sum up numerical data is to find out what a “typical” score might be, or some central number around which all the others seem to fall. This kind of summation is called a **measure of central tendency**, or the number that best represents the central part of a frequency distribution. There are three different measures of central tendency: the mean, the median, and the mode.

MEAN The most commonly used measure of central tendency is the **mean**, the arithmetic average of a distribution of numbers. That simply indicates that you add up all the numbers in a particular set and then divide them by how many numbers there are. This is usually the way teachers get the grade point average for a particular student, for example. If Rochelle's grades on the tests she has taken so far are 86, 92, 87, and 90, then the teacher would add $86 + 92 + 87 + 90 = 355$, and then divide 355 by 4 (the number of scores) to get the mean, or grade point average, of 88.75. Here is the formula for the mean:

$$\text{Mean} = \Sigma X/N$$

What does this mean?

- Σ is a symbol called sigma. It is a Greek letter and it is also called the summation sign.
- X represents a score. Rochelle's grades are represented by X .
- ΣX means add up or sum all the X scores or
 $\Sigma X = 86 + 92 + 37 + 90 = 355$.
- N means the number of scores. In this case, there are four grades.

We then divide the sum of the scores (ΣX) by N to get the mean or

$$\text{Mean} = \Sigma X/N = \frac{355}{4} = 88.75$$

The mean is a good way to find a central tendency if the set of scores clusters around the mean with no extremely different scores that are either far higher or far lower than the mean.

MEDIAN

 I remember that sometimes my teacher would “curve” the grades for a test, and it was always bad when just one person did really well and everyone else did lousy—is that what you mean about extremely different scores?

Yes, the mean doesn't work as well when there are extreme scores, as you would have if only two students out of an entire class had a perfect score of 100 and everyone else scored in the 70s or lower. If you want a truer measure of central tendency in such a case, you need one that isn't affected by extreme scores. The **median** is just such a measure. A median is the score that falls in the middle of an *ordered* distribution of scores. Half of the scores will fall above the median, and half of the scores will fall below it. If the distribution contains an odd number of scores, it's just the middle number, but if the number of scores is even, it's the average of the two middle scores. The median is also the 50th percentile. Look at **Table A.2** on the next page for an example of the median.

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- A.2
- A.3
- A.4
- A.5
- A.6

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Table A.2**Intelligence Test Scores For 10 People**

NAME IQ	ALLISON 160	BEN 150	CAROL 139	DENISE 102	EVAN 102	FETHIA 100	GEORGE 100	HAL 100	INGA 98	JAY 95
------------	----------------	------------	--------------	---------------	-------------	---------------	---------------	------------	------------	-----------

The mean IQ of this group would be 114.6, but the median would be 101 (the average between Evan with 102 and Fethia with 100, the average of the two middle numbers). This may not look like much of a difference, but it's really a change of about 13.6 IQ points—a big difference. Also, think about measures of income in a particular area. If most people earn around \$35,000 per year in a particular area, but there are just a few extremely wealthy people in the same area who earn \$1,000,000 a year, a mean of all the annual incomes would no doubt make the area look like it was doing much better than it really is economically. The median would be a more accurate measure of the central tendency of such data.

MODE The **mode** is another measure of central tendency, in which the most frequent score is taken as the central measure. In the numbers given in Table A.2, the mode would be 100 because that number appears more times in the distribution than any other. Three people have that score. This is the simplest measure of central tendency and is also more useful than the mean in some cases, especially when there are two sets of frequently appearing scores. For example, suppose a teacher notices that on the last exam the scores fall into two groups, with about 15 students making a 95 and another 14 students making a 67. The mean *and* the median would probably give a number somewhere between those two scores—such as 80. That number tells the teacher a lot less about the distribution of scores than the mode would because, in this case, the distribution is **bimodal**—there are two very different yet very frequent scores. (Refer back to Figure A.6 for another example.)

MEASURES OF CENTRAL TENDENCY AND THE SHAPE OF THE DISTRIBUTION When the distribution is normal or close to it, the mean, median, and mode are the same or very similar. There is no problem. When the distribution is not normal, then the situation requires a little more explanation.

Skewed Distributions If the distribution is skewed, then the mean is pulled in the direction of the tail of the distribution. The mode is still the highest point and the median is between the two. Let's look at an example. In **Figure A.7** we have a distribution of salaries at a company. A few people make a low wage, most make a mid-level wage, and the bosses make a lot of money. This gives us a positively skewed distribution with the measures of central tendency placed as in the figure. As mentioned earlier, with such a distribution, the median would be the best measure of central tendency to report. If the distribution were negatively skewed (tail to the left), the order of the measures of central tendency would be reversed.

Bimodal Distributions If you have a bimodal distribution, then none of the measures of central tendency will do you much good. You need to discover why you have seemingly two groups in your one distribution.

MEASURES OF VARIABILITY

What types of statistics examine variations in data?

Descriptive statistics can also determine how much the scores in a distribution differ, or vary, from the central tendency of the data. These **measures of variability** are used to discover how “spread out” the scores are from each other. The more the scores cluster around the central scores, the smaller the measure of variability will be, and the more widely the

scores differ from the central scores, the larger this measurement will be.

There are two ways that variability is measured. The simpler method is by calculating the **range** of the set of scores, or the difference between the highest score and the lowest score in the set of scores. The range is somewhat limited as a measure of variability when there are extreme scores in the distribution. For example, if you look at Table A.2, the range of those IQ scores would be 160–95, or 65. But if you just look at the numbers, you can see that there really isn't that much variation except for the three highest scores of 139, 150, and 160.

The other measure of variability that is commonly used is the one that is related to the normal curve, the **standard deviation**. This measurement is simply the square root of the average squared difference, or deviation, of the scores from the mean of the distribution. The mathematical formula for finding the standard deviation looks complicated, but it is really nothing more than taking each individual score, subtracting the mean from it, squaring that number (because some numbers will be negative and squaring them gets rid of the negative value), and adding up all of those squares. Then this total is divided by the number of scores and the square root of that number is the standard deviation. In the IQ example, it would go like this:

$$\text{Standard Deviation Formula } SD = \sqrt{\sum(X - M)^2/N}$$

The mean (M) of the 10 IQ scores is 114.6. To calculate the standard deviation we

1. Subtract each score from the mean to get a deviation score $\rightarrow (X - M)$
2. We square each deviation score $\rightarrow (X - M)^2$
3. We add them up. Remember that's what the sigma (Σ) indicates $\rightarrow \sum(X - M)^2$
4. We divide the sum of the squared deviation by N (the number of scores) $\rightarrow \sum(X - M)^2/N$
5. We take the square root ($\sqrt{ }$) of the sum for our final step. $\sqrt{\sum(X - M)^2/N}$

The process is laid out in **Table A.3** on the next page.

The standard deviation is equal to 23.5. What that tells you is that this particular group of data deviates, or varies, from the central tendencies quite a bit—there are some very different scores in the data set, or in this particular instance, three noticeably different scores.

This procedure may look very complicated. Let us assure you that computers and inexpensive calculators can figure out the standard deviation simply by entering the numbers and pressing a button. No one does a standard deviation by hand anymore.

How does the standard deviation relate to the normal curve? Let's look at the classic distribution of IQ scores. It has a mean of 100 and a standard deviation of 15 as set up by the test designers. It is a bell curve. With a true normal curve, researchers know exactly what percent of the population lies under the curve between each standard deviation from the mean. For example, notice that in the percentages in **Figure A.8** on the next page, one standard deviation above the mean has 34.13 percent of the population represented by the graph under that section. These are the scores between the

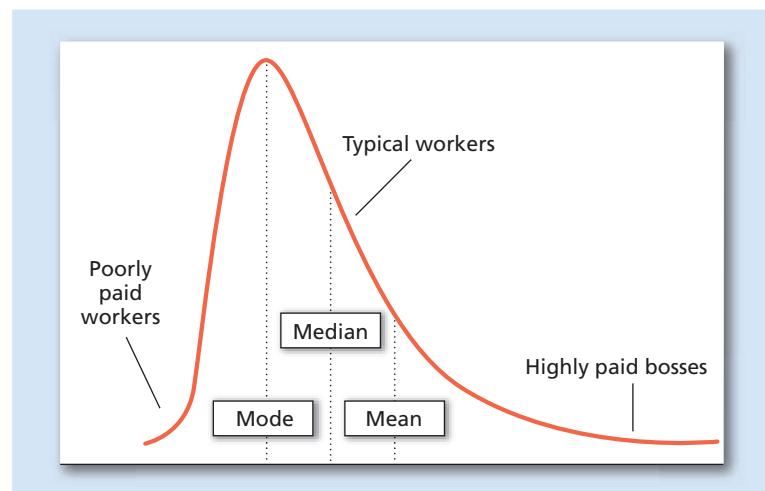


Figure A.7 Positively Skewed Distribution

In a skewed distribution, the high scores on one end will cause the mean to be pulled toward the tail of the distribution, making it a poor measure of central tendency for this kind of distribution. For example, in this graph many workers make very little money (represented by the mode) while only a few workers make a lot of money (the tail). The mean in this case would be much higher than the mode because of those few high scores distorting the average. In this case, the median is a much better measure of central tendency because it tends to be unaffected by extremely high or extremely low scores such as those in this distribution.

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- A.5
- A.6

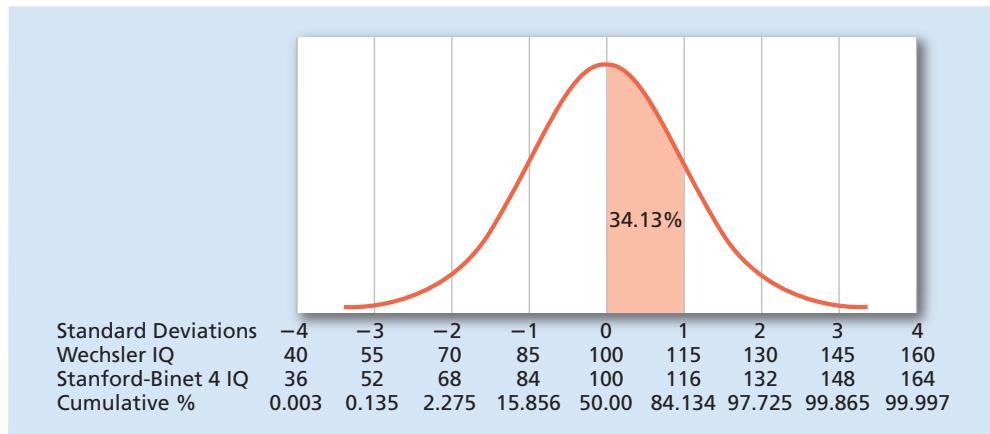
Table A.3
Finding the Standard Deviation

SCORE	DEVIATION FROM THE MEAN ($X \pm M$)	SQUARED DEVIATION
160.00	45.40	2,061.16
	(ex. $160 - 114.60 = 45.40$)	($45.40^2 = 2,061.16$)
150.00	35.4	1,253.16
139.00	24.4	595.36
102.00	-12.60	158.76
102.00	-12.60	158.76
100.00	-14.60	213.16
100.00	-14.60	213.16
100.00	-14.60	213.16
98.00	-16.60	275.56
95.00	-19.60	384.16
Sum of Scores $(\Sigma X) = 1,146.00$	$(\Sigma X - M) = 0.00$	$(\Sigma X - M) = 5,526.40$
Mean = $(\Sigma X)/N$ $= 1,146/10 = 114.60$		Standard Deviation $= \sqrt{[\Sigma(X - M)/N]}$ $= \sqrt{5,526.40/10} = 23.5$

IQs of 100 and 115. One standard deviation below the mean (-1) has exactly the same percent, 34.13, under that section—the scores between 85 to 100. This means that 68.26 percent of the population falls within one standard deviation from the mean, or one average “spread” from the center of the distribution. For example, “giftedness” is normally defined as having an IQ score that is two standard deviations *above* the mean. On the Wechsler Intelligence Scales, this means having an IQ of 130 or greater because the Wechsler’s standard deviation is 15. But if the test a person took to determine giftedness was the Stanford-Binet Fourth Edition (the previous version of the test), the IQ score must have been 132 or greater because the standard deviation of that test was 16, not 15. The current version, the Stanford-Binet Fifth Edition, was published in 2003 and it now has a mean of 100 and a standard deviation of 15 for composite scores.

Figure A.8 IQ Normal Curve

Scores on intelligence tests are typically represented by the normal curve. The dotted vertical lines each represent one standard deviation from the mean, which is always set at 100. For example, an IQ of 116 on the Stanford-Binet Fourth Edition (Stanford-Binet 4) represents one standard deviation above the mean, and the area under the curve indicates that 34.13 percent of the population falls between 100 and 116 on that test. The Stanford-Binet Fifth Edition was published in 2003 and it now has a mean of 100 and a standard deviation of 15 for composite scores.



Although the “tails” of this normal curve seem to touch the bottom of the graph, in theory they go on indefinitely, never touching the base of the graph. In reality, though, any statistical measurement that forms a normal curve will have 99.72 percent of the population it measures falling within three standard deviations either above or below the mean. Because this relationship between the standard deviation and the normal curve does not change, it is always possible to compare different test scores or sets of data that come close to a normal curve distribution. This is done by computing a ***z score***, which indicates how many standard deviations you are away from the mean. It is calculated by subtracting the mean from your score and dividing by the standard deviation. For example, if you had an IQ of 115, your *z* score would be 1.0. If you had an IQ of 70, your *z* score would be –2.0. So on any exam, if you had a positive *z* score you did relatively well. A negative *z* score means you didn’t do as well. The formula for a *z* score is:

$$Z = (X - M)/SD$$

Inferential Statistics

How can statistics be used to determine if differences in sets of data are large enough to be due to something other than chance variation?

Descriptive methods of statistics are not useful when it comes to comparing sets of numbers or scores to see if there are differences between them that are great enough to be caused by something other than chance variation. Inferential statistics consist of statistical techniques that allow researchers to determine the difference between results of a study that are meaningful and those that are merely due to chance variations. **Inferential statistics** also allow researchers to draw conclusions, or make *inferences*, about the results of research and about whether those results are only true for the specific group of animals or people involved in the study or whether the results can be applied to, or *generalized* to, the larger population from which the study participants were selected.

For example, in the Cheryan (Cheryan et al., 2009) study of the difference in male and female students’ attitudes toward computer science when exposed to environments that were either stereotypically masculine or non-stereotypical, there were a lot of variables that simply could not be controlled completely, even with random assignment of participants to the two conditions.  [LINK](#) to Learning Objective 1.1. For example, there was no guarantee that random assignment would account for the interfering effects of female participants who might have really liked the science fiction toys, posters, and pizza they saw in one of the test conditions. Maybe any difference found between the males and females was due to pure luck or chance and not to the variables under study.

In any analysis that compares two or more sets of data, there’s always the possibility of error in the data that comes from either within the group (all participants in one group, for example, will not be exactly like each other) or differences between groups (the experimental group and the control group are formed with different people, so there are differences between the two groups that have nothing to do with the manipulations of the experimenter). When researchers want to know if the differences they find in the data that come from studies like the Cheryan experiment are large enough to be caused by the experimental manipulation and *not* just by the chance differences that exist within and between groups, they have to use a kind of statistical technique that can take those chance variations into account. These kinds of statistical analysis use inferential statistics.

Inferential statistical analysis also allows researchers to determine how much confidence they should have in the results of a particular experiment. As you might

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remember, results from other kinds of studies that look for relationships—observations, surveys, and case studies—are often analyzed with descriptive statistics, especially correlations. But experiments look for *causes* of relationships, and researchers want to have some evidence that the results of their experiments really mean what they think they mean.

STATISTICAL SIGNIFICANCE

There are many different kinds of inferential statistical methods. The method that is used depends on the design of the experiment, such as the number of independent and dependent variables or the number of experimental groups. All inferential statistics have one thing in common—they look for differences in group measurements that are **statistically significant**. Statistical significance is a way to test differences to see how likely those differences are to be real and not just caused by the random variations in behavior that exist in everything animals and people do.

For example, in a classic study investigating the effects of intrinsic versus extrinsic motivation on children's creativity, Dr. Teresa Amabile's 1982 study showed that the collages of the children who were promised prizes (an extrinsic reward) were judged to be less creative than those of the children who created collages just for fun.  to [Learning Objective 9.1](#). But was that difference between the creativity scores of the two groups a real difference, or was it merely due to chance variations in the children's artistic creations? Dr. Amabile used an inferential test on her results that told her that the difference was too big to be just chance variations, which means her results were *significant*—they were most likely to be real differences. How likely? Tests of significance give researchers the probability that the results of their experiment were caused by chance and not by their experimental manipulation. For example, in one test called a *t-test*, the scores of the children's artwork would have been placed into a formula that would result in a single number (*t*) that evaluates the probability that the difference between the two group means is due to pure chance or luck. That number would be compared to a value that exists in a table of possible *t* values, which tells researchers the probability that the result is due to chance or luck. If the number obtained by the calculation is bigger than the value in the table, there will be a probability associated with that number in the table. The probability, symbolized by the letter *p*, will tell researchers the probability that the difference was due to chance. In Dr. Amabile's case, the probability was $p < .05$ which means the probability that the results were due to chance alone was less than 5 out of 100. Another way of stating the same result is that Dr. Amabile could be 95 percent certain that her results were real and not due to chance. Dr. Amabile would, thus, report that the study found a **significant difference**, which means a difference thought not to be due to chance.

There are several statistic techniques to test if groups are different from each other. Here are some common ones you might encounter if you read journal articles.

- *t*-test—determines if two means are different from each other.
- *F*-test or analysis of variance—determines if three or more means are different from each other. Can also evaluate more than one independent variable at a time.
- chi-square—compares frequencies of proportions between groups to see if they are different. For example, the proportion of women hired at a company is too low and might indicate discrimination. *Chi* is pronounced like the beginning of the word *kite*. Don't say "chee." It will be ugly.

If you do take a statistics course, you will find out that most analyses are done by computers and you don't have to manually go through the long formulas.

We've already talked about the correlation coefficient. Let's see how psychologists can predict one variable from another by using it.  to [Learning Objective 1.9](#).

THE CORRELATION COEFFICIENT

How are statistics used to predict one score from another?

A *correlation* is a measure of the relationship between two or more variables. For example, if you wanted to know if scores on the SAT are related to grade point average, you could get SAT scores and GPAs from a group of people and enter those numbers into a mathematical formula, which will produce a number called the **correlation coefficient**. The correlation coefficient represents the direction of the relationship and its strength. Chapter One discusses correlation in more detail and also emphasizes that correlation does not allow the assumption that one variable causes the other.

 Is the formula for the correlation coefficient really complicated?

Actually, the definitional formula for finding a correlation coefficient is not very complicated. Here it is:

$$r = \frac{\sum Z_x Z_y}{n}$$

The r is the correlation coefficient, the number representing the strength and direction of the relationship between the two variables. Z_x and Z_y are the z scores for each score. If you remember, the z score tells you how many standard deviations a score is away from the mean. You would calculate the Z_x and Z_y for each subject, multiply, and add them up. Then divide by the number of subjects. There is a very complicated-looking formula based on the raw scores.

$$r = \frac{\sum XY - \frac{\sum X \sum Y}{N}}{\sqrt{\left(\sum X^2 - \frac{(\sum X)^2}{N}\right)\left(\sum Y^2 - \frac{(\sum Y)^2}{N}\right)}}$$

Don't worry. You can do all this work on inexpensive calculators or on computers using common statistical programs or spreadsheets. Let's take the following example of two sets of scores, one on a test of drawing ability with scores from 1 (poor) to 5 (excellent) and the other on a test of writing ability using the same scale.

	Drawing (X)	Writing (Y)
Student 1	3	5
Student 2	1	2
Student 3	2	3
Student 4	4	4
Student 5	1	3
Student 6	4	6
Student 7	2	3
Student 8	3	4
Student 9	5	5
Student 10	1	2

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If we plugged our data set into our calculator or spreadsheet, we would find that r (the correlation coefficient) equals 0.86. That would indicate a fairly strong correlation. If you continue studies in statistics, you will find out how to see if the correlation coefficient we calculated is statistically significant or, if you recall, not due to just dumb luck when we picked our subjects. In our case, the r is very significant and would happen by chance only 1 in 100 times!

Remember that the correlation coefficient has values that range between +1.0 and -1.0. The closer the r is to these values, the stronger the relationship. A positive r means a positive relationship, whereas a negative r means a negative relationship.

 to Learning Objective 1.9; see Figure 1.3.

Our example had us trying to see if two scores were related. It is also possible to see if three or more scores are related with various techniques. The most common one is called multiple regression.

chapter summary

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A.1 Why are statistics important to psychologists and psychology majors?

- Statistics is a branch of mathematics that involves the collection, description, and interpretation of numerical data.
- Students who understand the process of research and the statistical methods used in research are more desirable to many university and business institutions than those who lack such skills.

Descriptive Statistics

- Descriptive statistics are ways of organizing numbers and summarizing them so that they can be understood.

A.2 What types of tables and graphs represent patterns in data?

- Frequency distributions are tables or graphs that show the patterns in a set of scores and can be a table, a bar graph or histogram, or a line graph or polygon.
- The normal curve is a special frequency polygon that is symmetrical and has the mean, median, and mode as the highest point on the curve.

A.3 What types of statistics examine central tendencies in data?

- Measures of central tendency are ways of finding numbers that best represent the center of a distribution of numbers and include the mean, median, and mode.

A.4 What types of statistics examine variations in data?

- Measures of variability provide information about the differences within a set of numbers and include the range and the standard deviation.

Inferential Statistics

A.5 How can statistics be used to determine if differences in sets of data are large enough to be due to something other than chance variation?

- Inferential statistics involves statistical analysis of two or more sets of numerical data to reduce the possibility of error in measurement and determine statistical significance of the results of research.

A.6 How are statistics used to predict one score from another?

- The correlation coefficient is a number that represents the strength and direction of a relationship existing between two variables.

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ANSWERS AVAILABLE IN ANSWER KEY.

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Pick the best answer.

- Polygons and histograms are examples of
 - frequency distributions.
 - correlations.
 - inferential statistics.
 - mode.
- If a chart shows that more than 80 percent of the students received either an A or B in the class, one would describe the chart as
 - normal distribution.
 - positively skewed.
 - negatively skewed.
 - bell-shaped.
- Your psychology instructor posts the results of the midterm on a histogram chart. On the chart, you see a high frequency of B's and a high frequency of D's. How else might you describe the results?
 - This is a normal curve.
 - This chart is skewed and bimodal.
 - This chart is a typical bell-shaped chart.
 - This chart is incapable of expressing an accurate picture of the results.
- The mean, median, and mode are all measures of
 - correlations.
 - inferential statistics.
 - variability.
 - central tendency.

5. Imagine that the following is a set of grades from your classes' first psychology exam: 71, 71, 71, 73, 75, 76, 81, 86, 97. What is the median score?
- a. 71
 - b. 75
 - c. 9
 - d. 700
6. Imagine that the following is a set of grades from your first psychology exam: 71, 71, 71, 73, 75, 76, 81, 86, 97. What is the mode?
- a. 71
 - b. 75
 - c. 9
 - d. 700
7. In the normal curve,
- a. the mean, median, and mode are all on the highest point of the curve.
 - b. the mean is on the highest point while the median and mode are on either side of the mean.
 - c. the median is on the highest point while the mean and mode are on either side of the median.
 - d. the standard deviation is located at the highest point of the curve.
8. _____ is a way of organizing numbers and summarizing them so that they can be understood whereas _____ allows researchers to draw conclusions about the results of research.
- a. Descriptive statistics; inferential statistics
 - b. Inferential statistics; descriptive statistics
 - c. Correlational research; mean statistics
 - d. Inferential statistics; mean, medium, and mode
9. Dr. White finds that the results of his t-test are significant at $p < .05$. That means that he can be
- a. reasonably assured that the results are not due to chance.
 - b. reasonably assured that the results are due to chance.
 - c. 5 percent certain that the results are not due to chance.
 - d. 95 percent certain that the results are not due to chance.
10. Your best friend tells you he got a correlational score of 14.6 from the research he conducted. What can you infer from his finding?
- a. Your friend's research shows only a small correlation since 14.6 is close to zero.
 - b. Your friend's research shows a positive score in 14.6 and therefore a positive relationship exists.
 - c. Your friend's research is inconclusive. You need more than a correlational score of 14.6 to know if there is any statistical significance.
 - d. Your friend's analysis is flawed. Correlational scores only range from -1.00 to +1.00.

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applied psychology and psychology careers

Why study applied psychology?

Many different kinds of psychologists study or work in many different fields. Whereas early psychologists were still discovering the processes that govern the human mind, today's psychologists are more often applying information and principles gained from research to people in the real world. Why study careers in psychology? With so many different areas of focus, a career in psychology can be varied and exciting. There is much more to psychology than helping people who have mental health problems.

Professor John Gambon of Ozarks Technical and Community College in Springfield, Missouri, begins his class like any other. After a few minutes two students rush in and each throw two water balloons at the professor. As they run out, they yell something about fried eggs. Professor Gambon, soaked from the balloons, asks his students to write down everything they just saw, including what was said. After a few minutes, he gathers up the paperwork and invites his two balloon-throwing accomplices back into the room.

As he reads the papers of his students, many realize that they made mistakes in identifying the perpetrators. Quite often, students mismatch hair color, height, facial features, and even the clothes that each was wearing. What's more, nearly 90 percent claim that they heard the two men yell, "That was for last Friday!" When students are shown the truth, many are shocked at their overall inaccuracy at identifying the two men.

Work such as this is not new to Professor Gambon. He has worked as a consultant in several trials where the issue of accurately identifying someone has been brought into question. His cases include several homicides, assault, breaking and entering, and armed robbery.

His demonstrations show the overall unreliability of eyewitness identification, as outlined by psychologist Elizabeth Loftus.

 [Learning Objective 6.7](#). The kind of issues that influence an eyewitness's accuracy include the presence of a weapon (people tend to look at a weapon more than the physical attributes of the assailant), time of day, fatigue, and the amount of time between the crime and when they are required to recall it. Clearly, there are flaws inherent in eyewitness identification.

Forensic psychology is just one of many areas in which psychological principles can be applied to issues and concerns of everyday life. This appendix will look at several areas of applied psychology, as well as the types of careers that are open to someone who studies psychology today.

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What Is Applied Psychology?

What is the definition of applied psychology?

The term **applied psychology** refers to using findings from psychological research to solve real-world problems. The psychological professional, who might be a psychiatrist, a psychologist, or even a psychiatric social worker (as described later in this appendix), may do testing or use some other type of assessment and then describe a plan of action intended to solve whatever problem is of concern. As is evident in the opening comments about John Gambon, you can see that his training in psychology and his specialized knowledge enabled him to testify in court as an expert witness. This is a practical application of psychological tools to a real problem—the professional literally “applies” psychology.

 It seems to me that psychology could be useful in a lot of different areas, not just education. In fact, wasn't that what all those “Applying Psychology” sections at the end of each chapter were about?

Every chapter in this text (and even this appendix) does end with some application of psychology to the real world. The field of applied psychology isn't just one field but rather a lot of different areas that all share the common goal of using psychology in a practical way. A large number of areas can be considered applied psychology, including one of the broadest areas of psychology: clinical and counseling psychology. For example, health psychologists examine the effects of stress on physical as well as mental health; educational and school psychologists look for ways to improve student learning and apply the findings to the classroom; sports psychologists help athletes prepare themselves mentally for competition; human-factors psychologists deal with the way people and machines interact; forensic psychologists deal with psychological issues within the legal system; and industrial/organizational (I/O) psychologists deal with the work environment. In addition, environmental psychologists examine the interaction of people with their surroundings at work, in social settings, and in schools, homes, and other buildings. Those surroundings include not just the physical structures but also the particular population of people who live, work, and play in those surroundings. Other psychologists look at the factors that influence people to buy certain products, analyze the best ways to market a product, and examine the buying habits of the typical consumer.

This appendix includes information on the different roles of psychological professionals and the type of education required for many professions, along with a brief overview of many of the specialized areas in psychology. The remainder of this appendix briefly explores how psychology can be used in practical ways in several different areas of life: the environment, law, education, the military, sports, and the world of work.

Psychology as a Career

When most people think of psychology as a potential career, they assume certain things about the profession: For example, to help people with their problems one has to be a psychologist, all psychologists are doctors, and all psychologists counsel mentally ill people. None of these assumptions are completely true.

TYPES OF PSYCHOLOGICAL PROFESSIONALS

What are the different types of psychological professionals?

There are several types of professionals who work in psychology. These professionals have different training with different focuses and may have different goals.

PSYCHIATRIC SOCIAL WORKERS A **psychiatric social worker** is trained in the area of social work and usually possesses a master of social work (M.S.W.) degree and may be licensed in the state he or she works as a licensed clinical social worker (LCSW). These professionals focus more on the social conditions that can have an impact on mental disorders, such as poverty, overcrowding, stress, and drug abuse. They may administer psychotherapy (talking with clients about their problems) and often work in a clinical setting where other types of psychological professionals are available.

PSYCHIATRISTS A **psychiatrist** has a medical doctorate (M.D. or D.O.) degree and is a physician who specializes in the diagnosis and treatment of psychological disorders. Like any other medical doctor who may specialize in emergency medicine, treating the diseases of the elderly, treating infants and children, or any other special area of medicine, psychiatrists are able to write prescriptions and perform medical procedures on their patients. They simply have special training in the diagnosis and treatment of disorders that are considered to be mental disorders, such as schizophrenia, depression, or extreme anxiety. Because they are medical doctors, they tend to have a biopsychological perspective on the causes of and treatments for such disorders.

PSYCHOLOGISTS A **psychologist** doesn't have a medical degree but instead undergoes intense academic training, learning about many different areas of psychology before choosing an area in which to specialize. Psychologists typically have either a doctor of philosophy (Ph.D.) or doctor of psychology (Psy.D.) degree. (People who hold a master of science or M.S. degree are not usually called psychologists except in a few states. They can be called therapists or counselors, or they may be teachers or researchers.)

What's the difference between a Ph.D. and a Psy.D.?

The Ph.D. is a type of degree that usually indicates the highest degree of learning available in almost any subject area—psychology, the study of languages, education, philosophy, the sciences, and many others. It is typically very research oriented, and earning the degree usually requires a previous master's degree in addition to course work for the doctorate itself, as well as a dissertation—a scholarly work of research in the area of focus that is as long as a book and may even be published as a book.

The Psy.D. is a type of degree developed in the late 1970s that is focused less on research and more on the practical application of psychological principles (Peterson, 1976, 1982). In addition to academic course work such as that required for the Ph.D., this degree may require a major paper instead of a dissertation, with the difference being that the paper is not a report of research designed and conducted by the student but is rather a large-scale term paper. Each year of a Psy.D. program will also require the student to participate in a *practicum*, an actual experience with observing and eventually conducting therapy and treatments under supervision.

Unlike psychiatrists, psychologists typically cannot prescribe medicines or perform medical procedures. Some states are seeking legislative changes to allow psychologists to prescribe psychotropic medications if they receive special education in the use of prescription drugs. Such privileges were first pursued by the U.S. military. The reasoning behind this move, for which the American Psychological Association has been lobbying since 1984, involves both cost and the delay in receiving mental health services. If a person sees a psychologist and then has to go to a psychiatrist for medical



Psychologists specialize in many different areas and work in many different settings. This child psychologist is evaluating the young boy by using puppets and dolls to encourage the boy to talk about his feelings.

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prescriptions, the cost can be prohibitive. There are also fewer psychiatrists in some states than in others, causing long waits for mental health services from those doctors—delays that can sometimes lead to an increase in suicide rates for patients who are not getting the help they need. Although some psychologists in the military or Indian Health Service can already prescribe, as of May 2013, only two states and one territory (New Mexico, Louisiana, and Guam) have successfully afforded prescription privileges to psychologists.

Some psychologists provide counseling or therapy and use a variety of techniques and approaches. [LINK](#) to [Learning Objectives 15.2-15.6](#). However, many psychologists do no counseling at all. There are psychologists who only engage in assessment, those who teach at colleges or universities, those who do only research in those same institutions or for industries, and those who do a combination of teaching and research (and some that do a combination of teaching, research, and counseling or clinical practice). Other psychologists are involved in designing equipment and workplaces, developing educational methods, or working as consultants to businesses and the court system.

Although becoming a psychologist requires a doctorate degree of some kind, many career fields can benefit from a 4-year college degree in psychology as the basis of that career or going on to obtain a master's degree in psychology.

CAREERS WITH A MASTER'S DEGREE IN PSYCHOLOGY

What kinds of careers are available to someone with a master's degree in psychology?

While individuals earning a master's degree in psychology are not typically able to engage in the same level of independent research or practice of psychology as someone with a doctoral degree, they can still work in a variety of areas, both within and beyond the field of psychology. They may work directly under the supervision of a doctoral psychologist if engaged in clinical, counseling, or school psychology, or engaged in assessment. Others work outside of the field in jobs requiring research or analysis skills and work in health, industry, or government areas.

For those interested in counseling or providing therapy, many states allow individuals with master's degrees and prerequisite training and supervision experiences to become licensed to provide unsupervised counseling and therapy. Titles may vary by state but some of the areas and titles associated with licensed master's level work include licensed marriage and family therapist (LMFT), licensed professional counselor (LPC), licensed mental health counselor (LMHC), or licensed clinical social worker (LCSW). These individuals may work in a larger organization or work independently in private practice. Beyond these areas, some individuals with a master's degree in psychology become certified or licensed to serve as school counselors at various levels and may work in an elementary, middle, or high school.

CAREERS WITH A BACHELOR'S DEGREE IN PSYCHOLOGY

What kinds of careers are available to someone with a bachelor's degree in psychology?

Although people earning only the baccalaureate (bachelor's) degree in psychology cannot be called psychologists or provide therapy in a private practice, there are many career fields open to such a person. More than 1 million bachelor's degrees in psychology have been awarded since 1970, and since 2000 the number has increased each year (Landrum, 2009; Snyder & Dillow, 2010). A bachelor's degree in psychology can be highly flexible and adaptable to many different kinds of careers (Landrum, 2009; Landrum & Davis,

2007; Schwartz, 2000). While surveys, both by the American Psychological Association and others, reveal many may work in health-related or social fields, individuals with a bachelor's degree in psychology may be employed in research development or research management, administration, business, education and teaching, professional services, sales, or management (Grocer & Kohout, 1997; Landrum, 2009).

Other possible careers include marketing researcher, social worker, and communications specialist (Landrum & Davis, 2007; Schwartz, 2000). With its emphasis on critical thinking and empirical observation, psychology trains people for a variety of potential workplace environments and requirements. Psychology is an excellent major even if you intend to do graduate work in some other career: Business, law, child care, teaching, and management are only a few of the areas that relate to psychology.

AREAS OF SPECIALIZATION

What are the areas of specialization in psychology?

 You said that some psychologists teach or do research. What kind of research do they do?

There are many different areas in which psychologists may focus their energies. They conduct experiments, surveys, observations, and so on to gather more information for their particular field of interest, to find support for current theories, or to develop new ones. Let's look at some of the areas in which psychologists may specialize.

CLINICAL PSYCHOLOGY Even though not all psychologists do counseling or therapy, many psychologists do. **Clinical psychology** is the most similar of the areas to psychiatry in that professionals with this focus traditionally work with individuals with more serious forms of mental illness. It is also the area of specialization with the largest number of psychologists. Clinical psychologists, like psychiatrists, diagnose and treat psychological disorders in people. However, the clinical psychologist cannot prescribe drugs or medical therapies (with the exceptions discussed earlier, of course) but instead relies on listening or observing the client's problems, possibly administering psychological tests, and then providing explanations for the client's behavior and feelings or directing the client in specific actions to make positive changes in his or her life.

COUNSELING PSYCHOLOGY **Counseling psychology** is similar to clinical psychology in that this type of psychologist diagnoses and treats problems. The difference is that a counseling psychologist usually works with relatively healthy people who have less severe forms of mental illness or problems, such as adjustment to college, marriage, family life, work problems, and so on. As of 2008, nearly 73 percent of surveyed psychologists currently providing health services identified themselves as clinical psychologists or counseling psychologists (Michalski et al., 2010).  to Learning Objective 1.5.

DEVELOPMENTAL PSYCHOLOGY **Developmental psychology** is an area that focuses on the study of change, or development. Developmental psychologists are interested in changes in the way people think, in how people relate to others, and in the ways people feel over the entire span of life. These psychologists work in academic settings such as colleges and universities and may do research in various areas of development. They do not provide therapy.  to Learning Objective 8.1.

EXPERIMENTAL PSYCHOLOGY **Experimental psychology** encompasses several different areas such as learning, memory, thinking, perception, motivation, and language. The focus of these psychologists, however, is on doing research and conducting studies and experiments with both people and animals in these various areas. They tend to work in academic settings, especially in large universities.  to Learning Objective 1.5.



Many people with a bachelor's degree in psychology work in health-related or social fields, such as this social worker who is working with a mother and child.

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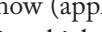
SOCIAL PSYCHOLOGY Social psychology is an area that focuses on how human behavior is affected by the presence of other people. For example, social psychologists explore areas such as prejudice, attitude change, aggressive behavior, and interpersonal attraction. Although most social psychologists work in academic settings teaching and doing research, some work in federal agencies and big business doing practical (applied) research. In fact, many social psychologists are experimental psychologists who perform their experiments in real-world settings rather than the laboratory to preserve the natural reactions of people. When people are in an artificial setting, they often behave in self-conscious ways, which is not the behavior the researcher wishes to study.  to Learning Objective 12.1.

PERSONALITY PSYCHOLOGY Personality psychology focuses on the differences in personality among people. These psychologists may look at the influence of heredity on personality. They study the ways in which people are both alike and different. They look at the development of personality and do personality assessment. They may be involved in forming new theories of how personality works or develops. Personality psychologists work in academic settings, doing research and teaching.  to Learning Objective 13.1.

PHYSIOLOGICAL PSYCHOLOGY Physiological psychology is an area that focuses on the study of the biological bases of behavior. Many professionals now refer to this area as *behavioral neuroscience* or *biopsychology*. Physiological psychologists study the brain, nervous system, and the influence of the body's chemicals, such as hormones and the chemicals in the brain, on human behavior. They study the effects of drug use and possible genetic influences on some kinds of abnormal and normal human behavior, such as schizophrenia or aspects of intelligence. Most physiological psychologists, like experimental psychologists, work in an academic setting.  to Learning Objective 2.1.

NEUROPSYCHOLOGY Neuropsychology is an area within the field of psychology in which professionals explore the relationships between the brain systems and behavior. Neuropsychologists may be engaged in research or more focused on the assessment, diagnosis, treatment, and/or rehabilitation of individuals with various neurological, medical, neurodevelopmental, or psychiatric conditions (National Academy of Neuropsychology, 2001).  to Learning Objective 7.5.

COMPARATIVE PSYCHOLOGY Comparative psychology is an area that focuses exclusively on animals and animal behavior. By comparing and contrasting animal behavior with what is already known about human behavior, comparative psychologists can contribute to the understanding of human behavior by studying animals. Research in animal behavior also helps people to learn how to treat animals more humanely and to coexist with the animals in a common environment. Comparative psychologists might work in animal laboratories in a university or may do observation and studies of animals in the animals' natural habitats.

Psychologists in these areas may do research that is directed at discovering basic principles of human behavior (basic research) or they may engage in research designed to find solutions to practical problems of the here and now (applied research).  to Learning Objective 1.5. There are many other areas in which psychologists may specialize that focus almost exclusively on applied research. These areas are those most often associated with applied psychology.

Psychology Beyond the Classroom

How does psychology interact with other career fields?

Individuals working in psychology can serve an important role in many different fields. Some are extensions of the areas of specialization just covered. Other fields are well suited due to the general, and sometimes specific, skills psychology professionals can provide.

PSYCHOLOGY AND HEALTH

Health psychology focuses on the relationship of human behavior patterns and stress reactions to physical health with the goal of improving and helping to maintain good health while preventing and treating illness. For example, a health psychologist might design a program to help people lose weight or stop smoking. Stress management techniques are also a major focus of this area. Health psychologists may work in hospitals, clinics, medical schools, health agencies, academic settings, or private practice.

In one study (Kerwin et al., 2010), researchers found an association between obesity in older women and a decline in memory functioning in those women. This finding was particularly true for women carrying the excess weight around their hips (pear shapes) and less so for women carrying the excess weight around their waists (apple shapes). The study controlled for other health variables, such as diabetes, heart disease, and stroke. This is a good example of the kind of research that health psychologists conduct. Other areas studied by health psychologists include the influence of optimistic attitudes on the progress of disease, the link between mental distress and health, and the promotion of wellness and hope in an effort to prevent illness. [LINK](#) to Learning Objective 11.4.



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PSYCHOLOGY AND EDUCATION

Educational psychology is concerned with the study of human learning. As educational psychologists come to understand some of the basic aspects of learning, they develop methods and materials for aiding the process of learning. For example, educational psychologists helped to design the phonics method of teaching children to read. This type of psychologist may have a doctorate of education (Ed.D.) rather than a Ph.D. and typically works in academic settings.

What types of research might an educational psychologist conduct? The August 2013 issue of *Journal of Educational Psychology* included articles on teacher self-efficacy and instructional quality, stereotype threat in girls' math performance ([LINK](#) to Learning Objective 7.8), student motivation, and effects of teacher's professional competence on both instruction and student development — just to name a few.

School psychology is related to, but not at all the same as, educational psychology. Whereas educational psychologists may do research and develop new learning techniques, school psychologists may take the results of that research or those methods and apply them in the actual school system. School psychologists work directly with children in the school setting. They do testing and other forms of assessment to place children in special programs or to diagnose educational problems such as dyslexia or attention-deficit/hyperactivity disorder. They may act as consultants to teachers, parents, and educational administrators. Counseling students is actually a relatively small part of the job of a school psychologist, although counseling takes a much bigger role when tragedies strike a school. When traumatic events such as the unexpected and tragic death of a classmate or even larger-scale tragedies such as the numerous school shootings of the past decade take place, school psychologists are often called on to offer help and counseling to students.

PSYCHOLOGY AND SPORTS

Sports psychology is a relatively new and fast-growing field in which the main focus is on helping athletes and others involved in sports activities prepare mentally, rather than just physically, for participation in sports. The idea behind this field is that a superior physical performance is not enough to guarantee success; rather, the mind must be prepared for the activity by setting clear short-term goals, holding positive thoughts, using visualization of the goal, stopping negative thoughts, and other techniques based primarily in the cognitive perspective. For example, a sports psychologist might have a golfer, who has been having trouble with the accuracy of his drives, perform visualization



School psychologists often administer tests to assess a child's level of achievement, intelligence, or psychological well-being.

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A Fort Lewis Army psychologist demonstrates a headset from the "Virtual Reality Iraq" therapy program on April 18, 2007, in Spanaway, Washington. The virtual reality program, which simulates the sights, sounds, and smells of combat, will be used in working with soldiers suffering from posttraumatic stress disorder.

exercises, mentally seeing himself hit the ball down the fairway again and again. Sports psychologists work in athletic organizations and may have a private practice or do consulting work. (For more on the techniques used in sports psychology, see the Applying Psychology to Everyday Life section at the end of this appendix.)

PSYCHOLOGY AND THE MILITARY

Within the military, psychologists work in a variety of areas ranging from assessment, teaching, management, research, and the provision of mental health services. The variety of psychologists in this field may include clinical, counseling, experimental, I/O, or human factors, among others, and may reflect any specialty area in the field of psychology. In short, they apply psychological skills to human issues in military environments, working with both military personnel and their families (American Psychological Association, Division 19, 2010). One poignant example, the rise of suicides in the armed forces associated with the conflicts in Iraq and Afghanistan have placed demands on both the military and military families at a level not seen before (Berman et al., 2010). For more on the work of psychologists (specifically neuropsychologists) in the military, see the Psychology in the News section of Chapter Seven.

PSYCHOLOGY AND THE LAW

Psychologists have often been involved in the world of legal matters in various ways. Social psychologists often do research in the areas of criminal behavior and may consult with attorneys or other agents of the court system on such topics as witness credibility, jury selection, and the kind of influences that exist for decision-making processes. Developmental psychologists may become involved in determining the accuracy of and influences on the testimony of children and adolescents, as well as the needs of children caught up in a custody battle between divorced or divorcing parents. Cognitive psychologists may become expert witnesses on the accuracy of memory and eyewitness testimony or ways to determine the truth or falsehood of statements made by witnesses or defendants. Clinical psychologists may deliver their services directly to incarcerated prisoners or may conduct assessments of intelligence and/or mental status to determine whether or not a person charged with a crime should stand trial.

All of the forms of psychological involvement in legal matters mentioned here can be considered as part of the growing field of **forensic psychology**. Forensic psychology is the practice of psychology related to the legal system and it involves examining criminal evidence and aiding law enforcement investigations into criminal activities. Some forensic psychologists provide information and advice to officials in the legal system, such as lawyers or judges; some act as expert witnesses (like Professor John Gammon in the opening story); some actually diagnose and treat criminals within the prison system; and others may administer psychological tests to criminal defendants. Forensic psychologists may aid either the prosecution or the defense in a trial by helping determine which potential jurors would be the best or worst choices. This type of professional may do consulting work in addition to maintaining a regular private practice in clinical or counseling psychology, or may work entirely within the justice system as a police psychologist or a full-time jury expert, for example.

PSYCHOLOGY AND THE COMMUNITY

Community psychology is an area that focuses on both individuals and their community. This field is often concerned with issues at various levels, including individual, group, neighborhood, and organizational. It is an area that focuses on promoting health and preventing common societal issues across all levels. Community psychology aims to understand human behavior in context, and recognizes the role of human diversity in promoting change. Advocacy is a key role for individuals in this area as they work to promote social justice, or practices and policies that directly impact aspects of life such

as equal opportunity for all people, prevention of violence, and active citizenship. Community psychologists are involved in a variety of life activities and may be engaged in promoting mental health, physical health, educational interventions, or work policies.

PSYCHOLOGY AND THE ENVIRONMENT

Another broad area in which psychological principles can be applied to solve practical problems is the area of managing the environment. **Environmental psychology** is an area that focuses on the relationship between human behavior and the environment in which the behavior takes place, such as an office, store, school, dormitory, or hospital. Because the concern of researchers in this field deals directly with behavior in a particular setting, research is always conducted in that setting rather than in a laboratory. Environmental psychologists may work with other professionals such as urban or city planners, economists, engineers, and architects, helping those professionals to plan the most efficient buildings, parks, housing developments, or plants.

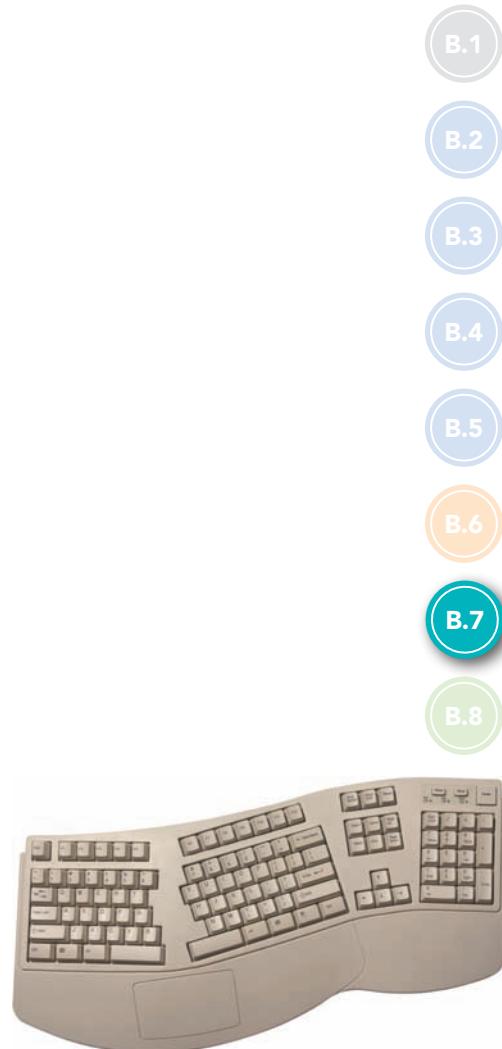
Psychology and Work

What are industrial/organizational psychology and human factors psychology?

Work is a tremendous part of many people's lives. People often spend more time at work than they do with their families or in social activities. One of the largest branches of applied psychology focuses on how psychology can help people in management, productivity, morale, and many other areas of the world of work.

Industrial/organizational (I/O) psychology is concerned with the relationships between people and their work environments. I/O psychologists may help in personnel selection, administer job performance assessments, design work schedules that help workers adjust to new time periods of work hours with less difficulty, or design new work areas to increase morale and productivity. Psychologists in this field may study the behavior of entire organizations. They are often hired by corporations and businesses to deal with the hiring and assessment of employees. They may research and develop ways for workers to be more efficient and productive. They may work in business, government agencies, and academic settings. **Table B.1** briefly lists some of the areas of specialization.

A specific kind of I/O specialist, called a *human factors engineer*, focuses on ergonomics, or designing machines, furniture, and other devices that people have to use so that those devices are the most practical, comfortable, and logical for human use. **Human factors psychology** consists of these researchers and designers who study the way humans



Human factors psychologists design machines that are more practical and comfortable for people to use. For example, this keyboard is designed to reduce the risk of pain in the wrists and increase accuracy in typing.

Table B.1

Areas in I/O Psychology

AREAS IN INDUSTRY	AREAS IN ORGANIZATIONS
Job analysis	Social behavior of work teams
Job evaluation and compensation	Job satisfaction
Characteristics critical to effective management	Personality characteristics critical to job performance
Personnel recruiting, selection, and placement	Relationships between management and workers
Occupational training	Leadership characteristics and training
Examination of working conditions	Consumer psychology
Interviewing and testing	Motivational concerns
Performance appraisal and feedback	Conflict management

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and machines interact with each other. They may work directly in the companies involved in the design of appliances, airplane controls, and the operation of computers or other mechanical devices. For example, recall a recent iPhone® commercial about how your thumb can reach all parts of the screen. Or have you ever seen a ergonomic chair? Most likely a human factors engineer was involved in the design or testing of these products.

Psychologists working in I/O settings apply psychological principles and theories to the workplace. For example, Maslow's humanistic theory and hierarchy of needs ([LINK](#) to Learning Objective 9.4) has had a powerful influence on the field of management (Heil et al., 1998). Douglas McGregor, in his explanations of two different styles of management (McGregor, 1960), relates the older and less productive "Theory X" (workers are unmotivated and need to be managed and directed) to Maslow's lower needs and the newer, more productive style of management called "Theory Y" (workers want to work and want that work to be meaningful) to the higher needs.

Industrial/organizational psychology got its start near the beginning of the twentieth century with the work of Walter D. Scott, a former student of famed physiologist and founder of the first psychological laboratory, Wilhelm Wundt. Scott applied psychological principles to hiring, management, and advertising techniques (Schultz & Schultz, 2004). He also wrote one of the first books about the application of psychology to industry and advertising, called *The Theory and Practice of Advertising* (Scott, 1908). Another early figure in the newly developing field of industrial/organizational psychology was Hugo Munsterberg, a psychologist also trained by Wundt, who conducted research on such varied topics as the power of prayer and eyewitness testimony (Hothersall, 1995). Munsterberg wrote a book about eyewitness testimony called *On the Witness Stand* (1907) and later wrote *Psychology and Industrial Efficiency* (1913).

The I/O field became important during World War I when the army needed a way to test the intelligence of potential recruits. Psychologist Robert Yerkes, who would later become known for his groundbreaking research in comparative psychology while working with the great apes, developed the Army Alpha and Army Beta tests. The Army Alpha test was used with applicants who were able to read, whereas the Army Beta test was administered to applicants who were illiterate (McGuire, 1994; Yerkes, 1921).

In the mid-1920s a series of studies conducted by Elton Mayo for the Western Electric Company (Franke & Kaul, 1978; Parsons, 1992; Roethlisberger & Dickson, 1939) broadened the field. These were the first studies to view the workplace as a social system rather than as just a production line. Instead of treating workers as simply other pieces of equipment, these studies suggested that allowing workers some input into the decision-making process not only improved worker morale* but also reduced workers' resistance to changes in the workplace. These studies led the way for others to examine how management of employees and production could be improved. For example, Google® is one of the leaders in creating a rewarding work environment and providing various perks to its employees. It was selected as *Fortune* magazine's top company to work for in both 2012 and 2013 ("Best Companies to Work For 2013 – Fortune"). From free gourmet food, to an on-site laundry and dry cleaners, and both indoor and outdoor recreation facilities, Google works to create an intimate environment for its employees (Mangalindan, 2012). Management theories and strategies may also be applied to other kinds of settings such as schools, colleges, and universities. Yet another setting I/O psychologists are currently involved in is working with NASA for the planned 2030 trip to Mars (Novotney, 2013, March). I/O psychologists are researching ways to improve team selection and training for the astronauts who will have to endure a longer and further space voyage than anyone ever has, a trip that will take close to 3 years. Promotion of resiliency, adaptability, and group cohesion are some of the areas being investigated, especially in light of the lack of privacy and cramped quarters they will be living in.



These women were participants in one of the early industrial/organizational psychology experiments conducted by Elton Mayo for the Western Electric Company.

*morale: a sense of common purpose, enthusiasm, confidence, and loyalty.

issues in psychology



Workplace Violence



Acts of violence in the workplace have increased dramatically in the past few decades—nearly tripling in the 1980s alone (Baron, 1993). Psychologists are devoting time and energy to studying the reasons for this violence and are looking for ways to recognize and prevent future incidents. Some highlights from research in workplace violence show that people in some types of jobs face a higher probability of becoming a victim of a crime because of the characteristics of the job. For example, three of the most likely occupations are police officers, corrections officers, and taxi drivers (Centers for Disease Control and Prevention, 2009). For taxi drivers (along with convenience-store clerks), it is the availability of cash and the solitary nature of the job that entices many criminals to attempt robbery. In the case of police and correctional officers, violence is part of the very nature of their job. Consider the following statistics:

- Between 1992 and 2006, there were 11,613 workplace homicide victims reported.
- Of those homicides, 11.6 police officers out of every 100,000 were killed on the job compared to the national average for all occupations of 4.0 out of every 100,000.
- From 2004 to 2008 there was an average of 564 work-related homicides each year—10 percent of all fatal work injuries.
- Four out of every 5 homicide victims in 2008 were male.
- Men were more likely to be killed by a stranger, while women were more likely to be killed by a relative or personal acquaintance.
- In 2008, there were 30 multiple-fatality workplace homicide incidents, with an average of 2 people dying in each incident. Most were shot, and in 12 percent of the shootings the assailants were coworkers or former coworkers (Bureau of Labor Statistics, 2010).

Industrial/organizational psychologists have developed a term for the employee who becomes highly violent and commits violent crimes resulting in serious injury or death to other employees: the berserker. What are the characteristics of persons who “go berserk” in the workplace? Typically, they have at least a high school diploma or some college. Their self-esteem, or sense of worth as a person, is intimately tied to their job. They tend to like watching violent television or movies. Prevention of violence in the workplace can include some simple, commonsense steps as well as more complicated training and preparation (Arbury, 2005; Harvey & Keashly, 2003; Security Director's Report, 2008; VandenBos & Bulatao, 1996):

- entrances and exits that are well lighted
- presence of video cameras or security guards, especially at night
- criminal background checks performed on all potential new employees
- training managers and supervisors to identify signs of potential workplace violence, including such things as employees (1) who have a tendency to use verbal threats or who use low-grade acts of violence, such as pushing or shoving; (2) who are fascinated with and have access to firearms; or (3) who appear desensitized to television and movie violence and show a preference for watching such media.

Questions for Further Discussion

1. Refer back to the Learning and Social Psychology chapters. [LINK](#) to [Chapter Five: Learning](#), [LINK](#) to [Chapter Twelve: Social Psychology](#). What might be some other reasons for workplace violence?
2. In what ways might a psychologist serve as a resource for individuals working in an occupation with higher risks of violence?

B.1

B.2

B.3

B.4

B.5

B.6

B.7

B.8



The aftermath of workplace violence: A somber crowd gathers at a candlelight vigil Sunday, August 8, 2010, in honor of the victims of a workplace shooting at a Connecticut beer distribution company, which took place on August 3, 2010. Less than one week prior to this vigil, Omar Thornton killed eight coworkers and wounded two others before killing himself at the Hartford Distributors building.

B.1

B.2

B.3

B.4

B.5

B.6

B.7

B.8

Applying Psychology to Everyday Life: Techniques Used by Sports Psychologists

What are some techniques used in sports psychology?

Many athletes become frustrated when their performance seems to be less than it could be or when they reach some “roadblock” on their way to achieving new goals. The techniques that follow are designed to help athletes get around the roadblocks and get the most out of their performance. The same techniques are also helpful in the careers of acting, musical performance, professional speaking, teaching, or any career in which there is an element of performance in front of others.

1. *Visualization.* In this technique, athletes try to “see” their performance in their minds as if watching from the sidelines before actually doing it.
2. *Imagery/mental rehearsal.* Similar to visualization, imagery can be used to mentally rehearse the desired performance. Instead of visualizing oneself as if from the sidelines, however, imagery/mental rehearsal involves actually “seeing” and “feeling” the performance in one’s mind from one’s own viewpoint. This helps prepare the muscles that will be used for action.
3. *Distraction desensitization.* Athletes can be trained to ignore distractions, such as the shouts of spectators.
4. *Thought stopping.* People often have negative thoughts about things that might happen: “I’m going to miss it, I just know it!” is a good example of a negative, self-defeating thought. Sports psychologists train athletes to stop such thoughts in the making, replacing them with more positive thoughts: “I can do this. I’ve done it before and it was easy.”
5. *Confidence training.* Another thing that sports psychologists do is try to build confidence and self-esteem in the athletes who come to them for help. Lack of confidence in one’s own abilities is a major roadblock.
6. *Focus training.* Athletes can also be trained to focus attention, often through the use of hypnosis, concentrative meditation, or similar psychological techniques.
7. *Relaxation training.* Athletes can be trained to use special breathing methods, tension and relaxation of muscles, and other strategies for relaxation to reduce anxiety and tension before a performance.
8. *Autogenic training.* Autogenic essentially means “from within the self.” In the sense used here, autogenic training involves helping athletes learn about their physiological responses to stress. Once learned, athletes can gain control over these responses, such as learning to slow one’s heart rate or to lower anxiety.
9. *Fostering realistic goals and expectations.* Sports psychologists try to teach athletes that although setting goals is important, setting unrealistic goals can lead to burnout, frustration, and feelings of failure. Sports psychologists try to help athletes modify their expectations and goals to be more realistic.
10. *Fostering team unity.* Sports psychologists may also work with entire teams of athletes, helping them to become a unit that works as one single “organism” while still providing support for each individual athlete.



The sports psychologist on the right is helping Red Sox player David Ortiz work through his frustration at being injured during the game.

Questions for Further Discussion

1. What are some other occupations in which people might benefit from using some of these techniques?
2. Are there factors outside of the game itself that might interfere with fostering team unity?

chapter summary

 Listen to the **Audio File** of your chapter **MyPsychLab**

What Is Applied Psychology?

B.1 What is the definition of applied psychology?

- Applied psychology refers to using psychological principles and research to solve problems in the real world.

psychologists apply those methods in the school, administer assessments, recommend placement, and provide counseling and diagnosis of educational problems.

- Sports psychologists help athletes prepare themselves mentally for participation in sports.
- Psychologists working in the military represent almost all sub-fields of psychology and work with both military personnel and their families in military environments.
- Psychologists may act as expert witnesses for legal matters, help in jury selection, provide clinical services to defendants or prisoners, or produce personality profiles of various types of criminals in the field of forensic psychology.
- Community psychologists help solve social issues and work to promote health for individuals and for the larger community in which people live.
- Environmental psychology looks at the relationship between human behavior and the physical environment in which that behavior takes place.

Psychology as a Career

B.2 What are the different types of psychological professionals?

- Different types of psychological professionals vary by level of education and training. Examples include psychiatrists, psychiatric social workers, and psychologists.
- Psychologists hold either a Ph.D. or Psy.D. degree.

B.3 What kinds of careers are available to someone with a master's degree in psychology?

- Individuals with a master's degree may work under the supervision of a doctoral-level psychology professional, practice independently if licensed, or work in private or educational settings.

B.4 What kinds of careers are available to someone with a bachelor's degree in psychology?

- Education, statistical consulting, administration and other business occupations, as well as health services are examples of careers that a person with a bachelor's degree in psychology might enter.

B.5 What are the areas of specialization in psychology?

- Areas of specialization include clinical and counseling psychology, developmental, experimental, social, personality, and physiological psychology, neuropsychology, and comparative psychology.

Psychology and Work

B.7 What are industrial/organizational psychology and human factors psychology?

- Industrial/organizational psychology is concerned with how people function in and are affected by their work environments.
- Human factors is a type of I/O psychology in which the focus is on the way humans and machines interact with each other, designing or helping to design the machines used by people in various science and industrial settings.

Applying Psychology to Everyday Life: Techniques Used by Sports Psychologists

B.8 What are some techniques used in sports psychology?

- Sports psychologists use many techniques to help athletes better their performances, including visualization, imagery, thought stopping, confidence training, relaxation training, and fostering team unity.

test YOURSELF

ANSWERS AVAILABLE IN ANSWER KEY.

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Pick the best answer.

1. Which of the following professionals has a medical degree?
 - a. clinical psychologist
 - b. psychiatrist
 - c. psychiatric social worker
 - d. counseling psychologist

2. Elaine has always wanted to be a psychologist. She dreams of helping people with their problems and wants to become "Dr. Elaine." However, she is not interested in conducting scientific research or in becoming a medical doctor. What type of degree would be best for Elaine to pursue?
 - a. a master's degree in psychology
 - b. a Ph.D.
 - c. a Psy.D.
 - d. a master's degree in social work

3. Dr. Troxell conducts scientific studies on topics such as the power of prejudice, attitude change, aggressive behavior, and interpersonal attraction in teenagers. Dr. Troxell's area of specialization is most likely in _____ psychology.
- a. social
 - b. personality
 - c. comparative
 - d. developmental
4. Dr. Cavendish is a _____ psychologist who conducts experiments using animals as her subjects. Her focus of study includes animal learning, memory, and even language.
- a. experimental
 - b. comparative
 - c. developmental
 - d. social
5. What type of psychologist would be most likely to put together an anti-bullying program for middle school students?
- a. experimental
 - b. clinical
 - c. forensic
 - d. educational
6. In working with a professional athlete, what aspects of performance might a sports psychologist likely focus on?
- a. strength and agility training
 - b. focus and relaxation
 - c. memory and motivation
 - d. perceptual and problem solving
7. Dr. Lewis studies the topic of crowding. She often wonders why people can feel crowded in an elevator that has 8–10 people in it but not at a large sporting event where over 2,000 people are present. What is Dr. Lewis's specialty?
- a. developmental
 - b. physiological
 - c. social
 - d. environmental
8. Which type of psychologist is most concerned with maximizing job satisfaction in night-shift employees?
- a. industrial/organizational
 - b. clinical
 - c. forensic
 - d. environmental
9. Suzanne is working to redesign the controls for a new type of plane so that pilots can tell the difference between instruments in the dark just by the way each control feels. Suzanne is probably a(n) _____ psychologist.
- a. industrial/organizational
 - b. human factors
 - c. experimental
 - d. military
10. Thought stopping, mental rehearsal, and focus training are some of the tools of the _____ psychologist.
- a. experimental
 - b. clinical
 - c. sports
 - d. military



answer key

PSYCHOLOGY IN ACTION

Practice Quiz page PIA-11

1. b; 2. a; 3. a; 4. a; 5. c

Practice Quiz page PIA-16

1. a; 2. c; 3. d; 4. a; 5. a; 6. c

Test Yourself page PIA-19

1. d; 2. d; 3. c; 4. c; 5. a; 6. c; 7. d; 8. b; 9. a; 10. a

CHAPTER 1

Practice Quiz page 13

1. a; 2. b; 3. c; 4. b; 5. a; 6. a

Practice Quiz page 19

1. d; 2. c; 3. c; 4. a; 5. d; 6. a

Practice Quiz page 26

1. a; 2. b; 3. b; 4. b; 5. b

Practice Quiz page 37

1. c; 2. a; 3. b; 4. a; 5. c; 6. c

Test Yourself pages 42–43

1. c; 2. b; 3. c; 4. d; 5. b; 6. d; 7. d; 8. d; 9. b; 10. a; 11. b; 12. a; 13. c; 14. b; 15. b; 16. a; 17. c; 18. a; 19. d; 20. c

CHAPTER 2

Practice Quiz page 55

1. a; 2. b; 3. b; 4. a; 5. a; 6. d

Practice Quiz page 66

1. a; 2. d; 3. b; 4. b; 5. a; 6. c

Practice Quiz page 76

1. c; 2. c; 3. a; 4. d; 5. d

Practice Quiz page 84

1. d; 2. c; 3. b; 4. a; 5. b

Test Yourself pages 89

1. b; 2. c; 3. c; 4. a; 5. a; 6. c; 7. b; 8. b; 9. d; 10. b; 11. b; 12. d; 13. c; 14. d; 15. a; 16. a; 17. d; 18. b; 19. d; 20. b

CHAPTER 3

Practice Quiz page 95

1. d; 2. a; 3. d; 4. a

Practice Quiz page 104

1. a; 2. b; 3. a; 4. b; 5. c; 6. b

Practice Quiz page 109

1. a; 2. c; 3. b; 4. a; 5. d

Practice Quiz page 117

1. c; 2. d; 3. d; 4. b; 5. a; 6. a

Practice Quiz page 128

1. b; 2. c; 3. b; 4. c; 5. a; 6. b

Test Yourself pages 132–133

1. b; 2. d; 3. a; 4. b; 5. a; 6. c; 7. b; 8. b; 9. a; 10. a; 11. b; 12. b; 13. c; 14. a; 15. a; 16. c; 17. a; 18. d; 19. b; 20. c

CHAPTER 4

Practice Quiz page 142

1. b; 2. d; 3. c; 4. b; 5. b

Practice Quiz page 150

1. a; 2. c; 3. c; 4. d; 5. c; 6. a

Practice Quiz page 154

1. a; 2. c; 3. a; 4. d; 5. b

Practice Quiz page 157

1. a; 2. c; 3. c; 4. d

Practice Quiz page 168

1. a; 2. d; 3. a; 4. c; 5. b; 6. a

Test Yourself pages 172–173

1. a; 2. b; 3. d; 4. c; 5. a; 6. a; 7. c; 8. b; 9. d; 10. b; 11. d; 12. b; 13. c; 14. d; 15. a; 16. b; 17. b; 18. c; 19. a; 20. c

CHAPTER 5

Practice Quiz page 182

1. a; 2. b; 3. a; 4. d; 5. a

Practice Quiz page 186

1. a; 2. a; 3. c; 4. d

Practice Quiz page 190

1. a; 2. b; 3. b; 4. a

Practice Quiz page 204

1. c; 2. c; 3. d; 4. a; 5. c; 6. d

Practice Quiz page 212

1. b; 2. a; 3. b; 4. d; 5. a; 6. b

Test Yourself pages 216–217

1. a; 2. b; 3. b; 4. d; 5. b; 6. a; 7. a; 8. d; 9. a; 10. b; 11. b; 12. c; 13. c; 14. c; 15. a; 16. b; 17. c; 18. b; 19. b; 20. b

CHAPTER 6

Practice Quiz page 222

1. b; 2. c; 3. b; 4. a

Practice Quiz page 234

1. b; 2. c; 3. a; 4. c; 5. d; 6. b

Practice Quiz page 241

1. b; 2. b; 3. d; 4. d; 5. a

Practice Quiz page 245

1. a; 2. c; 3. a; 4. a

Practice Quiz page 254

1. a; 2. c; 3. d; 4. a; 5. d

Test Yourself pages 257–259

1. b; 2. a; 3. b; 4. d; 5. c; 6. c; 7. c; 8. a; 9. b; 10. a; 11. d; 12. d; 13. a; 14. b; 15. b; 16. d; 17. b; 18. a; 19. d; 20. d

CHAPTER 7

Practice Quiz page 269

1. a; 2. c; 3. a; 4. b; 5. d; 6. d

Practice Quiz page 273

1. a; 2. b; 3. a; 4. a

Practice Quiz page 284

1. c; 2. a; 3. c; 4. c; 5. d; 6. b

Practice Quiz page 293

1. d; 2. c; 3. d; 4. b; 5. a

Practice Quiz page 299

1. d; 2. b; 3. b; 4. a

Test Yourself pages 302–303

1. a; 2. b; 3. a; 4. d; 5. c; 6. b; 7. c; 8. a; 9. a; 10. d; 11. d; 12. b; 13. c; 14. a; 15. c; 16. b; 17. d; 18. a; 19. a; 20. a

CHAPTER 8

Practice Quiz page 311

1. a; 2. d; 3. b; 4. c; 5. c; 6. b

Practice Quiz page 316

1. b; 2. c; 3. b; 4. a; 5. b

Practice Quiz page 328

1. b; 2. b; 3. c; 4. a; 5. d

Practice Quiz page 334

1. d; 2. c; 3. b; 4. c; 5. b

Practice Quiz page 338

1. b; 2. c; 3. c; 4. a; 5. d

Practice Quiz page 343

1. a; 2. d; 3. c; 4. b; 5. a; 6. a

Practice Quiz page 345

1. a; 2. b; 3. a; 4. d

Test Yourself pages 349–351

1. a; 2. b; 3. c; 4. c; 5. b; 6. c; 7. a; 8. a; 9. b; 10. d; 11. c; 12. b; 13. a; 14. d; 15. a; 16. a; 17. b; 18. d; 19. c; 20. d

CHAPTER 9**Practice Quiz page 359**

1. a; 2. b; 3. c; 4. c; 5. b; 6. a

Practice Quiz page 365

1. c; 2. a; 3. b; 4. c; 5. b

Practice Quiz page 370

1. d; 2. b; 3. b; 4. c; 5. d; 6. d

Practice Quiz page 381

1. b; 2. a; 3. c; 4. a; 5. d

Test Yourself pages 384–3851. d; 2. b; 3. b; 4. c; 5. a; 6. a; 7. b; 8. a; 9. b; 10. a; 11. c; 12. b;
13. d; 14. b; 15. d; 16. d; 17. a; 18. a; 19. b; 20. c**CHAPTER 10****Practice Quiz page 395**

1. b; 2. c; 3. c; 4. c; 5. d; 6. d

Practice Quiz page 399

1. d; 2. a; 3. a; 4. a

Practice Quiz page 402

1. a; 2. a; 3. c; 4. d

Practice Quiz page 409

1. b; 2. d; 3. d; 4. b; 5. b; 6. c

Practice Quiz page 414

1. a; 2. b; 3. c; 4. d

Test Yourself pages 416–4171. d; 2. b; 3. b; 4. c; 5. a; 6. d; 7. b; 8. d; 9. b; 10. b; 11. c; 12. d;
13. a; 14. a; 15. b; 16. c; 17. c; 18. a; 19. a; 20. d**CHAPTER 11****Practice Quiz page 425**

1. c; 2. b; 3. c; 4. c

Practice Quiz page 429

1. c; 2. b; 3. a; 4. a; 5. c

Practice Quiz page 441

1. a; 2. b; 3. b; 4. a; 5. a; 6. d

Practice Quiz page 444

1. a; 2. c; 3. b; 4. d

Practice Quiz page 448

1. c; 2. b; 3. b; 4. a; 5. d

Test Yourself pages 4511. d; 2. b; 3. b; 4. a; 5. a; 6. b; 7. d; 8. a; 9. b; 10. c; 11. c; 12. a;
13. d; 14. b; 15. b; 16. d; 17. b; 18. a; 19. d; 20. a**CHAPTER 12****Practice Quiz page 464**

1. b; 2. a; 3. d; 4. b; 5. c

Practice Quiz page 470

1. d; 2. a; 3. d; 4. a; 5. b; 6. c

Practice Quiz page 475

1. b; 2. a; 3. b; 4. b; 5. d

Practice Quiz page 481

1. d; 2. b; 3. c; 4. a

Practice Quiz page 486

1. c; 2. d; 3. a; 4. b; 5. d

Practice Quiz page 494

1. a; 2. d; 3. d; 4. d; 5. c

Test Yourself pages 498–4991. d; 2. d; 3. a; 4. b; 5. d; 6. c; 7. b; 8. d; 9. a; 10. d; 11. c; 12. a;
13. b; 14. b; 15. a; 16. b; 17. b; 18. d; 19. d; 20. a**CHAPTER 13****Practice Quiz page 511**

1. c; 2. d; 3. c; 4. c; 5. d; 6. a

Practice Quiz page 517

1. b; 2. d; 3. a; 4. c; 5. c

Practice Quiz page 521

1. a; 2. d; 3. b; 4. d

Practice Quiz page 531

1. a; 2. b; 3. a; 4. b; 5. c; 6. a

Test Yourself pages 534–5351. d; 2. a; 3. b; 4. b; 5. b; 6. a; 7. a; 8. a; 9. b; 10. d; 11. c; 12. c;
13. b; 14. d; 15. d; 16. c; 17. d; 18. c; 19. a; 20. a**CHAPTER 14****Practice Quiz page 546**

1. b; 2. a; 3. d; 4. b; 5. d

Practice Quiz page 556

1. c; 2. d; 3. a; 4. c; 5. a; 6. d

Practice Quiz page 561

1. a; 2. b; 3. a; 4. a; 5. b; 6. c

Practice Quiz page 568

1. b; 2. b; 3. a; 4. d

Test Yourself pages 572–5731. c; 2. d; 3. c; 4. a; 5. d; 6. c; 7. b; 8. a; 9. b; 10. c; 11. d; 12. d;
13. b; 14. b; 15. a; 16. a; 17. a; 18. b; 19. d; 20. a**CHAPTER 15****Practice Quiz page 583**

1. b; 2. a; 3. d; 4. c; 5. b; 6. c

Practice Quiz page 593

1. b; 2. b; 3. c; 4. a; 5. b; 6. c

Practice Quiz page 606

1. c; 2. a; 3. b; 4. b; 5. d; 6. a

Test Yourself pages 610–6111. a; 2. b; 3. a; 4. a; 5. d; 6. c; 7. d; 8. d; 9. b; 10. a; 11. b; 12. d;
13. c; 14. b; 15. d; 16. b; 17. c; 18. c; 19. a; 20. b**APPENDICES****Test Yourself pages A-12–A-13**

1. a; 2. c; 3. b; 4. d; 5. b; 6. a; 7. a; 8. a; 9. d; 10. d

Test Yourself pages B-13–B-14

1. b; 2. c; 3. a; 4. b; 5. d; 6. b; 7. d; 8. a; 9. b; 10. c



glossary

absolute threshold the lowest level of stimulation that a person can consciously detect 50 percent of the time the stimulation is present.

accommodation as a monocular cue of depth perception, the brain's use of information about the changing thickness of the lens of the eye in response to looking at objects that are close or far away.

acculturative stress stress resulting from the need to change and adapt a person's ways to the majority culture.

acquired (secondary) drives those drives that are learned through experience or conditioning, such as the need for money or social approval.

acrophobia fear of heights.

action potential the release of the neural impulse, consisting of a reversal of the electrical charge within the axon.

action therapy therapy in which the main goal is to change disordered or inappropriate behavior directly.

activation-information-mode model (AIM) revised version of the activation-synthesis explanation of dreams in which information that is accessed during waking hours can have an influence on the synthesis of dreams.

activation-synthesis hypothesis premise that states that dreams are created by the higher centers of the cortex to explain the activation by the brain stem of cortical cells during REM sleep periods.

activity theory theory of adjustment to aging that assumes older people are happier if they remain active in some way, such as volunteering or developing a hobby.

acute stress disorder (ASD) a disorder resulting from exposure to a major stressor, with symptoms of anxiety, dissociation, recurring nightmares, sleep disturbances, problems in concentration, and moments in which people seem to "relive" the event in dreams and flashbacks for as long as 1 month following the event.

adaptive theory theory of sleep proposing that animals and humans evolved sleep patterns to avoid predators by sleeping when predators are most active.

adolescence the period of life from about age 13 to the early 20s, during which a young person is no longer physically a child but is not yet an independent, self-supporting adult.

adrenal glands endocrine glands located on top of each kidney that secrete over 30 different hormones to deal with stress, regulate salt intake, and provide a secondary source of sex hormones affecting the sexual changes that occur during adolescence.

aerial (atmospheric) perspective monocular depth perception cue, the haziness that surrounds objects that are farther away from the viewer, causing the distance to be perceived as greater.

affect in psychology, a term indicating "emotion" or "mood."

afferent (sensory) neuron a neuron that carries information from the senses to the central nervous system.

afterimages images that occur when a visual sensation persists for a brief time even after the original stimulus is removed.

aggression actions meant to harm or destroy; behavior intended to hurt or destroy another person.

agonists chemical substances that mimic or enhance the effects of a neurotransmitter on the receptor sites of the next cell, increasing or decreasing the activity of that cell.

agoraphobia fear of being in a place or situation from which escape is difficult or impossible.

agreeableness the emotional style of a person that may range from easygoing, friendly, and likeable to grumpy, crabby, and unpleasant.

AIDS or acquired immune deficiency syndrome sexually transmitted viral disorder that causes deterioration of the immune system and eventually results in death due to complicating infections that the body can no longer fight.

alcohol the chemical resulting from fermentation or distillation of various kinds of vegetable matter.

algorithms very specific, step-by-step procedures for solving certain types of problems.

all-or-none referring to the fact that a neuron either fires completely or does not fire at all.

all-or-nothing thinking the tendency to believe that one's performance must be perfect or the result will be a total failure.

alpha waves brain waves that indicate a state of relaxation or light sleep.

altered state of consciousness state in which there is a shift in the quality or pattern of mental activity as compared to waking consciousness.

altruism prosocial behavior that is done with no expectation of reward and may involve the risk of harm to oneself.

amphetamines stimulants that are synthesized (made) in laboratories rather than being found in nature.

amygdala brain structure located near the hippocampus, responsible for fear responses and memory of fear.

anal stage the second stage in Freud's psychosexual stages, occurring from about 18 to 36 months of age, in which the anus is the erogenous zone and toilet training is the source of conflict.

analytical intelligence the ability to break problems down into component parts, or analysis, for problem solving.

androgens male hormones.

androgyny characteristic of possessing the most positive personality characteristics of males and females regardless of actual sex.

andropause gradual changes in the sexual hormones and reproductive system of middle-aged males.

anorexia nervosa (anorexia) a condition in which a person reduces eating to the point that their body weight is significantly low, or less than minimally expected. In adults, this is likely associated with a BMI < 18.5.

antagonists chemical substances that block or reduce a cell's response to the action of other chemicals or neurotransmitters.

anterograde amnesia loss of memory from the point of injury or trauma forward, or the inability to form new long-term memories.

antianxiety drugs drugs used to treat and calm anxiety reactions, typically minor tranquilizers.

antidepressant drugs drugs used to treat depression and anxiety.

antipsychotic drugs drugs used to treat psychotic symptoms such as delusions, hallucinations, and other bizarre behavior.

antisocial personality disorder (ASPD) disorder in which a person uses other people without worrying about their rights or feelings and often behaves in an impulsive or reckless manner without regard for the consequences of that behavior.

anxiety disorders class of disorders in which the primary symptom is excessive or unrealistic anxiety.

applied behavior analysis (ABA) modern term for a form of functional analysis and behavior modification that uses a variety of behavioral techniques to mold a desired behavior or response.

applied psychology the use of psychological concepts in solving real-world problems.

applied research research focused on finding practical solutions to real-world problems.

approach–approach conflict conflict occurring when a person must choose between two desirable goals.

approach–avoidance conflict conflict occurring when a person must choose or not choose a goal that has both positive and negative aspects.

arbitrary inference distortion of thinking in which a person draws a conclusion that is not based on any evidence.

archetypes Jung's collective, universal human memories.

arousal theory theory of motivation in which people are said to have an optimal (best or ideal) level of tension that they seek to maintain by increasing or decreasing stimulation.

association areas areas within each lobe of the cortex responsible for the coordination and interpretation of information, as well as higher mental processing.

attachment the emotional bond between an infant and the primary caregiver.

attitude a tendency to respond positively or negatively toward a certain person, object, idea, or situation.

attribution the process of explaining one's own behavior and the behavior of others.

attribution theory the theory of how people make attributions.

auditory canal short tunnel that runs from the pinna to the eardrum.

auditory nerve bundle of axons from the hair cells in the inner ear.

authenticity the genuine, open, and honest response of the therapist to the client.

authoritarian parenting style of parenting in which parent is rigid and overly strict, showing little warmth to the child.

authoritative parenting style of parenting in which parent combines warmth and affection with firm limits on a child's behavior.

autobiographical memory the memory for events and facts related to one's personal life story.

automatic encoding tendency of certain kinds of information to enter long-term memory with little or no effortful encoding.

autonomic nervous system (ANS) division of the PNS consisting of nerves that control all of the involuntary muscles, organs, and glands.

availability heuristic estimating the frequency or likelihood of an event based on how easy it is to recall relevant information from memory or how easy it is for us to think of related examples.

aversion therapy form of behavioral therapy in which an undesirable behavior is paired with an aversive stimulus to reduce the frequency of the behavior.

avoidance–avoidance conflict conflict occurring when a person must choose between two undesirable goals.

axon tubelike structure of neuron that carries the neural message from the cell body to the axon terminals, for communication with other cells..

axon terminals enlarged ends of axonal branches of the neuron, specialized for communication between cells.

basal metabolic rate (BMR) the rate at which the body burns energy when the organism is resting.

basic anxiety anxiety created when a child is born into the bigger and more powerful world of older children and adults.

basic research research focused on adding information to the scientific knowledge base.

behavioral genetics field of study devoted to discovering the genetic bases for personality characteristics.

behaviorism the science of behavior that focuses on observable behavior only.

behavior modification or applied behavior analysis the use of learning techniques to modify or change undesirable behavior and increase desirable behavior.

behavior therapies action therapies based on the principles of classical and operant conditioning and aimed at changing disordered behavior without concern for the original causes of such behavior.

benevolent sexism acceptance of positive stereotypes of males and females that leads to unequal treatment.

benzodiazepines drugs that lower anxiety and reduce stress.

beta waves smaller and faster brain waves, typically indicating mental activity.

bilateral anterior cingulotomy psychosurgical technique in which an electrode wire is inserted into the anterior cingulate gyrus, with the guidance of magnetic resonance imaging, to destroy a very small portion of that brain area with electric current.

bimodal condition in which a distribution has two modes.

bimodal distribution frequency distribution in which there are two high points rather than one.

binge-eating disorder a condition in which a person overeats, or binges, on enormous amounts of food at one sitting, but unlike bulimia nervosa, the individual does not then purge or use other unhealthy methods to avoid weight gain.

binocular cues cues for perceiving depth based on both eyes.

binocular disparity binocular depth perception cue, the difference in images between the two eyes, which is greater for objects that are close and smaller for distant objects.

biofeedback using feedback about biological conditions to bring involuntary responses, such as blood pressure and relaxation, under voluntary control.

biological model model of explaining behavior as caused by biological changes in the chemical, structural, or genetic systems of the body.

biological preparedness referring to the tendency of animals to learn certain associations, such as taste and nausea, with only one or few pairings due to the survival value of the learning.

biological psychology or behavioral neuroscience branch of neuroscience that focuses on the biological bases of psychological processes, behavior, and learning.

biomedical therapies therapies that directly affect the biological functioning of the body and brain; therapies for mental disorders in which a person with a problem is treated with biological or medical methods to relieve symptoms.

biopsychological perspective perspective that attributes human and animal behavior to biological events occurring in the body, such as genetic influences, hormones, and the activity of the nervous system.

biopsychosocial model perspective in which abnormal behavior is seen as the result of the combined and interacting forces of biological, psychological, social, and cultural influences.

bipolar disorder periods of mood that may range from normal to manic, with or without episodes of depression (bipolar I disorder), or spans of normal mood interspersed with episodes of major depression and episodes of hypomania (bipolar II disorder).

bisexual person attracted to both men and women.

blind spot area in the retina where the axons of the three layers of retinal cells exit the eye to form the optic nerve, insensitive to light.

borderline personality disorder (BPD) maladaptive personality pattern in which the person is moody, unstable, lacks a clear sense of identity, and often clings to others with a pattern of self-destructiveness, chronic loneliness, and disruptive anger in close relationships.

bottom-up processing the analysis of the smaller features to build up to a complete perception.

brightness constancy the tendency to perceive the apparent brightness of an object as the same even when the light conditions change.

Broca's aphasia condition resulting from damage to Broca's area, causing the affected person to be unable to speak fluently, to mispronounce words, and to speak haltingly.

bulimia nervosa (bulimia) a condition in which a person develops a cycle of "binging," or overeating enormous amounts of food at one sitting, and then using unhealthy methods to avoid weight gain.

burnout negative changes in thoughts, emotions, and behavior as a result of prolonged stress or frustration, leading to feelings of exhaustion.

bystander effect referring to the effect that the presence of other people has on the decision to help or not help, with help becoming less likely as the number of bystanders increases.

caffeine a mild stimulant found in coffee, tea, and several other plant-based substances.

Cannon-Bard theory of emotion theory in which the physiological reaction and the emotion are assumed to occur at the same time.

case study study of one individual in great detail.

catastrophe an unpredictable, large-scale event that creates a tremendous need to adapt and adjust as well as overwhelming feelings of threat.

catatonia disturbed behavior ranging from statue-like immobility to bursts of energetic, frantic movement, and talking.

central nervous system (CNS) part of the nervous system consisting of the brain and spinal cord.

central-route processing type of information processing that involves attending to the content of the message itself.

centration in Piaget's theory, the tendency of a young child to focus only on one feature of an object while ignoring other relevant features.

cerebellum part of the lower brain located behind the pons that controls and coordinates involuntary, rapid, fine motor movement, and may have some cognitive functions.

cerebral hemispheres the two sections of the cortex on the left and right sides of the brain.

cerebrum the upper part of the brain consisting of the two hemispheres and the structures that connect them.

character value judgments of a person's moral and ethical behavior.

chromosome tightly wound strand of genetic material or DNA.

circadian rhythm a cycle of bodily rhythm that occurs over a 24-hour period.

classical conditioning learning to make an involuntary response to a stimulus other than the original, natural stimulus that normally produces the response.

claustrophobia fear of being in a small, enclosed space.

clinical psychology area of psychology in which the psychologists diagnose and treat people with psychological disorders that may range from mild to severe.

closure a Gestalt principle of perception, the tendency to complete figures that are incomplete.

cocaine a natural drug derived from the leaves of the coca plant.

cochlea snail-shaped structure of the inner ear that is filled with fluid.

cognitive arousal theory (two-factor theory) theory of emotion in which both the physical arousal and the labeling of that arousal based on cues from the environment must occur before the emotion is experienced.

cognitive-behavioral therapy (CBT) action therapy in which the goal is to help clients overcome problems by learning to think more rationally and logically, which in turn will impact their behavior.

cognitive development the development of thinking, problem solving, and memory.

cognitive dissonance sense of discomfort or distress that occurs when a person's behavior does not correspond to that person's attitudes.

cognitive-mediational theory theory of emotion in which a stimulus must be interpreted (appraised) by a person in order to result in a physical response and an emotional reaction.

cognitive neuroscience study of the physical changes in the brain and nervous system during thinking.

cognitive perspective modern perspective in psychology that focuses on memory, intelligence, perception, problem solving, and learning.

cognitive perspective in classical conditioning, modern theory in which conditioning is seen to occur because the conditioned stimulus provides information or an expectancy about the coming of the unconditioned stimulus.

cognitive psychologists psychologists who study the way people think, remember, and mentally organize information.

cognitive therapy therapy in which the focus is on helping clients recognize distortions in their thinking and replacing distorted, unrealistic beliefs with more realistic, helpful thoughts.

cognitive universalism theory that concepts are universal and influence the development of language.

cohort effect the impact on development occurring when a group of people share a common time period or common life experience.

collective unconscious Jung's name for the memories shared by all members of the human species.

College Undergraduate Stress Scale (CUSS) assessment that measures the amount of stress in a college student's life over a 1-year period resulting from major life events.

community psychology area of psychology in which psychologists serve at various levels including individual, group, and community, focusing on promoting social welfare and preventing social problems.

companionate love type of love consisting of intimacy and commitment.

comparative psychology area of psychology in which the psychologists study animals and their behavior for the purpose of comparing and contrasting it to human behavior.

compensation (substitution) defense mechanism in which a person makes up for inferiorities in one area by becoming superior in another area.

compliance changing one's behavior as a result of other people directing or asking for the change.

computed tomography (CT) brain-imaging method using computer-controlled X-rays of the brain.

concentrative meditation form of meditation in which a person focuses the mind on some repetitive or unchanging stimulus so that the mind can be cleared of disturbing thoughts and the body can experience relaxation.

concept map an organized visual representation of knowledge consisting of concepts and their relationships to other concepts.

concepts ideas that represent a class or category of objects, events, or activities.

concrete operations stage Piaget's third stage of cognitive development, in which the school-age child becomes capable of logical thought processes but is not yet capable of abstract thinking.

conditional positive regard positive regard that is given only when the person is doing what the providers of positive regard wish.

conditioned emotional response (CER) emotional response that has become classically conditioned to occur to learned stimuli, such as a fear of dogs or the emotional reaction that occurs when seeing an attractive person.

conditioned response (CR) in classical conditioning, a learned response to a conditioned stimulus.

conditioned stimulus (CS) in classical conditioning, a previously neutral stimulus that becomes able to produce a conditioned response, after pairing with an unconditioned stimulus.

conditioned taste aversion development of a nausea or aversive response to a particular taste because that taste was followed by a nausea reaction, occurring after only one association.

cones visual sensory receptors found at the back of the retina, responsible for color vision and sharpness of vision.

confirmation bias the tendency to search for evidence that fits one's beliefs while ignoring any evidence that does not fit those beliefs.

conformity changing one's own behavior to match that of other people.

conscience part of the superego that produces guilt, depending on how acceptable behavior is.

conscientiousness the care a person gives to organization and thoughtfulness of others; dependability.

consciousness a person's awareness of everything that is going on around him or her at any given time.

conservation in Piaget's theory, the ability to understand that simply changing the appearance of an object does not change the object's nature.

consolidation the changes that take place in the structure and functioning of neurons when a memory is formed.

- constructive processing** referring to the retrieval of memories in which those memories are altered, revised, or influenced by newer information.
- consumer psychology** branch of psychology that studies the habits of consumers in the marketplace.
- contiguity** a Gestalt principle of perception, the tendency to perceive two things that happen close together in time as being related.
- contingency contract** a formal, written agreement between the therapist and client (or teacher and student) in which goals for behavioral change, reinforcements, and penalties are clearly stated.
- continuity** a Gestalt principle of perception, the tendency to perceive things as simply as possible with a continuous pattern rather than with a complex, broken-up pattern.
- continuous reinforcement** the reinforcement of each and every correct response.
- control group** subjects in an experiment who are not subjected to the independent variable and who may receive a placebo treatment.
- conventional morality** second level of Kohlberg's stages of moral development in which the child's behavior is governed by conforming to the society's norms of behavior.
- convergence** binocular depth perception cue, the rotation of the two eyes in their sockets to focus on a single object, resulting in greater convergence for closer objects and lesser convergence if objects are distant.
- convergent thinking** type of thinking in which a problem is seen as having only one answer, and all lines of thinking will eventually lead to that single answer, using previous knowledge and logic.
- coping strategies** actions that people can take to master, tolerate, reduce, or minimize the effects of stressors.
- coronary heart disease (CHD)** the buildup of a waxy substance called plaque in the arteries of the heart.
- corpus callosum** thick band of neurons that connects the right and left cerebral hemispheres.
- correlation** a measure of the relationship between two variables.
- correlation coefficient** a number that represents the strength and direction of a relationship existing between two variables; number derived from the formula for measuring a correlation.
- cortex** outermost covering of the brain consisting of densely packed neurons, responsible for higher thought processes and interpretation of sensory input.
- counseling psychology** area of psychology in which the psychologists help people with problems of adjustment.
- creative intelligence** the ability to deal with new and different concepts and to come up with new ways of solving problems.
- creativity** the process of solving problems by combining ideas or behavior in new ways.
- critical periods** times during which certain environmental influences can have an impact on the development of the infant.
- critical thinking** making reasoned judgments about claims.
- cross-sectional design** research design in which several different participant age-groups are studied at one particular point in time.
- cross-sequential design** research design in which participants are first studied by means of a cross-sectional design but are also followed and assessed longitudinally.
- cult** any group of people with a particular religious or philosophical set of beliefs and identity.
- cultural relativity** the need to consider the unique characteristics of the culture in which behavior takes place.
- cultural syndromes** sets of particular symptoms of distress found in particular cultures, which may or may not be recognized as an illness within the culture.
- curve of forgetting** a graph showing a distinct pattern in which forgetting is very fast within the first hour after learning a list and then tapers off gradually.
- cybertherapy** psychotherapy that is offered on the Internet. Also called online, Internet, or Web therapy or counseling.
- dark adaptation** the recovery of the eye's sensitivity to visual stimuli in darkness after exposure to bright lights.
- decay** loss of memory due to the passage of time, during which the memory trace is not used.
- decision making** process of cognition that involves identifying, evaluating, and choosing among several alternatives.
- declarative (explicit) memory** type of long-term memory containing information that is conscious and known.
- deindividuation** the lessening of personal identity, self-restraint, and the sense of personal responsibility that can occur within a group.
- delta waves** long, slow brain waves that indicate the deepest stage of sleep.
- delusions** false beliefs held by a person who refuses to accept evidence of their falseness.
- dendrites** branchlike structures of a neuron that receive messages from other neurons.
- denial** psychological defense mechanism in which the person refuses to acknowledge or recognize a threatening situation.
- dependent variable** variable in an experiment that represents the measurable response or behavior of the subjects in the experiment.
- depressants** drugs that decrease the functioning of the nervous system.
- depth perception** the ability to perceive the world in three dimensions..
- descriptive statistics** a way of organizing numbers and summarizing them so that patterns can be determined.
- developmental psychology** area of psychology in which the psychologists study the changes in the way people think, relate to others, and feel as they age.
- deviation IQ scores** a type of intelligence measure that assumes that IQ is normally distributed around a mean of 100 with a standard deviation of about 15.
- diffusion** process of molecules moving from areas of high concentration to areas of low concentration.
- diffusion of responsibility** occurring when a person fails to take responsibility for actions or for inaction because of the presence of other people who are seen to share the responsibility.
- directive** therapy in which the therapist actively gives interpretations of a client's statements and may suggest certain behavior or actions.
- direct observation** assessment in which the professional observes the client engaged in ordinary, day-to-day behavior in either a clinical or natural setting.
- discrimination** treating people differently because of prejudice toward the social group to which they belong.
- discriminative stimulus** any stimulus, such as a stop sign or a doorknob, that provides the organism with a cue for making a certain response in order to obtain reinforcement.
- displaced aggression** taking out one's frustrations on some less threatening or more available target.
- displacement** redirecting feelings from a threatening target to a less threatening one.
- display rules** learned ways of controlling displays of emotion in social settings.
- dispositional cause** cause of behavior attributed to internal factors such as personality or character.
- dissociation** divided state of conscious awareness.
- dissociative disorders** disorders in which there is a break in conscious awareness, memory, the sense of identity, or some combination.
- dissociative identity disorder (DID)** disorder occurring when a person seems to have two or more distinct personalities within one body.
- distress** the effect of unpleasant and undesirable stressors.
- distributed practice** spacing the study of material to be remembered by including breaks between study periods.

disuse another name for decay, assuming that memories that are not used will eventually decay and disappear.

divergent thinking type of thinking in which a person starts from one point and comes up with many different ideas or possibilities based on that point.

dizygotic twins often called fraternal twins, occurring when two individual eggs get fertilized by separate sperm, resulting in two zygotes in the uterus at the same time.

DNA (deoxyribonucleic acid) special molecule that contains the genetic material of the organism.

dominant referring to a gene that actively controls the expression of a trait.

door-in-the-face technique asking for a large commitment and being refused and then asking for a smaller commitment.

double approach-avoidance conflict conflict in which the person must decide between two goals, with each goal possessing both positive and negative aspects.

double-blind study study in which neither the experimenter nor the subjects know if the subjects are in the experimental or the control group.

drive a psychological tension and physical arousal arising when there is a need that motivates the organism to act in order to fulfill the need and reduce the tension.

drive-reduction theory approach to motivation that assumes behavior arises from physiological needs that cause internal drives to push the organism to satisfy the need and reduce tension and arousal.

drug tolerance the decrease of the response to a drug over repeated uses, leading to the need for higher doses of drug to achieve the same effect.

echoic memory auditory sensory memory, lasting only 2–4 seconds.

eclectic approach to therapy that results from combining elements of several different approaches or techniques.

educational psychology area of psychology in which the psychologists are concerned with the study of human learning and development of new learning techniques.

efferent (motor) neuron a neuron that carries messages from the central nervous system to the muscles of the body.

ego part of the personality that develops out of a need to deal with reality; mostly conscious, rational, and logical.

egocentrism the inability to see the world through anyone else's eyes.

ego integrity sense of wholeness that comes from having lived a full life possessing the ability to let go of regrets; the final completion of the ego.

eidetic imagery the ability to access a visual memory for 30 seconds or more.

elaboration likelihood model model of persuasion stating that people will either elaborate on the persuasive message or fail to elaborate on it and that the future actions of those who do elaborate are more predictable than those who do not.

elaborative rehearsal a method of transferring information from STM into LTM by making that information meaningful in some way.

electroconvulsive therapy (ECT) form of biomedical therapy to treat severe depression in which electrodes are placed on either one or both sides of a person's head and an electric current is passed through the electrodes that is strong enough to cause a seizure or convulsion.

electroencephalogram (EEG) a recording of the electrical activity of large groups of cortical neurons just below the skull, most often using scalp electrodes.

electroencephalograph machine designed to record the electroencephalogram.

embryo name for the developing organism from 2 weeks to 8 weeks after fertilization.

embryonic period the period from 2 to 8 weeks after fertilization, during which the major organs and structures of the organism develop.

emotion the “feeling” aspect of consciousness, characterized by a certain physical arousal, a certain behavior that reveals the emotion to the outside world, and an inner awareness of feelings.

emotional intelligence the awareness of and ability to manage one's own emotions to facilitate thinking and attain goals, as well as the ability to understand emotions in others.

emotion-focused coping coping strategies that change the impact of a stressor by changing the emotional reaction to the stressor.

empathy the ability of the therapist to understand the feelings of the client.

encoding the set of mental operations that people perform on sensory information to convert that information into a form that is usable in the brain's storage systems.

encoding failure failure to process information into memory.

encoding specificity the tendency for memory of information to be improved if related information (such as surroundings or physiological state) that is available when the memory is first formed is also available when the memory is being retrieved.

endocrine glands glands that secrete chemicals called hormones directly into the bloodstream.

environmental psychology area of psychology in which the focus is on how people interact with and are affected by their physical environments.

enzymatic degradation process by which the structure of a neurotransmitter is altered so it can no longer act on a receptor.

episodic memory type of declarative memory containing personal information not readily available to others, such as daily activities and events.

equal status contact contact between groups in which the groups have equal status with neither group having power over the other.

escape or withdrawal leaving the presence of a stressor, either literally or by a psychological withdrawal into fantasy, drug abuse, or apathy.

estrogens female hormones.

eustress the effect of positive events, or the optimal amount of stress that people need to promote health and well-being.

evidence-based treatment also called empirically supported treatment, refers to interventions, strategies, or techniques that have been found to produce therapeutic and desired changes during controlled research studies.

evolutionary perspective perspective that focuses on the biological bases of universal mental characteristics that all humans share.

excitatory synapse synapse at which a neurotransmitter causes the receiving cell to fire.

expectancy a person's subjective feeling that a particular behavior will lead to a reinforcing consequence.

experiment a deliberate manipulation of a variable to see if corresponding changes in behavior result, allowing the determination of cause-and-effect relationships.

experimental group subjects in an experiment who are subjected to the independent variable.

experimental psychology area of psychology in which the psychologists primarily do research and experiments in the areas of learning, memory, thinking, perception, motivation, and language.

experimenter effect tendency of the experimenter's expectations for a study to unintentionally influence the results of the study.

exposure therapies behavioral techniques that expose individuals to anxiety- or fear-related stimuli, under carefully controlled conditions, to promote new learning.

extinction the disappearance or weakening of a learned response following the removal or absence of the unconditioned stimulus (in classical conditioning) or the removal of a reinforcer (in operant conditioning).

extraversion dimension of personality referring to one's need to be with other people.

extraverts people who are outgoing and sociable.

intrinsic motivation type of motivation in which a person performs an action because it leads to an outcome that is separate from or external to the person.

facial feedback hypothesis theory of emotion that assumes that facial expressions provide feedback to the brain concerning the emotion being expressed, which in turn causes and intensifies the emotion.

family counseling (family therapy) a form of group therapy in which family members meet together with a counselor or therapist to resolve problems that affect the entire family.

fertilization the union of the ovum and sperm.

fetal alcohol syndrome (FAS) the physical and mental defects caused by consumption of alcohol during pregnancy.

fetal period the time from about 8 weeks after conception until the birth of the baby.

fetus name for the developing organism from 8 weeks after fertilization to the birth of the baby.

figure-ground the tendency to perceive objects, or figures, as existing on a background.

five-factor model (Big Five) model of personality traits that describes five basic trait dimensions.

fixation disorder in which the person does not fully resolve the conflict in a particular psychosexual stage, resulting in personality traits and behavior associated with that earlier stage.

fixed interval schedule of reinforcement schedule of reinforcement in which the interval of time that must pass before reinforcement becomes possible is always the same.

fixed ratio schedule of reinforcement schedule of reinforcement in which the number of responses required for reinforcement is always the same.

flashbulb memories type of automatic encoding that occurs because an unexpected event has strong emotional associations for the person remembering it.

flat affect a lack of emotional responsiveness.

flooding technique for treating phobias and other stress disorders in which the person is rapidly and intensely exposed to the fear-provoking situation or object and prevented from making the usual avoidance or escape response.

foot-in-the-door technique asking for a small commitment and, after gaining compliance, asking for a bigger commitment.

forensic psychology area of psychology concerned with people in the legal system, including psychological assessment of criminals, jury selection, and expert witnessing.

formal operations stage Piaget's last stage of cognitive development, in which the adolescent becomes capable of abstract thinking.

free association psychoanalytic technique in which a patient was encouraged to talk about anything that came to mind without fear of negative evaluations.

free-floating anxiety anxiety that is unrelated to any specific and known cause.

frequency count assessment in which the frequency of a particular behavior is counted.

frequency distribution a table or graph that shows how often different numbers or scores appear in a particular set of scores.

frequency theory theory of pitch that states that pitch is related to the speed of vibrations in the basilar membrane.

frontal lobes areas of the brain located in the front and top, responsible for higher mental processes and decision making as well as the production of fluent speech.

frustration the psychological experience produced by the blocking of a desired goal or fulfillment of a perceived need.

fully functioning person a person who is in touch with and trusting of the deepest, innermost urges and feelings.

functional fixedness a block to problem solving that comes from thinking about objects in terms of only their typical functions.

functionalism early perspective in psychology associated with William James, in which the focus of study is how the mind allows people to adapt, live, work, and play.

functional magnetic resonance imaging (fMRI) MRI-based brain-imaging method that allows for functional examination of brain areas through changes in brain oxygenation.

fundamental attribution error the tendency to overestimate the influence of internal factors in determining behavior while underestimating situational factors.

gender the psychological aspects of being male or female.

gender identity the individual's sense of being male or female.

gender roles the culture's expectations for male or female behavior, including attitudes, actions, and personality traits associated with being male or female in that culture.

gender schema theory theory of gender identity acquisition in which a child develops a mental pattern, or schema, for being male or female and then organizes observed and learned behavior around that schema.

gender stereotype a concept held about a person or group of people that is based on being male or female.

gender typing the process of acquiring gender-role characteristics.

gene section of DNA having the same arrangement of chemical elements.

general adaptation syndrome (GAS) the three stages of the body's physiological reaction to stress, including alarm, resistance, and exhaustion.

generalized anxiety disorder disorder in which a person has feelings of dread and impending doom along with physical symptoms of stress, which lasts 6 months or more.

generativity providing guidance to one's children or the next generation, or contributing to the well-being of the next generation through career or volunteer work.

genetics the science of inherited traits.

genital stage the final stage in Freud's psychosexual stages, from puberty on, sexual urges are allowed back into consciousness and the individual moves toward adult social and sexual behavior.

germinal period first 2 weeks after fertilization, during which the zygote moves down to the uterus and begins to implant in the lining.

Gestalt psychology early perspective in psychology focusing on perception and sensation, particularly the perception of patterns and whole figures.

Gestalt therapy form of directive insight therapy in which the therapist helps clients to accept all parts of their feelings and subjective experiences, using leading questions and planned experiences such as role-playing.

g factor the ability to reason and solve problems, or general intelligence.

gifted the 2 percent of the population falling on the upper end of the normal curve and typically possessing an IQ of 130 or above.

glial cells cells that provide support for the neurons to grow on and around, deliver nutrients to neurons, produce myelin to coat axons, clean up waste products and dead neurons, influence information processing, and, during prenatal development, influence the generation of new neurons.

glucagon hormone that is secreted by the pancreas to control the levels of fats, proteins, and carbohydrates in the body by increasing the level of glucose in the bloodstream.

gonads sex glands; secrete hormones that regulate sexual development and behavior as well as reproduction.

grammar the system of rules governing the structure and use of a language.

group polarization the tendency for members involved in a group discussion to take somewhat more extreme positions and suggest riskier actions when compared to individuals who have not participated in a group discussion.

group therapy form of therapy or treatment during which a small group of clients with similar concerns meet together with a therapist to address their issues.

groupthink kind of thinking that occurs when people place more importance on maintaining group cohesiveness than on assessing the facts of the problem with which the group is concerned.

habits in behaviorism, sets of well-learned responses that have become automatic.

habituation tendency of the brain to stop attending to constant, unchanging information.

hallucinations false sensory perceptions, such as hearing voices that do not really exist.

hallucinogenics drugs including hallucinogens and marijuana that produce hallucinations or increased feelings of relaxation and intoxication.

hallucinogens drugs that cause false sensory messages, altering the perception of reality.

halo effect tendency of an interviewer to allow positive characteristics of a client to influence the assessments of the client's behavior and statements.

hardy personality a person who seems to thrive on stress but lacks the anger and hostility of the Type A personality.

hassles the daily annoyances of everyday life.

health psychology area of psychology focusing on how physical activities, psychological traits, stress reactions, and social relationships affect overall health and rate of illnesses.

heritability degree to which the changes in some trait within a population can be considered to be due to genetic influences; the extent individual genetic differences affect individual differences in observed behavior; in IQ, proportion of change in IQ within a population that is caused by hereditary factors.

heroin narcotic drug derived from opium that is extremely addictive.

hertz (Hz) cycles or waves per second, a measurement of frequency.

heterosexual person attracted to the opposite sex.

heuristic an educated guess based on prior experiences that helps narrow down the possible solutions for a problem. Also known as a "rule of thumb."

higher-order conditioning occurs when a strong conditioned stimulus is paired with a neutral stimulus, causing the neutral stimulus to become a second conditioned stimulus.

hindsight bias the tendency to falsely believe, through revision of older memories to include newer information, that one could have correctly predicted the outcome of an event.

hippocampus curved structure located within each temporal lobe, responsible for the formation of long-term declarative memories.

histogram a bar graph showing a frequency distribution.

homeostasis the tendency of the body to maintain a steady state.

homosexual person attracted to the same sex.

hormones chemicals released into the bloodstream by endocrine glands.

human development the scientific study of the changes that occur in people as they age from conception until death.

human factors psychology area of industrial/organizational psychology concerned with the study of the way humans and machines interact with each other.

humanistic perspective the "third force" in psychology that focuses on those aspects of personality that make people uniquely human, such as subjective feelings and freedom of choice.

hypnosis state of consciousness in which the person is especially susceptible to suggestion.

hypothalamus small structure in the brain located below the thalamus and directly above the pituitary gland, responsible for motivational behavior such as sleep, hunger, thirst, and sex.

hypothesis tentative explanation of a phenomenon based on observations.

iconic memory visual sensory memory, lasting only a fraction of a second.

identification defense mechanism in which a person tries to become like someone else to deal with anxiety.

identity versus role confusion stage of personality development in which the adolescent must find a consistent sense of self.

id part of the personality present at birth and completely unconscious.

imaginary audience type of thought common to adolescents in which young people believe that other people are just as concerned about the adolescent's thoughts and characteristics as they themselves are.

immune system the system of cells, organs, and chemicals of the body that responds to attacks from diseases, infections, and injuries.

implicit personality theory sets of assumptions about how different types of people, personality traits, and actions are related to each other.

impression formation the forming of the first knowledge that a person has concerning another person.

incentive approaches theories of motivation in which behavior is explained as a response to the external stimulus and its rewarding properties.

incentives things that attract or lure people into action.

independent variable variable in an experiment that is manipulated by the experimenter.

industrial/organizational (I/O) psychology area of psychology concerned with the relationships between people and their work environment.

infantile amnesia the inability to retrieve memories from much before age 3.

inferential statistics statistical analysis of two or more sets of numerical data to reduce the possibility of error in measurement and to determine if the differences between the data sets are greater than chance variation would predict.

information-processing model model of memory that assumes the processing of information for memory storage is similar to the way a computer processes memory in a series of three stages.

in-groups social groups with whom a person identifies; "us."

inhibitory synapse synapse at which a neurotransmitter causes the receiving cell to stop firing.

insight the sudden perception of relationships among various parts of a problem, allowing the solution to the problem to come quickly.

insight therapies therapies in which the main goal is helping people to gain insight with respect to their behavior, thoughts, and feelings.

insomnia the inability to get to sleep, stay asleep, or get a good quality of sleep.

instinctive drift tendency for an animal's behavior to revert to genetically controlled patterns.

instincts the biologically determined and innate patterns of behavior that exist in both people and animals.

insulin a hormone secreted by the pancreas to control the levels of fats, proteins, and carbohydrates in the body by reducing the level of glucose in the bloodstream.

intellectual disability (intellectual developmental disorder) condition in which a person's behavioral and cognitive skills exist at an earlier developmental stage than the skills of others who are the same chronological age; may also be referred to as developmentally delayed. This condition was formerly known as mental retardation.

intelligence the ability to learn from one's experiences, acquire knowledge, and use resources effectively in adapting to new situations or solving problems.

intelligence quotient (IQ) a number representing a measure of intelligence, resulting from the division of one's mental age by one's chronological age and then multiplying that quotient by 100.

interneuron a neuron found in the center of the spinal cord that receives information from the afferent neurons and sends commands to the muscles through the efferent neurons. Interneurons also make up the bulk of the neurons in the brain.

interpersonal attraction liking or having the desire for a relationship with another person.

interpersonal therapy (IPT) form of therapy for depression which incorporates multiple approaches and focuses on interpersonal problems.

intersexed, intersexual modern term for a hermaphrodite, a person who possesses ambiguous sexual organs, making it difficult to determine actual sex from a visual inspection at birth.

interview method of personality assessment in which the professional asks questions of the client and allows the client to answer, either in a structured or unstructured fashion.

intimacy an emotional and psychological closeness that is based on the ability to trust, share, and care, while still maintaining a sense of self.

intrinsic motivation type of motivation in which a person performs an action because the act itself is rewarding or satisfying in some internal manner.

introversion dimension of personality in which people tend to withdraw from excessive stimulation.

introverts people who prefer solitude and dislike being the center of attention.
irreversibility in Piaget's theory, the inability of the young child to mentally reverse an action.

James-Lange theory of emotion theory in which a physiological reaction leads to the labeling of an emotion.

"jigsaw classroom" educational technique in which each individual is given only part of the information needed to solve a problem, causing the separate individuals to be forced to work together to find the solution.

just noticeable difference (jnd or the difference threshold) the smallest difference between two stimuli that is detectable 50 percent of the time.

kinesthetic sense the awareness of where body parts such as the legs, arms, etc. are located in relation to each other and the ground.

language a system for combining symbols (such as words) so that an unlimited number of meaningful statements can be made for the purpose of communicating with others.

latency the fourth stage in Freud's psychosexual stages, occurring during the school years, in which the sexual feelings of the child are repressed while the child develops in other ways.

latent content the symbolic or hidden meaning of dreams.

latent learning learning that remains hidden until its application becomes useful.

law of effect law stating that if an action is followed by a pleasurable consequence, it will tend to be repeated, and if followed by an unpleasant consequence, it will tend not to be repeated.

learned helplessness the tendency to fail to act to escape from a situation because of a history of repeated failures in the past.

learning any relatively permanent change in behavior brought about by experience or practice.

learning/performance distinction referring to the observation that learning can take place without actual performance of the learned behavior.

leptin a hormone that, when released into the bloodstream, signals the hypothalamus that the body has had enough food and reduces the appetite while increasing the feeling of being full.

lesioning insertion of a thin, insulated electrode into the brain through which an electrical current is sent, destroying the brain cells at the tip of the wire.

levels-of-processing model model of memory that assumes information that is more "deeply processed," or processed according to its meaning rather than just the sound or physical characteristics of the word or words, will be remembered more efficiently and for a longer period of time.

light adaptation the recovery of the eye's sensitivity to visual stimuli in light after exposure to darkness.

limbic system a group of several brain structures located primarily under the cortex and involved in learning, emotion, memory, and motivation.

linear perspective monocular depth perception cue, the tendency for parallel lines to appear to converge on each other.

linguistic relativity hypothesis the theory that thought processes and concepts are controlled by language.

locus of control the tendency for people to assume that they either have control or do not have control over events and consequences in their lives.

longitudinal design research design in which one participant or group of participants is studied over a long period of time.

long-term memory (LTM) the system of memory into which all the information is placed to be kept more or less permanently.

lowball technique getting a commitment from a person and then raising the cost of that commitment.

LSD (lysergic acid diethylamide) powerful synthetic hallucinogen.

magnetic resonance imaging (MRI) brain-imaging method using radio waves and magnetic fields of the body to produce detailed images of the brain.

magnification the tendency to interpret situations as far more dangerous, harmful, or important than they actually are.

magnification and minimization distortions of thinking in which a person blows a negative event out of proportion to its importance (magnification) while ignoring relevant positive events (minimization).

maintenance rehearsal practice of saying some information to be remembered over and over in one's head in order to maintain it in short-term memory.

major depressive disorder severe depression that comes on suddenly and seems to have no external cause, or is too severe for current circumstances.

maladaptive anything that does not allow a person to function within or adapt to the stresses and everyday demands of life.

mammary glands glands within the breast tissue that produce milk when a woman gives birth to an infant.

manic having the quality of excessive excitement, energy, and elation or irritability.

marijuana mild hallucinogen (also known as "pot" or "weed") derived from the leaves and flowers of a particular type of hemp plant.

MDMA (Ecstasy or X) designer drug that can have both stimulant and hallucinatory effects.

mean the arithmetic average of a distribution of numbers.

measure of central tendency numbers that best represent the most typical score of a frequency distribution.

measures of variability measurement of the degree of differences within a distribution or how the scores are spread out.

median the middle score in an ordered distribution of scores, or the mean of the two middle numbers; the 50th percentile.

meditation mental series of exercises meant to refocus attention and achieve a trancelike state of consciousness.

medulla the first large swelling at the top of the spinal cord, forming the lowest part of the brain, which is responsible for life-sustaining functions such as breathing, swallowing, and heart rate.

memory an active system that receives information from the senses, puts that information into a usable form, and organizes it as it stores it away, and then retrieves the information from storage.

memory trace physical change in the brain that occurs when a memory is formed.

menarche the first menstrual cycle, the monthly shedding of the blood and tissue that line the uterus in preparation for pregnancy when conception does not occur.

menopause the cessation of ovulation and menstrual cycles and the end of a woman's reproductive capability.

mental images mental representations that stand for objects or events and have a picturelike quality.

mental set the tendency for people to persist in using problem-solving patterns that have worked for them in the past.

microsleeps brief sidesteps into sleep lasting only a few seconds.

minimization the tendency to give little or no importance to one's successes or positive events and traits.

mirror neurons neurons that fire when an animal or person performs an action and also when an animal or person observes that same action being performed by another.

misinformation effect the tendency of misleading information presented after an event to alter the memories of the event itself.

mode the most frequent score in a distribution of scores.

modeling learning through the observation and imitation of others.

monocular cues (pictorial depth cues) cues for perceiving depth based on one eye only.

monozygotic twins identical twins formed when one zygote splits into two separate masses of cells, each of which develops into a separate embryo.

mood disorders disorders in which mood is severely disturbed.

morphemes the smallest units of meaning within a language.

- morphine** narcotic drug derived from opium, used to treat severe pain.
- motion parallax** monocular depth perception cue, the perception of motion of objects in which close objects appear to move more quickly than objects that are farther away.
- motivation** the process by which activities are started, directed, and continued so that physical or psychological needs or wants are met.
- motor cortex** rear section of the frontal lobe, responsible for sending motor commands to the muscles of the somatic nervous system.
- motor pathway** nerves coming from the CNS to the voluntary muscles, consisting of efferent neurons.
- Müller-Lyer illusion** illusion of line length that is distorted by inward-turning or outward-turning corners on the ends of the lines, causing lines of equal length to appear to be different.
- multiple approach avoidance conflict** conflict in which the person must decide between more than two goals, with each goal possessing both positive and negative aspects.
- myelin** fatty substances produced by certain glial cells that coat the axons of neurons to insulate, protect, and speed up the neural impulse.
- narcolepsy** sleep disorder in which a person falls immediately into REM sleep during the day without warning.
- narcotics** a class of opium-related drugs that suppress the sensation of pain by binding to and stimulating the nervous system's natural receptor sites for endorphins.
- natural killer (NK) cell** immune-system cell responsible for suppressing viruses and destroying tumor cells.
- nature** the influence of our inherited characteristics on our personality, physical growth, intellectual growth, and social interactions.
- need** a requirement of some material (such as food or water) that is essential for survival of the organism.
- need for achievement (nAch)** a need that involves a strong desire to succeed in attaining goals, not only realistic ones but also challenging ones.
- need for affiliation (nAff)** the need for friendly social interactions and relationships with others.
- need for power (nPow)** the need to have control or influence over others.
- negatively skewed** a distribution of scores in which scores are concentrated in the high end of the distribution.
- negative reinforcement** the reinforcement of a response by the removal, escape from, or avoidance of an unpleasant stimulus.
- negative symptoms** symptoms of schizophrenia that are less than normal behavior or an absence of normal behavior; poor attention, flat affect, and poor speech production.
- neo-Freudians** followers of Freud who developed their own competing psychodynamic theories.
- nerves** bundles of axons coated in myelin that travel together through the body.
- nervous system** an extensive network of specialized cells that carries information to and from all parts of the body.
- neurofeedback** form of biofeedback using brain-scanning devices to provide feedback about brain activity in an effort to modify behavior.
- neuron** the basic cell that makes up the nervous system and that receives and sends messages within that system.
- neuroplasticity** the ability within the brain to constantly change both the structure and function of many cells in response to experience or trauma.
- neuropsychology** area of psychology in which psychologists specialize in the research or clinical implications of brain-behavior relationships.
- neuroscience** a branch of the life sciences that deals with the structure and function of neurons, nerves, and nervous tissue.
- neuroticism** degree of emotional instability or stability.
- neurotic personalities** personalities typified by maladaptive ways of dealing with relationships in Horney's theory.
- neurotransmitter** chemical found in the synaptic vesicles that, when released, has an effect on the next cell.
- neutral stimulus (NS)** in classical conditioning, a stimulus that has no effect on the desired response prior to conditioning.
- nicotine** the active ingredient in tobacco.
- nightmares** bad dreams occurring during REM sleep.
- night terrors** relatively rare disorder in which the person experiences extreme fear and screams or runs around during deep sleep without waking fully.
- nondeclarative (implicit) memory** type of long-term memory including memory for skills, procedures, habits, and conditioned responses. These memories are not conscious but are implied to exist because they affect conscious behavior.
- nondirective** therapy style in which the therapist remains relatively neutral and does not interpret or take direct actions with regard to the client, instead remaining a calm, nonjudgmental listener while the client talks.
- non-REM (NREM) sleep** any of the stages of sleep that do not include REM.
- normal curve** a special frequency polygon, shaped like a bell, in which the scores are symmetrically distributed around the mean, and the mean, median, and mode are all located on the same point on the curve with scores decreasing as the curve extends from the mean.
- nurture** the influence of the environment on personality, physical growth, intellectual growth, and social interactions.
- obedience** changing one's behavior at the command of an authority figure.
- objective introspection** the process of examining and measuring one's own thoughts and mental activities.
- object permanence** the knowledge that an object exists even when it is not in sight.
- observational learning** learning new behavior by watching a model perform that behavior.
- observer bias** tendency of observers to see what they expect to see.
- observer effect** tendency of people or animals to behave differently from normal when they know they are being observed.
- obsessive-compulsive disorder** disorder in which intruding, recurring thoughts or obsessions create anxiety that is relieved by performing a repetitive, ritualistic behavior or mental act (compulsion).
- occipital lobe** section of the brain located at the rear and bottom of each cerebral hemisphere containing the primary visual centers of the brain.
- Oedipus complex/Electra complex** situation occurring in the phallic stage in which a child develops a sexual attraction to the opposite-sex parent and jealousy of the same-sex parent. Males develop an Oedipus complex whereas females develop an Electra complex.
- olfaction (olfactory sense)** the sensation of smell.
- olfactory bulbs** two bulb-like projections of the brain located just above the sinus cavity and just below the frontal lobes that receive information from the olfactory receptor cells.
- openness** one of the five factors; willingness to try new things and be open to new experiences.
- operant** any behavior that is voluntary and not elicited by specific stimuli.
- operant conditioning** the learning of voluntary behavior through the effects of pleasant and unpleasant consequences to responses.
- operational definition** definition of a variable of interest that allows it to be measured.
- opium** substance derived from the opium poppy from which all narcotic drugs are derived.
- opponent-process theory** theory of color vision that proposes visual neurons (or groups of neurons) are stimulated by light of one color and inhibited by light of another color.
- optimists** people who expect positive outcomes.
- oral stage** the first stage in Freud's psychosexual stages, occurring in the first 18 months of life in which the mouth is the erogenous zone and weaning is the primary conflict.
- orgasm** a series of rhythmic contractions of the muscles of the vaginal walls or the penis, also the third and shortest phase of sexual response.

- out-groups** social groups with whom a person does not identify; "them."
- ovaries** the female gonads or sex glands.
- overgeneralization** distortion of thinking in which a person draws sweeping conclusions based on only one incident or event and applies those conclusions to events that are unrelated to the original; the tendency to interpret a single negative event as a neverending pattern of defeat and failure.
- overlap (interposition)** monocular depth perception cue, the assumption that an object that appears to be blocking part of another object is in front of the second object and closer to the viewer.
- ovum** the female sex cell, or egg.
- oxytocin** hormone released by the posterior pituitary gland that is involved in reproductive and parental behaviors.
- pancreas** endocrine gland; controls the levels of sugar in the blood.
- panic attack** sudden onset of intense panic in which multiple physical symptoms of stress occur, often with feelings that one is dying.
- panic disorder** disorder in which panic attacks occur more than once or repeatedly, and cause persistent worry or changes in behavior.
- parallel distributed processing (PDP) model** a model of memory in which memory processes are proposed to take place at the same time over a large network of neural connections.
- parasympathetic division (eat-drink-and-rest system)** part of the ANS that restores the body to normal functioning after arousal and is responsible for the day-to-day functioning of the organs and glands..
- parietal lobes** sections of the brain located at the top and back of each cerebral hemisphere containing the centers for touch, temperature, and body position.
- partial reinforcement effect** the tendency for a response that is reinforced after some, but not all, correct responses to be very resistant to extinction.
- participant modeling** technique in which a model demonstrates the desired behavior in a step-by-step, gradual process while the client is encouraged to imitate the model.
- participant observation** a naturalistic observation in which the observer becomes a participant in the group being observed.
- PCP** synthesized drug now used as an animal tranquilizer that can cause stimulant, depressant, narcotic, or hallucinogenic effects.
- peak experiences** according to Maslow, times in a person's life during which self-actualization is temporarily achieved.
- penis** the organ through which males urinate and which delivers the male sex cells or sperm.
- perception** the method by which the sensations experienced at any given moment are interpreted and organized in some meaningful fashion.
- perceptual set (perceptual expectancy)** the tendency to perceive things a certain way because previous experiences or expectations influence those perceptions.
- peripheral nervous system (PNS)** all nerves and neurons that are not contained in the brain and spinal cord but that run through the body itself.
- peripheral-route processing** type of information processing that involves attending to factors not involved in the message, such as the appearance of the source of the message, the length of the message, and other noncontent factors.
- permissive indulgent** permissive parenting in which parent is so involved that children are allowed to behave without set limits.
- permissive neglectful** permissive parenting in which parent is uninvolved with child or child's behavior.
- permissive parenting** style of parenting in which parent makes few, if any, demands on a child's behavior.
- personal fable** type of thought common to adolescents in which young people believe themselves to be unique and protected from harm.
- personality** the unique and relatively stable ways in which people think, feel, and behave.
- personality disorders** disorders in which a person adopts a persistent, rigid, and maladaptive pattern of behavior that interferes with normal social interactions.
- personality inventory** paper-and-pencil or computerized test that consists of statements that require a specific, standardized response from the person taking the test.
- personality psychology** area of psychology in which the psychologists study the differences in personality among people.
- personalization** distortion of thinking in which a person takes responsibility or blame for events that are unconnected to the person.
- personal unconscious** Jung's name for the unconscious mind as described by Freud.
- person-centered therapy** a nondirective insight therapy based on the work of Carl Rogers in which the client does all the talking and the therapist listens.
- persuasion** the process by which one person tries to change the belief, opinion, position, or course of action of another person through argument, pleading, or explanation.
- phallic stage** the third stage in Freud's psychosexual stages, occurring from about 3 to 6 years of age, in which the child discovers sexual feelings.
- phobia** an irrational, persistent fear of an object, situation, or social activity.
- phonemes** the basic units of sound in language.
- physical dependence** condition occurring when a person's body becomes unable to function normally without a particular drug.
- physiological psychology** area of psychology in which the psychologists study the biological bases of behavior.
- pineal gland** endocrine gland located near the base of the cerebrum; secretes melatonin.
- pinna** the visible part of the ear.
- pitch** psychological experience of sound that corresponds to the frequency of the sound waves; higher frequencies are perceived as higher pitches.
- pituitary gland** gland located in the brain that secretes human growth hormone and influences all other hormone-secreting glands (also known as the master gland).
- placebo effect** the phenomenon in which the expectations of the participants in a study can influence their behavior.
- place theory** theory of pitch that states that different pitches are experienced by the stimulation of hair cells in different locations on the organ of Corti.
- pleasure principle** principle by which the id functions; the desire for the immediate satisfaction of needs without regard for the consequences.
- polygon** line graph showing a frequency distribution.
- pons** the larger swelling above the medulla that connects the top of the brain to the bottom and that plays a part in sleep, dreaming, left-right body coordination, and arousal.
- population** the entire group of people or animals in which the researcher is interested.
- positively skewed** a distribution of scores in which scores are concentrated in the low end of the distribution.
- positive regard** warmth, affection, love, and respect that come from significant others in one's life.
- positive reinforcement** the reinforcement of a response by the addition or experiencing of a pleasurable stimulus.
- positive symptoms** symptoms of schizophrenia that are excesses of behavior or occur in addition to normal behavior; hallucinations, delusions, and distorted thinking.
- positron emission tomography (PET)** brain-imaging method in which a radioactive sugar is injected into the subject and a computer compiles a color-coded image of the activity of the brain.
- postconventional morality** third level of Kohlberg's stages of moral development in which the person's behavior is governed by moral principles that have been decided on by the individual and that may be in disagreement with accepted social norms.

posttraumatic stress disorder (PTSD) a disorder resulting from exposure to a major stressor, with symptoms of anxiety, dissociation, nightmares, poor sleep, reliving the event, and concentration problems, lasting for more than 1 month; symptoms may appear immediately, or not occur until 6 months or later after the traumatic event.

practical intelligence the ability to use information to get along in life and become successful.

pragmatics aspects of language involving the practical ways of communicating with others, or the social “niceties” of language.

preconventional morality first level of Kohlberg’s stages of moral development, in which the child’s behavior is governed by the consequences of the behavior.

prefrontal lobotomy psychosurgery in which the connections of the prefrontal cortex to other areas of the brain are severed.

prejudice negative attitude held by a person about the members of a particular social group.

preoperational stage Piaget’s second stage of cognitive development, in which the preschool child learns to use language as a means of exploring the world.

pressure the psychological experience produced by urgent demands or expectations for a person’s behavior that come from an outside source.

primacy effect tendency to remember information at the beginning of a body of information better than the information that follows.

primary appraisal the first step in assessing stress, which involves estimating the severity of a stressor and classifying it as either a threat or a challenge.

primary drives those drives that involve needs of the body such as hunger and thirst.

primary reinforcer any reinforcer that is naturally reinforcing by meeting a basic biological need, such as hunger, thirst, or touch.

primary sex characteristics sexual organs present at birth and directly involved in human reproduction.

proactive interference memory problem that occurs when older information prevents or interferes with the learning or retrieval of newer information.

problem-focused coping coping strategies that try to eliminate the source of a stress or reduce its impact through direct actions.

problem solving process of cognition that occurs when a goal must be reached by thinking and behaving in certain ways.

projection psychological defense mechanism in which unacceptable or threatening impulses or feelings are seen as originating with someone else, usually the target of the impulses or feelings.

projective tests personality assessments that present ambiguous visual stimuli to the client and ask the client to respond with whatever comes to mind.

prosocial behavior socially desirable behavior that benefits others.

prostate gland gland that secretes most of the fluid holding the male sex cells or sperm.

prototype an example of a concept that closely matches the defining characteristics of the concept.

proximity a Gestalt principle of perception, the tendency to perceive objects that are close to each other as part of the same grouping; physical or geographical nearness.

psychiatric social worker a social worker with some training in therapy methods who focuses on the environmental conditions that can have an impact on mental disorders, such as poverty, overcrowding, stress, and drug abuse.

psychiatrist a physician who specializes in the diagnosis and treatment of psychological disorders.

psychoactive drugs chemical substances that alter thinking, perception, and memory.

psychoanalysis an insight therapy based on the theory of Freud, emphasizing the revealing of unconscious conflicts; Freud’s term for both the theory of personality and the therapy based on it.

psychodynamic perspective modern version of psychoanalysis that is more focused on the development of a sense of self and the discovery of motivations behind a person’s behavior other than sexual motivations.

psychodynamic therapy a newer and more general term for therapies based on psychoanalysis with an emphasis on transference, shorter treatment times, and a more direct therapeutic approach.

psychological defense mechanisms unconscious distortions of a person’s perception of reality that reduce stress and anxiety.

psychological dependence the feeling that a drug is needed to continue a feeling of emotional or psychological well-being.

psychological disorder any pattern of behavior or thinking that causes people significant distress, causes them to harm others, or harms their ability to function in daily life.

psychologist a professional with an academic degree and specialized training in one or more areas of psychology.

psychology scientific study of behavior and mental processes.

psychoneuroimmunology the study of the effects of psychological factors such as stress, emotions, thoughts, and behavior on the immune system.

psychopathology the study of abnormal behavior and psychological dysfunction.

psychopharmacology the use of drugs to control or relieve the symptoms of psychological disorders.

psychosexual stages five stages of personality development proposed by Freud and tied to the sexual development of the child.

psychosurgery surgery performed on brain tissue to relieve or control severe psychological disorders.

psychotherapy therapy for mental disorders in which a person with a problem talks with a psychological professional.

psychotic refers to an individual’s inability to separate what is real and what is fantasy.

puberty the physical changes that occur in the body as sexual development reaches its peak.

punishment any event or object that, when following a response, makes that response less likely to happen again.

punishment by application the punishment of a response by the addition or experiencing of an unpleasant stimulus.

punishment by removal the punishment of a response by the removal of a pleasurable stimulus.

random assignment process of assigning subjects to the experimental or control groups randomly, so that each subject has an equal chance of being in either group.

range the difference between the highest and lowest scores in a distribution.

rapid eye movement (REM) sleep stage of sleep in which the eyes move rapidly under the eyelids and the person is typically experiencing a dream.

rating scale assessment in which a numerical value is assigned to specific behavior that is listed in the scale.

rational emotive behavior therapy (REBT) cognitive behavioral therapy in which clients are directly challenged in their irrational beliefs and helped to restructure their thinking into more rational belief statements.

rationalization psychological defense mechanism in which a person invents acceptable excuses for unacceptable behavior.

reaction formation psychological defense mechanism in which a person forms an opposite emotional or behavioral reaction to the way he or she really feels to keep those true feelings hidden from self and others.

realistic conflict theory theory stating that prejudice and discrimination will be increased between groups that are in conflict over a limited resource.

reality principle principle by which the ego functions; the satisfaction of the demands of the id only when negative consequences will not result.

recall type of memory retrieval in which the information to be retrieved must be “pulled” from memory with very few external cues.

recency effect tendency to remember information at the end of a body of information better than the information that precedes it.

receptor sites three-dimensional proteins on the surface of the dendrites or certain cells of the muscles and glands, which are shaped to fit only certain neurotransmitters.

- recessive** referring to a gene that only influences the expression of a trait when paired with an identical gene.
- reciprocal determinism** Bandura's explanation of how the factors of environment, personal characteristics, and behavior can interact to determine future behavior.
- reciprocity of liking** tendency of people to like other people who like them in return.
- recognition** the ability to match a piece of information or a stimulus to a stored image or fact.
- reflection** therapy technique in which the therapist restates what the client says rather than interpreting those statements.
- reflex** an involuntary response, one that is not under personal control or choice.
- reflex arc** the connection of the afferent neurons to the interneurons to the efferent neurons, resulting in a reflex action.
- refractory period** time period in males just after orgasm in which the male cannot become aroused to another orgasm or achieve erection.
- regression** psychological defense mechanism in which a person falls back on childlike patterns of responding in reaction to stressful situations.
- reinforcement** any event or stimulus, that when following a response, increases the probability that the response will occur again.
- reinforcers** any events or objects that, when following a response, increase the likelihood of that response occurring again.
- relative size** monocular depth perception cue, perception that occurs when objects that a person expects to be of a certain size appear to be small and are, therefore, assumed to be much farther away.
- reliability** the tendency of a test to produce the same scores again and again each time it is given to the same people.
- REM behavior disorder** a rare disorder in which the mechanism that blocks the movement of the voluntary muscles fails, allowing the person to thrash around and even get up and act out nightmares.
- REM rebound** increased amounts of REM sleep after being deprived of REM sleep on earlier nights.
- replicate** in research, repeating a study or experiment to see if the same results will be obtained in an effort to demonstrate reliability of results.
- representativeness heuristic** assumption that any object (or person) sharing characteristics with the members of a particular category is also a member of that category.
- representative sample** randomly selected sample of subjects from a larger population of subjects.
- repression** psychological defense mechanism in which the person refuses to consciously remember a threatening or unacceptable event, instead pushing those events into the unconscious mind.
- resistance** occurring when a patient becomes reluctant to talk about a certain topic, by either changing the subject or becoming silent.
- resolution** the final phase of the sexual response in which the body is returned to a normal state.
- resting potential** the state of the neuron when not firing a neural impulse.
- restorative theory** theory of sleep proposing that sleep is necessary to the physical health of the body and serves to replenish chemicals and repair cellular damage.
- reticular formation (RF)** an area of neurons running through the middle of the medulla and the pons and slightly beyond that is responsible for general attention, alertness, and arousal.
- retrieval** getting information that is in storage into a form that can be used.
- retrieval cue** a stimulus for remembering.
- retroactive interference** memory problem that occurs when newer information prevents or interferes with the retrieval of older information.
- retrograde amnesia** loss of memory from the point of some injury or trauma backwards, or loss of memory for the past.
- reuptake** process by which neurotransmitters are taken back into the synaptic vesicles.
- reversible figures** visual illusions in which the figure and ground can be reversed.
- rods** visual sensory receptors found at the back of the retina, responsible for noncolor sensitivity to low levels of light.
- romantic love** type of love consisting of intimacy and passion.
- Rorschach inkblot test** projective test that uses 10 inkblots as the ambiguous stimuli.
- sample** group of subjects selected from a larger population of subjects, usually selected randomly.
- scaffolding** process in which a more skilled learner gives help to a less skilled learner, reducing the amount of help as the less skilled learner becomes more capable.
- scheme** in this case, a mental concept formed through experiences with objects and events.
- schizophrenia** severe disorder in which the person suffers from disordered thinking, bizarre behavior, hallucinations, and inability to distinguish between fantasy and reality.
- school psychology** area of psychology in which the psychologists work directly in the schools, doing assessments, educational placement, and diagnosing educational problems.
- scientific method** system of gathering data so that bias and error in measurement are reduced.
- scrotum** external sac that holds the testes.
- secondary appraisal** the second step in assessing a stressor, which involves estimating the resources available to the person for coping with the threat.
- secondary reinforcer** any reinforcer that becomes reinforcing after being paired with a primary reinforcer, such as praise, tokens, or gold stars.
- secondary sex characteristics** sexual organs and traits that develop at puberty and are indirectly involved in human reproduction.
- selective attention** the ability to focus on only one stimulus from among all sensory input.
- selective thinking** distortion of thinking in which a person focuses on only one aspect of a situation while ignoring all other relevant aspects.
- self** an individual's awareness of his or her own personal characteristics and level of functioning.
- self-actualization** according to Maslow, the point that is seldom reached at which people have sufficiently satisfied the lower needs and achieved their full human potential.
- self-actualizing tendency** the striving to fulfill one's innate capacities and capabilities.
- self-concept** the image of oneself that develops from interactions with important significant people in one's life.
- self-determination theory (SDT)** theory of human motivation in which the social context of an action has an effect on the type of motivation existing for the action.
- self-efficacy** individual's expectancy of how effective his or her efforts to accomplish a goal will be in any particular circumstance.
- self-fulfilling prophecy** the tendency of one's expectations to affect one's behavior in such a way as to make the expectations more likely to occur.
- self-help groups (support groups)** a group composed of people who have similar problems and who meet together without a therapist or counselor for the purpose of discussion, problem solving, and social and emotional support.
- semantic memory** type of declarative memory containing general knowledge, such as knowledge of language and information learned in formal education.
- semantic network model** model of memory organization that assumes information is stored in the brain in a connected fashion, with concepts that are related stored physically closer to each other than concepts that are not highly related.
- semantics** the rules for determining the meaning of words and sentences.
- semen** fluid released from the penis at orgasm that contains the sperm.

sensation the process that occurs when special receptors in the sense organs are activated, allowing various forms of outside stimuli to become neural signals in the brain.

sensation seeker someone who needs more arousal than the average person.

sensorimotor stage Piaget's first stage of cognitive development, in which the infant uses its senses and motor abilities to interact with objects in the environment.

sensory adaptation tendency of sensory receptor cells to become less responsive to a stimulus that is unchanging.

sensory conflict theory an explanation of motion sickness in which the information from the eyes conflicts with the information from the vestibular senses, resulting in dizziness, nausea, and other physical discomfort.

sensory memory the very first stage of memory, where raw information from the senses is held for a very brief period of time.

sensory pathway nerves coming from the sensory organs to the CNS consisting of afferent neurons.

serial position effect tendency of information at the beginning and end of a body of information to be remembered more accurately than information in the middle of the body of information.

sexism prejudice about males and/or females leading to unequal treatment.

sexual dysfunction a problem in sexual functioning.

sexually transmitted infection (STI) an infection spread primarily through sexual contact.

sexual orientation a person's sexual attraction to and affection for members of either the opposite or the same sex.

s factor the ability to excel in certain areas, or specific intelligence.

shape constancy the tendency to interpret the shape of an object as being constant, even when its shape changes on the retina.

shaping the reinforcement of simple steps in behavior through successive approximations that lead to a desired, more complex behavior.

short-term memory (STM) the memory system in which information is held for brief periods of time while being used.

significant difference a difference between groups of numerical data that is considered large enough to be due to factors other than chance variation.

similarity a Gestalt principle of perception, the tendency to perceive things that look similar to each other as being part of the same group.

single-blind study study in which the subjects do not know if they are in the experimental or the control group.

situational cause cause of behavior attributed to external factors, such as delays, the action of others, or some other aspect of the situation.

situational context the social or environmental setting of a person's behavior.

size constancy the tendency to interpret an object as always being the same actual size, regardless of its distance.

skewed distribution frequency distribution in which most of the scores fall to one side or the other of the distribution.

skin senses the sensations of touch, pressure, temperature, and pain.

sleep apnea disorder in which the person stops breathing for 10 seconds or more.

sleep deprivation any significant loss of sleep, resulting in problems in concentration and irritability.

sleep paralysis the inability of the voluntary muscles to move during REM sleep.

sleepwalking (somnambulism) occurring during deep sleep, an episode of moving around or walking around in one's sleep.

social anxiety disorder (social phobia) fear of interacting with others or being in social situations that might lead to a negative evaluation.

social categorization the assignment of a person one has just met to a category based on characteristics the new person has in common with other people with whom one has had experience in the past.

social cognition the mental processes that people use to make sense of the social world around them.

social cognitive learning theorists theorists who emphasize the importance of both the influences of other people's behavior and of a person's own expectancies on learning.

social cognitive theory referring to the use of cognitive processes in relation to understanding the social world.

social cognitive theory of hypnosis theory that assumes that people who are hypnotized are not in an altered state but are merely playing the role expected of them in the situation.

social cognitive view learning theory that includes cognitive processes such as anticipating, judging, memory, and imitation of models.

social comparison the comparison of oneself to others in ways that raise one's self-esteem.

social facilitation the tendency for the presence of other people to have a positive impact on the performance of an easy task.

social identity the part of the self-concept including one's view of self as a member of a particular social category.

social identity theory theory in which the formation of a person's identity within a particular social group is explained by social categorization, social identity, and social comparison.

social impairment the tendency for the presence of other people to have a negative impact on the performance of a difficult task.

social influence the process through which the real or implied presence of others can directly or indirectly influence the thoughts, feelings, and behavior of an individual.

social loafing the tendency for people to put less effort into a simple task when working with others on that task.

social neuroscience the study of the relationship between biological systems and social processes and behavior.

social psychology the scientific study of how a person's thoughts, feelings, and behavior influence and are influenced by social groups; area of psychology in which psychologists focus on how human behavior is affected by the presence of other people.

Social Readjustment Rating Scale (SRRS) assessment that measures the amount of stress in a person's life over a 1-year period resulting from major life events.

social role the pattern of behavior that is expected of a person who is in a particular social position.

social-support system the network of family, friends, neighbors, coworkers, and others who can offer support, comfort, or aid to a person in need.

sociocultural perspective perspective that focuses on the relationship between social behavior and culture; in psychopathology, perspective in which abnormal thinking and behavior (as well as normal) is seen as the product of learning and shaping within the context of the family, the social group to which one belongs, and the culture within which the family and social group exist.

soma the cell body of the neuron responsible for maintaining the life of the cell.

somatic nervous system division of the PNS consisting of nerves that carry information from the senses to the CNS and from the CNS to the voluntary muscles of the body.

somatosensory cortex area of cortex at the front of the parietal lobes responsible for processing information from the skin and internal body receptors for touch, temperature, and body position.

somesthetic senses the body senses consisting of the skin senses, the kinesthetic sense, and the vestibular senses.

source traits the more basic traits that underlie the surface traits, forming the core of personality.

spatial neglect condition produced most often by damage to the parietal lobe association areas of the right hemisphere, resulting in an inability to recognize objects or body parts in the left visual field.

specific phobia fear of objects or specific situations or events.

spinal cord a long bundle of neurons that carries messages between the body and the brain and is responsible for very fast, lifesaving reflexes.

spontaneous recovery the reappearance of a learned response after extinction has occurred.

sports psychology area of psychology in which the psychologists help athletes and others to prepare themselves mentally for participation in sports activities.

standard deviation the square root of the average squared deviations from the mean of scores in a distribution; a measure of variability.

statistically significant referring to differences in data sets that are larger than chance variation would predict.

statistics branch of mathematics concerned with the collection and interpretation of numerical data.

stem cells special cells found in all the tissues of the body that are capable of becoming other cell types when those cells need to be replaced due to damage or wear and tear.

stereotype a set of characteristics that people believe is shared by all members of a particular social category; a concept held about a person or group of people that is based on superficial, irrelevant characteristics.

stereotype threat condition in which being made aware of a negative performance stereotype interferes with the performance of someone that considers himself or herself part of that group.

stereotype vulnerability the effect that people's awareness of the stereotypes associated with their social group has on their behavior.

stimulants drugs that increase the functioning of the nervous system.

stimulatory hallucinogenics drugs that produce a mixture of psychomotor stimulant and hallucinogenic effects.

stimulus discrimination the tendency to stop making a generalized response to a stimulus that is similar to the original conditioned stimulus because the similar stimulus is never paired with the unconditioned stimulus.

stimulus generalization the tendency to respond to a stimulus that is only similar to the original conditioned stimulus with the conditioned response.

stimulus motive a motive that appears to be unlearned but causes an increase in stimulation, such as curiosity.

storage holding on to information for some period of time.

stress the term used to describe the physical, emotional, cognitive, and behavioral responses to events that are appraised as threatening or challenging.

stressors events that cause a stress reaction.

stress-vulnerability model explanation of disorder that assumes a biological sensitivity, or vulnerability, to a certain disorder will result in the development of that disorder under the right conditions of environmental or emotional stress.

structuralism early perspective in psychology associated with Wilhelm Wundt and Edward Titchener, in which the focus of study is the structure or basic elements of the mind.

subjective referring to concepts and impressions that are only valid within a particular person's perception and may be influenced by biases, prejudice, and personal experiences.

subjective discomfort emotional distress or emotional pain.

sublimation channeling socially unacceptable impulses and urges into socially acceptable behavior.

superego part of the personality that acts as a moral center.

surface traits aspects of personality that can easily be seen by other people in the outward actions of a person.

sympathetic division (fight-or-flight system) part of the ANS that is responsible for reacting to stressful events and bodily arousal.

synapse (synaptic gap) microscopic fluid-filled space between the axon terminal of one cell and the dendrites or surface of the next cell.

synaptic vesicles saclike structures found inside the synaptic knob containing chemicals.

synesthesia disorder in which the signals from the various sensory organs are processed in the wrong cortical areas, resulting in the sense information being interpreted as more than one sensation.

syntax the system of rules for combining words and phrases to form grammatically correct sentences.

systematic desensitization behavior technique used to treat phobias, in which a client is asked to make a list of ordered fears and taught to relax while concentrating on those fears.

temperament the behavioral characteristics that are fairly well established at birth, such as "easy," "difficult," and "slow to warm up;" the enduring characteristics with which each person is born.

temporal lobes areas of the cortex located along the side of the brain, starting just behind the temples, containing the neurons responsible for the sense of hearing and meaningful speech.

teratogen any factor that can cause a birth defect.

testes (testicles) the male gonads or sex glands.

texture gradient monocular depth perception cue, the tendency for textured surfaces to appear to become smaller and finer as distance from the viewer increases.

thalamus part of the limbic system located in the center of the brain, this structure relays sensory information from the lower part of the brain to the proper areas of the cortex and processes some sensory information before sending it to its proper area.

Thematic Apperception Test (TAT) projective test that uses 20 pictures of people in ambiguous situations as the visual stimuli.

therapeutic alliance the relationship between therapist and client that develops as a warm, caring, accepting relationship characterized by empathy, mutual respect, and understanding.

therapy treatment methods aimed at making people feel better and function more effectively.

theta waves brain waves indicating the early stages of sleep.

thinking (cognition) mental activity that goes on in the brain when a person is organizing and attempting to understand information and communicating information to others.

thyroid gland endocrine gland found in the neck; regulates metabolism.

time-out an extinction process in which a person is removed from the situation that provides reinforcement for undesirable behavior, usually by being placed in a quiet corner or room away from possible attention and reinforcement opportunities.

token economy the use of objects called tokens to reinforce behavior in which the tokens can be accumulated and exchanged for desired items or privileges.

top-down processing the use of preexisting knowledge to organize individual features into a unified whole.

trait a consistent, enduring way of thinking, feeling, or behaving.

trait-situation interaction the assumption that the particular circumstances of any given situation will influence the way in which a trait is expressed.

trait theories theories that endeavor to describe the characteristics that make up human personality in an effort to predict future behavior.

transduction the process of converting outside stimuli, such as light, into neural activity.

transference in psychoanalysis, the tendency for a patient or client to project positive or negative feelings for important people from the past onto the therapist.

trial and error (mechanical solution) problem-solving method in which one possible solution after another is tried until a successful one is found.

triarchic theory of intelligence Sternberg's theory that there are three kinds of intelligence: analytical, creative, and practical.

trichromatic theory theory of color vision that proposes three types of cones: red, blue, and green.

t-test type of inferential statistical analysis typically used when two means are compared to see if they are significantly different.

Type 2 diabetes disease typically occurring in middle adulthood when the body either becomes resistant to the effects of insulin or can no longer secrete enough insulin to maintain normal glucose levels.

Type A personality person who is ambitious, time conscious, extremely hard-working, and tends to have high levels of hostility and anger as well as being easily annoyed.

Type B personality person who is relaxed and laid-back, less driven and competitive than Type A, and slow to anger.

Type C personality pleasant but repressed person, who tends to internalize his or her anger and anxiety and who finds expressing emotions difficult.

unconditional positive regard referring to the warmth, respect, and accepting atmosphere created by the therapist for the client in person-centered therapy; positive regard that is given without conditions or strings attached.

unconditioned response (UCR) in classical conditioning, an involuntary and unlearned response to a naturally occurring or unconditioned stimulus.

unconditioned stimulus (UCS) in classical conditioning, a naturally occurring stimulus that leads to an involuntary and unlearned response.

unconscious mind level of the mind in which thoughts, feelings, memories, and other information are kept that are not easily or voluntarily brought into consciousness.

uterus the womb in which the baby grows during pregnancy.

vagina the tube that leads from the outside of a female's body to the opening of the womb.

validity the degree to which a test actually measures what it's supposed to measure.

variable interval schedule of reinforcement schedule of reinforcement in which the interval of time that must pass before reinforcement becomes possible is different for each trial or event.

variable ratio schedule of reinforcement schedule of reinforcement in which the number of responses required for reinforcement is different for each trial or event.

vestibular senses the awareness of the balance, position, and movement of the body through space in relation to gravity's pull.

vicarious conditioning classical conditioning of an involuntary response or emotion by watching the reaction of another person.

visual accommodation the change in the thickness of the lens as the eye focuses on objects that are far away or close.

volley principle theory of pitch that states that frequencies from about 400 Hz to 4000 Hz cause the hair cells (auditory neurons) to fire in a volley pattern, or take turns in firing.

waking consciousness state in which thoughts, feelings, and sensations are clear, organized, and the person feels alert.

weight set point the particular level of weight that the body tries to maintain.

Wernicke's aphasia condition resulting from damage to Wernicke's area, causing the affected person to be unable to understand or produce meaningful language.

withdrawal physical symptoms that can include nausea, pain, tremors, crankiness, and high blood pressure, resulting from a lack of an addictive drug in the body systems.

working memory an active system that processes the information in short-term memory.

Yerkes-Dodson law law stating that when tasks are simple, a higher level of arousal leads to better performance; when tasks are difficult, lower levels of arousal lead to better performance.

zone of proximal development (ZPD) Vygotsky's concept of the difference between what a child can do alone and what that child can do with the help of a teacher.

z score a statistical measure that indicates how far away from the mean a particular score is in terms of the number of standard deviations that exist between the mean and that score.

zygote cell resulting from the uniting of the ovum and sperm.

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References

- AAA Foundation. (2009, April). Aggressive driving: Research update. Retrieved from <https://www.aaafoundation.org/sites/default/files/AggressiveDrivingResearch-Update2009.pdf>
- Abadinsky, H. (1989). *Drug abuse: An introduction*. Chicago: Nelson-Hall Series in Law, Crime, and Justice.
- Abbott, L., Nadler, J., & Rude, R. K. (1994). Magnesium deficiency in alcoholism: Possible contribution to osteoporosis and cardiovascular disease in alcoholics. *Alcoholism, Clinical & Experimental Research*, 18(5), 1076–1082.
- Abe, K., Amatomi, M., & Oda, N. (1984). Sleepwalking and recurrent sleep talking in children of childhood sleepwalkers. *American Journal of Psychiatry*, 141, 800–801.
- Abela, J. R. Z., & D'Allesandro, D. U. (2002). Beck's cognitive theory of depression: The diathesis-stress and causal mediation components. *British Journal of Clinical Psychology*, 41, 111–128.
- Abel, E. L., & Sokol, R. J. (1987). Incidence of fetal alcohol syndrome and economic impact of FAS-related anomalies: Drug alcohol syndrome and economic impact of FAS-related anomalies. *Drug and Alcohol Dependency*, 19(1), 51–70.
- Abel, G. G., & Osborn, C. A. (1992). The paraphilias: The extent and nature of sexually deviant and criminal behavior. In J. M. W. Bradford (Ed.), *Psychiatric Clinics of North America*, 15(3) (pp. 675–687). Philadelphia: W. B. Saunders Company.
- Åberg, M. A., Pedersen, N. L., Torén, K., Svartengren, M., Bäckstrand, B., Johnsson, T., Cooper-Kuhn, C. M., Åberg, N. D., Nilsson, M., & Kuhn, H. G. (2009). Cardiovascular fitness is associated with cognition in young adulthood. *Proceedings of the National Academy of Sciences*, 106(49), 20906–20911.
- Abraham, W. C., & Williams, J. M. (2003). Properties and mechanisms of LTP maintenance. *The Neuroscientist*, 9(6), 463–474.
- Abramson, D., Redlener, I., Stehling-Ariza, T., Sury, J., Banister, A., & Soo Park, Y. (2010). Impact on children and families of the Deepwater Horizon Oil Spill: Preliminary findings of the Coastal Population Impact Study. National Center for Disaster Preparedness Mailman School of Public Health at Columbia University August 3rd, 2010. Retrieved December 15, 2013, from http://www.eoearth.org/article/Impact_on_children_and_families_of_the_Deepwater_Horizon_oil_spill?topic=50364
- Abramson, L. Y., Garber, J., & Seligman, M. E. P. (1980). Learned helplessness in humans: An attributional analysis. In J. Garber & M. E. P. Seligman (Eds.), *Human Helplessness* (pp. 3–34). New York: Academic Press.
- Abramson, L. Y., Seligman, M. E. P., & Teasdale, J. D. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology*, 87, 49–74.
- Acheson, D. J., MacDonald, M. C., & Postle, B. R. (2010). The interaction of concreteness and phonological similarity in verbal working memory. *Journal of Experimental Psychology: Learning, Memory and Cognition*, 36(1), 17–36.
- Adam, K. (1980). Sleep as a restorative process and a theory to explain why. *Progressive Brain Research*, 53, 289–305.
- Adams, D. B. (1968). The activity of single cells in the midbrain and hypothalamus of the cat during affective defense behavior. *Archives Italiennes de Biologie*, 106, 243–269.
- Adams, R. J. (1987). An evaluation of colour preferences in early infancy. *Infant Behaviour and Development*, 10, 143–150.
- Addis, D. R., Leclerc, C. M., Muscatell, K., & Kensinger, E. A. (2010). There are age-related changes in neural connectivity during the encoding of positive, but not negative, information. *Cortex*, 46: 9.
- Ader, R. (2003). Conditioned immunomodulation: Research needs and directions. *Brain, Behavior, and Immunity*, 17(1), 51–57.
- Adeyemo, B. O., Simis, M., Macea, D. D., & Fregni, F. (2012). Systematic review of parameters of stimulation, clinical trial design characteristics, and motor outcomes in non-invasive brain stimulation in stroke. *Frontiers in Psychiatry*, 3, 88. doi: 10.3389/fpsyg.2012.00088
- Adler, A. (1954). *Understanding human nature*. New York: Greenburg Publisher.
- Adler, S. R., Fosket, J. R., Kagawa-Singer, M., McGraw, S. A., Wong-Kim, E., Gold, E., & Sternfeld, B. (2000). Conceptualizing menopause and midlife: Chinese American and Chinese women in the U.S. *Maturitas* 35(1), 11–23.
- Adolphs, R. (2010). Conceptual challenges and directions for social neuroscience. *Neuron*, 65(6), 752–767.
- Adolphs, R., Gosselin, F., Buchanan, T. W., Tranel, D., Schyns, P., & Damasio, A. R. (2005). A mechanism for impaired fear recognition after amygdala damage. *Nature*, 433, 68–72.
- Adolphs, R., & Tranel, D. (2003). Amygdala damage impairs emotion recognition from scenes only when they contain facial expressions. *Neuropsychologia*, 41, 1281–1289.
- Affifi, T. O., Mota, N. P., Dasiewicz, P., MacMillan, H. L., & Sareen, J. (2012). Physical punishment and mental disorders: Results from a nationally representative US sample. *Pediatrics*, 130(2), 184–192. doi: 10.1542/peds.2011–2947
- Agresti, A., & Finlay, B. (1997). *Statistical Methods for the Social Sciences*, New Jersey, Prentice Hall.
- Aguiar, A., & Baillargeon, R. (2003). Perseverative responding in a violation-of-expectation task in 6.5-month-old infants. *Cognition*, 88(3), 277–316.
- Ahlskog, J. E. (2003). Slowing Parkinson's disease progression: Recent dopamine agonist trials. *Neurology*, 60(3), 381–389.
- Ahn, W. (1998). Why are different features central for natural kinds and artifacts? The role of causal status in determining feature centrality. *Cognition*, 69, 135–178.
- Aiello, J. R., & Douthitt, E. A. (2001). Social facilitation from Triplett to electronic performance monitoring. *Group Dynamics: Theory, Research, and Practice*, 5(3), 163–180.
- Ainsworth, M. D. S. (1985). Attachments across the life span. *Bulletin of the New York Academy of Medicine*, 61, 792–812.
- Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A study of the strange situation*. Hillsdale, NJ: Erlbaum.
- Aitchison, J. (1992). Good birds, better birds, and amazing birds: The development of prototypes. In P. J. Arnaud & H. Béjoint (Eds.), *Vocabulary and applied linguistics* (pp. 71–84). London: Macmillan.
- Ajzen, I. (2001). Nature and operation of attitudes. *Annual Review of Psychology*, 52, 27–58.
- Ajzen, I., & Fishbein, M. (2000). Attitudes and the attitude-behavior relation: Reasoned and automatic processes. In W. Stroebe & M. Hewstone (Eds.), *European review of social psychology* (pp. 1–33). New York: John Wiley & Sons.
- Akil, M., Kolachana, B. S., et al. (2003). Catechol-o-methyltransferase genotype and dopamine regulation in the human brain. *Journal of Neuroscience*, 23(6), 2008–2013.
- Albert, D. J., & Richmond, S. E. (1977). Reactivity and aggression in the rat: Induction by alpha-adrenergic blocking agents injected ventral to anterior septum but not into lateral septum. *Journal of Comparative and Physiological Psychology*, 91, 886–896 [DBA] *Physiology and Behavior*, 20, 755–761.
- Alderfer, C. P. (1972). *Existence, relatedness and growth: Human needs in organisational settings*. New York: Free Press.
- Aldridge-Morris, R. (1989). *Multiple personality: An exercise in deception*. Hillsdale, NJ: Erlbaum.
- Alexander, G., DeLong, M. R., & Strick, P. L. (1986). Parallel organization of functionally segregated circuits linking basal ganglia and cortex. *Annual Review of Neuroscience*, 9, 357–381.
- Aligne, C. A., Auinger, P., Byrd, R. S., & Weitzman, M. (2000). Risk factors for pediatric asthma contributions of poverty, race, and urban residence. *American Journal of Respiratory Critical Care Medicine*, 162(3), 873–877.
- Alkon, D. (1989). Memory storage and neural systems. *Scientific American*, 261(1), 42–50.
- Allen, D. (2001). *Getting things done: the art of stress-free productivity*. New York: Viking Adult.
- Allen, D. (2008). *Making it all work*. New York: Viking Adult.
- Allen, F. (1994). *Secret formula*. New York: HarperCollins.
- Allen, G. E. (2006). *Intelligence tests and immigration to the United States, 1900–1940*. Hoboken, NJ: John Wiley and Sons.
- Allen, G., & Parisi, P. (1990). Trends in monozygotic and dizygotic twinning rates by maternal age and parity. Further analysis of Italian data, 1949–1985, and rediscussion of U.S. data, 1964–1985. *Acta Genetic Medicine & Gemellology*, 39, 317–328.

- Allen, K., Blascovich, J., & W. Mendes. (2002). Cardiovascular reactivity and the presence of pets, friends, and spouses: The truth about cats and dogs. *Psychosomatic Medicine*, 64, 727–739.
- Allen, L. S., & Gorski, R. A. (1991). Sexual dimorphism of the anterior commissure and massa intermedia of the human brain. *Journal of Comparative Neurology*, 312, 97–104.
- Allen, L. S., Hines, M., Shryne, J. E., & Gorski, R. A. (1989). Two sexually dimorphic cell groups in the human brain. *Journal of Neuroscience*, 9(9), 496–506.
- Allik, J., Realo, A., & McCrae, R. R. (2013). Univerality of the five-factor model of personality. In T. A. Widiger & P. T. Costa (Eds.), *Personality disorders and the five-factor model of personality* (Third ed., pp. 61–74). Washington, DC: American Psychological Association.
- Alloway, T. P., Rajendran, G., & Archibald, L. (2009). Working memory in children with developmental disorders. *Journal of Learning Disabilities*, 42(4), 372–382.
- Alloy, L. B., & Clements, C. M. (1998). Hopelessness theory of depression: Tests of the symptom component. *Cognitive Therapy and Research*, 22, 303–335.
- Allport, G. W., & Odbert, H. S. (1936). Trait names: A psycho-lexical study. *Psychological Monographs*, 47(211).
- Alm, H., & Nilsson, L. (1995). The effects of a mobile telephone conversation on driver behaviour in a car following situation. *Accident Analysis and Prevention*, 27(5), 707–715.
- Alperstein, L. (2001, May). *For two: Some basic perspectives and skills for couples therapy*. Paper presented at the XXXIII Annual Conference of the American Association of Sex Educators, Counselors, and Therapists, San Francisco.
- Alzheimer's Association. (2010). Alzheimer's disease facts and figures. *Alzheimer's & Dementia*, 6, 4–54.
- Amabile, T., Hadley, C. N., & Kramer, S. J. (2002). Creativity under the gun. *Harvard Business Review*, 80(8), 52–60.
- Amabile, T. M., DeJong, W., & Lepper, M. R. (1976). Effects of externally imposed deadlines on subsequent intrinsic motivation. *Journal of Personality and Social Psychology*, 34, 92–98.
- Amaral, D. G., & Strick, P. L. (2013). The organization of the central nervous system. In E. R. Kandel, J. H. Schwartz, T. M. Jessell, S. A. Siegelbaum, & A. J. Hudspeth (Eds.), *Principles of neural science* (5th ed., pp. 337–355). USA: McGraw-Hill.
- Amat, J., Aleksejev, R. M., Paul, E., Watkins, L. R., & Maier, S. F. (2010). Behavioral control over shock blocks behavioral and neurochemical effects of later social defeat. *Neuroscience*, 165(4), 1031–1038. doi: 10.1016/j.neuroscience.2009.11.005
- Amat, J., Baratta, M. V., Paul, E., Bland, S. T., Watkins, L. R., & Maier, S. F. (2005). Medial prefrontal cortex determines how stressor controllability affects behavior and dorsal raphe nucleus. *Nature Neuroscience*, 8(3), 365–371.
- American Academy of Pediatrics. (1995). Health supervision for children with Turner syndrome. *Pediatrics*, 96(6), 1166–1173.
- American Association of University Women. (1992). *How schools shortchange girls*. Washington, DC: AAUW Educational Foundation, The Wellesley College Center for Research on Women.
- American Association of University Women. (1998). *Separated by sex: A critical look at single-sex education for girls*. Washington, DC: AAUW Educational Foundation, The Wellesley College Center for Research on Women.
- American Association on Intellectual and Developmental Disabilities [AAIDD]. (2009). FAQ on intellectual disability. Retrieved June 8, 2010, from www.aamr.org/content_104.cfm
- American College Counseling Association's (ACCA) Community College Task Force (2010). *2009–2010 Community college counselors survey*. Retrieved August 12, 2010, from www.collegecounseling.org/pdf/2009-2010_Community_College_Counselors_Survey_Results.pdf
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: Author.
- American Psychiatric Association. (2000a). Appendix I: Outline for cultural formulation and glossary of culture-bound syndromes. In *DSM-IV-TR: Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: Author.
- American Psychiatric Association Committee on Electroconvulsive Therapy. (2001). *The practice of electroconvulsive therapy: Recommendations for treatment, training, and privileging*, (2nd ed.). Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060–1073.
- American Psychological Association (2005). Policy statement on evidence-based practice in psychology. Retrieved September 22, 2010, from http://www.apa.org/practice/guidelines/evidence-based.pdf
- American Psychological Association, Division 19 (2010). Society for Military Psychology. Retrieved from http://www.apadivision19.org/about.htm
- Amsterdam, B. (1972). Mirror self-image reactions before age two. *Developmental Psychobiology*, 5(4), 297–305. doi:10.1002/dev.420050403
- Anand, B. K., & Brobeck, J. R. (1951). Hypothalamic control of food intake in rats and cats. *Yale Journal of Biological Medicine*, 24, 123–146.
- Anastasi, A., & Urbina, S. (1997). *Psychological testing* (7th ed.). Upper Saddle River, NJ: Prentice-Hall.
- Anderson, C. A. (1987). Temperature and aggression: Effects on quarterly, yearly, and city rates of violent and nonviolent crime. *Journal of Personality and Social Psychology*, 52(6), 1161–1173.
- Anderson, C. A. (2003). Video games and aggressive behavior. In D. Ravitch & J. P. Viteritti (Eds.), *Kid stuff: Marketing sex and violence to America's children* (p. 157). Baltimore/London: The Johns Hopkins University Press.
- Anderson, C. A., Berkowitz, L., Donnerstein, E., Huesmann, L. R., Johnson, J. D., Linz, D., Malamuth, N. M., & Wartella, E. (2003). The influence of media violence on youth. *Psychological Science in the Public Interest*, 4(3), 81–110.
- Anderson, C. A., & Bushman, B. J. (2001). Effects of violent video games on aggressive behavior, aggressive cognition, aggressive affect, physiological arousal, and prosocial behavior: A meta-analytic review of the scientific literature. *Psych Science*, 12(5), 353–359.
- Anderson, C. A., & Dill, K. E. (2000). Video games and aggressive thoughts, feelings, and behavior in the laboratory and in life. *Journal of Personality and Social Psychology*, 78(4), 772–790.
- Anderson, C., Sakamoto, A., Gentile, D., Ihori, N., Shibuya, A., Yukawa, S., Naito, M., & Kobayashi, K. (2008). Longitudinal effects of violent video games on aggression in Japan and the United States, *Pediatrics*, 122(5), e1067–e1072.
- Anderson, L. W., Krathwohl, D. R., Airasian, P. W., Cruikshank, K. A., Mayer, R. E., Pintrich, P. R., Raths, J., & Wittrock, M. C. (Eds.). (2001). *A taxonomy for learning, teaching, and assessing—A revision of Bloom's Taxonomy of Educational Objectives*. New York: Addison Wesley Longman.
- Anderson, M. C., & Neely, J. H. (1995). Interference and inhibition in memory retrieval. In E. L. Bjork & R. A. Bjork (Eds.), *Handbook of perception and cognition, Vol. 10. Memory*. San Diego, CA: Academic Press.
- Andrews, J. D. W. (1989). Integrating visions of reality: Interpersonal diagnosis and the existential vision. *American Psychologist*, 44, 803–817.
- Anschuetz, B. L. (1999). The high cost of caring: Coping with workplace stress. *The Journal, the Newsletter of the Ontario Association of Children's Aid Societies*, 43(3), 1–63.
- Antony, J. W., Gobel, E. W., O'Hare, J. K., Reber, P. J., & Paller, K. A. (2012). Cued memory reactivation during sleep influences skill learning. *Nature Neuroscience*, 15(8), 1114–1116. doi: 10.1038/nn.3152
- Antuono, P. G., Jones, J. L., Wang, Y., & Li, S. (2001). Decreased glutamate [plus] glutamine in Alzheimer's disease detected in vivo with (1)H-MRS at 0.5 T. *Neurology*, 56(6), 737–742.
- Arbury, S. (2005). Workplace Violence: Training Young Workers in Preventative Strategies. *NFIB Business Toolbox*, March 4.
- Arcelus, J., Mitchell, A. J., Wales, J., & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders: A meta-analysis of 36 studies. *Archives of General Psychiatry*, 68(7), 724–731. doi: 10.1001/archgenpsychiatry.2011.74
- Archer, J. (1991). The influence of testosterone on human aggression. *British Journal of Psychology*, 82, 1–28.
- Argamon, S., Koppel, M., Fine, J., & Shimoni, A. (2003, August). Gender, genre, and writing style in formal written texts. *Text*, 23(3).
- Arkowitz, H., & Miller, W. R. (2008). Learning, applying, and extending motivational interviewing. In H. Arkowitz, H. A. Westra, W. R. Miller, & S. Rollnick (Eds.), *Motivational interviewing in the treatment of psychological disorders* (pp. 1–25). New York: Guilford Press.
- Armstrong, R. (1997). When drugs are used for rape. *Journal of Emergency Nursing*, 23(4), 378–381.
- Arnett, J. J. (2000). Emerging adulthood. A theory of development from the late teens through the twenties. *American Psychologist*, 55(5), 469–480.

- Arnett, P. A., Smith, S. S., & Newman, J. P. (1997). Approach and avoidance motivation in psychopathic criminal offenders during passive avoidance. *Journal of Personality and Social Psychology*, 72(6), 1413–1428.
- Arns, M., de Ridder, S., Strehl, U., Breteler, M., & Coenen, A. (2009). Efficacy of neurofeedback treatment in ADHD: The effects on inattention, impulsivity and hyperactivity: A meta-analysis. *Clinical EEG and Neuroscience*, 40(3), 180–189.
- Arns, M., van der Heijden, K. B., Arnold, L. E., & Kenemans, J. L. (2013). Geographic variation in the prevalence of attention-deficit/hyperactivity disorder: The sunny perspective. *Biological Psychiatry*. doi: 10.1016/j.biopsych.2013.02.010
- Aron, A., Aron, E., & Coups, E. (2005). *Statistics for the behavioral and social sciences: Brief course*. (4th edition). Upper Saddle River, NJ: Prentice-Hall.
- Aronson, E. (1997). Back to the future. Retrospective review of Leon Festinger's—A theory of cognitive dissonance. *American Journal of Psychology*, 110, 127–137.
- Aronson, E., Blaney, N., Stephan, C., Sikes, J., & Snapp, M. (1978). *The jigsaw classroom*. Beverly Hills, CA: Sage.
- Asarnow, R. F., Granholm, E., & Sherman, T. (1991). Span of apprehension in schizophrenia. In H. A. Nasrallah (Ed.), *Handbook of Schizophrenia*, Vol. 5. In S. R. Steinhauer, J. H. Gruzelier, & J. Zubin (Eds.), *Neuropsychology, psychophysiology and information processing* (pp. 335–370). Amsterdam: Elsevier.
- Asch, S. E. (1951). Effects of group pressure upon the modification and distortion of judgement. In H. Guetzkow (Ed.), *Groups, leadership and men*. Pittsburgh: Carnegie Press.
- Asch, S. E. (1956). Studies of independence and conformity: A minority of one against a unanimous majority. *Psychological Monographs*, 70 (Whole no. 416).
- Aserinsky, E., & Kleitman, N. (1953). Regularly occurring periods of eye motility, and concomitant phenomena, during sleep. *Science*, 118, 273–274.
- Ash, M. G. (1998). *Gestalt psychology in German culture, 1890–1967: Holism and the quest for objectivity*. Cambridge: Cambridge University Press.
- Asp, E., & Tranel, D. (2013). False tagging theory. In D. T. Stuss & R. T. Knight (Eds.), *Principles of frontal lobe function* (pp. 383–416). New York, NY: Oxford University Press.
- Assaf, Y., & Pasternak, O. (2008). Diffusion tensor imaging (DTI)-based white matter mapping in brain research: A review. *Journal of Molecular Neuroscience*, 34(1), 51–61.
- Atkinson, R. C., & Shiffрин, R. M. (1968). Human memory: A proposed system and its control processes. In K. W. Spence & J. T. Spence (Eds.). *The psychology of learning and motivation* (Vol. 2, pp. 89–105). New York: Academic Press.
- Atladóttir, H. O., Pedersen, M. G., Thorsen, C., Mortensen, P. B., Deleuran, B., Eaton, W. W., & Parner, E. T. (2009). Association of family history of autoimmune diseases and autism spectrum disorders. *Pediatrics*, 124(2), 687–694.
- Aton, S., Seibt, J., Dumoulin, M., Jha, S. K., Steinmetz, N., Coleman, T., Naidoo, N., & Frank, M. G. (2009). Mechanisms of sleep-dependent consolidation of cortical plasticity. *Neuron*, 61(3): 454–466.
- Azmanita, M., Syed, M., & Radmacher, K. (2008). On the intersection of personal and social identities: Introduction and evidence from a longitudinal study of emerging adults. In M. Azmitia, M. Syed, & K. Radmacher (Eds.), *The intersections of personal and social identities. New Directions for Child and Adolescent Development*, 120, 1–16. San Francisco: Jossey-Bass.
- Babiloni, C., Vecchio, F., Buffo, P., Buttiglione, M., Cibelli, G., & Rossini, P. M. (2010). Cortical responses to consciousness of schematic emotional facial expressions: A high-resolution EEG study. *Human Brain Mapping*, 8, 8.
- Backensträß, M., Pfeiffer, N., Schwarz, T., Catanzaro, S. J., & Mearns, J. (2008). Reliability and validity of the German version of the Generalized Expectancies for Negative Mood Regulation (NMR) Scale. *Diagnostica*, 54, 43–51.
- Backer, B., Hannon, R., & Russell, N. (1994). *Death and dying: Understanding and care* (2nd ed.). Albany, NY: Delmar.
- Baddeley, A. (1988). Cognitive psychology and human memory. *Trends in Neuroscience*, 11, 176–181.
- Baddeley, A. (2012). Working memory: Theories, models, and controversies. *Annual Review of Psychology*, 63(1), 1–29. doi: 10.1146/annurev-psych-120710-100422
- Baddeley, A. D. (1986). *Working memory*. London/New York: Oxford University Press.
- Baddeley, A. D. (1996). Exploring the central executive. *Quarterly Journal of Experimental Psychology*, 49A, 5–28.
- Baddeley, A. D. (2003). Working memory: Looking back and looking forward. *Nature Reviews Neuroscience*, 4(10), 829–839.
- Baddeley, A. D., & Hitch, G. (1974). Working memory. In G. A. Bower (Ed.), *The psychology of learning and motivation*, 8 (pp. 47–89). New York: Academic Press.
- Baddeley, A. D., & Larson, J. D. (2007). The phonological loop unmasked? A comment on the evidence for a “perceptual-gestural” alternative. *Quarterly Journal of Experimental Psychology*, 60(4), 497–504.
- Baehr, E. K., Revelle, W., & Eastman, C. I. (2000). Individual difference in the phase amplitude of the human circadian temperature rhythm: With an emphasis on morningness-eveningness. *Journal of Sleep Research*, 9, 117–127.
- Baer, D. M., Wolf, M. M., & Risley, T. R. (1968). Some current dimensions of applied behavior analysis. *Journal of Applied Behavior Analysis*, 1, 91–97.
- Bahrick, H. (1984). Fifty years of second language attrition: Implications for programmatic research. *Modern Language Journal*, 68, 105–118.
- Bahrick, H. P., Hall, L. K., & Berger, S. A. (1996, September). Accuracy and distortion in memory for high school grades. *Psychological Science*, 7, 265–271.
- Bailey, J., Dunne, M. P., & Martin, N. G. (2000). Genetic and environmental influences on sexual orientation and its correlates in an Australian twin sample. *Journal of Personality and Social Psychology Volume*, 78(3), 524–536.
- Bailey, J. M., & Pillard, R. C. (1991). A genetic study of male sexual orientation. *Archives of General Psychiatry*, 48, 1089–1096.
- Bailey, J. M., Pillard, R. C., Neale, M. C., & Agyei, Y. (1993). Heritable factors influence sexual orientation in women. *Archives of General Psychiatry*, 50, 217–223.
- Bailey, J. M., & Zucker, K. J. (1995). Childhood sex-typed behavior and sexual orientation: A conceptual analysis and quantitative review. *Developmental Psychology*, 31, 43–55.
- Baillargeon, R. (1986). Representing the existence and the location of hidden objects: Object permanence in 6- and 8-month-old infants. *Cognition*, 23, 21–41.
- Baker, L. D., Frank, L. L., Foster-Schubert, K., Green, P. S., Wilkinson, C. W., McTiernan, A., et al. (2010). Effects of aerobic exercise on mild cognitive impairment: A controlled trial. *Archives of Neurology*, 67(1), 71–79.
- Ball, K., Berch, D. B., Helmers, K. F., Jobe, J. B., Leveck, M. D., Marsiske, M., Morris, J. N., Rebok, G. W., Smith, D. M., Tennstedt, S. L., Unverzagt, F. W., & Willis, S. L. (2002). Advanced Cognitive Training for Independent and Vital Elderly Study Group. Effects of cognitive training interventions with older adults: A randomized controlled trial. *Journal of the American Medical Association*, 288, 2271–2281.
- Baltes, P. B., Reese, H. W., & Nesselroade, J. R. (1988). *Introduction to research methods, life-span developmental psychology*. Hillsdale, NJ: Lawrence Erlbaum.
- Bandura, A. (1965). Influence of models' reinforcement contingencies on the acquisition of imitative responses. *Journal of Social Psychology*, 1, 589–595.
- Bandura, A. (1980). The social learning theory of aggression. In R. A. Falk & S. S. Kim (Eds.), *The war system: An interdisciplinary approach* (p. 146). Boulder, CO: Westview Press.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.
- Bandura, A. (1989). Human agency in social cognitive theory. *American Psychologist*, 44, 1175–1184.
- Bandura, A. (1998). Exploration of fortuitous determinants of life paths. *Psychological Inquiry*, 9, 95–99.
- Bandura, A., Blanchard, E. B., & Ritter, B. (1969). Relative efficacy of desensitization and modeling approaches for inducing behavioral, affective, and attitudinal changes. *Journal of Personality and Social Psychology*, 13, 173–199.
- Bandura, A., Jeffrey, R. W., & Wright, C. L. (1974). Efficacy of participant modeling as a function of response induction aids. *Journal of Abnormal Psychology*, 83, 56–64.
- Bandura, A., & Rosenthal, T. L. (1966). Vicarious classical conditioning as a functioning of arousal level. *Journal of Personality and Social Psychology*, 3, 54–62.
- Bandura, A., Ross, D., & Ross, S. A. (1961). Transmission of aggression through imitation of aggressive models. *Journal of Abnormal and Social Psychology*, 63, 575–582.
- Bandura, A., Ross, D., & Ross, S. A. (1963). Imitation of film-mediated aggressive models. *Journal of Abnormal and Social Psychology*, 66, 3–11.
- Barak, A. (1999). Psychological applications on the Internet: A discipline on the threshold of a new millennium. *Applied and Preventive Psychology*, 8, 231–246.
- Barak, A., & Hen, L. (2008). Exposure in cyberspace as means of enhancing psychological assessment. In A. Barak (Ed.), *Psychological aspects of cyberspace: Theory, research, applications* (pp. 129–162). Cambridge, UK: Cambridge University Press.
- Barak, A., & Suler, J. (2008). Reflections on the psychology and social science of cyberspace. In A. Barak (Ed.), *Psychological aspects of cyberspace: Theory, research, applications* (pp. 1–12). Cambridge, UK: Cambridge University Press.

- Bard, P. (1934). On emotional expression after decortication with some remark on certain theoretical views. *Psychological Review*, 41, 309–329, 424–449.
- Bargh, J. A., Chen, M., & Burrows, C. (1996). Automaticity of social behavior: Direct effects of trait construct and stereotype activation on action. *Journal of Personality & Social Psychology*, 71(2), 230–244.
- Barker, E. (1983). The ones who got away: People who attend Unification Church workshops and do not become Moonies. In E. Barker (Ed.), *Of gods and men: New religious movements in the West*. Macon, GA: Mercer University Press.
- Barker, Eileen (2007) Religious movements: cult and anticult since Jonestown In: Hamilton, Malcolm, (ed.) Sociology of religion. Critical concepts in sociology, 5. Routledge, Abingdon, UK, 157-177.
- Barkley, R. A., Murphy, K. R., & Fischer, M. (2008). *ADHD in adults: What the science says*. New York: Guilford Press.
- Barlow, D. H., Allen, L. B., & Basden, S. L. (2007). Psychological treatments for panic disorders, phobias, and generalized anxiety disorder. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (3rd ed., pp. 351–394). New York: Oxford University Press.
- Barlow, D. H., Bullis, J. R., Comer, J. S., & Ametaj, A. A. (2013). Evidence-based psychological treatments: An update and a way forward. *Annual Review of Clinical Psychology*, 9, 1–27. doi: 10.1146/annurev-clinpsy-050212-185629
- Barnes, A. M., & Carey, J. C. (2002, January). Common problems of babies with trisomy 18 or 13. Rochester, NY, *Support Organization for Trisomy 18, 13, and Related Disorders*, January 11, New York: Soft Publications.
- Barnes, V., Schneider, R., Alexander, C., & Staggers, F. (1997). Stress, stress reduction, and hypertension in African Americans: An updated review. *Journal of the National Medical Association*, 89(7), 464–476.
- Barnyard, P., & Grayson, A. (1996). *Introducing psychological research*. London: MacMillan Press.
- Barondes, S. H. (1998). *Mood genes: Hunting for origins of mania and depression*. New York: W. H. Freeman.
- Baron, J. N., & Reiss, P. C. (1985). Same time, next year: Aggregate analyses of the mass media and violent behavior. *American Sociological Review*, 50, 347–363.
- Baron, S. A. (1993). *Violence in the workplace*. Ventura, CA: Pathfinder Publishing of California.
- Barsalou, L. W. (1992). *Cognitive psychology: An overview for cognitive scientists*. Hillsdale, NJ: Lawrence Erlbaum.
- Barsch, J. (1996). *Barsch learning style inventory* (rev. ed.). Novato, CA: Academic Therapy Publications.
- Barsh, G. S., Farooqi, I. S., & O’Rahilly, S. (2000). Genetics of body-weight regulation. *Nature*, 404, 644–651.
- Barstow, A. L. (1995). *Witchcraze: A new history of the European witch hunts*. London: Pandora.
- Bartels, A., & Zeki, S. (2000). The neural basis of romantic love. *NeuroReport*, 11, 3829–3834.
- Barth, J. M., & Boles, D. B. (1999, September). *Positive relations between emotion recognition skills and right hemisphere processing*. Paper presented at the 11th Annual Convention of the American Psychological Society, Denver, CO.
- Bartholomew, K. (1990). Avoidance of intimacy: An attachment perspective. *Journal of Social and Personal Relationships*, 7, 147–178.
- Bartlett, C., Harris, R., & Bruey, C. (2008). The effect of the amount of blood in a violent video game on aggression, hostility, and arousal. *Journal of Experimental Social Psychology*, 44(3), 539–546.
- Bartlett, F. C. (1932). *Remembering: A study in experimental ad social psychology*. Cambridge, U.K.: Cambridge University Press.
- Bartlett, N. R. (1965). Dark and light adaptation. In C. H. Graham (Ed.), *Vision and visual perception*. New York: John Wiley & Sons.
- Barton, M. E., & Komatsu, L. K. (1989). Defining features of natural kinds and artifacts. *Journal of Psycholinguistic Research*, 18, 433–447.
- Bartoshuk, L. M. (1993). The biological basis for food perception and acceptance. *Food Quality and Preference*, 4(1/2), 21–32.
- Bartoshuk, L. M., Duffy, V. B., Hayes, J. E., Moskowitz, H. R., & Snyder, D. J. (2006). Psychophysics of sweet and fat perception in obesity: Problems, solutions and new perspectives. *Philosophical transactions of the Royal Society of London. Series B, Biological sciences*, 361(1471), 1137–1148.
- Bartoshuk, L. M., Fast, K., & Snyder, D. J. (2005). Differences in our sensory worlds. *Current Directions in Psychological Science*, 14(3), 122–125.
- Bartz, J. A., Zaki, J., Bolger, N., Hollander, E., Ludwig, N. N., Kolevzon, A., & Ochsner, K. N. (2010). Oxytocin selectively improves empathic accuracy. *Psychological Science*, 21(10), 1426–1428. doi: 10.1177/0956797610383439
- Bartz, J. A., Zaki, J., Bolger, N., & Ochsner, K. N. (2011). Social effects of oxytocin in humans: Context and person matter. *Trends in Cognitive Sciences*, 15(7), 301–309. doi: 10.1016/j.tics.2011.05.002
- Basadur, M., Pringle, P., & Kirkland, D. (2002). Crossing cultures: Training effects on the divergent thinking attitudes of Spanish-speaking South American managers. *Creativity Research Journal*, 14(3, 4), 395–408.
- Basner, M., Rao, H., Goel, N., & Dinges, D. F. (2013). Sleep deprivation and neurobehavioral dynamics. *Current Opinion in Neurobiology*. doi: 10.1016/j.conb.2013.02.008
- Bastien, C. H., Morin, C. M., Ouellet, M., Blais, F. C., Bouchard, S. (2004). Cognitive-behavioral therapy for insomnia: Comparison of individual therapy, group therapy, and telephone consultations. *Journal of Consulting and Clinical Psychology*, 72(4), 653–659.
- Bator, R. J., & Cialdini, R. B. (2006). “The nature of consistency motivation: Consistency, aconsistency, and anticonsistency in a dissonance paradigm.” *Social Influence*, 1, 208–233.
- Battaglia, M., Bernardeschi, L., Franchini, L., Bellodi, L., & Smeraldi, E. (1995). A family study of schizotypal disorder. *Schizophrenia Bulletin*, 2(1)1, 133–146.
- Baumrind, D. (1964). Some thoughts on ethics of research: After reading Milgram’s “Behavioral Study of Obedience.” *American Psychologist*, 19, 421–423.
- Baumrind, D. (1967). Child care practices anteceding three patterns of preschool behavior. *Genetic Psychology Monograph*, 75, 43–88.
- Baumrind, D. (1991). The influence of parenting style on adolescent competence and substance abuse. *Journal of Early Adolescence*, 11(1), 56–95.
- Baumrind, D. (1997). Necessary distinctions. *Psychological Inquiry*, 8, 176–182.
- Baumrind, D. (2005). Patterns of parental authority and adolescent autonomy. In J. Smetana (Ed.), *New directions for child development: Changes in parental authority during adolescence* (pp. 61–69). San Francisco: Jossey-Bass.
- Bayliss, D. M., Baddeley, J. C., & Gunn, D. M. (2005). The relationship between short-term memory and working memory: Complex span made simple? *Memory*, 13(3–4), 414–421.
- Beardsley, T. (1995, January). For whom the bell curve really tolls. *Scientific American*, 14–17.
- Beauchamp, G. K., & Mennella, J. A. (2011). Flavor perception in human infants: Development and functional significance. *Digestion*, 83 Suppl 1, 1–6. doi: 10.1159/000323397
- Bechtel, W., & Abrahamsen, A. (2002). *Connectionism and the mind: Parallel processing, dynamics, and evolution in networks* (2nd ed.). Oxford, UK: Basil Blackwell.
- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.
- Beck, A. T. (1979). *Cognitive therapy and the emotional disorders*. New York: Penguin Books.
- Beck, A. T. (1984). Cognitive approaches to stress. In C. Lehrer & R. L. Woolfolk (Eds.), *Clinical guide to stress management*. New York: Guilford Press.
- Beck, J. S. (2007). Cognitive therapy for personality disorders. Retrieved November 17, 2010, from <http://www.academyofct.org/Library/InfoManage/Guide.asp?FolderID=196>.
- Beckman, M. & Pierrehumbert, J. (1986). Intonational structure in English and Japanese. *Phonology Year Book III*, 15–70.
- Behr, T. A., Jex, S. M., Stacy, B. A., & Murray, M. A. (2000). Work stressors and coworker support as predictors of individual strain and job performance. *Journal of Organizational Behavior*, 21(4), 391–405.
- Beer, J. M., & Horn, J. M. (2001). The influence of rearing order on personality development within two adoption cohorts. *Journal of Personality*, 68, 789–819.
- Beer, J. S. (2009). The neural basis of emotion regulation: Making emotion work for you and not against you. In M. S. Gazzaniga (Ed.), *The Cognitive Neurosciences* (pp. 961–972). Cambridge, MA: The MIT Press.
- Behne, T., Carpenter, M., & Tomasello, M. (2005). One-year-olds comprehend the communicative intentions behind gestures in a hiding game. *Developmental Science*, 8, 492–499.
- Békésy, G. V. (1960). *Experiments in Hearing* (E. G. Wever, Trans.). New York: McGraw-Hill Book Company.
- Bellis, M. A., Downing, J., & Ashton, J. A. (2006). Adults at 12? Trends in puberty and their public health consequences. *Journal of Epidemiology and Community Health*, 60, 910–911. doi: 10.1136/jech.2006.049379
- Belsky, J. (2005). Differential susceptibility to rearing influence: An evolutionary hypothesis and some evidence. In B. Ellis & D. Bjorklund (Eds.), *Origins of the social mind: Evolutionary psychology and child development* (pp. 139–163). New York: Guilford.

- Belsky, J., & Johnson, C. D. (2005). Developmental outcome of children in day care. In J. Murph, S. D. Palmer, & D. Glassy (Eds.), *Health in child care: A manual for health professionals* (4th ed., pp. 81–95). Elks Grove Village, IL: American Academy of Pediatrics.
- Belsky, J., Vandell, D., Burchinal, M., Clarke-Stewart, K. A., McCartney, K., Owen, M., & NICHD Early Child Care Research Network. (2007). Are there long-term effects of early child care? *Child Development*, 78, 681–701.
- Bem, D. J. (1972). Self-perception theory. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 6, pp. 1–62). New York: Academic Press.
- Bem, S. L. (1975). Sex role adaptability: The consequence of psychological androgyny. *Journal of Personality and Social Psychology*, 31, 634–643.
- Bem, S. L. (1981). Gender schema theory: A cognitive account of sex typing. *Psychological Review*, 88, 354–364.
- Bem, S. L. (1987). Gender schema theory and the romantic tradition. In P. Shaver & C. Hendrick (Eds.), *Review of personality and social psychology* (Vol. 7, pp. 251–271). Newbury Park, CA: Sage.
- Bem, S. L. (1993). Is there a place in psychology for a feminist analysis of the social context? *Feminism & Psychology*, 3, 247–251.
- Bengtson, V. L. (1970). The generation gap. *Youth and Society*, 2, 7–32.
- Benito, J. M., Kumru, H. P., Murillo, N. P., Costa, U. P., Medina, J. P., Tormos, J. M. P., ... Vidal, J. P. (2012). Motor and gait improvement in patients with incomplete spinal cord injury induced by high-frequency repetitive transcranial magnetic stimulation. *Topics in Spinal Cord Injury Rehabilitation*, 18(2), 106–112. doi: 10.1310/sci1802-106
- Benjafield, J. J. G. (1996). *A history of psychology*. Boston: Allyn and Bacon.
- Benjamin, S. L. (1996). An interpersonal theory of personality disorders. In J. F. Clarkin & M. F. Lenzenweger (Eds.), *Major theories of personality disorder*. New York: Guilford Press.
- Benowitz, N. L. (1988). Pharmacologic aspects of cigarette smoking and nicotine addiction. *New England Journal of Medicine*, 319, 1318–1330.
- Benson, H. (1975). *The relaxation response*. New York: Morrow.
- Benson, H., Beary, J., & Carol, M. (1974a). The relaxation response. *Psychiatry*, 37, 37–46.
- Benson, H., Rosner, B. A., Marzetta, B. R., & Klemchuk, H. M. (1974b). Decreased blood pressure in pharmacologically treated hypertensive patients who regularly elicited the relaxation response. *Lancet*, 1(7852), 289–291.
- Benton, D., & Parker P. (1998). Breakfast, blood glucose and cognition. *American Journal of Clinical Nutrition*, 67(Suppl:772S).
- Berenbaum, S. A., & Snyder, E. (1995). Early hormonal influences on childhood sex-typed activity and playmate preferences: Implications for the development of sexual orientation. *Developmental Psychology*, 31, 31–42.
- Berent, S. (1977). Functional asymmetry of the human brain in the recognition of faces. *Neuropsychologia*, 15, 829–831.
- Berg, F. (1999). Health risks associated with weight loss and obesity treatment programs. *Journal of Social Issues*, 55(2), 277–297.
- Berk, L. E. (1992). Children's private speech: An overview of theory and the status of research. In R. M. Diaz & L. E. Berk (Eds.), *Private speech: From social interaction to self-regulation* (pp. 17–53). Hillsdale, NJ: Erlbaum.
- Berk, L. E., & Spuhl, S. T. (1995). Maternal interaction, private speech, and task performance in preschool children. *Early Childhood Research Quarterly*, 10, 145–169.
- Berk, L., Prowse, M., Petrofsky, J. S., Batt, J., Laymon, M., Bains, G., Daher, N., Tan, S., & Berk, D. (2009, May). *Laughercise: Health benefits similar of exercise lowers cholesterol and systolic blood pressure*. Presented at the Association for Psychological Science 21st Annual Convention, San Francisco, California.
- Berk, L. S., Felten, D. L., Tan, S. A., Bittman, B. B., & Westengard, J. (2001). Modulation of neuroimmune parameters during the eustress of humor-associated mirthful laughter. *Alternative Therapy Health Medicines*, 7(2), 62–72, 74–76.
- Berk L., Tan, S. A., & Berk, D. (2008, April). *Cortisol and catecholamine stress hormone decrease is associated with the behavior of perceptual anticipation of mirthful laughter*. Presented at the 121st Annual Meeting of the American Physiological Society, San Diego, California.
- Berkowitz, L. (1993). *Aggression: Its causes, consequences and control*. New York: McGraw-Hill.
- Berman, A., Bradley, J. C., Carroll, B., Certain, R. D., Gabrelcik, J. C., Green, R., et al. (2010). *The challenge and the promise: Strengthening the force, preventing suicide and saving lives. Final report of the Department of Defense task force on the prevention of suicide by members of the armed forces*. Washington, DC.
- Bermond, B., Nieuwenhuyse, B., Fasotti, L., & Schuerman, J. (1991). Spinal cord lesions, peripheral feedback, and intensities of emotional feelings. *Cognition and Emotion*, 5, 201–220.
- Bernat, E., Shevrin, H., & Snodgrass, M. (2001). Subliminal visual oddball stimuli evoke a P300 component. *Clinical Neurophysiology*, 112, 159–171.
- Berry, J. W., & Kim, U. (1998). Acculturation and mental health. In P. R. Dasen, J. W. Berry, & N. Sartorius (Eds.), *Health and cross-cultural psychology: Toward applications* (pp. 207–236). Newbury Park, CA: Sage.
- Berry, J. W., & Sam, D. L. (1997). Acculturation and adaptation. In J. W. Berry, M. H. Segall, & C. Kagticbasi (Eds.), *Handbook of cross-cultural psychology*, Vol. 3: *Social behaviour and applications* (2nd ed., pp. 291–326). Boston: Allyn & Bacon.
- Berscheid, E., & Reis, H. T. (1998). Attraction and close relationships. In D. T. Gilbert & S. T. Fiske et al. (Eds.), *The handbook of social psychology*, Vol. 2 (4th ed., pp. 193–281). New York: McGraw-Hill.
- Berteretche, M. V., Dalix, A. M., Cesar d'Ornano, A. M., Bellisle, F., Khayat, D., & Faurion, A. (2004). Decreased taste sensitivity in cancer patients under chemotherapy. *Supportive Care in Cancer*, 12(8), 571–576.
- Bertram, L., & Tanzi, R. E. (2005). The genetic epidemiology of neurodegenerative disease. *The Journal of Clinical Investigation*, 115(6), 1449–1457.
- Best, D. L., & Williams, J. E. (2001). Gender and culture. In D. Matsumoto (Ed.), *The handbook of culture and psychology* (pp. 195–212). New York: Oxford University Press.
- Betancourt, J. R., & Jacobs, E. A. (2000). Language barriers to informed consent and confidentiality: The impact on women's health. *Journal of American Medical Women's Association*, 55, 294–295.
- Beyer, B. K. (1995). *Critical thinking*. Bloomington, IN: Phi Delta Kappa Educational Foundation.
- Beyreuther, K., Biesalski, H. K., Fernstrom, J. D., Grimm, P., Hammes, W. P., Heinemann, U., Kempinski, O., Stehle, P., Steinhart, H., & Walker, R. (2007). Consensus meeting: Monosodium glutamate, an update. *European Journal of Clinical Nutrition*, 61, 304–313.
- Bidinosti, M., Ran, I., Sanchez-Carbente, M. R., Martineau, Y., Gingras, A. C., Gkogkas, C., Raught, B., Bramham, C. R., Sossin, W. S., Costa-Mattioli, M., DesGroiseilliers, L., Lacaille, J. C., & Sonenberg, N. (2010). Postnatal deamidation of 4E-BP2 in brain enhances its association with raptor and alters kinetics of excitatory synaptic transmission. *Molecular Cell*, 37(6), 797–808.
- Bigler, E. D., Johnson, S. C., Anderson, C. V., Blatter, D. D., Gale, S. D., Russo, A. A., Ryser, D. K., Macnamara, S. E., Bailey, B. R., & Hopkins, R. O. (1996). Traumatic brain injury and memory: The role of hippocampal atrophy. *Neuropsychology*, 10, 333–342.
- Binet, A., & Simon, T. (1916). *The development of intelligence in children*. Baltimore: Williams & Wilkins.
- Bivens, J. A., & Berk, L. E. (1990). A longitudinal study of the development of elementary school children's private speech. *Merill-Palmer Quarterly*, 36, 443–463.
- Bjork, R. A., & Bjork, E. L. (1992). A new theory of disuse and an old theory of stimulus fluctuation. In A. Healy, S. Kosslyn, & R. Shiffrin (Eds.), *From learning processes to cognitive processes: Essays in honor of William K. Estes* (Vol. 2, pp. 35–67). Hillsdale, NJ: Erlbaum.
- Bjork, R. A., & Whitten, W. B. (1974). Recency-sensitive retrieval processes in long-term free recall. *Cognitive Psychology*, 6, 173–189.
- Blackless, M., Charuvastra, A., Derryck, A., Fausto-Sterling, A., Lauzanne, K., & Lee, E. (2000). How sexually dimorphic are we? Review and synthesis. *American Journal of Human Biology*, 12, 151–166.
- Blackmon, L. R., Batton, D. G., Bell, E. F., Engle, W. A., Kanto, W. P., Martin, G. I., Rosenfeld, W. N., Stark, A. R., & Lemons, J. A. (Committee on Fetus and Newborn). (2003). *Apnea, sudden infant death syndrome, and home monitoring*. *Pediatrics*, 111(4), 914–917.
- Blair, R. J. R., Sellars, C., Strickland, I., Clark, F., Williams, A. O., Smith, M., & Jones, L. (1995). Emotion attributions in the psychopath. *Personality and Individual Differences*, 19(4), 431–437.
- Blanchard-Fields, F., Chen, Y., Horhota, M., & Wang, M. (2007). Cultural differences in the relationship between aging and the correspondence bias. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 62(6), 362–365.
- Blanchard-Fields, F., & Horhota, M. (2005). Age differences in the correspondence bias: When a plausible explanation matters. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 60(5), 259–267.
- Blanchard, M., & Main, M. (1979). Avoidance of the attachment figure and social-emotional adjustment in day-care infants. *Developmental Psychology*, 15, 445–446.
- Blanchard, R. (2001). Fraternal birth order and the maternal immune hypothesis of male homosexuality. *Hormones and Behavior*, 40(2), 105–114.

- Blank, T., & Prinz, M. (2013). Microglia as modulators of cognition and neuropsychiatric disorders. *Glia*, 61(1), 62–70. doi: 10.1002/glia.22372
- Blass, T. (1991). Understanding behavior in the Milgram obedience experiment: The role of personality, situations, and their interactions. *Journal of Personality and Social Psychology*, 60, 398–413.
- Blass, T. (1999). The Milgram paradigm after 35 years: Some things we now know about obedience to authority. *Journal of Applied Social Psychology*, 25, 955–978.
- Bledsoe, C. H., & Cohen, B. (1993). *Social dynamics of adolescent fertility in sub-Saharan Africa*. Washington DC: National Academy Press.
- Blehar, M. C., & Oren, D. A. (1997). Gender differences in depression. *Medscape General Medicine*, 1(2). Retrieved June 27, 2004, from <http://www.medscape.com/viewarticle/719236>
- Bleiberg, K. L., & Markowitz, J. C. (2008). Interpersonal psychotherapy for depression. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (pp. 306–327). New York: Guilford Press.
- Bleuler, E. (1911, reissued 1950). *Dementia praecox or the group of schizophrenias*. New York: International Universities Press.
- Block, N. (2005). Two neural correlates of consciousness. *Trends in Cognitive Sciences*, 9, 41–89.
- Bloom, B. S. (Ed.). (1956) Taxonomy of educational objectives, the classification of educational goals—Handbook I: Cognitive domain. New York: McKay.
- Bloom, L. (1974). Talking, understanding and thinking. In R. Schiefelbusch & L. L. Lloyd (Eds.), *Language perspectives: Acquisition, retardation and intervention*. New York: Macmillan.
- Bloom, P. (2000). *How children learn the meaning of words*. Cambridge, MA: MIT Press.
- Blumenfeld, H. (2002). *Neuroanatomy through clinical cases*. Sunderland, MA: Sinauer.
- Blumer, D. (2002). The illness of Vincent van Gogh. *American Journal of Psychiatry*, 159(4), 519–526.
- Bock, R. (1993, August). *Understanding Klinefelter syndrome: A guide for XXY males and their families*. NIH Publication No. 93-3202. National Institutes of Health, Office of Research Reporting. Washington, DC: Retrieved August 10, 2010, from <http://www.nichd.nih.gov/publications/pubs/klinefelter.cfm>
- Bodrova, E., & Leong, D. J. (1996). *Tools of the mind: The Vygotskian approach to early childhood education*. Englewood Cliffs, NJ: Prentice Hall.
- Boggio, P. S., Campanha, C., Valasek, C. A., Fecteau, S., Pascual-Leone, A., & Fregni, F. (2010). Modulation of decision-making in a gambling task in older adults with transcranial direct current stimulation. *The European Journal of Neuroscience*, 31(3), 593–597.
- Boggio, P. S., Fregni, F., Valasek, C., Ellwood, S., Chi, R., Gallate, J., et al. (2009). Temporal lobe cortical electrical stimulation during the encoding and retrieval phase reduces false memories. *PLoS One*, 4(3), e4959.
- Boggio, P. S., Rocha, M., Oliveira, M. O., Fecteau, S., Cohen, R. B., Campanha, C., Ferreira-Santos, E., Meleiro, A., Corchs, F., Zaghi, S., Pascual-Leone, A., & Fregni, F. (2009). Noninvasive brain stimulation with high-frequency and low-intensity repetitive transcranial magnetic stimulation treatment for post-traumatic stress disorder. *The Journal of Clinical Psychiatry*, 29, 29.
- Bogle, K. D. (2000). Effect of perspective, type of student, and gender on the attribution of cheating. *Proceedings of the Oklahoma Academy of Science*, 80, 91–97.
- Bolton, P., Bass, J., Betancourt, T., Speelman, L., Onyango, G., Clougherty, K. F., et al. (2007). Interventions for depression symptoms among adolescent survivors of war and displacement in northern Uganda. *Journal of Medical Association*, 298, 519–527.
- Bondarenko, L. A. (2004). Role of methionine in nocturnal melatonin peak in the pineal gland. *Bulletin of Experimental Biological Medicine*, 137(5), 431–432.
- Bond, R. A., & Smith, P. B. (1996). Culture and conformity: A meta-analysis of studies using Asch's (1952, 1956) line judgment task. *Psychological Bulletin*, 119, 111–137.
- Bonnellykke, B. (1990). Maternal age and parity as predictors of human twinning. *Acta Genetic Medicine & Gemellology*, 39, 329–334.
- Boor, M. (1982). The multiple personality epidemic: Additional cases and inferences regarding diagnosis, etiology, dynamics, and treatment. *Journal of Nervous and Mental Disease*, 170, 302–304.
- Booth-Butterfield, S. (1996). Message characteristics. *Steve's primer of practical persuasion and influence*. Retrieved August 2, 2004, from <http://www.austinc.edu/colangelo/1311/persuasivecharacteristics.htm>
- Borgeat, F., & Goulet, J. (1983, June). Psychophysiological changes following auditory subliminal suggestions for activation and deactivation. *Perceptual & Motor Skills*, 56(3), 759–766.
- Borges, M. A., Stepnowsky, M. A., & Holt, L. H. (1977). Recall and recognition of words and pictures by adults and children. *Bulletin of the Psychonomic Society*, 9, 113–114.
- Boroditsky, L. (2001). Does language shape thought? Mandarin and English speakers' conceptions of time. *Cognitive Psychology*, 43(1), 1–22.
- Boroditsky, L. (2009). How does our language shape the way we think? In M. Brockman (Ed.), *What's next? Dispatches on the future of science* (pp. 116–129). New York: Vintage.
- Bossert, W., & Schworm, W. (2008). A class of two-group polarization measures. *Journal of Public Economic Theory*, 10(6): 1169–1187.
- Bosworth, H. B., & Schaie, K. W. (1997). The relationship of social environment, social networks, and health outcomes in the Seattle Longitudinal Study: Two analytical approaches. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 52(5), 197–205.
- Botwin, M. D., & Buss, D. M. (1989). The structure of act data: Is the Five-Factor Model of personality recaptured? *Journal of Personality and Social Psychology*, 56, 988–1001.
- Bouchard, C., Tremblay, A., Nadeau, A., Dussault, J., Despres, J. P., Theriault, G., Lupien, P. J., Serresse, O., Boulay, M. R., & Fournier, G. (1990). Long-term exercise training with constant energy intake. 1: Effect on body composition and selected metabolic variables. *International Journal on Obesity*, 14(1), 57–73.
- Bouchard, T. (1994). Genes, environment, and personality. *Science*, 264, 1700–1701.
- Bouchard, T. J., Jr. (1997). Whenever the twain shall meet. *The Science*, 37(5), 52–57.
- Bouchard, T. J., & Segal, N. L. (1985). Environment and IQ. In B. B. Wolman (Ed.), *Handbook of intelligence: Theories, measurements, and applications* (pp. 391–464). New York: John Wiley.
- Bowden, C. L., Calabrese, J. R., McElroy, S. L., Gyulai, L., Wassef, A., Petty, F., Pope, H. G., Jr., Chou, J. C., Keck, P. E., Jr., Rhodes, L. J., Swann, A. C., Hirschfeld, R. M., & Wozniak, P. J. (2000). For the Divalproex Maintenance Study Group. A randomized, placebo-controlled 12-month trial of divalproex and lithium in treatment of outpatients with bipolar I disorder. *Archives of General Psychiatry*, 57(5), 481–489.
- Bowers, K. S., & Woody, E. Z. (1996). Hypnotic amnesia and the paradox of intentional forgetting. *Journal of Abnormal Psychology*, 105, 381–390.
- Bowman, E. S. (1996). Delayed memories of child abuse: Part II: An overview of research findings relevant to understanding their reliability and suggestibility. *Dissociation: Progress in the Dissociative Disorders*, 9, 232–243.
- Boyd, C. H., & Peeler, C. M. (May, 2004). *Highlighting vs note taking: A comparison of students' performance on tests*. Poster presented at 16th Annual Convention of the American Psychological Society, Chicago, Illinois, USA.
- Boyd, L. A., & Weinstein, C. J. (2004). Cerebellar stroke impairs temporal but not spatial accuracy during implicit motor learning. *Neurorehabilitation and Neural Repair*, 18(3), 134–143.
- Boyson-Bardies, B., deHalle, P., Sagart, L., & Durand, C. (1989). A cross-linguistic investigation of vowel formats in babbling. *Journal of Child Language*, 16, 1–17.
- Bracey, G. (1997). A few facts about poverty. *Phi Delta Kappan*, 79, 163–164.
- Braun, S. R. (1996). *Buzz: the science and lore of alcohol and caffeine*, pp. 137–169. New York: Oxford University Press.
- Brazelton, T. B. (1992). *Touchpoints: Your child's emotional and behavioral development*. Reading, MA: Addison-Wesley.
- Brecher, M., Wang, B. W., Wong, H., & Morgan, J. P. (1988). Phencyclidine and violence: Clinical and legal issues. *Journal of Clinical Psychopharmacology*, 8, 397–401.
- Breedlove, S. M. (2010). Minireview: Organizational hypothesis: instances of the fingerpost. *Endocrinology*, 151(9), 4116–4122. doi: 10.1210/en.2010-0041
- Breier, A., Albus, M., Pickar, D., Zahn, T. P., Wolkowitz, O. M., & Paul, S. M. (1987). Controllable and uncontrollable stress in humans: Alterations in mood, neuroendocrine and psychophysiological function. *American Journal of Psychiatry*, 144, 1419–1425.
- Breiter, H. C., Gollub, R. L., Weisskoff, R. M., Kennedy, D. N., Makris, N., Berke, J. D., Goodman, J. M., Kantor, H. L., Gastfriend, D. R., Riorden, J. P., Mathew, R. T., Rosen, B. R., & Hyman, S. E. (1997). Acute effects of cocaine on human brain activity and emotion. *Neuron*, 19(3), 591–611.
- Breland, K., & Breland, M. (1961). The misbehavior of organisms. *American Psychologist*, 16, 681–684.
- Bremmer, J. D. (2005). *Brain imaging handbook*. New York: W. W. Norton.
- Brennan, J. F. (2002). *History and systems of psychology* (6th ed.). Upper Saddle River, NJ: Prentice Hall.

- Brennan, P. A., Raine, A., Schulsinger, F., Kirkegaard-Sorensen, L., Knop, J., Hutchings, B., Rosenberg, R., & Mednick, S. A. (1997). Psychophysiological protective factors for male subjects at high risk for criminal behavior. *American Journal of Psychiatry*, 154, 853–855.
- Brenner, J. (2007, August). Parental impact on attitude formation—A siblings study on worries about immigration. *Rubr Economic Paper No. 22*. Available at Social Science Research Network (SSRN) at <http://ssrn.com/abstract=1012110>
- Breslau, N., Chilcoat, H. D., Kessler, R. C., Peterson, E. L., & Lucia, V. C. (1999). Vulnerability to assaultive violence: Further specification of the sex difference in posttraumatic stress disorder. *Psychological Medicine*, 29, 813–821.
- Breslau, N., Davis, G. C., Andreski, P., & Peterson, E. L. (1997). Sex differences in posttraumatic stress disorder. *Archives of General Psychiatry*, 54(11), 1044–1048.
- Breuer, J., & Freud, S. (1895). *Studies on hysteria (cathartic method)*. Special Edition, 2, 1–309.
- Brewer, M. B. (2001). Ingroup identification and intergroup conflict: When does ingroup love become outgroup hate? In R. D. Ashmore, L. Jussim, & D. Wilder (Eds.), *Social identity, intergroup conflict, and conflict reduction*. New York: Oxford University Press.
- Brick, J. (2003). The characteristics of alcohol: Chemistry, use and abuse. In J. Brick (Ed.), *Handbook of the medical consequences of alcohol and drug abuse* (pp. 1–11). New York: Haworth Medical Press.
- Briem, V., & Hedman, L. R. (1995). Behavioural effects of mobile telephone use during simulated driving. *Ergonomics*, 38, 2536–2562.
- Briggs, K. C., & Myers, I. B. (1998). *The Myers-Briggs Type Indicator-Form M*. Palo Alto, CA: Consulting Psychologists Press.
- Brigham, A. (1844). Asylums exclusively for the incurably insane. Classic article in *The American Journal of Psychiatry*, 151, 50–70.
- Broadbent, D. (1958). *Perception and communication*. Elmsford, NY: Pergamon.
- Brondolo, E., Rieppi, R., Erickson, S. A., Bagiella, E., Shapiro, P. A., McKinley, P., & Sloan, R. P. (2003). Hostility, interpersonal interactions, and ambulatory blood pressure. *Psychosomatic Medicine*, 65, 1003–1011.
- Bronkhorst, A. W. (2000). The cocktail party phenomenon: A review on speech intelligibility in multiple-talker conditions. *Acta Acustica united with Acustica* 86, 117–128. PDF available from http://eaa-fenestra.org/products/acta-acustica-most-cited/acta_86_2000_Bronkhorst.pdf
- Brooks, J. G., & Brooks, M. G. (1993). *In search of understanding: The case for constructivist classrooms*. Alexandria, VA: The Association for Supervision and Curriculum Development.
- Brown, A. S., & Derkits, E. J. (2010). Prenatal infection and schizophrenia: A review of epidemiologic and translational studies. *The American Journal of Psychiatry*, 167(3), 261–280. doi: 10.1176/appi.ajp.2009.09030361
- Brown, C. A., & Jones, A. K. P. (2010). Meditation experience predicts less negative appraisal of pain: Electrophysiological evidence for the involvement of anticipatory neural responses. *Pain*. doi: 10.1016/j.pain.2010.04.017
- Brown, C., Taylor, J., Green, A., Lee, B. E., Thomas, S. B., & Ford, A. (2003). *Managing depression in African Americans: Consumer and provider perspectives*. (Final Report to Funders). Pittsburgh: Mental Health Association of Allegheny County.
- Brown, E. (2012, September 2). Sun Myung Moon dies at 92; Washington Times owner led the Unification Church. *The Washington Post*. Retrieved May 24, 2013, from http://www.washingtonpost.com/world/asia_pacific/sun-myung-moon-dies-at-92-washington-times-owner-led-the-unification-church/2012/09/02/001b747a-f531-11e1-aab7-f199a16396cf_story.html
- Brown, G., Lawrence, T. B., & Robinson, S. L. (2005). Territoriality in management organizations. *Academy of Management Review*, 30(3), 577–594.
- Brown, G. L., & Linnola, M. I. (1990). CSF serotonin metabolite (5-HIAA) studies in depression, impulsivity, and violence. *Journal of Clinical Psychiatry*, 51(4), 31–43.
- Brown, J. (1958). Some tests of the decay theory of immediate memory. *Quarterly Journal of Experimental Psychology*, 10, 12–21.
- Brown, R. (1973). *A first language: The early stages*. Cambridge, MA: Harvard University Press.
- Brown, R., & McNeill, D. (1966). The “tip of the tongue” phenomenon. *Journal of Verbal Learning & Verbal Behavior*, 5(4), 325–337.
- Browne, D. (2004). Do dolphins know their own minds? *Biology & Philosophy*, 19, 633–653.
- Browne, M. N., & Keeley, S. M. (2009). *Asking the right questions: A guide to critical thinking* (9th ed., pp. 37–129). Upper Saddle River, NJ: Pearson Prentice-Hall.
- Broyles, S. (2006). Subliminal advertising and the perpetual popularity of playing to people's paranoia. *Journal of Consumer Affairs*, 40(2), 392–406.
- Brubaker, D. A., & Leddy, J. J. (2003). Behavioral contracting in the treatment of eating disorders. *The Physician and Sportsmedicine*, 31(9).
- Brunner, E. J., Hemingway, H., Walker, B., Page, M., Clarke, P., Juneja, M., Shipley, M. J., Kumari, M., Andrew, R., Seckl, J. R., Papadopoulos, A., Checkley, S., Rumley, A., Lowe, G. D., Stansfeld, S. A., & Marmot, M. G. (2002). Adrenocortical, autonomic and inflammatory causes of the metabolic syndrome: Nested case-control study. *Circulation*, 106, 2659–2665.
- Bryan, E. B., & Hallett, F. (2001). *Guidelines for professionals. Twins and triplets: The first five years and beyond*. London: Multiple Births Foundation.
- Bryan, J., & Freed, F. (1982). Corporal punishment: Normative data and sociological and psychological correlates in a community college population. *Journal of Youth and Adolescence*, 11(2), 77–87.
- Bryant, R. A., & McConkey, K. M. (1989). Hypnotic blindness: A behavioral and experimental analysis. *Journal of Abnormal Psychology*, 98, 71–77.
- Brzustowicz, L. M., Simone, J., Mohseni, P., Hayter, J. E., Hodgkinson, K. A., Chow, E. W., & Bassett, A. S. (2004). Linkage disequilibrium mapping of schizophrenia susceptibility to the CAPON region of chromosome 1q22. *American Journal of Human Genetics*, 74(5), 1057–1063.
- Buccino, G., Binkofski, F., Fink, G. R., Fadiga, L., Fogassi, L., Gallese, V., et al. (2001). Action observation activates premotor and parietal areas in a somatotopic manner: An fMRI study. *European Journal of Neuroscience*, 13(2), 400–404.
- Buccino, G., Binkofski, F., & Fadiga, L. (2004). The mirror neuron system and action recognition. *Brain and Language*, 89(2), 370–376.
- Bucher, B. D., & Lovaas, O. I. (1967). Use of aversive stimulation in behavior modification. In M. R. Jones (Ed.), *Miami Symposium on the Prediction of Behavior 1967: Aversive Stimulation*, 77–145. Coral Gables: University of Miami Press.
- Buck, L. B., & Bargmann, C. I. (2013). Smell and taste: The chemical senses. In E. R. Kandel, J. H. Schwartz, T. M. Jessell, S. A. Siegelbaum, & A. J. Hudspeth (Eds.), *Principles of neural science* (5th ed., pp. 712–735). USA: McGraw-Hill.
- Buck, R. (1980). Nonverbal behavior and the theory of emotion: The facial feedback hypothesis. *Journal of Personality and Social Psychology*, 38, 811–824.
- Bullock, T. H., Bennett, M. V., Johnston, D., Josephson, R., Marder, E., & Fields, R. D. (2005). Neuroscience. The neuron doctrine, redux. *Science*, 310(5749), 791–793.
- Bureau of Labor Statistics. (2010). *Census of fatal occupational injuries*. Retrieved August 9, 2010, from <http://www.bls.gov/iif/oshcfo1.htm>
- Burger, J. M. (1997). The psychoanalytic approach: Neo-Freudian theory, application, and assessment. *Personality* (4th ed.). Pacific Grove, CA: Brooks/Cole.
- Burger, J. M. (1999). The foot-in-the-door compliance procedure: A multiple-process analysis and review. *Personality and Social Psychology Review*, 3(4), 303–325. doi: 10.1207/s15327957pspr0304_2
- Burger, J. M. (2009). Replicating Milgram: Would people still obey today? *American Psychologist*, 64(1), 1–11. doi: 10.1037/a0010932
- Burger, J. M., Girgis, Z. M., & Manning, C. C. (2011). In their own words: Explaining obedience to authority through an examination of participants' comments. *Social Psychological and Personality Science*, 2, 460–466. doi: 10.1177/1948550610397632
- Burger, J. M., & Petty, R. E. (1981). The low-ball compliance technique: Task or person commitment? *Journal of Personality and Social Psychology*, 40, 492–500.
- Burgio, K. L. (1998). Behavioral vs. drug treatment for urge urinary incontinence in older women: A randomized controlled trial. *Journal of the American Medical Association*, 280, 1995–2000.
- Burke, D. M., MacKay, D. G., Worthley, J. S., & Wade, E. (1991). On the tip of the tongue: What causes word finding failures in young and older adults. *Journal of Memory and Language*, 30, 542–579.
- Burks, N., & Martin, B. (1985). Everyday problems and life change events: Ongoing versus acute sources of stress. *Journal of Human Stress*, 11, 27–35.
- Burns, J. F. (May 24, 2010). British medical council bars doctor who linked vaccine with autism. *New York Times*.
- Bush, G., Frazier, J. A., Rauch, S. L., Seidman, L. J., Whalen, P. J., Jenike, M. A., et al. (1999). Anterior cingulate cortex dysfunction in attention-deficit/hyperactivity disorder revealed by fMRI and the Counting Stroop. *Biological Psychiatry*, 45(12), 1542–1552.
- Bush, G., Spencer, T. J., Holmes, J., Shin, L. M., Valera, E. M., Seidman, L. J., et al. (2008). Functional magnetic resonance imaging of methylphenidate and placebo in attention-deficit/hyperactivity disorder during the Multi-Source Interference Task. *Archives of General Psychiatry*, 65(1), 102–114.
- Bushey, D., Tononi, G., & Cirelli, C. (2011). Sleep and synaptic homeostasis: Structural evidence in Drosophila. *Science*, 332(6037): 1576–1581.

- Bushman, B. J. (1997). Effects of alcohol on human aggression: Validity of proposed explanations. In M. Galanter (Ed.), *Recent developments in alcoholism. Vol. 1: Alcohol and violence—Epidemiology, neurobiology, psychology, family issues* (pp. 227–243). New York: Plenum Press.
- Bushman, B. J., & Huesmann, L. R. (2001). Effects of televised violence on aggression. In D. G. Singer & J. L. Singer (Eds.), *Handbook of children and the media* (Ch. 11, pp. 223–254). Thousand Oaks, CA: Sage.
- Buss, D. (2007). The evolution of human mating. *Acta Psychologica Sinica*, 39(3), 502–512.
- Buss, D. M. (1989). Sex differences in human mate preferences: Evolutionary hypotheses testing in 37 cultures. *Behavioral and Brain Sciences*, 12, 1–49.
- Buss, D. M. (2009). How can evolutionary psychology successfully explain personality and individual differences? *Perspectives on Psychological Science*, 4(4), 359–366. doi: 10.1111/j.1745-6924.2009.01138.x
- Buss, D. M. (2009). The multiple adaptive problems solved by human aggression. *Behavioral and Brain Sciences*, 32, 271–272.
- Buss, D. M. (2011). Personality and the adaptive landscape: The role of individual differences in creating and solving social adaptive problems. In D. M. Buss & P. H. Hawley (Eds.), *The evolution of personality and individual differences*. New York: Oxford University Press.
- Buss, D. M., Larsen, R. J., Westen, D., & Semmelroth, J. (1992). Sex differences in jealousy: Evolution, physiology, and psychology. *Psychological Science*, 3, 251–255.
- Buss, D., & Schmitt, D. (1993). Sexual strategies theory: An evolutionary perspective on human mating. *Psychological Review*, 100(2), 204–232. doi: 10.1037/0033-295X.100.2.204
- Buss, D., & Schmitt, D. (2011). Evolutionary psychology and feminism. *Sex Roles*, 64(9–10), 768–787. doi: 10.1007/s11199-011-9987-3
- Bussa, B., & Kaufman, C. (2000). What can self-help do? *The Journal of the California Alliance of the Mentally Ill*, 2(2), 34–45.
- Butcher, J. N., Graham, J. R., Ben-Poarth, Y. S., Tellegen, A., Dahlstrom, W. G., & Kaemmer, B. (2001). *Minnesota Multiphasic Personality Inventory-2. Manual for administration, scoring, and interpretation* (Rev. ed.). Minneapolis, MN: University of Minnesota Press.
- Butcher, J. N., & Rouse, S. V. (1996). Personality: Individual differences and clinical assessment. *Annual Review of Psychology*, 47, 87–111.
- Butcher, J. N., Rouse, S. V., & Perry, J. N. (2000). Empirical description of psychopathology in therapy clients: Correlates of MMPI-2 scales. In J. N. Butcher (Ed.), *Basic sources on the MMPI-2* (pp. 487–500). Minneapolis, MN: University of Minnesota Press.
- Cabeza, R., Anderson, N. D., Locantore, J. K. & McIntosh, A. R. (2002). Aging gracefully: Compensatory brain activity in high-performing older adults. *NeuroImage*, 17(3), 1394–1402.
- Cabeza, R., & Nyberg, L. (2000). Imaging cognition II: An empirical review of 275 PET and fMRI studies. *Journal of Cognitive Neuroscience*, 12(1), 1–47.
- Cacioppo, J. T., Berntson, G. G. (1992). Social psychological contributions to the decade of the brain: Doctrine of multilevel analysis. *American Psychologist*, 47, 1019–1028.
- Cain, D., & Seeman, J. (Eds.). (2001). *Humanistic psychotherapies: Handbook of research and practice*. Washington, DC: APA Publications.
- Cajal, S. R. y. (1995). *Histology of the nervous system of man and vertebrates* (translated from the French by Neely Swanson and Larry W. Swanson ed.). New York, NY: Oxford University Press.
- Caley, L. M., Kramer, C., & Robinson, L. K. (2005). Fetal alcohol spectrum disorder. *The Journal of School Nursing*, 21(3), 139–146.
- Califia, P. (1997). *Sex changes: The politics of transgenderism*. San Francisco: Cleis Press.
- Calvo, E., Haverstick, K. & Sass, S. A. (2009). Gradual retirement, sense of control, and retirees' happiness. *Research on Aging*, 31, 112–135.
- Camacho, E. M., Verstappen, S. M., Chipping, J., & Symmons, D. P. (2013). Learned helplessness predicts functional disability, pain and fatigue in patients with recent-onset inflammatory polyarthritis. *Rheumatology (Oxford)*. doi: 10.1093/rheumatology/kes434
- Camacho, M. (2012). Abby and Brittany. *Common Sense Media*. Retrieved April 26, 2013, from <http://www.commonsemmedia.org/tv-reviews/abby-and-brittany>
- Camara, W. J., Nathan, J. S., & Puente, A. E. (2000). Psychological test usage: Implications in professional psychology. *Professional Psychology: Research and Practice*, 31(2), 141–154.
- Camchong, J., Lim, K. O., Sponheim, S. R., & Macdonald, A. W. (2009). Frontal white matter integrity as an endophenotype for schizophrenia: Diffusion tensor imaging in monozygotic twins and patients' nonpsychotic relatives. *Frontiers in Human Neuroscience*, 3, 35.
- Cameron, J. A., Alvarez, J. M., Ruble, D. N., & Fuligni, A. J. (2001). Children's lay theories about ingroups and outgroups: Reconceptualizing research on prejudice. *Personality and Social Psychology Review*, 5, 118–128.
- Cameron, J., Banko, K. M., & Pierce, W. D. (2001). Pervasive negative effects of rewards on intrinsic motivation: The myth continues. *The Behavior Analyst*, 24, 1–44.
- Cami, J., Farre, M., Mas, M., Roset, P. N., Poudevida, S., Mas, A., San, L., & de la Torre, R. (2000). Human pharmacology of 3,4-methylenedioxymethamphetamine ("ecstasy"): Psychomotor performance and subjective effects. *Journal of Clinical Psychopharmacology*, 20, 455–466.
- Campbell, J. C., & Wolf, A. D. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American Journal of Public Health*, 93(7).
- Cannon, W. B. (1927). The James-Lange theory of emotion: A critical examination and an alternative theory. *American Journal of Psychology*, 39, 10–124.
- Cannon, W. B., & Washburn, A. L. (1912). An explanation of hunger. *American Journal of Physiology*, 29, 444–454.
- Cardinali, D. P., Scacchi Bernasconi, P. A., Reynoso, R., Reyes Toso, C. F., & Scacchi, P. (2013). Melatonin may curtail the metabolic syndrome: Studies on initial and fully established fructose-induced metabolic syndrome in rats. *International Journal of Molecular Sciences*, 14(2): 2502–2514.
- Cardno, A. G., & Gottesman, I. I. (2000). Twin studies of schizophrenia: From bow-and-arrow concordances to Star Wars Mx and functional genomics. *American Journal of Medical Genetics*, 97(1), 12–17. doi: 10.1002/(SICI)1096-8628(200021)97:1<12::AID-AJMG3>3.0.CO;2-U [pii]
- Carducci, B. (1998). *The psychology of personality*. Pacific Grove, CA: Brooks/Cole Publishing Co.
- Carey, B. (2009, December 21). Building a search engine of the brain, slice by slice. *New York Times*. Retrieved June 10, 2010, from http://www.nytimes.com/2009/12/22/health/22brain.html?Pref=henry_gustav_molaison
- Carlsen, A. (2013, March 18). Some people really can taste the rainbow [Web log post]. Retrieved from <http://www.npr.org/blogs/thesalt/2013/03/12/174132392/synesthetes-really-can-taste-the-rainbow>
- Carlson, G. A., Jensen, P. S., & Nottelmann, E. D. (Eds.). (1998). Current issues in childhood bipolarity [Special issue]. *Journal of Affective Disorders*, 51.
- Carnot, M. J., Dunn, B., Cañas, A. J., Graham, P. & Muldoon, J. (2001). Concept Maps vs. Web Pages for Information Searching and Browsing. Manuscript in preparation. Institute for Human and Machine Cognition.
- Carpenter, P. A., Just, M. A., & Shell, P. (1990). What one intelligence test measures: A theoretical account of the processing in the Raven Progressive Matrices test. *Psychological Review*, 97(3), 404–431.
- Carr, E. G., & Lovaas, O. I. (1983). Contingent electric shock as a treatment for severe behavior problems. In S. Axelrod & J. Apsche (Eds.), *The effects of punishment on human behavior* (pp. 221–245). New York: Academic Press.
- Carrión, V. G., Weems, C. F., & Reiss, A. L. (2007). Stress predicts brain changes in children: A pilot longitudinal study on youth stress, posttraumatic stress disorder, and the hippocampus. *Pediatrics*, 119(3), 509–516.
- Carruthers, M. (2001). A multifactorial approach to understanding andropause. *Journal of Sexual and Reproductive Medicine*, 1, 69–74.
- Carskadon, M. A., & Dement, W. C. (2005). Normal human sleep overview. In M. H. Kryger, T. Roth, & W. C. Dement (Eds.), *Principles and practice of sleep medicine* (4th ed., pp. 13–23). Philadelphia: Elsevier/Saunders.
- Carskadon, M. A., & Dement, W. C. (2011). Normal human sleep: An overview. In M. H. Kryger, T. Roth, & W. C. Dement (Eds.), *Principles and practice of sleep medicine*. St. Louis, MO: Elsevier Saunders.
- Carson, R. C. (1969). *Interaction concepts of personality*. Chicago: Aldine.
- Carter, C., Bishop, J., & Kravits, S. L. (2006). Keys to success: Building successful intelligence for college, career, and life (5th ed.). Englewood Cliffs, NJ: Prentice Hall.
- Carter, R. M., Bowling, D. L., Reeck, C., & Huettel, S. (2012). A distinct role of the temporal-parietal junction in predicting socially guided decisions. *Science*, 337(6090), 109–111.
- Carver, C. S., & Antoni, M. H. (2004). Finding benefit in breast cancer during the year after diagnosis predicts better adjustment 5 to 8 years after diagnosis. *Health Psychology*, 26, 595–598.

- Carver, L. J., & Bauer, P. J. (2001). The dawning of a past: The emergence of long-term explicit memory in infancy. *Journal of Experimental Psychology: General*, 130, 726–745.
- Case, B. G., Bertollo, D. N., Laska, E. M., Price, L. H., Siegel, C. E., Olfson, M., & Marcus, S. C. (2013). Declining use of electroconvulsive therapy in United States general hospitals. *Biological Psychiatry*, 73(2), 119–126. doi: 10.1016/j.biopsych.2012.09.005
- Case, B. G., Bertollo, D. N., Laska, E. M., Siegel, C. E., Wanderling, J. A., & Olfson, M. (2012). Racial differences in the availability and use of electroconvulsive therapy for recurrent major depression. *Journal of Affective Disorders*, 136(3), 359–365. doi: 10.1016/j.jad.2011.11.026
- Cassidy, A., Bingham, S., & Setchell, K. D. R. (1994). Biological effects of a diet of soy protein rich in isoflavones on the menstrual cycle of premenopausal women. *American Journal of Clinical Nutrition*, 60, 333–340.
- Castillo, R. J. (1997). Eating disorders. In R. J. Castillo (Ed.), *Culture and mental illness: A client-centered approach* (p. 152). Pacific Grove, CA: Brooks/Cole.
- Catani, M., & Thiebaut de Schotten, M. (2012). *Atlas of human brain connections*. New York, NY: Oxford University Press.
- Catanzaro, S. J., Wasch, H. H., Kirsch, I., & Mearns, J. (2000). Coping-related expectancies and dispositions as prospective predictors of coping responses and symptoms: Distinguishing mood regulation expectancies, dispositional coping, and optimism. *Journal of Personality*, 68, 757–788.
- Cattell, R. B. (1950). *Personality: A systematic, theoretical, and factual study*. New York: McGraw-Hill.
- Cattell, R. B. (1973). *Personality and mood by questionnaire*. San Francisco: Jossey-Bass.
- Cattell, R. B. (1990). Advances in Cattellian personality theory. In L. A. Pervin (Ed.), *Handbook of personality: Theory and research* (pp. 101–110). New York: Guilford.
- Cattell, R. B. (1994). *Sixteen Personality Factor Questionnaire* (5th ed.). Champaign, IL: Institute for Personality and Ability Testing, Inc.
- Cattell, R. B. (1995). Personality structure and the new fifth edition of the 16PF. *Educational & Psychological Measurement*, 55(6), 926–937.
- Cattell, R. B. (Ed.). (1966). *Handbook of multivariate experimental psychology*. Chicago: Rand McNally.
- Cattell, R. B., & Kline, P. (1977). *The scientific analysis of personality and motivation*. New York: Academic Press.
- Cave, K. R., & Kim, M. (1999). Top-down and bottom-up attentional control: On the nature of interference from a salient distractor. *Perception & Psychophysics*, 61, 1009–1023.
- Centers for Disease Control and Prevention (CDC). (1992). *Smoking and health in the Americas: The Surgeon General's report*. National Center for Chronic Disease Prevention and Health Promotion. Atlanta, Georgia.
- Centers for Disease Control and Prevention (CDC). (1994). *Addressing emerging infectious disease threats: A prevention strategy for the United States*. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service.
- Centers for Disease Control and Prevention (CDC). (1999). Achievements in public health, 1900–1999: Impact of vaccines universally recommended for children, United States 1990–1998. *Morbidity and Mortality Weekly Report*, 48, 243–248. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service.
- Centers for Disease Control and Prevention (CDC). (2000). *What would happen if we stopped vaccinations?* Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service. Retrieved from the Internet on August 23, 2004, at www.cdc.gov/nip/publications/fs/gen/WhatIfStop.htm.
- Centers for Disease Control and Prevention (CDC). (2004). *Parents' guide to childhood immunization*. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service.
- Centers for Disease Control and Prevention (CDC). (2008). National Health and Nutrition Survey. Retrieved February 8, 2008, from http://www.cdc.gov/nchs/data/nhanes/survey_content_99_10.pdf
- Centers for Disease Control and Prevention (CDC). (2009a). HIV/AIDS Surveillance Report 2007 (Vol. 19). National Center for Chronic Disease Prevention and Health Promotion. Atlanta, Georgia.
- Centers for Disease Control and Prevention (CDC). (2009b). Health effects of cigarette smoking. Retrieved January 13, 2010, from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm
- Centers for Disease Control and Prevention (CDC). (2009c). Down syndrome. Retrieved June 19, 2010, from www.cdc.gov/ncbddd/birthdefects/DownSyndrome.htm
- Centers for Disease Control and Prevention (CDC). (2009d). Occupational violence. Retrieved August 9, 2010, from <http://www.cdc.gov/niosh/topics/violence>
- Centers for Disease Control and Prevention (CDC). (2010). HIV transmission. Divisions of HIV/AIDS Prevention. Retrieved from <http://www.cdc.gov/hiv/resources/qa/transmission.htm>
- Centers for Disease Control and Prevention (CDC). (2010). How tobacco smoke causes disease: The biology and behavioral basis for smoking-attributable disease: A report of the Surgeon General. Retrieved from the Internet March 27, 2013, from http://www.cdc.gov/tobacco/data_statistics/sgr/2010/index.htm
- Centers for Disease Control and Prevention (CDC). (2011). FastStats: Alcohol use. Retrieved from the Internet March 27, 2013, from <http://www.cdc.gov/nchs/faststats/alcohol.htm>
- Centers for Disease Control and Prevention (CDC). (2011). Vaccines & immunizations: Some common misconceptions. Retrieved April 26, 2013, from <http://www.cdc.gov/vaccines/vac-gen/6mishome.htm>
- Centers for Disease Control and Prevention (CDC). (2013). HIV basics: HIV transmission. Divisions of HIV/AIDS Prevention. Retrieved from <http://www.cdc.gov/hiv/basics/transmission.html>
- Centers for Disease Control and Prevention (CDC). (2013, February). *HIV Surveillance Report, 2011*. Divisions of HIV/AIDS Prevention, Centers for Disease Control and Prevention Retrieved from <http://www.cdc.gov/hiv/library/reports/surveillance/index.html>
- Centers for Disease Control and Prevention (CDC). (2013). Prevention benefits of HIV treatment. Retrieved May 14, 2013, from <http://www.cdc.gov/hiv/prevention/research/tap/index.html>
- Centers for Disease Control and Prevention (CDC). (2013). Vaccine safety: Addressing common concerns. Retrieved April 26, 2013, from <http://www.cdc.gov/vaccinesafety/Concerns/Index.html>
- Centerwall, B. S. (1989). Exposure to television as a risk factor for violence. *American Journal of Epidemiology*, 129, 643–652.
- Cepeda, N. J., Pashler, H., Vul, E., Wixted, J. T., & Rohrer, D. (2006). Distributed practice in verbal recall tasks: A review and quantitative synthesis. *Psychological Bulletin*, 132, 354–380.
- Cermak, L., & Craik, F. (1979). *Levels of processing in human memory*. Hillsdale, NJ: Erlbaum.
- Cha, J. H., & Nam, K. D. (1985). A test of Kelley's cube theory of attribution: A cross-cultural replication of McArthur's study. *Korean Social Science Journal*, 12, 151–180.
- Chaddock, L., Hillman, C. H., Buck, S. M., & Cohen, N. J. (2010). Aerobic fitness and executive control of relational memory in preadolescent children. *Medicine and Science in Sports and Exercise*. doi: 10.1249/MSS.0b013e3181e9af48
- Chandola, T., Britton, A., Brunner, E., Hemingway, H., Malik, M., Kumari, M., Badrick, E., Kivimaki, M., & Marmot, M. (2008). Work stress and coronary heart disease: What are the mechanisms? *European Heart Journal*, doi:10.1093/eurheartj/ehm584
- Chang, P. P., Ford, D. E., Meoni, L. A., Wang, N., & Klag, M. J. (2002). Anger in young men and subsequent premature cardiovascular disease: The precursors study. *Archives of Internal Medicine*, 162, 901–906.
- Chang, S. W., Gariépy, J. F., & Platt, M. L. (2013). Neuronal reference frames for social decisions in primate frontal cortex. *Nature Neuroscience*, 16, 243–250.
- Charlesworth, W. R., & Kreutzer, M. A. (1973). Facial expression of infants and children. In P. Ekman (Ed.), *Darwin and facial expression: A century of research in review*. New York: Academic.
- Chee, M. W. L., & Choo, W. C. (2004, April 24–May 1). Functional imaging of working memory following 24 hours of total sleep deprivation. *Program and abstracts of the 56th Annual Meeting of the American Academy of Neurology*. San Francisco.
- Chen, J. Y. (2007). Do Chinese and English speakers think about time differently? Failure of replicating Boroditsky (2001). *Cognition*, 104(2), 427–436.
- Chen, L. Y., Rex, C. S., Sanaiha, Y., Lynch, G., & Gall, C. M. (2010). Learning induces neurotrophin signaling at hippocampal synapses. *Proceedings of the National Academy of Sciences, USA* 107(15), 7030–7035.
- Chen, R., & Ende, N. (2000). The potential for the use of mononuclear cells from human umbilical cord blood in the treatment of amyotrophic lateral sclerosis in SOD1 mice. *Journal of Medicine*, 31, 21–31.
- Chen, Y., Huang, X., Zhang, Y.-W., Rockenstein, E., Bu, G., Golde, T. E., Masliah, E., & Xu, H. (2012). Alzheimer's -Secretase (BACE1) regulates the cAMP/PKA/CREB pathway independently of -Amyloid. *Journal of Neuroscience*, 32(33), 11390. doi: 10.1523/JNEUROSCI.0757-12.2012

- Cheng, H., Cao, Y., & Olson, L. (1996). Spinal cord repair in adult paraplegic rats: Partial restoration of hind limb function. *Science*, 273, 510–513.
- Cherry, E. C. (1953). Some experiments on the recognition of speech, with one and with two ears. *Journal of the Acoustical Society of America*, 25(5), 975–979.
- Cheryan, S., Plaut, V., Davis, P., & Steele, C. (2009). Ambient belonging: How stereotypical cues impact gender participation in computer science. *Journal of Personality and Social Psychology*, 97(6), 1045–1060.
- Chess, S., & Thomas, A. (1986). *Temperament in clinical practice*. New York: Guilford Press.
- Chesterton, L. S., Barlas, P., Foster, N. E., Baxter, G. D., & Wright, C. C. (2003). Gender differences in pressure pain threshold in healthy humans. *Pain*, 101, 259–266.
- Cheyne, J. A. (2003). Sleep paralysis and the structure of waking-nightmare hallucinations. *Dreaming*, 13(3), 163–179.
- Chidester, D. (2003). *Salvation and suicide: Jim Jones, the Peoples Temple, and Jonestown* (Rev. ed., pp. 1–51). Bloomington, IN: Indiana University Press.
- Chinn, A. B. & Trujillo, K. A. (1996). Drugs and the brain: A World Wide Web tutorial in neuropsychopharmacology. *Society for Neuroscience Abstracts*, 22, 246.
- Chirkov, V. I. (2009). A cross-cultural analysis of autonomy in education: A self-determination theory perspective. *Theory and Research in Education*, 7(2), 253–262.
- Chirkov, V. I., Lebedeva, N. M., Molodtsova, I., & Tatarko, A. (2011). Social capital, motivational autonomy, and health behavior: A comparative study of Canadian and Russian youth. In D. Chadee & A. Kosti (Eds.), *Social psychological dynamics* (pp. 211–241). Trinidad: University of West Indies Press.
- Chiu, C., Hong, Y., & Dweck, C. S. (1997). Lay dispositionism and implicit theories of personality. *Journal of Personality and Social Psychology*, 73, 19–30.
- Choca, J. P. (2013). *The Rorschach inkblot test: An interpretive guide for clinicians*. Washington, DC, US: American Psychological Association.
- Choi, I., & Nisbett, R. E. (1998). Situational salience and cultural differences in the correspondence bias and in the actor–observer bias. *Personality and Social Psychology Bulletin*, 24, 949–960.
- Choi, I., Nisbett, R. E., & Norenzayan, A. (1999). Causal attribution across cultures: Variation and universality. *Psychological Bulletin*, 125, 47–63.
- Chomsky, N. (1957). *Syntactic structures*. The Hague: Mouton.
- Chomsky, N. (1964). *Current issues in linguistic theory*. The Hague: Mouton.
- Chomsky, N. (1981). Principles and parameters in syntactic theory. In N. Hornstein & D. Lightfoot (Eds.), *Explanation in linguistics: The logical problem of language acquisition*. London: Longman.
- Chomsky, N. (1986). *Knowledge of language: Its nature, origin and use*. New York: Praeger.
- Chomsky, N. (2006). *Language and mind* (3rd ed.). New York: Cambridge University Press.
- Chomsky, N., Belletti, A., & Rizzi, L. (2002). *On nature and language*. New York: Cambridge University Press.
- Chou, S. Y., Grossman, M., & Saffer, H. (2004). An economic analysis of adult obesity: Results from the behavioral risk factor surveillance system. *Journal of Health Economics*, 23, 565–587.
- Christensen, A., Jacobson, N. S., & Babcock, J. C. (1995). Integrative behavioral couple therapy. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couple therapy* (pp. 31–64). New York: Norton.
- Chu, J. A., Frey, L. M., Ganzel, B. L., & Matthews, J. A. (1999). Memories of childhood abuse: Dissociation, amnesia, and corroboration. *American Journal of Psychiatry*, 156, 749–755.
- Chwalisz, K., Diener, E., & Gallagher, D. (1988). Autonomic arousal feedback and emotional experience: Evidence from the spinal cord injured. *Journal of Personality and Social Psychology*, 54, 820–828.
- Cialdini, R. B., & Goldstein, N. J. (2004). Social influence: Compliance and conformity. *Annual Review of Psychology*, 55, 591–621. doi: 10.1146/annurev.psych.55.090902.142015
- Cialdini, R. B., Trost, M. R., & Newsom, J. T. (1995). Preference for consistency: The development of a valid measure and the discovery of surprising behavioral implications. *Journal of Personality and Social Psychology*, 69, 318–328.
- Cialdini, R., Vincent, J., Lewis, S., Catalan, J., Wheeler, D., & Darby, B. (1975). Reciprocal concessions procedure for inducing compliance: The door-in-the-face technique. *Journal of Personality and Social Psychology*, 31, 206–215.
- Cialdini, R., Wosinska, W., Barrett, D., Butner, J., & Gornik-Durose, M. (1999). Compliance with a request in two cultures: The differential influence of social proof and commitment/consistency on collectivists and individualists. *Personality and Social Psychology Bulletin*, 25, 1242–1253.
- Ciardiello, A. (1998). Did you ask a good question today? Alternative cognitive and metacognitive strategies. *Journal of Adolescent & Adult Literacy*, 42, 210–219.
- Cinnirella, M., & Green, B. (2007). Does “cyber-conformity” vary cross-culturally? Exploring the effect of culture and communication medium on social conformity. *Computers in Human Behavior*, 23(4), 2011–2025.
- Cirelli, C. (2012). Brain plasticity, sleep and aging. *Gerontology*, 58, 441–445.
- Clancy, S. A., McNally, R. J., Schacter, D. L., Lenzenweger, M. F., & Pitman, R. K. (2002). Memory distortion in people reporting abduction by aliens. *Journal of Abnormal Psychology*, 111(3), 455–461.
- Clark, A. (1991). *Microcognition: Philosophy, cognitive science, and parallel distributed processing*. Cambridge, MA: MIT Press, reprint edition (1989).
- Clark, D. A., Beck, A. T., & Brown, G. (1989). Cognitive mediation in general psychiatric outpatients: A test of the content-specificity hypothesis. *Journal of Personality and Social Psychology*, 56, 958–964.
- Clark, D. A., Hollifield, M., Leahy, R. L., & Beck, J. S. (2009). Theory of cognitive therapy. In G. Gabbard, J. S. Beck, & J. Wright (Eds.), *Textbook of psychotherapeutic treatments in psychiatry*, pp. 165–200. Washington, DC: American Psychiatric Press.
- Clarke, A., Harvey, M. L., & Kane, D. J. (1999). *Attitudes and behavior: Are produce consumers influenced by eco-labels?* Paper presented at a National Conference on Eco-labels, “Making Change in the Marketplace,” October 22–23, 1998. Retrieved August 1, 2004, from <http://www.ssi.nrcs.usda.gov/ssienvpsy/nrcs/ecolabel.pdf>
- Clarke, A. R., Barry, R. J., McCarthy, R., Selikowitz, M., Johnstone, S. J., Hsu, C. I., et al. (2007). Coherence in children with Attention-Deficit/Hyperactivity Disorder and excess beta activity in their EEG. *Clinical Neurophysiology*, 118(7), 1472–1479.
- Clarke, J. (1994). Pieces of the puzzle: The jigsaw method. In S. Sharan (Ed.), *Handbook of cooperative learning methods* (pp. 34–50). Westport, CT: Greenwood Press.
- Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *American Journal of Psychiatry*, 164(6), 922–928.
- Coates, J. (1986). *Women, men, and language*. New York: Longman.
- Coccaro, E. F., & Kavoussi, R. J. (1996). Neurotransmitter correlates of impulsive aggression. In D. M. Stoff & R. B. Cairns (Eds.), *Aggression and violence* (pp. 67–86). Mahwah, NJ: Lawrence Erlbaum.
- Cohen, L. J. (1997). Rational drug use in the treatment of depression. *Pharmacotherapy*, 17, 45–61.
- Cohen, M. S., Chen, Y. Q., McCauley, M., Gamble, T., Hosseinipour, M. C., Kumarasamy, N., Hakim, J. G., Kumwenda, J., Grinsztejn, B., Pilotto, J. H., Godbole, S. V., Mehendale, S., Chariyalertsak, S., Santos, B. R., Mayer, K. H., Hoffman, I. F., Eshleman, S. H., Piwowar-Manning, E., Wang, L., Makhema, J., Mills, L. A., de Bruyn, G., Sanne, L., Eron, J., Gallant, J., Havlir, D., Swindells, S., Ribaudo, H., Elharrar, V., Burns, D., Taha, T. E., Nielsen-Saines, K., Celentano, D., Essex, M., & Fleming, T. R. (2011). Prevention of HIV-1 infection with early antiretroviral therapy. *New England Journal of Medicine*, 365, 493–505.
- Cohen, N. J., Eichenbaum, R., Decedo, J. C., & Corkin, S. (1985). Preserved learning capacity in amnesia: Evidence for multiple memory systems. In L. S. Squire & N. Butters (Eds.), *Neuropsychology of memory*. New York: Guilford Press.
- Cohen, S., Frank, E., Doyle, B. J., Skoner, D. P., Rabin, B. S., & Gwaltney, J. M. (1998). Types of stressors that increase susceptibility to the common cold. *Health Psychology*, 17, 214–223.
- Cohen, S., & Herbert, T. B. (1996). Health psychology: Psychological factors and physical disease from the perspective of human psychoneuroimmunology. *Annual Review of Psychology*, 47, 113–142.
- Cohen, S., Janicki-Deverts, D., & Miller, G. E. (2007). Psychological stress and disease. *Journal of the American Medical Association*, 298(14), 1685–1687.
- Coker, T., Austin, S., & Schuster, M. (2009). The health and health care of lesbian, gay, and bisexual adolescents. *Annual Review of Public Health*, 31, 457–477.
- Colcombe, S. J., Erickson, K. I., Raz, N., Webb, A. G., Cohen, N. J., McAuley, E., & Kramer, A. F. (2003). Aerobic fitness reduces brain tissue loss in aging humans. *Journal of Gerontology Series A: Biological Sciences and Medical Sciences*, 58, 176–180.
- Cole, S. W., Arevalo, J. M. G., Takahashi, R., Sloan, E. K., Lutgendorf, S. K., Sood, A. K., Sheridan, J. F., & Seeman, T. E. (2010). Computational identification of gene-social environment interaction at the human IL6 locus. *Proceedings of the National Academy of Sciences of the United States of America*. Retrieved September 27, 2010, from <http://www.pnas.org/content/107/12/5681.full>.

- Colligan, J. (1983). Musical creativity and social rules in four cultures. *Creative Child and Adult Quarterly*, 8, 39–44.
- Collignon, O., Girard, S., Gosselin, F., Saint-Amour, D., Lepore, F., & Lassonde, M. (2010). Women process multisensory emotion expressions more efficiently than men. *Neuropsychologia*, 48, 220–225.
- Collins, A. M., & Loftus, E. F. (1975). A spreading activation theory of semantic processing. *Psychological Review*, 82, 407–428.
- Collins, A. M., & Quillian, M. R. (1969). Retrieval time from semantic memory. *Journal of Verbal Learning and Verbal Behaviour*, 8, 240–247.
- Collins, C. J., Hanges, P. J., & Locke, E. A. (2004). The relationship of achievement motivation to entrepreneurial behavior: A meta-analysis. *Human Performance*, 17(1), 95–117.
- Colom, R., Shih, P. C., Flores-Mendoza, C., & Quiroga, M. A. (2006). The real relationship between short-term memory and working memory. *Memory*, 14(7), 804–813.
- Columbo, J., & Mitchell, D. W. (2009). Infant visual habituation. *Neurobiology of Learning and Memory*, 92(2), 225–234.
- Committee on Animal Research and Ethics. (2004). *Research with animals in psychology*. Retrieved October 12, 2004, from www.apa.org/science/animal2.html
- Cone-Wesson, B. (2005). Prenatal alcohol and cocaine exposure: Influences on cognition, speech, language, and hearing. *Journal of Communication Disorders*, 38(4), 279–302.
- Connor, S., Tenorio, G., Clandinin, M. T., & Sauv, Y. (2012). DHA supplementation enhances high-frequency, stimulation-induced synaptic transmission in mouse hippocampus. *Applied Physiology, Nutrition, and Metabolism*, 37(5), 880–887. doi: 10.1139/h2012-062
- Conrad, R., & Hull, A. J. (1964). Information, acoustic confusion, and memory span. *British Journal of Psychology*, 55, 429–432.
- Constantine, M. G., Alleyne, V. L., Caldwell, L. D., McRae, M. B., & Suzuki, M. B. (2005). Coping responses of Asian, Black, and Latino/Latina New York City residents following the September 11, 2001 terrorist attacks against the United States. *Cultural Diversity & Ethnic Minority*, 11, 293–308.
- Consumer Reports*. (1995, November). Mental health: Does psychotherapy help? 734–739.
- Conway, M. A., Cohen, G., & Stanhope, N. (1992). Very long-term memory for knowledge acquired at school and university. *Applied Cognitive Psychology*, 6, 467–482.
- Cook, M., & Mineka, S. (1989). Observational conditioning of fear to fear-relevant versus fear-irrelevant stimuli in rhesus monkeys. *Journal of Abnormal Psychology*, 98(4), 448–459.
- Coolidge, F. L. (2006). *Dream interpretation as a psychotherapeutic technique*. London: Radcliffe.
- Cooper, L. A., Gonzales, J. J., Gallo, J. J., Rost, K. M., Meredith, L. S., Rubenstein, L. V., Wang, N. Y., & Ford, D. E. (2003). The acceptability of treatment for depression among African-American, Hispanic, and White primary care patients. *Medical Care*, 41(4), 479–489.
- Corbetta, M., Kincade, M. J., Lewis, C., Snyder, A. Z., & Sapir, A. (2005). Neural basis and recovery of spatial attention deficits in spatial neglect. *Nature Neuroscience*, 8, 1603–1610.
- Cormier, J. F., & Thelen, M. H. (1998). Professional skepticism of multiple personality disorder. *Professional Psychology: Research and Practice*, 29, 163–167.
- Corr, C. A. (1993). Coping with dying: Lessons that we should and should not learn from the works of Elisabeth Kübler-Ross. *Death Studies*, 17, 69–83.
- Cosgrove, G. R., & Rauch, S. L. (1995). Psychosurgery. *Neurosurgery Clinics of North America*, 6, 167–176.
- Cosmides, L., & Tooby, J. (2013). Evolutionary psychology: New perspectives on cognition and motivation. *Annual Review of Psychology*, 64, 201–229.
- Costa, P. T., Jr., & McCrae, R. R. (2000). The Revised NEO Personality Inventory (NEO PI-R). In J. Cheek & E. M. Donahue (Eds.), *Handbook of personality inventories*. New York: Plenum.
- Costello, D. M., Swendsen, J., Rose, J. S., & Dierker, L. C. (2008). Risk and protective factors associated with trajectories of depressed mood from adolescence to early adulthood. *Journal of Consulting and Clinical Psychology*, 76(2), 173–183.
- Couperus, J. W., & Nelson, C. A. (2006). Early brain development and plasticity. In K. McCartney & D. Phillips (Eds.), *The Blackwell handbook of early childhood development* (pp. 85–105). Oxford, UK: Blackwell Press.
- Courage, M. L., & Howe, M. L. (2002). From infant to child: The dynamics of cognitive change in the second year of life. *Psychological Bulletin*, 128, 250–277.
- Cowan, N. (1988). Evolving conceptions of memory storage, selective attention, and their mutual constraints within the human information processing system. *Psychological Bulletin*, 104, 163–191.
- Cowan, N. (2001). The magical number 4 in short-term memory: A reconsideration of mental storage capacity. *Behavioral and Brain Sciences*, 24, 97–185.
- Cowan, N., Elliott, E. M., Saults, J. S., Morey, C. C., Mattox, S., Hismajatullina, A., & Conway, A. R. A. (2005). On the capacity of attention: Its estimation and its role in working memory and cognitive aptitudes. *Cognitive Psychology*, 51(1), 42–100.
- Craddock, N., O'Donovan, M. C., & Owen, M. J. (2005). The genetics of schizophrenia and bipolar disorder: Dissecting psychosis. *Journal of Medical Genetics*, 42, 288–299.
- Crago, M. B., Shisslak, C. M., & Estes, L. S. (1996). Eating disturbances among American minority groups: A review. *International Journal of Eating Disorders*, 19, 239–248.
- Craik, F. I. M. (1970). The fate of primary memory items in free recall. *Journal of Verbal Learning and Verbal Behavior*, 9, 143–148.
- Craik, F. I. M. (1994). Memory changes in normal aging. *Current Directions in Psychological Science*, 3(5), 155–158.
- Craik, F. I. M., & Lockhart, R. S. (1972). Levels of processing: A framework for memory research. *Journal of Verbal Learning and Verbal Behaviour*, 11, 671–684.
- Craik, F. I. M., & Tulving, E. (1975). Depth of processing and the retention of words in episodic memory. *Journal of Experimental Psychology: General*, 104, 268–294.
- Craske, M. G., & Barlow, D. H. (2008). Panic disorder and agoraphobia. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (pp. 1–64). New York: Guilford Press.
- Crawford, M., & Unger, R. (2004). *Women and gender: A feminist psychology* (4th ed.). Boston: McGraw-Hill.
- Crick, F., & Koch, C. (1990). Towards a neurobiological theory of consciousness. *Seminars in the Neurosciences*, 2, 263–275.
- Crick, F., & Koch, C. (2003). A framework for consciousness. *Nature Neuroscience*, 6, 119–127.
- Cristancho, M. A., Helmer, A., Connolly, R., Cristancho, P., & O'Reardon, J. P. (2013). Transcranial magnetic stimulation maintenance as a substitute for maintenance electroconvulsive therapy: A case series. *J ECT*, 29(2), 106–108. doi: 10.1097/YCT.0b013e31827470ba
- Critchfield, T. S., Haley, R., Sabo, B., Colbert, J., & Macropoulis, G. (2003). A half century of scalloping in the work habits of the United States Congress. *Journal of Applied Behavior Analysis*, 36(4), 465–486.
- Crowley, A. E., & Hoyer, W. D. (1994). An integrative framework for understanding two-sided persuasion. *Journal of Consumer Research*, 20, 561–574.
- Csikszentmihalyi, M. (1996). *Creativity: Flow and the psychology of discovery and invention*. New York: Harper Perennial.
- Csikszentmihalyi, M. (1997). *Finding flow: The psychology of engagement with everyday life*. New York: Basic Books.
- Cua, A. B., Wilhelm, K. P., & Maibach, H. I. (1990). Elastic properties of human skin: Relation to age, sex and anatomical region. *Archives of Dermatology Research*, 282, 283–288.
- Culbertson, F. (2003). *The phobia list*. Retrieved June 22, 2004, from www.phobalist.com
- Cummings, J. L., & Coffey, C. E. (1994). Neurobiological basis of behavior. In C. E. Coffey & J. L. Cummings (Eds.), *Textbook of geriatric neuropsychiatry* (pp. 72–96). Washington, DC: American Psychiatric Press.
- Cummings, S. R., & Melton, L. J., III. (2002). Epidemiology and outcomes of osteoporotic fractures. *Lancet*, 359(9319), 1761–1767.
- Curtis, R. C., & Miller, K. (1986). Believing another likes or dislikes you: Behaviors making the beliefs come true. *Journal of Personality and Social Psychology*, 51, 284–290.
- Curtis, R. H. (1993). *Great lives: Medicine*. New York: Charles Scribner's Sons Books for Young Readers.
- Czeisler, C. A. (1995). The effect of light on the human circadian pacemaker. In D. J. Chadwick & K. Ackrill (Eds.), *Circadian clocks and their adjustment* (pp. 254–302). West Sussex, England: John Wiley & Sons.
- Czeisler, C. A., Moore-Ede, M. C., & Coleman, R. M. (1982). Rotating shift work schedules that disrupt sleep are improved by applying circadian principles. *Science*, 217, 460–463.
- Czeisler, C. A., Weitzman, E. D., Moore-Ede, M. C., Zimmerman, J. C., & Knauer, R. S. (1980). Human sleep: Its duration and organization depend on its circadian phase. *Science*, 210, 1264–1267.

- Dabbs, J. M., Jr., Bernieri, F. J., Strong, R. K., Campo, R., & Milun, R. (2001). Going on stage: Testosterone in greetings and meetings. *Journal of Research in Personality*, 35, 27–40.
- Dalenberg, C. J. (1996). Accuracy, timing and circumstances of disclosure in therapy of recovered and continuous memories of abuse. *The Journal of Psychiatry and Law*, 24(2), 229–275.
- Dallman, M., Pecoraro, N., Akana, S., la Fleur, S. E., Gomez, F., Houshyar, H., Bell, M. E., Bhatnagar, S., Laugero, K. D., & Manalo, S. (2003). Chronic stress and obesity: A new view of “comfort food.” *Proceedings of the National Academy of Sciences, USA*, 100(20), 11696–11701.
- Daly, M., Wilson, M., & Weghorst, S. J. (1982). Male sexual jealousy. *Ethology and Sociobiology*, 3, 11–27.
- Damasio, H., Grabowski, T., Frank, R., Galaburda, A. M., & Damasio, A. R. (1994). The return of Phineas Gage: Clues about the brain from the skull of a famous patient. *Science*, 264, 1102–1105.
- Dani, J., Burrill, C., & Demmig-Adams, B. (2005). The remarkable role of nutrition in learning and behavior. *Nutrition & Food Science*, 35(4), 258–263.
- Darley, J. M., & Latané, B. (1968). Bystander intervention in emergencies: Diffusion of responsibility. *Journal of Personality and Social Psychology*, 8, 377–383.
- Darvill, T., Lonky, E., Reihman, J., Stewart, P., & Pagano, J. (2000). Prenatal exposure to PCBs and infant performance on the Fagan test of infant intelligence. *Neurotoxicology*, 21(6), 1029–1038.
- Darwin, C. (1859). *The origin of species by means of natural selection*. London: John Murray.
- Darwin, C. (1898). *The expression of the emotions in man and animals*. New York: D. Appleton.
- Daum, I., & Schugens, M. M. (1996). On the cerebellum and classical conditioning. *Current Directions in Psychological Science*, 5, 58–61.
- Davidson, R. J. (2003). Affective neuroscience and psychophysiology: Toward a synthesis. *Psychophysiology*, 40(5), 655–665.
- Davidson, R. J., Kabat-Zinn, J., Schumacher, J., Rosenkranz, M., Muller, D., Santorelli, S., Urbanowski, F., Harrington, A., Bonus, K. & Sheridan, J. (2003). Alterations in brain and immune function produced by mindfulness meditation. *Psychosomatic Medicine*, 65, 564–570.
- Davidson, R. J., Putman, K. M., & Larson, C. L. (2000). Dysfunction in the neural circuitry of emotion regulation—A possible prelude to violence. *Science*, 289, 591–594.
- Davies, I. R. L., Laws, G., Corbett, G. G., & Jerrett, D. J. (1998a). Cross-cultural differences in colour vision: Acquired “colour blindness” in Africa. *Personality and Individual Differences*, 25, 1153–1162.
- Davies, I. R. L., Sowden, P., Jerrett, D. T., Jerrett, T., & Corbett, G. G. (1998b). A cross-cultural study of English and Setswana speakers on a colour triads task: A test of the Sapir-Whorf hypothesis. *British Journal of Psychology*, 89, 1–15.
- Davis, C. J., Harding, J. W., & Wright, J. W. (2003). REM sleep deprivation induced deficits in the latency-to-peak induction and maintenance of longterm potentiation within the CA1 region of hippocampus. *Brain Research*, 973, 293–297.
- Davis, H. A., DiStefano, C., & Schutz, P. A. (2008). Identifying patterns of appraising tests in first-year college students: Implications for anxiety and emotion regulation during test taking. *Journal of Educational Psychology*, 100(4), 942–960. doi: 10.1037/a0013096
- Davis, J. O., Phelps, J. A., & Bracha, H. S. (1995). Prenatal development of monozygotic twins and concordance for schizophrenia. *Schizophrenia Bulletin*, 21, 357–366.
- Davis, K. F., Parker, K. P., & Montgomery, G. (2004). Sleep in infants and young children: Part 1: Normal sleep. *Journal of Pediatric Healthcare*, 18(2), 65–71.
- Davis, M., & Whalen, P. J. (2001). The amygdala: Vigilance and emotion. *Molecular Psychiatry*, 6, 13–34.
- Davis, O. S. P., Haworth, C. M. A., Lewis, C. M., & Plomin, R. (2012). Visual analysis of geocoded twin data puts nature and nurture on the map. *Molecular Psychiatry*, 17, 867–874. doi: 10.1038/mp.2012.68
- Dawood, K., Pillard, R. C., Horvath, C., Revelle, W., & Bailey, J. M. (2000). Familial aspects of male homosexuality. *Archives of Sexual Behavior*, 29(2).
- Dean, G., & Kelly, I. W. (2000). Does astrology work? Astrology and skepticism 1975–2000. In P. Kurtz (Ed.), *Skepticism: A 25 Year Retrospective* (pp. 191–207). Amherst, NY: Prometheus Books.
- Dębiec, J., Diaz-Mataix, L., Bush, D. E. A., Doyère, V., & LeDoux, J. E. (2010). The amygdala encodes specific sensory features of an aversive reinforcer. *Nature Neuroscience*, 13, 536–537.
- DeCasper, A. J., & Fifer, W. P. (1980). Of human bonding: Newborns prefer their mothers' voices. *Science*, 208, 1174–1176.
- DeCasper, A. J., & Spence, M. J. (1986). Prenatal maternal speech influence on newborns' perception of sounds. *Infant Behaviour and Development*, 9, 133–150.
- deCharms, R. (1968). *Personal causation*. New York: Academic Press.
- Deci, E. L., Eghrari, H., Patrick, B. C., & Leone, D. R. (1994). Facilitating internalization: The self-determination theory perspective. *Journal of Personality*, 62, 119–142.
- Deci, E. L., Koestner, R., & Ryan, R. M. (1999). A meta-analytic review of experiments examining the effects of extrinsic rewards on intrinsic motivation. *Psychological Bulletin*, 125, 627–668.
- Deci, E. L., & Ryan, R. M. (1985). *Intrinsic motivation and self-determination in human behavior*. New York: Plenum.
- DeCoster, J., & Claypool, H. M. (2004). A meta-analysis of priming effects on impression formation supporting a general model of informational biases. *Personality and Social Psychology Review*, 8(1), 2–27.
- Deger, M., Helias, M., Rotter, S., & Diesmann, M. (2012). Spike-timing dependence of structural plasticity explains cooperative synapse formation in the neocortex. *PLoS Computational Biology*, 8(9), e1002689. doi: 10.1371/journal.pcbi.1002689
- DeGrandpre, R. J. (2000). A science of meaning: Can behaviorism bring meaning to psychological science? *American Psychologist*, 55, 721–739.
- Deinzer, R., Kleineidam, C. H., Winkler, R., Idel, H., & Bachg, D. (2000). Prolonged reduction of salivary immunoglobulin A (slgA) after a major academic exam. *International Journal of Psychophysiology*, 37, 219–232.
- de Jongh, A., Ernst, R., Marques, L., & Hornsveld, H. (2013). The impact of eye movements and tones on disturbing memories involving PTSD and other mental disorders. *Journal of Behavior Therapy and Experimental Psychiatry*, 44(4), 477–483. doi: 10.1016/j.jbtep.2013.07.002
- Delagrange, P., & Guardiola-Lemaitre, B. (1997). Melatonin, its receptors, and relationships with biological rhythm disorders. *Clinical Neuropharmacology*, 20, 482–510.
- Delaney, A. J., Crane, J. W., & Sah, P. (2007). Noradrenaline modulates transmission at a central synapse by a presynaptic mechanism. *Neuron*, 56(6), 880–892.
- Delfiner, R. (2001, November 16). “Kitty Left at Death’s Door.” *New York Post*.
- DeLongis, A., Lazarus, R. S., & Folkman, S. (1988). The impact of daily stress on health and mood: Psychological and social resources as mediators. *Journal of Personality and Social Psychology*, 54(3), 486–495.
- Dement, W. C. (1960). The effect of dream deprivation. *Science*, 131, 1705–1707.
- Dement, W. C., Henry, P., Cohen, H., & Ferguson, J. (1969). Studies on the effect of REM deprivation in humans and animals. In K. H. Pribram (Ed.), *Mood, states, and mind*. Baltimore: Penguin.
- Demers, R. A. (1988). Linguistics and animal communication. In F. J. Newmeyer (Ed.), *Language form and language function* (pp. 314–335). Cambridge, MA: MIT Press.
- Dempster, F. N., & Farris, R. (1990). The spacing effect: Research and practice. *Journal of Research and Development in Education* 23(2), 97–101.
- Deng, L. X., Deng, P., Ruan, Y., Xu, Z. C., Liu, N. K., Wen, X., ... Xu, X. M. (2013). A novel growth-promoting pathway formed by GDNF-overexpressing Schwann cells promotes propriospinal axonal regeneration, synapse formation, and partial recovery of function after spinal cord injury. *The Journal of Neuroscience*, 33(13), 5655–5667. doi: 10.1523/jneurosci.2973-12.2013
- Dennett, D. C. (1991). *Consciousness explained*. New York: Little, Brown.
- Deno, D. W. (2002). Crime and consciousness: Science and involuntary acts. *Minnesota Law Review*, 87, 269–399.
- Deregowski, J. B. (1969). Perception of the two-pronged trident by two- and three-dimensional perceivers. *Journal of Experimental Psychology*, 82, 9–13.
- DeRubeis, R. J., Gelfand, L. A., Tang, T. Z., & Simons, A. D. (1999). Medications versus cognitive behavior therapy for severely depressed outpatients: Meta-analysis of four randomized comparisons. *American Journal of Psychiatry*, 156(7), 1007–1013.
- De Valois, R. L., & Jacobs, G. H. (1968). Primate color vision. *Science*, 162, 553–540.
- Dew, M. A., Whyte, E. M., Lenze, E. J., Houck, P. R., Mulsant, B. H., Pollock, B. G., Stack, J. A., Bensasi, S., & Reynolds, C. F. (2007). Recovery from major depression in older adults receiving augmentation of antidepressant pharmacotherapy. *American Journal of Psychiatry*, 164(6), 892–899.
- DeYoung, C. G., Hirsh, J. B., Shane, M. S., Papademetris, X., Rajeevan, N., & Gray, J. R. (2010). Testing predictions from personality neuroscience: Brain structure and the Big Five. *Psychological Science*, 21(6), 820–828.

- Diamond, L. M. (2003). What does sexual orientation orient? A biobehavioral model distinguishing romantic love and sexual desire. *Psychological Review*, 110, 173–192.
- Diamond, M. (1995). Biological aspects of sexual orientation and identity. In L. Diamond & R. McAnulty (Eds.), *The psychology of sexual orientation, behavior, and identity: A handbook* (pp. 45–80). Westport, CT: Greenwood Press.
- Diamond, M. C. (1991). Hormonal effects on the development of cerebral lateralization. *Psychoneuroendocrinology*, 16, 121–129.
- Diamond, M., & Sigmundson, H. K. (1997). Sex reassignment at birth. Long-term review and clinical implications. *Archives of Pediatric Adolescent Medicine*, 151(3), 298–304.
- DiazGranados, N., Ibrahim, L. A., Brutsche, N. E., Ameli, R., Henter, I. D., Luckenbaugh, D. A., ... Zarate, C. A., Jr. (2010). Rapid resolution of suicidal ideation after a single infusion of an N-methyl-D-aspartate antagonist in patients with treatment-resistant major depressive disorder. *The Journal of Clinical Psychiatry*, 71(12), 1605–1611. doi: 10.4088/JCP.09m05327blu
- DiazGranados, N., Ibrahim, L., Brutsche, N. E., Newberg, A., Kronstein, P., Khalife, S., ... Zarate, C. A., Jr. (2010). A randomized add-on trial of an N-methyl-D-aspartate antagonist in treatment-resistant bipolar depression. *Archives of General Psychiatry*, 67(8), 793–802. doi: 10.1001/archgenpsychiatry.2010.90
- Dickens, W. T., & Flynn, J. R. (2001 April). Heritability estimates vs. large environmental effects: The IQ paradox resolved. *Psychological Review*, 108(2), 346–369.
- Dickerson, F., Ringel, N., Parente, F., & Boronow, J. (1994). Seclusion and restraint, assaultiveness, and patient performance in a token economy. *Hospital and Community Psychiatry*, 45, 168–170.
- Dieffenbach, C. W., & Fauci, A. S. (2011). Thirty years of HIV and AIDS: Future challenges and opportunities. *Annals of Internal Medicine*, 11(154), 766–771.
- Diener, E., Lusk, R., DeFour, D., & Flax, R. (1980). Deindividuation: Effects of group size, density, number of observers, and group member similarity on self-consciousness and disinhibited behavior. *Journal of Personality and Social Psychology*, 39, 449–459.
- Dillard, J. (1990). Self-inference and the foot-in-the-door technique: Quantity of behavior and attitudinal mediation. *Human Communication Research*, 16, 422–447.
- Dillard, J. (1991). The current status of research on sequential-request compliance techniques. *Personality and Social Psychology Bulletin*, 17, 282–288.
- Dinges, D. F. (1995). An overview of sleepiness and accidents. *Journal of Sleep Research*, 4(2), 4–14.
- Dobson, K. S., & Block, L. (1988). Historical and philosophical bases of the cognitive-behavioral therapies. In K. S. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (pp. 3–38). New York: Guilford Press.
- Dodge, K. A., Bates, J. E., & Pettit, G. S. (1990). Mechanisms in the cycle of violence. *Science*, 250, 1678–1683.
- Dolan, K., Kite, B., Black, E., Aceijas, C., & Stimson, G. V. (2007). HIV in prison in low-income and middle-income countries. *The Lancet: Infectious Diseases*, 7(1), 32–41.
- Dolcos, F., LaBar, K. S., Cabeza, R., & Purves, D. (2005). Remembering one year later: Role of the amygdala and the medial temporal lobe memory system in retrieving emotional memories. *Proceedings of the National Academy of Sciences, USA*. doi: 10.1073/pnas.0409848102
- Dollard, J., Doob, L. W., Miller, N. E., Mowrer, O. H., & Sears, R. R. (1939). *Frustration and aggression*. New Haven, CT: Yale University Press.
- Dollard, J., & Miller, N. F. (1950). *Personality and psychotherapy*. New York: McGraw-Hill.
- Domagalski, T. A., & Steelman, L. A. (2007). The impact of gender and organizational status on workplace anger expression. *Management Communication Quarterly*, 20(3), 297–315.
- Domhoff, G. W. (1996). *Finding meaning in dreams: A quantitative approach*. New York: Plenum Publishing.
- Domhoff, G. W. (2005). The content of dreams: Methodologic and theoretical implications. In M. Kryger, T. Roth, & W. Dement (Eds.), *Principles and practices of sleep medicine* (4th ed., pp. 522–534). Philadelphia: Saunders.
- Domhoff, G. W., & Schneider, A. (2008). Similarities and differences in dream content at the cross-cultural, gender, and individual levels. *Consciousness and Cognition*, 17, 1257–1265.
- Dominey, P. F., & Dodane, C. (2004). Indeterminacy in language acquisition: The role of child-directed speech and joint attention. *Journal of Neurolinguistics*, 17(2–3), 121–145.
- Domjan, M., Cusato, B., & Villarreal, R. (2000). Pavlovian feed-forward mechanisms in the control of social behavior. *Behavioral and Brain Sciences*, 23, 235–282.
- Donaldson, Z. R., & Young, L. J. (2008). Oxytocin, vasopressin, and the neurogenetics of sociality. *Science*, 322(5903), 900–904. doi: 10.1126/science.1158668
- Donohue, S. E., James, B., Eslick, A. N., & Mitroff, S. R. (2012). Cognitive pitfall! Videogame players are not immune to dual-task costs. *Attention, Perception, & Psychophysics*. doi: 10.3758/s13414-012-0323-y
- Donovan, J. J., & Radosevich, D. R. (1999). A meta-analytic review of the distribution of practice effect: Now you see it, now you don't. *Journal of Applied Psychology*, 84, 795–805.
- Dorahy, M. J. (2001). Dissociative identity disorder and memory dysfunction: The current state of experimental research and its future directions. *Clinical Psychology Review*, 21(5), 771–795.
- Dougherty, D. D., Baer, L., Cosgrove, G. R., Cassem, E. H., Price, B. H., Nierenberg, A. A., Jenike, M. A., & Rauch, S. L. (2002). Prospective long-term follow-up of 44 patients who received cingulotomy for treatment-refractory obsessive-compulsive disorder. *The American Journal of Psychiatry*, 159(2), 269–275.
- Dove, A. (1971). The "Chitling" Test. In L. R. Aiken Jr. (Ed.), *Psychological and educational testings*. Boston: Allyn and Bacon.
- Downs, J. F. (1984). *The Navajo* (p. 108). Prospect Heights, IL: Waveland Press, International.
- Dreger, A. D. (1998). "Ambiguous sex"—or ambivalent medicine? Ethical issues in the treatment of intersexuality. *Hastings Center Report*, 28(3), 24–35.
- Dreger, A. D. (1999). *Intersex in the age of ethics*. Hagerstown, MD: University Publishing Groups.
- Drenth, P. J., Thierry, H., Willems, P. J., & de Wolff, C. J. (1984). *Handbook of work and organizational psychology*. Chichester, England: John Wiley and Sons.
- Druckman, D., & Bjork, R. A. (Eds.). (1994). *Learning, remembering, believing: Enhancing human performance*. (Study conducted by the National Research Council). Washington, DC: National Academy Press.
- Duben, A., & Behar, C. (1991). *Istanbul households: Marriage, family and fertility 1880–1940*. Cambridge, NY: Cambridge University Press.
- Dubowitz, H., & Bennett, S. (2007). Physical abuse and neglect of children. *Lancet*, 369(9576), 1891–1899.
- Duckworth, A. L., Quinn, P. D., Lynam, D. R., Loeber, R., & Stouthamer-Loeber, M. (2011). Role of test motivation in intelligence testing. *Proceedings of the National Academy of Sciences*, 108(19), 7716–7720. doi: 10.1073/pnas.1018601108
- Duckworth, A. L., & Seligman, M. E. P. (2005). Self-discipline outdoes IQ in predicting academic performance of adolescents. *Psychological Science*, 16(12), 939–944. doi: 10.1111/j.1467-9280.2005.01641.x
- Dudai, Y. (2004). The neurobiology of consolidations, or, how stable is the engram? *Annual Review of Psychology*, 55, 51–86.
- Duker, P. C., & Seys, D. M. (1996). Long-term use of electrical aversion treatment with self-injurious behaviors. *Research in Developmental Disabilities*, 17, 293–301.
- Duman, R. S., & Aghajanian, G. K. (2012). Synaptic dysfunction in depression: Potential therapeutic targets. *Science*, 338(6103), 68–72. doi: 10.1126/science.1222939
- Dumont, F. (2010). *A history of personality psychology*. New York: Cambridge University Press.
- Duncan, R. M. (1995). Piaget and Vygotsky revisited: Dialogue or assimilation? *Developmental Review*, 15, 458–472.
- Dundas, I., Wormnes, B. R., & Hauge, H. (2009). Making exams a manageable task. *Nordic Psychology*, 61(1), 26–41.
- Dunn, J. C., Whelton, W. J., & Sharpe, D. (2006). Maladaptive perfectionism, hassles, coping, and psychological distress in university professors. *Journal of Counseling Psychology*, 53(4), 511–523.
- Dunn, R. S., Beaudry, J. S., & Klavas, A. (1989). Survey of research on learning styles. *Educational Leadership*, 46(6), 50–58.
- Dunn, R. S., Denig, S. J., & Lovelace, M. K. (2001). Two sides of the same coin or different strokes for different folks? *Teacher Librarian*, 28(3), 9–16.
- Durrant, J., & Ensom, R. (2012). Physical punishment of children: Lessons from 20 years of research. *Canadian Medical Association Journal*, 184(12), 1373–1377. doi: 10.1503/cmaj.101314
- Durrant, M. (Ed.). (1993). *Aristotle's De anima in focus*. London: Routledge.
- Durso, F., Rea, C., & Dayton, T. (1994). Graph-theoretic confirmation of restructuring during insight. *Psychological Science*, 5, 94–98.
- Durston, S. (2003). A review of the biological bases of ADHD: What have we learned from imaging studies? *Mental Retardation and Developmental Disabilities Research Reviews*, 9, 184–195.

- Dwairy, M. (2004). Parenting styles and mental health of Palestinian-Arab adolescents in Israel. *Transcultural Psychiatry*, 41(2), 233–252.
- Dweck, C. (1986). Motivational processes affecting learning. *American Psychologist*, 41(10), 1040–1048.
- Dweck, C., & Elliott, E. (1983). Achievement motivation. In P. Mussen (Ed.), *Handbook of child psychology: Vol. 4. Socialization, personality, and social development* (pp. 643–691). New York: Wiley.
- Dweck, C. S. (1999). *Self-theories: Their role in motivation, personality and development*. Philadelphia: Psychology Press.
- Dweck, C. S., Chiu, C., & Hong, Y. (1995). Implicit theories and their role in judgments and reactions: A world from two perspectives. *Psychological Inquiry*, 6, 267–285.
- Dweck, C. S., & Leggett, E. L. (1988). A social-cognitive approach to motivation and personality. *Psychological Review*, 95, 256–273.
- Dweck, C. S., & Molden, D. C. (2008). Self-theories: The construction of free will. In J. Baer, J. C. Kaufman, & R. F. Baumeister (Eds.), *Are we free? Psychology and free will* (pp. 44–64). New York: Oxford University Press.
- Dykens, E. M., Hodapp, R. M., & Leckman, J. F. (1994). *Behavior and development in fragile X syndrome*. Thousand Oaks, CA: Sage.
- Eagleman, D. M. (2001). Visual illusions and neurobiology. *Nature reviews: Neuroscience*, 2(12), 920–926.
- Eagly, A., & Chaiken, S. (1975). An attribution analysis of the effect of communicator characteristics on opinion change: The case of communicator attractiveness. *Journal of Personality and Social Psychology*, 37, 136–144.
- Eagly, A., & Crowley, M. (1986). Gender and helping behavior: A meta-analytic review of the social psychological literature. *Psychological Bulletin*, 100, 283–308.
- Eagly, A. H. (1987). *Sex difference in social behavior: A social-role interpretation*. Hillsdale, NJ: Lawrence Erlbaum.
- Eagly, A. H., Ashmore, R. D., Makhijani, M. G., & Longo, L. C. (1991). What is beautiful is good, but ... : A meta-analytic review of the physical attractiveness stereotype. *Psychological Bulletin*, 110, 109–128.
- Eagly, A. H., & Carli, L. L. (2007). *Through the labyrinth: The truth about how women become leaders*, pp. 119–136. Boston: Harvard Business School Press.
- Eagly, A. H., & Chaiken, S. (1993). *The psychology of attitudes*. Fort Worth, TX: Harcourt Brace.
- Eagly, A. H., & Chaiken, S. (1998). Attitude structure and function. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *The handbook of social psychology* (4th ed., pp. 269–322). New York: McGraw-Hill.
- Eagly, A. H., Wood, W., & Diekman, A. B. (2000). Social role theory of sex differences and similarities: A current appraisal. In T. Eckes & H. M. Trautner (Eds.), *The developmental social psychology of gender* (pp. 123–174). Mahwah, NJ: Lawrence Erlbaum.
- Eaker, E. D., & Castelli, W. P. (1988). Type A behavior and mortality from coronary disease in the Framingham Study. *New England Journal of Medicine*, 319, 1480–1481.
- Eastern Virginia Medical School (2009, May 5). Texting while driving can be deadly, study shows. *ScienceDaily*. Retrieved May 5, 2010, from <http://www.sciencedaily.com/releases/2009/05/090504094434.htm>
- Eaton, W. W., Kessler, R. C., Wittchen, H. U., & Magee, W. J. (1994). Panic and panic disorder in the United States. *American Journal of Psychiatry* 151(3), 413–420.
- Ebbinghaus, H. (1885). *Memory: A contribution to experimental psychology*. New York: Dover Publications.
- Ebbinghaus, H. (1913). *Memory: A contribution to experimental psychology*. New York: Teachers College Press. (Translated from the 1885 German original.)
- Eddy, J., Fitzhugh, E., & Wang, M. (2000). Smoking acquisition: Peer influence and self-selection. *Psychological Reports*, 86, 1241–1246.
- Edelmann, R. J., & Iwawaki, S. (1987). Self-reported expression of embarrassment in five European cultures. *Psychologia: An International Journal of Psychology*, 30, 205–216.
- Edlund, J. E., Heider, J. D., Scherer, C. R., Farc, M.-M., & Sagarin, B. J. (2006). Sex differences in jealousy in response to actual infidelity. *Evolutionary Psychology*, 4, 462–470.
- Egan, L. C., Bloom, P., & Santos, L. R. (2010). Choice-induced preferences in the absence of choice: Evidence from a blind two choice paradigm with young children and capuchin monkeys. *Journal of Experimental Social Psychology*, 46(1), 204–207.
- Egan, L. C., Santos, L. R., & Bloom, P. (2007). The origins of cognitive dissonance. Evidence from children and monkeys. *Psychological Science*, 18(11), 978–983.
- Ehlers, A., Bisson, J., Clark, D. M., Creamer, M., Pilling, S., Richards, D., Schnurr, P. P., Turner, S., & Yule, W. (2010). Do all psychological treatments really work the same in posttraumatic stress disorder? *Clinical Psychology Review*, 30(2), 269–276.
- Eich, E., & Metcalfe, J. (1989). Mood dependent memory for internal vs. external events. *Journal of Experimental Psychology: Learning, Memory and Cognition*, 15, 443–455.
- Eiden, R. D., McAuliffe, S., Kachadourian, L., Coles, C., Colder, C., & Schuetze, P. (2009). Effects of prenatal cocaine exposure on infant reactivity and regulation. *Neurotoxicology and Teratology*, 31, 60–68.
- Ekman, P. (1973). Darwin and cross-cultural studies of facial expression. In P. Ekman (Ed.), *Darwin and facial expression: A century of research in review*. New York: Academic Press.
- Ekman, P. (1980). Asymmetry in facial expression. *Science*, 209, 833–834.
- Ekman, P., & Friesen, W. (1969). The repertoire of nonverbal behavior: Categories, origins, usage, and coding. *Semiotica*, 1, 49–98.
- Ekman, P., & Friesen, W. (1971). Constants across cultures in the face and emotion. *Journal of Personality and Social Psychology*, 17(2), 124–129.
- Ekman, P., & Friesen, W. V. (1978). *The facial action coding system*. Palo Alto, CA: Consulting Psychologists Press.
- Ekman, P., Sorenson, E. R., & Friesen, W. V. (1969). Pan-cultural elements in facial displays of emotion. *Science*, 164, 86–88.
- Elkind, D. (1985). Egocentrism redux. *Developmental Review*, 5, 218–226.
- Ellenbogen, J. M., Payne, J. D., & Stickgold, R. (2006). The role of sleep in declarative memory consolidation: Passive, permissive, active or none? *Current Opinions in Neurobiology*, 16, 716–722.
- Elliott, E., & Dweck, C. (1988). Goals: An approach to motivation and achievement. *Journal of Personality and Social Psychology*, 54, 5–12.
- Elliott, L., & Brantley, C. (1997). *Sex on campus: The naked truth about the real sex lives of college students*. New York: Random House.
- Ellis, A. (1997). *The practice of rational emotive behavior therapy*. New York: Springer.
- Ellis, A. (1998). *The Albert Ellis reader: A guide to well-being using rational emotive behavior therapy*. Secaucus, NJ: Carol Publishing Group.
- Ellis, H. D. (1983). The role of the right hemisphere in face perception. In A. W. Young (Ed.), *Functions of the right cerebral hemisphere* (pp. 33–64). London: Academic Press.
- Ellis, L., Ames, M. A., Peckham, W., & Burke, D. (1988). Sexual orientation of human offspring may be altered by severe maternal stress during pregnancy. *The Journal of Sex Research*, 25, 152–157.
- Ellis, L. K., Gay, P. E., & Paige, E. (2001). Daily pleasures and hassles across the lifespan. Poster presented at the September annual meeting of the American Psychological Association, San Francisco.
- Elmenhorst, D., Kroll, T., Matusch, A., & Bauer, A. (2012). Sleep deprivation increases cerebral serotonin 2a receptor binding in humans. *Sleep*, 35(12), 1615–1623. doi: 10.5665/sleep.2230
- Else-Quest, N., Shibley Hyde, J., Linn, M. C. (2010). Cross-national patterns of gender differences in mathematics: A meta-analysis. *Psychological Bulletin*, 136(1), 103–127.
- Emeny, R. T., Lacruz, M-E., Baumert, J., Zierer, A., von Eisenhart Rothe, A., Autenrieth, C., Herder, C., Koenig, W., Thorand, B., & Ladwig, K-H. (2012). Job strain associated CRP is mediated by leisure time physical activity: Results from the MONICA/KORA study. *Brain, Behaviour and Immunity*, 26, 1077–1084.
- Emeny, R. T., Zierer, A., Lacruz, M-E., Baumert, J., Herder, C., Gornitzka, G., Koenig, W., Thorand, B., & Ladwig, K-H. (2013). Job strain-associated inflammatory burden and long-term risk of coronary events: Findings from the MONICA/KORA Augsburg case-cohort study. *Psychosomatic Medicine*, 75(3), 317–325.
- Endler, N. S. (1988). The origins of electroconvulsive therapy (ECT). *Convulsive Therapy*, 4, 5–23.
- Engle, R. W., & Kane, M. J. (2004). Executive attention, working memory capacity, and a two-factor theory of cognitive control. *The Psychology of Learning and Motivation*, 44, 145–199.
- Enns, J. T., & Coren, S. (1995). The box alignment illusion: An orientation illusion induced by pictorial depth. *Perception & Psychophysics*, 57, 1163–1174.
- Ephraim, P. L., Wegener, S. T., MacKenzie, E. J., Dillingham, T. R., & Pezzin, L. E. (2005). Phantom pain, residual limb pain and back pain in persons with limb loss: Results of a national survey. *Archives of Physical Medicine and Rehabilitation*, 86, 1910–1919.

- Epping-Jordan, M., Waltkis, S. S., Koob, G. F., & Markou, A. (1998). Dramatic decreases in brain reward function during nicotine withdrawal. *Nature*, 393, 76–79.
- Erdley, C. A., & Dweck, C. S. (1993). Children's implicit personality theories as predictors of their social judgments. *Child Development*, 64, 863–878.
- Erickson, K. I., Prakash, R. S., Voss, M. W., Chaddock, L., Hu, L., Morris, K. S., et al. (2009). Aerobic fitness is associated with hippocampal volume in elderly humans. *Hippocampus*, 19(10), 1030–1039.
- Erikson, E. (1980). Elements of a psychoanalytic theory of psychosocial development. In S. Greenspan & G. Pollock (Eds.), *The Course of Life, Vol. 1* (pp. 11–61). Washington, DC: U.S. Dept. of Health and Human Services.
- Erikson, E. H. (1950). *Childhood and society*. New York: Norton.
- Erikson, E. H. (1959). Growth and crises of the healthy personality. *Psychological Issues*, 1, 50–100.
- Erikson, E. H. (1982). *The life cycle completed*. New York: Norton.
- Erikson, E. H., & Erikson, J. M. (1997). *The life cycle completed*. New York: Norton.
- Eriksson, P., Ankarberg, E., Viberg, H., & Fredriksson, A. (2001). The developing cholinergic system as target for environmental toxicants, nicotine and polychlorinated biphenyls (PCBs): Implications for neurotoxicological processes in mice. *Neurotoxicity Research*, 3(1), 37–51.
- Escandon, A., Al-Hammadi, N., Galvin, J. E. (2010). Effect of cognitive fluctuation on neuropsychological performance in aging and dementia. *Neurology*, 74, 210–217.
- Eschenbeck, H., Kohlmann, C.-W., & Lohaus, A. (2008). Gender differences in coping strategies in children and adolescents. *Journal of Individual Differences*, 28(1), 18–26.
- Eskenazi, B., Bradman, A., & Castorina, R. (1999). Exposures of children to organophosphate pesticides and their potential adverse health effects. *Environmental Health Perspectives*, 107(Suppl. 3), 409–419.
- Ethen, M. K., Ramadhan, T. A., Scheuerle, A. E., Canfield, M. A., Wyszynski, D. F., Druschel, C. M., & Romitti, P. A. (2008). Alcohol consumption by women before and during pregnancy. *Maternal and Child Health Journal*, 13(2), 274–285. doi: 10.1007/s10995-008-0328-2
- Evans, D., Hodgkinson, B., O'Donnell, A., Nicholson, J., & Walsh, K. (2000). The effectiveness of individual therapy and group therapy in the treatment of schizophrenia. In *Best Practice*, 5(3), 1–54.
- Evans, I. M., & Meyer, L. H. (1985). *An educative approach to behavior problems: A practical decision model for interventions with severely handicapped learners*. Baltimore: Paul H. Brookes.
- Evans, W. H., Evans, S. S., & Schmid, R. E. (1989). *Behavior and instructional management: An ecological approach*. Boston: Allyn and Bacon.
- Everson, S. (1995). Psychology. In J. Barnes (Ed.), *The Cambridge companion to Aristotle* (pp. 168–194). Cambridge, England: Cambridge University Press.
- Exner, J. E. (1980). But it's only an inkblot. *Journal of Personality Assessment*, 44, 562–577.
- Eysenck, H. (1994a). *Test your IQ*. Toronto: Penguin Books.
- Eysenck, H. J. (1957). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, 16, 319–324.
- Eysenck, H. J. (1994b). Synergistic interaction between psychosocial and physical factors in the causation of lung cancer. In C. Lewis, C. O'Sullivan, & J. Barracough (Eds.), *The psychoimmunology of human cancer* (pp. 163–178). London: Oxford University Press.
- Eysenck, H. J., & Eysenck, S. B. G. (1993). *Eysenck Personality Questionnaire [Revised]*. London: Hodder & Stoughton Educational.
- Fagot, B. I., & Hagan, R. (1991). Observations of parent reactions to sex-stereotyped behaviours: Age and sex effects. *Child Development*, 62, 617–628.
- Fairchild, G., Van Goozen, S. H., Stollery, S. J., & Goodyer, I. M. (2008). Fear conditioning and affective modulation of the startle reflex in male adolescents with early-onset or adolescence-onset conduct disorder and healthy control subjects. *Biological Psychiatry* 63(3), 279–285.
- Fanselow, M. S., & Gale, G. D. (2003). The amygdala, fear, and memory. *Annals of the New York Academy of Sciences*, 985, 125–134.
- Fantz, R. L. (1961). The origin of form perception. *Scientific American*, 204, 66–72.
- Fantz, R. L. (1964). Visual experience in infants: Decreased attention to familiar patterns relative to novel ones. *Science*, 146, 668–670.
- Faraone, S. V., Biederman, J., & Wozniak, J. (2012). Examining the comorbidity between attention deficit hyperactivity disorder and bipolar I disorder: A meta-analysis of family genetic studies. *The American Journal of Psychiatry*, 169(12), 1256–1266. doi: 10.1176/appi.ajp.2012.12010087
- Farmer, A. E. (1996). The genetics of depressive disorders. *International Review of Psychiatry*, 8(4).
- Farmer, L. M., Le, B. N., & Nelson, D. J. (2013). CLC-3 chloride channels moderate long-term potentiation at Schaffer collateral-CA1 synapses. *The Journal of Physiology*, 591(Pt 4), 1001–1015. doi: 10.1113/jphysiol.2012.243485
- Farthing, W. (1992). *The psychology of consciousness*. Upper Saddle River, NJ: Prentice-Hall.
- Faucett, J., Gordon, N., & Levine, J. (1994). Differences in postoperative pain severity among four ethnic groups. *Journal of Pain Symptom Management*, 9, 383–389.
- Fawzy, F. I., Fawzy, N. W., Hyun, C. S., Elashoff, R., Guthrie, D., Fahey, J. L., & Morton, D. L. (1993). Malignant melanoma effects of an early structured psychiatric intervention, coping, and affective state on recurrence and survival 6 years later. *Archives of General Psychiatry*, 50(9), 681–689.
- Fazel-Rezai, R., & Peters, J. F. (2005). P300 wave feature extraction: Preliminary results, in *Proceedings of the 18th Annual Canadian Conference on Electrical and Computer Engineering (CCECE '05)*, pp. 390–393. Saskatoon, Saskatchewan, Canada.
- Fazio, R. H., & Olson, M. A. (2003). Attitudes: Foundations, functions, and consequences. In M. A. Hogg & J. Cooper (Eds.), *The Handbook of Social Psychology* (pp. 139–160). London: Sage.
- Fechner, G. T. (1860). *Elemente der Psychophysik*. Leipzig: Breitkopf und Härtel.
- Federal Service for Surveillance of Consumer Rights Protection and Human Well-Being of the Russian Federation and UNAIDS. (2008). *Country progress report of the Russian Federation on the implementation of the declaration of commitment on HIV/AIDS*. Adopted at the 26th United Nations General Assembly Special Session, June 2001. Moscow, Russia: UNAIDS.
- Fedoroff, I. C., & McFarlane, T. (1998). Cultural aspects of eating disorders. In S. S. Kazarian & D. R. Evans (Eds.), *Cultural clinical psychology: Theory, research and practice* (pp. 152–176). New York: Oxford University Press.
- Feingold, A. (1992). Good-looking people are not what we think. *Psychological Bulletin*, 111, 304–341.
- Felder, R. M., & Spurlin, J. E. (2005). Applications, reliability and validity of the index of learning styles. *International Journal of Engineering Education*, 21(1), 103–112.
- Feldman, D. H. (2003). Cognitive development in childhood. In R. M. Lerner, M. A. Easterbrooks et al. (Eds.), *Handbook of psychology: Developmental psychology: Vol. 6* (pp. 195–201). New York: Wiley.
- Ferguson, C., Rueda, S., Cruz, A., Ferguson, D., & Fritz, S. (2008). Violent video games and aggression: Causal relationship or byproduct of family violence and intrinsic violence motivation? *Criminal Justice and Behavior*, 35(3), 311–332.
- Ferguson, J. N., Aldag, J. M., Insel, T. R., & Young, L. J. (2001). Oxytocin in the medial amygdala is essential for social recognition in the mouse. *The Journal of Neuroscience*, 21(20), 8278–8285.
- Ferguson, N. B., & Keesey, R. E. (1975). Effect of a quinine-adulterated diet upon body weight maintenance in male rats with ventromedial hypothalamic lesions. *Journal of Comparative Physiological Psychology*, 89(5), 478–488.
- Ferguson-Noyes, N. (2005). Bipolar disorder in children. *Advanced Nurse Practitioner*, 13, 35.
- Fernald, A. (1984). The perceptual and affective salience of mothers' speech to infants. In L. Feagans, C. Garvey, & R. Golinkoff (Eds.), *The origins and growth of communication*. Norwood, NJ: Ablex.
- Fernald, A. (1992). Human maternal vocalizations to infants as biologically relevant signals: An evolutionary perspective. In J. H. Barkow, L. Cosmides, & J. Tooby (Eds.), *The adapted mind: Evolutionary psychology and the generation of culture*. New York: Oxford University Press.
- Fernandez, E., & Sheffield, J. (1996). Relative contributions of life events versus daily hassles to the frequency and intensity of headaches. *Headache*, 36(10), 595–602.
- Feroah, T. R., Sleeper, T., Brozoski, D., Forder, J., Rice, T. B., & Forster, H. V. (2004). *Circadian slow wave sleep and movement behavior are under genetic control in inbred strains of rat*. Paper presented at the American Physiological Society Annual Conference, April 17–21, 2004, Washington, DC.
- Ferron, F., Considine, R. V., Peino, R., Lado, I. G., Dieguez, C., & Casanueva, F. F. (1997). Serum leptin concentrations in patients with anorexia nervosa, bulimia nervosa and non-specific eating disorders correlate with the body mass index but are independent of the respective disease. *Clinical Endocrinology (Oxford)*, 46, 289–293.
- Feshbach, M. (2008, August 13). What's in a number? A new projection by Pokrovskiy's Center for HIV prevention and treatment and some consequences for Russia, Johnson's Russia List. Retrieved June 17, 2010, from <http://www.cdi.org/russia/johnson/2008-153-36.cfm>.

- Festinger, L. (1954). A theory of social comparison processes. *Human Relations*, 7, 117–140.
- Festinger, L. (1957). *A theory of cognitive dissonance*. Stanford, CA: Stanford University Press.
- Festinger, L., & Carlsmith, J. (1959). \$1/\$20 experiment: Cognitive consequences of forced compliance. *Journal of Abnormal and Social Psychology*, 58(2), 203–210.
- Fiatarone, M. (1996). Physical activity and functional independence in aging. *Research Quarterly for Exercise & Sport*, 67, 70–75.
- Fincham, F. D., Harold, G. T., & Gano-Phillips, S. (2000). The longitudinal association between attributions and marital satisfaction: Direction of effects and role of efficacy expectations. *Journal of Family Psychology*, 14, 267–285.
- Finger, S. (1994). *Origins of neuroscience: A history of explorations into brain function*. New York: Oxford University Press.
- Fink, M. (1984). Meduna and the origins of convulsive therapy. *American Journal of Psychiatry*, 141, 1034–1041.
- Finke, C., Esfahani, N. E., & Ploner, C. J. (2012). Preservation of musical memory in an amnesic professional cellist. *Current Biology*, 22(15), R59.
- Finke, R. (1995). Creative realism. In S. Smith, T. Ward & R. Finke (Eds.), *The creative cognition approach* (pp. 301–326). Cambridge, MA: Cambridge University Press.
- Finkel, D., & McGue, M. (1997). Sex differences and nonadditivity in heritability of the Multidimensional Personality Questionnaire scales. *Journal of Personality and Social Psychology*, 72, 929–938.
- Fischl, B., Liu, A., & Dale, A. M. (2001). Automated manifold surgery: Constructing geometrically accurate and topologically correct models of the human cerebral cortex. *IEEE Transactions on Medical Imaging*, 20, 70–80.
- Fisher, M., Holland, C., Merzenich, M. M., & Vinogradov, S. (2009). Using neuroplasticity-based auditory training to improve verbal memory in schizophrenia. *The American Journal of Psychiatry*, 166(7), 805–811.
- Fisher, R., Salanova, V., Witt, T., Worth, R., Henry, T., Gross, R., et al. (2010). Electrical stimulation of the anterior nucleus of thalamus for treatment of refractory epilepsy. *Epilepsia*, 17, 17.
- Fiske, S. T. (1998). Stereotyping, prejudice, and discrimination. In D. T. Gilbert & S. T. Fiske (Eds.), *The handbook of social psychology* (4th ed., Vol. 2, pp. 357–411). New York: McGraw-Hill.
- Fitzpatrick, M. (2004). MMR and autism (pp. 133–149). New York: Routledge.
- Fivush, R., Haden, C., & Reese, E. (1996). Remembering, recounting, and reminiscing: The development of autobiographical memory in social context. In D. C. Rubin (Ed.), *Remembering our past: Studies in autobiographical memory* (pp. 341–359). New York: Cambridge University Press.
- Fivush, R., & Nelson, K. (2004). Culture and language in the emergence of autobiographical memory. *Psychological Science*, 15(9), 573.
- Flaherty, J. A., & Adams, S. A. (1998). Therapist–patient race and sex matching: Predictors of treatment duration. *Psychiatric Times*, 15(1).
- Flaskerud, J. H. (1991). Effects of an Asian client–therapist language, ethnicity and gender match on utilization and outcome of therapy. *Community Mental Health Journal*, 27, 31–42.
- Flavell, J. H. (1999). Cognitive development: Children's knowledge about the mind. *Annual Review of Psychology*, 50, 21–45.
- Flegal, K. M., Carroll, M. D. & Ogden, C. L. (2012). Prevalence of obesity and trends in the distribution of body mass index among US adults, 1999–2010. *Journal of the American Medical Association*, 307(5): 491–497.
- Fleming, M. F., & Barry, K. L. (1992). Clinical overview of alcohol and drug disorders. In M. F. Fleming & K. L. Barry (Eds.), *Addictive disorders*. St. Louis: Mosby Year Book.
- Flemons, W. W. (2002). Obstructive sleep apnea. *New England Journal of Medicine*, 347, 498–504.
- Flynn, J. R. (2009). *What is intelligence? Beyond the Flynn effect*. New York: Cambridge University Press.
- Folkard, S., Arendt, J., & Clark, M. (1993). Can melatonin improve shift workers' tolerance of the night shift? Some preliminary findings. *Circadian International: The Journal of Biological and Medical Rhythm Research*, 10(5), 315–320.
- Folkard, S., Lombardi, D. A., & Spencer, M. B. (2006). Estimating the circadian rhythm in the risk of occupational injuries and accidents. *Circadian International: The Journal of Biological and Medical Rhythm Research*, 23(6), 1181–1192.
- Folkard, S., Lombardi, D. A., & Tucker, P. (2005). Shiftwork: Safety, sleepiness, and sleep. *Industrial Health*, 43(1), 20–23.
- Folkard, S., & Tucker, P. (2003). Shift work, safety, and productivity. *Medicine*, 53, 95–101.
- Folkman, S., & Chesney, M. A. (1995). Coping with HIV infection. In M. Stein & A. Baum (Eds.), *Perspectives in behavioral medicine* (pp. 115–133). Hillsdale, NJ: Lawrence Erlbaum.
- Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behavior*, 21(3), 219–239.
- Follett, K. J., & Hess, T. M. (2002). Aging, cognitive complexity, and the fundamental attribution error. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 57, 312–323.
- Forbes, G., Zhang, X., Doroszewicz, K., & Haas, K. (2009). Relationships between individualism-collectivism, gender, and direct or indirect aggression: a study in China, Poland, and the U.S. *Aggressive Behavior*, 35(1), 24–30.
- Fornito, A., Yucel, M., & Pantelis, C. (2009). Reconciling neuroimaging and neuropathological findings in schizophrenia and bipolar disorder. *Current Opinion in Psychiatry*, 22(3), 312–319.
- Fortuna, L. R., Alegria, M., & Gao, S. (2010). Retention in depression treatment among ethnic and racial minority groups in the United States. *Depression and Anxiety*, 27(5), 485–494. doi: 10.1002/da.20685
- Fortune. (2013). Best Companies to Work For 2013. Retrieved May 30, 2013, from <http://money.cnn.com/magazines/fortune/best-companies/>
- Foulkes, D. (1982). *Children's dreams*. New York: Wiley.
- Foulkes, D., & Schmidt, M. (1983). Temporal sequence and unit comparison composition in dream reports from different stages of sleep. *Sleep*, 6, 265–280.
- Frank, E., Kupfer, D. J., Buysse, D. J., Swartz, H. A., Pilkonis, P. A., Houck, P. R., Rucci, P., Novick, D. M., Grochocinski, V. J., & Staaf, D. M. (2007). Randomized trial of weekly, twice-monthly, and monthly interpersonal psychotherapy as maintenance treatment for women with recurrent depression. *American Journal of Psychiatry*, 164(5), 761–767.
- Frank, M. G., & Benington, J. (2006). The role of sleep in brain plasticity: Dream or reality? *The Neuroscientist*, 12: 477–488.
- Franke, R. H., & Kaul, J. D. (1978). The Hawthorne experiments: First statistical interpretation. *American Sociological Review*, 43, 623–643.
- Frankel, B. R., & Piercy, F. P. (1990). The relationship among selected supervisor, therapist, and client behaviors. *Journal of Marital and Family Therapy*, 16, 407–421.
- Franklin, D. (1990). Hooked: Why isn't everyone an addict? *In Health*, 4(6), 38–52.
- Fredrickson, B. L., Maynard, K. E., Helms, M. J., Haney, T. L., Siegler, I. C., & Barefoot, J. C. (2000). Hostility predicts magnitude and duration of blood pressure response to anger. *Journal of Behavioral Medicine*, 23, 229–243.
- Freedman, J., & Fraser, S. (1966). Compliance without pressure: The foot-in-the-door technique. *Journal of Personality and Social Psychology*, 4, 195–202.
- Freeman, A., Simon, K. M., Beutler, L. E., & Arkowitz, H. (Eds.). (1989). *Comprehensive handbook of cognitive therapy*. New York: Plenum Press.
- Freeman, J. (2001). *Gifted children grown up*. London: David Fulton.
- Freeman, W., & Watts, J. W. (1937). Prefrontal lobotomy in the treatment of mental disorders. *Southern Medical Journal*, 30, 23–31.
- Freese, J., Powell, B., & Steelman, L. C. (1999). Rebel without a cause or effect: Birth order and social attitudes. *American Sociological Review*, 64, 207–231.
- Frensch, P. A., & Runger, D. (2003). Implicit learning. *Current Directions in Psychological Science*, 12, 13–18.
- Freud, A. (1946). *The ego and the mechanisms of defense*. American Edition, New York: I.U.P.
- Freud, S. (1900). The interpretation of dreams. *S.E.*, 4–5. (cf. J. Crick, Trans., 1999). London: Oxford University Press.
- Freud, S. (1901). The psychopathology of everyday life. *S.E.*, 6, 1–290.
- Freud, S. (1904a). *Psychopathology of everyday life*. New York: Macmillan; London: Fisher Unwin.
- Freud, S. (1904b). Freud's psycho-analytic procedure. *S.E.*, 7, 249–254.
- Freud, S. (1915/1974). Repression, The standard edition of the complete psychological works of Sigmund Freud: Vol. 14. J. Strachey (Ed.). London: Hogart Press and the Institute of Psychoanalysis.
- Freud, S. (1923). The ego and the id. *S.E.*, 19, 12–66.
- Freud, S. (1930). *Civilization and its discontents*. New York: Jonathon Cape and Co.
- Freud, S. (1933). *New introductory lectures on psycho-analysis*. London: Hogarth.
- Freud, S. (1940). Splitting of the ego in the process of defence. *International Journal of Psychoanalysis*, 22, 65 [1938], *S.E.*, 23, 275–278.
- Freud, S. (1977). *Inhibitions, symptoms and anxiety*. Standard edition of the complete works of Sigmund Freud. New York: W. W. Norton.
- Freud, S., Strachey, J., & Riviere, J. (1990). *The ego and the id (The standard edition of the complete psychological works of Sigmund Freud)*. New York: W. W. Norton and Company.

- Friederich, H.-C., Wu, M., Simon, J. J., & Herzog, W. (2013). Neurocircuit function in eating disorders. *International Journal of Eating Disorders*, 46(5), 425–432. doi: 10.1002/eat.22099
- Friedman, J. M. (2000). Obesity in the new millennium. *Nature*, 404, 632–634.
- Friedman, J. M. (2003). A war on obesity, not the obese. *Science*, 299(5608), 856–858.
- Friedman, J. M., & Halaas, J. L. (1998). Leptin and the regulation of body weight in mammals. *Nature*, 395, 763.
- Friedman, M., & Kasanin, J. D. (1943). Hypertension in only one of identical twins. *Archives of Internal Medicine*, 72, 767–774.
- Friedman, M., & Rosenman, R. H. (1959). Association of specific behavior pattern with blood and cardiovascular findings. *Journal of the American Medical Association*, 169, 1286–1296.
- Froh, J. J. (2004). The history of positive psychology: Truth be told. *NYS Psychologist*, 16(3), 18–20.
- Frontera, W. R., Hughes, V. A., Lutz, K. J., & Evans, W. J. (1991). A cross-sectional study of muscle strength and mass in 45- to 78-year-old men and women. *Journal of Applied Physiology*, 71, 644–650.
- Frydenberg, E., Lewis, R., Ardila, R., Cairns, E., & Kennedy, G. (2001). Adolescent concern with social issues: An exploratory comparison between Australian, Colombian and North Irish students. *Journal of Peace Psychology*, 7, 59–76.
- Fulcher, J. S. (1942). "Voluntary" facial expression in blind and seeing children. *Archives of Psychology*, 38, 1–49.
- Fumeron, F., Betouille, D., Aubert, R., Herbeth, B., Siest, G., & Rigaud, D. (2001). Association of a functional 5-HT transporter gene polymorphism with anorexia nervosa and food intake. *Molecular Psychiatry*, 6, 9–10.
- Furumoto, L. (1979). Mary Whiton Calkins (1863–1930): Fourteenth president of the American Psychological Association. *Journal of the History of Behavioral Sciences*, 15, 346–356.
- Fuster, J. M. (2008). *The prefrontal cortex* (4th ed.). London: Academic Press.
- Gable, R. S. (2004). Acute toxic effects of club drugs. *Journal of Psychoactive Drugs*, 36(1), 303–313.
- Gado, M. (2004). A cry in the night: The Kitty Genovese murder. *Court TV's Crime Library: Criminal Minds and Methods*. Retrieved August 2, 2004, from www.crimelibrary.com/serial_killers/predators/kitty_genovese/1.html?sect=2.
- Galanter, M. (1983). Unification Church ("Moonie") dropouts: Psychological readjustment after leaving a charismatic religious group. *American Journal of Psychiatry*, 140(8), 984–989.
- Galanti, G. A. (1997). *Caring for patients from different cultures* (2nd ed.). Philadelphia: University of Pennsylvania Press.
- Galea, S., Resnick, H., Kilpatrick, D., Bucuvalas, M., Gold, J., & Vlahov, D. (2002, March 28). Psychological sequelae of the September 11 terrorist attacks in New York City. *New England Journal of Medicine*, 346(13), 982–987.
- Gallagher, R. P. (2009). National Survey of Counseling Center Directors, 2009. *The American College Counseling Association (ACCA)*. Retrieved from http://www.iacsinc.org/2009%20National%20Survey.pdf
- Gamwell, L., & Tomes, N. (1995). *Madness in America: Cultural and medical perspectives of mental illness before 1914*. Ithaca, NY: Cornell University Press.
- Ganchrow, J. R., Steiner, J. E., & Munif, D. (1983). Neonatal facial expressions in response to different qualities and intensities of gustatory stimuli. *Infant Behavior Development*, 6, 473–478.
- Ganellen, R. J. (1996). *Integrating the Rorschach and the MMPI-2 in personality assessment*. Mahwah, NJ: Erlbaum.
- Ganis, G., Thompson, W. L., & Kosslyn, S. M. (2004). Brain areas underlying visual mental imagery and visual perception: An fMRI study. *Cognitive Brain Research*, 20(2), 226–241.
- Garb, H. N., Florio, C. M., & Grove, W. M. (1998). The validity of the Rorschach and the Minnesota Multiphasic Personality Inventory: Results from metaanalyses. *Psychological Science*, 9, 402–404.
- García-Campayo, J., Fayed, N., Serrano-Blanco, A., & Roca, M. (2009). Brain dysfunction behind functional symptoms: Neuroimaging and somatoform, conversive, and dissociative disorders. *Current Opinion in Psychiatry*, 22(2), 224–231.
- Garcia, J., Brett, L. P., & Rusiniak, K. W. (1989). Limits of Darwinian conditioning. In S. B. Klein & R. R. Mowrer (Eds.), *Contemporary learning theories: Instrumental conditioning theory and the impact of biological constraints on learning* (pp. 237–275). Hillsdale, NJ: Erlbaum.
- Garcia, J., & Koelling, R. A. (1966). Relation of cue to consequence in avoidance learning. *Psychonomic Science*, 4, 123.
- Gardner, E. P., & Johnson, K. O. (2013). Sensory coding. In E. R. Kandel, J. H. Schwartz, T. M. Jessell, S. A. Siegelbaum, & A. J. Hudspeth (Eds.), *Principles of neural science* (5th ed., pp. 449–474). USA: McGraw-Hill.
- Gardner, H. (1993a). *Creating minds: An anatomy of creativity seen through the lives of Freud, Einstein, Picasso, Stravinsky, Eliot, Graham, and Ghandi*. New York: Basic Books.
- Gardner, H. (1993b). *Multiple intelligences: The theory in practice*. New York: Basic Books.
- Gardner, H. (1998). Are there additional intelligences? The case for naturalist, spiritual, and existential intelligences. In J. Kane (Ed.), *Education, information, and transformation* (pp. 111–131). Upper Saddle River, NJ: Merrill-Prentice Hall.
- Gardner, H. (1999a). *Intelligence reframed: Multiple intelligences for the 21st century*. New York: Basic Books.
- Gardner, H. (1999b, February). Who owns intelligence? *Atlantic Monthly*, 67–76.
- Gardner, H., Kornhaber, M. L., & Wake, W. K. (1996). *Intelligence: Multiple perspectives*. Orlando, FL: Harcourt Brace & Co.
- Gardner, H., & Moran, S. (2006). The science in multiple intelligences: A response to Lynn Waterhouse. *Educational Psychologist*, 41, 227–232.
- Gardner, J., & Oswald, A. J. (2004). How is mortality affected by money, marriage, and stress? *Journal of Health Economics*, 23(6), 1181–1207.
- Gardner, R. J. M., & Sutherland, G. R. (1996). Chromosome abnormalities and genetic counseling. *Oxford Monographs on Medical Genetics No. 29*. New York: Oxford University Press.
- Garland, E. J., & Smith, D. H. (1991). Simultaneous prepubertal onset of panic disorder, night terrors, and somnambulism. *Journal of American Academic Child and Adolescent Psychiatry*, 30(4), 553–555.
- Garnier-Dykstra, L. M., Caldeira, K. M., Vincent, K. B., O'Grady, K. E., & Arria, A. M. (2012). Nonmedical use of prescription stimulants during college: Four-year trends in exposure opportunity, use, motives, and sources. *Journal of American College Health*, 60(3), 226–234. doi: 10.1080/07448481.2011.589876
- Gazzaniga, M. S. (2006). *The ethical brain: The science of our moral dilemmas*. New York: HarperCollins.
- Gazzaniga, M. S. (2009). *Human: The science behind what makes us unique*. New York: Harper Perennial.
- Geary, D. C. (2000). Evolution and proximate expression of human paternal investment. *Psychological Bulletin*, 126, 55–77.
- Geary, D. C. (2012). Sex differences. In V. S. Ramachandran (Editor in Chief), *Encyclopedia of human behavior* (2nd ed., Vol. 3, pp. 403–410). San Diego, CA: Elsevier.
- Gebhard, P. H., & Johnson, A. B. (1979/1998). *The Kinsey data: Marginal tabulations of 1938–1963 interviews conducted by the Institute for Sex Research*. Philadelphia: W. B. Saunders.
- Geddes, D. P. (Ed.). (1954). *An analysis of the Kinsey reports*. New York: New American Library.
- Geen, R. G., & Thomas, S. L. (1986). The immediate effects of media violence on behavior. *Journal of Social Issues*, 42, 7–27.
- Geier, J., Bernáth, L., Hudák, M., & Sára, L. (2008). Straightness as the main factor of the Hermann grid illusion. *Perception*, 37(5), 651–665.
- Gelder, M. (1976). Flooding. In T. Thompson & W. Dockens (Eds.), *Applications of behavior modification* (pp. 250–298). New York: Academic Press.
- Geliebter, A. (1988). Gastric distension and gastric capacity in relation to food intake in humans. *Physiological Behavior*, 44, 665–668.
- Geller, B., Williams, M., Zimerman, B., Frazier, J., Beringer, L., & Warner, K. L. (1998). Prepubertal and early adolescent bipolarity differentiate from ADHD by manic symptoms, grandiose delusions, ultra-rapid or ultradian cycling. *Journal of Affective Disorders*, 51(2), 81–91.
- Gelman, S. A. (1988). The development of induction within natural kind and artifact categories. *Cognitive Psychology*, 20, 65–95.
- Gelman, S. A., & Markman, E. M. (1986). Categories and induction in young children. *Cognition*, 23, 183–209.
- Gershoff, E. T. (2000). The short- and long-term effects of corporal punishment on children: A meta-analytical review. In D. Elliman & M. A. Lynch, *The physical punishment of children* (pp. 196–198).
- Gershoff, E. T. (2002). Corporal punishment by parents: Effects on children and links to physical abuse. *Child Law Practice*, 21 (10), 154–157.
- Geschwind, D. H., & Iacoboni, M. (2007). Structural and functional asymmetries of the frontal lobes. In B. L. Miller & J. K. Cummings (Eds.), *The human frontal lobes* (2nd ed., pp. 68–91). New York: Guilford Press.

- Gessel, L. M., Fields, S. K., Collins, C. L., Dick, R. W., & Comstock, R. D. (2007). Concussions among United States high school and collegiate athletes. *Journal of Athletic Training*, 42(4), 495–503.
- Ghaziri, J., Tucholka, A., Larue, V., Blanchette-Sylvestre, M., Reyburn, G., Gilbert, G., ... Beauregard, M. (2013). Neurofeedback training induces changes in white and gray matter. *Clinical EEG and Neuroscience*. doi: 10.1177/1550059413476031
- Giancola, F. (2006). The generation gap: More myth than reality. *Human Resource Planning*, 29(4), 32–37.
- Gibbons, J. L., Stiles, D. A., & Shkodriani, G. M. (1991). Adolescents' attitudes toward family and gender roles: An international comparison. *Sex Roles*, 25, 625–643.
- Gibbons, R. D., Brown, C. H., Hur, K., Davis, J., & Mann, J. J. (2012). Suicidal thoughts and behavior with antidepressant treatment: Reanalysis of the randomized placebo-controlled studies of fluoxetine and venlafaxine. *Archives of General Psychiatry*, 69(6), 580–587. doi: 10.1001/archgenpsychiatry.2011.2048
- Gibson, E. J., & Walk, R. D. (1960). The "visual cliff." *Scientific American*, 202, 67–71.
- Gilberg, C., & Coleman, M. (2000). *The biology of the autistic syndromes* (3rd ed.). London: Mac Keith Press.
- Gilbert, S. J. (1981). Another look at the Milgram obedience studies: The role of the graduated series of shocks. *Personality and Social Psychology Bulletin*, 7(4), 690–695.
- Gill, S. T. (1991). Carrying the war into the never-never land of psi. *Skeptical Inquirer*, 15(1), 269–273.
- Gillen-O'Neal, C., Huynh, V. W., & Fuligni, A. J. (2012). To study or to sleep? The academic costs of extra studying at the expense of sleep. *Child Development*, 84(1): 133–142.
- Gillespie, M. A., Kim, B. H., Manheim, L. J., Yoo, T., Oswald, F. L., & Schmitt, N. (June, 2002). The development and validation of biographical data and situational judgment tests in the prediction of college student success. Presented in A. M. Ryan (Chair), *Beyond g: Expanding thinking on predictors of college success*. Symposium conducted at the 14th Annual Convention of the American Psychological Society, New Orleans, LA.
- Gillham, B., Tanner, G., Cheyne, B., Freeman, I., Rooney, M., & Lambie, A. (1998). Unemployment rates, single parent density, and indices of child poverty: Their relationship to different categories of child abuse and neglect. *Child Abuse and Neglect*, 22(2), 79–90.
- Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.
- Gillund, G., & Shiffrin, R. M. (1984). A retrieval model for both recognition and recall. *Psychological Review*, 91, 1–67.
- Gilmour, J., & Skuse, D. (1999). A case-comparison study of the characteristics of children with a short stature syndrome induced by stress (hyperphagic short stature) and a consecutive series of unaffected "stressed" children. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 40(6), 969–978.
- Ginzburg, K., Solomon, Z., Koifman, B., Keren, G., Roth, A., Kriwsky, M., Kutz, I., David, D., & Bleich, A. (2003). Trajectories of post-traumatic stress disorder following myocardial infarction: A prospective study. *Journal of Clinical Psychiatry*, 64(10), 1217–1223.
- Gittelman-Klein, R. (1978). Validity in projective tests for psychodiagnosis in children. In R. L. Spitzer & D. F. Klein (Eds.), *Critical issues in psychiatric diagnosis* (pp. 141–166). New York: Raven Press.
- Glaser, M., Kolvin, I., Campbell, D., Glasser, A., Leitch, I., & Farrelly, S. (2001). Cycle of child sexual abuse: links between being a victim and becoming a perpetrator. *British Journal of Psychiatry*, 179: 482–494.
- Glenn, A. L., Raine, A., Mednick, S. A., & Venables, P. (2007). Early temperamental and psychophysiological precursors of adult psychopathic personality. *Journal of Abnormal Psychology*, 116(3), 508–518.
- Glick, P., & Fiske, S. (2001). An ambivalent alliance: Hostile and benevolent sexism as complementary justifications for gender inequality. *American Psychologist*, 56, 109–118.
- Gluckman, P. D., & Hanson, M. A. (2006). Evolution, development and timing of puberty. *Trends in Endocrinology and Metabolism*, 17(1), 7–12.
- Glucksman, M. L. (2006). Psychoanalytic and psychodynamic education in the 21st century. *Journal of American Academy of Psychoanalysis*, 34, 215–22.
- Glynn, S. M. (1990). Token economy approaches for psychiatric patients: Progress and pitfalls over 25 years. *Behavior Modification*, 14, 383–407.
- Godden, D. R., & Baddeley, A. D. (1975). Context-dependent memory in two natural environments: On land and underwater. *British Journal of Psychology*, 66, 325–331.
- Gogtay, N., Lu, A., Leow, A. D., Klunder, A. D., Lee, A. D., Chavez, A., Greenstein, D., Giedd, J. N., Toga, A. W., Rapoport, J. L., & Thompson, P. M. (2008). Three-dimensional brain growth abnormalities in childhood-onset schizophrenia visualized by using tensor-based morphometry. *Proceedings of the National Academy of Sciences, USA*, 105(41), 15979–15984.
- Gogtay, N., & Thompson, P. M. (2010). Mapping gray matter development: Implications for typical development and vulnerability to psychopathology. *Brain and Cognition*, 72(1), 6–15.
- Goin, M. K. (2005). Practical psychotherapy: A current perspective on the psychotherapies. *Psychiatric Services*, 56(3), 255–257.
- Gold, E. B., Leung, K., Crawford, S. L., Huang, M. H., Waetjen, L. E., & Greendale, G. A. (2013). Phytoestrogen and fiber intakes in relation to incident vasomotor symptoms: Results from the Study of Women's Health Across the Nation. *Menopause*, 20(3), 305–314. doi: 10.1097/GME.0b013e31826d2f43
- Goldman, A. L., Pezawas, L., Mattay, V. S., Fischl, B., Verchinski, B. A., Chen, Q., Weinberger, D. R., & Meyer-Lindenberg, A. (2009). Widespread reductions of cortical thickness in schizophrenia and spectrum disorders and evidence of heritability. *Archives of General Psychiatry*, 66(5), 467–477.
- Goldman-Rakic, P. S. (1998). The prefrontal landscape: Implications of functional architecture for understanding human mentation and the central executive. In A. C. Roberts, T. W. Robbins, & L. Weiskrantz (Eds.), *The prefrontal cortex: Executive and cognitive functions* (pp. 87–102). Oxford, UK: Oxford University Press.
- Goldsmith, H. H., & Campos, J. (1982). Toward a theory of infant temperament. In R. Emde & R. Harmon (Eds.), *The development of attachment and affiliative systems: Psychobiological aspects* (pp. 161–193). New York: Plenum Press.
- Goldstein, L. E., Fisher, A. M., Tagge, C. A., Zhang, X. L., Velisek, L., Sullivan, J. A., ... McKee, A. C. (2012). Chronic traumatic encephalopathy in blast-exposed military veterans and a blast neurotrauma mouse model. *Science Translational Medicine*, 4(134), 134ra160. doi: 10.1126/scitranslmed.3003716
- Goleman, D. (1982). Staying up: The rebellion against sleep's gentle tyranny. *Psychology Today*, 3, 24–35.
- Goleman, D. (1995). *Emotional intelligence: Why it can matter more than IQ*. New York: Bantam Books.
- Golkaramnay, V., Bauer, S., Haug, S., Wolf, M., & Kordy, H. (2007). The exploration of the effectiveness of group therapy through an Internet chat as aftercare: A controlled naturalistic study. *Psychotherapy and Psychosomatics*, 76, 219–225.
- Goncalves, R., Pedrozo, A. L., Coutinho, E. S., Figueira, I., & Ventura, P. (2012). Efficacy of virtual reality exposure therapy in the treatment of PTSD: A systematic review. *PLoS One*, 7(12), e48469. doi: 10.1371/journal.pone.0048469
- Gong-Guy, E., & Hammen, C. (1980). Causal perceptions of stressful events in depressed and nondepressed outpatients. *Journal of Abnormal Psychology*, 89, 662–669.
- Gonsalves, B., Reber, P. J., Gitelman, D. R., Parrish, T. B., Mesulam, M. M., & Paller, K. A. (2004). Neural evidence that vivid imagining can lead to false remembering. *Psychological Science*, 15, 655–660.
- Gonzales, P. M., Blanton, H., & Williams, K. J. (2002). The effects of stereotype threat and double-minority status on the test performance of Latino women. *Personality and Social Psychology Bulletin*, 28(5), 659–670.
- Gonzalez, J. S., Penedo, F. J., Antoni, M. H., Durán, R. E., Fernandez, M. I., McPherson-Baker, S., Ironson, G., Klimas, N. G., Fletcher, M. A., & Schneiderman, N. (2004). Social support, positive states of mind, and HIV treatment adherence in men and women living with HIV/AIDS. *Health Psychology*, 23(4), 413–418.
- Goodglass, H., Kaplan, E., & Barresi, B. (2001). *The assessment of aphasia and related disorders* (3rd ed.). Baltimore: Lippincott, Williams & Wilkins.
- Goodman, E. S. (1980). Margaret Floy Washburn (1871–1939) first woman Ph.D. in psychology. *Psychology of Women Quarterly*, 5, 69–80.
- Gooijers, J., Caeyenberghs, K., Sisti, H. M., Geurts, M., Heitger, M. H., Leemans, A., & Swinnen, S. P. (2013). Diffusion tensor imaging metrics of the corpus callosum in relation to bimanual coordination: Effect of task complexity and sensory feedback. *Human Brain Mapping*, 34(1), 241–252. doi: 10.1002/hbm.21429
- Gosselin, R. E., Smith, R. P., Hodge, H. C., & Braddock, J. E. (1984). *Clinical toxicology of commercial products* (5th ed.). Sydney, Australia: Williams & Wilkins.
- Gotlib, I. H., Sivers, H., Canli, T., Kasch, K. L., & Gabrieli, J. D. E. (November, 2001). Neural activation in depression in response to emotional stimuli. In I. H. Gotlib (Chair), *New directions in the neurobiology of affective disorders*. Symposium conducted at the annual meeting of the Society for Research in Psychopathology, Madison, WI.
- Gottesman, I. I. (1991). *Schizophrenia genesis: The origins of madness*. New York: Free-man.
- Gottesman, I. I., McGuffin, P., & Farmer, A. E. (1987). Clinical genetics as clues to the "Real" genetics of schizophrenia (A decade of modest gains while playing for time). *Schizophrenia Bulletin*, 13, 23–47.

- Gottesman, I. I., & Shields, J. (1976). A critical review of recent adoption, twin and family studies of schizophrenia: Behavioural genetics perspectives. *Schizophrenia Bulletin*, 2, 360–401.
- Gottesman, I., & Shields, J. (1982). *Schizophrenia: The epigenetic puzzle*. New York: Cambridge University Press.
- Gottman, J. M., & Krokoff, L. J. (1989). Marital interaction and satisfaction: A longitudinal view. *Journal of Consulting and Clinical Psychology*, 57, 47–52.
- Gough, H. G. (1995). *California Psychological Inventory* (3rd ed.). Palo Alto, CA: Consulting Psychologist-Press.
- Gould, J. L., & Gould, C. G. (1994). *The animal mind*. New York: Scientific American Library.
- Gould, S. J. (1981). *The mismeasure of man*. New York: Norton.
- Gould, S. J. (1996). *The mismeasure of man*. New York: W. W. Norton.
- Graf, W. D., Nagel, S. K., Epstein, L. G., Miller, G., Nass, R., & Larriviere, D. (2013). Pediatric neuroenhancement: Ethical, legal, social, and neurodevelopmental implications. *Neurology*, 80(13), 1251–1260. doi: 10.1212/WNL.0b013e318289703b
- Grandjean, P., Weihe, P., White, R. F., Debes, F., Araki, S., Yokoyama, K., Murata, K., Sorensen, N., Dahl, R., & Jorgensen, P. J. (1997). Cognitive deficit in 7-year-old children with prenatal exposure to methylmercury. *Neurotoxicology and Teratology*, 19(6), 417–428.
- Graner, J., Oakes, T. R., French, L. M., & Riedy, G. (2013). Functional MRI in the investigation of blast-related traumatic brain injury. *Frontiers in Neurology*, 4, 16. doi: 10.3389/fneur.2013.00016
- Graven, S. N., & Browne, J. V. (2008). Sleep and brain development: The critical role of sleep in fetal and early neonatal brain development. *Newborn & Infant Nursing Review*, 8, 173–179.
- Greeley, A. (1987). Mysticism goes mainstream. *American Health*, 1, 47–49.
- Greenwald, A. G., & Banaji, M. R. (1995). Implicit social cognition: Attitudes, self-esteem, and stereotypes. *Psychological Review*, 102, 4–27.
- Greenwald, A. G., McGhee, D. E., & Schwartz, J. K. L. (1998). Measuring individual differences in implicit cognition: The Implicit Association Test. *Journal of Personality and Social Psychology*, 74, 1464–1480.
- Gregory, R. L. (1990). *Eye and brain, the psychology of seeing*. Princeton, NJ: Princeton University Press.
- Gresham, L. G., & Shimp, T. A. (1985). Attitude toward the advertisement and brand attitudes: A classical conditioning prospective. *Journal of Advertising*, 14(1), 10–17, 49.
- Griggs, E. M., Young, E. J., Rumbaugh, G., & Miller, C. A. (2013). MicroRNA-182 regulates amygdala-dependent memory formation. *Journal of Neuroscience*, 33(4), 1734. doi: 10.1523/JNEUROSCI.2873-12.2013
- Grimbos, T., Dawood, K., Burriss, R. P., Zucker, K. J., & Puts, D. A. (2010). Sexual orientation and the second to fourth finger length ratio: A meta-analysis in men and women. *Behavioral Neuroscience*, 124(2), 278–287. doi: 10.1037/a0018764
- Grocer, S., & Kohout, J. (1997). The 1995 APA survey of 1992 baccalaureate recipients. Washington, DC: American Psychological Association.
- Gross, C. G. (1999). A hole in the head. *The Neuroscientist*, 5, 263–269.
- Grumbach, M. M., & Kaplan, S. L. (1990). The neuroendocrinology of human puberty: An ontogenetic perspective. In M. M. Grumbach, P. C. Sizonenko, & M. L. Aubert (Eds.), *Control of the onset of puberty* (pp. 1–6). Baltimore: Williams & Wilkins.
- Grumbach, M. M., & Styne, D. M. (1998). Puberty: Ontogeny, neuroendocrinology, physiology, and disorders. In J. D. Wilson, D. W. Foster, H. M. Kronenberg, & P. R. Larsen (Eds.), *Williams textbook of endocrinology* (9th ed. pp. 1509–1625). Philadelphia: W. B. Saunders.
- Grünbaum, A. (1984). *The foundations of psychoanalysis: A philosophical critique*. Berkeley, CA: University of California Press.
- Guar, A., Dominguez, K., Kalish, M., Rivera-Hernandez, D., Donohoe, M., & Mitchell, C. (2008, February). Practice of offering a child pre-masticated food: An unrecognized possible risk factor for HIV transmission. Paper presented at the 15th Conference on Retroviruses and Opportunistic Infections, Boston, MA.
- Guerri, C. (2002). Mechanisms involved in central nervous system dysfunctions induced by prenatal ethanol exposure. *Neurotoxicity Research*, 4(4), 327–335.
- Guilford, J. P. (1967). *The nature of human intelligence*. New York: McGraw-Hill.
- Gunderson, E. A., Gripshover, S. J., Romero, C., Dweck, C. S., Goldin-Meadow, S., & Levine, S. C. (2013). Parent praise to 1- to 3-year-olds predicts children's motivational frameworks 5 years later. *Child Development*, ePUB ahead of print. doi: 10.1111/cdev.12064
- Gupta, M. (1994). Sexuality in the Indian sub-continent. *Sex and Marital Therapy*, 9, 57–69.
- Guskiewicz, K. M., Marshall, S. W., Bailes, J., McCrea, M., Cantu, R. C., Randolph, C., & Jordan, B. D. (2005). Association between recurrent concussion and late-life cognitive impairment in retired professional football players. *Neurosurgery*, 57(4), 719–726.
- Guskiewicz, K. M., Marshall, S. W., Bailes, J., McCrea, M., Harding, H. P., Jr., Matthews, A., Mihalik, J. R., & Cantu, R. C. (2007). Recurrent concussion and risk of depression in retired professional football players. *Medicine and Science in Sports and Exercise*, 39(6), 903–909.
- Gustavson, C. R., Kelly, D. J., Seeney, M., & Garcia, J. (1976). Prey lithium aversions I: Coyotes and wolves. *Behavioral Biology*, 17, 61–72.
- Guthrie, R. V. (2004). *Even the rat was white: A historical view of psychology*. Boston: Allyn & Bacon.
- Haber, R. N. (1979). Twenty years of haunting eidetic imagery: Where's the ghost? *The Behavioral and Brain Sciences*, 2, 583–619.
- Hahn, H. C., & Adkins, C. (2009). A model of Asian and Pacific Islander sexual minority acculturation. *Journal of LGBT Youth*, 6, 155–173.
- Halbesleben, J. R. B., & Bowler, W. M. (2007). Emotional exhaustion and job performance: The mediating role of motivation. *Journal of Applied Psychology*, 91, 93–106.
- Hall, A. P., & Henry, J. A. (2006). Acute toxic effects of 'Ecstasy' (MDMA) and related compounds: Overview of pathophysiology and clinical management. *British Journal of Anaesthesia*, 96(6): 678–685.
- Hall, C. (1966). Studies of dreams collected in the laboratory and at home. *Institute of Dream Research Monograph Series* (No. 1). Santa Cruz, CA: Privately printed.
- Hall, W., & Degenhardt, L. (2009). Adverse health effects of non-medical cannabis use. *Lancet*, 374, 1383–1391.
- Hamann, S., Herman, R. A., Nolan, C. L., & Wallen, K. (2004). Men and women differ in amygdala response to visual sexual stimuli. *Nature Neuroscience*, 7(4), 411–419.
- Hamer, D. H., Hu, S., Magnuson, V. L., Hu, N., & Pattatucci, A. M. L. (1993). A linkage between DNA markers on the X chromosome and male sexual orientation. *Science*, 261, 321–327.
- Hamers, F. F., and Downs, A. M. (2003, March). HIV in central and eastern Europe. *Lancet*, 362, 9362.
- Hamilton, D. L., & Gifford, R. K. (1976). Illusory correlation in interpersonal perception: A cognitive basis of stereotypic judgments. *Journal of Experimental Social Psychology*, 12, 392–407.
- Handel, S. (1989). *Listening: An introduction to the perception of auditory events*. Cambridge, MA: MIT Press.
- Hansen, C. P. (1988). Personality characteristics of the accident involved employee. *Journal of Business and Psychology*, 2(4), 346–365.
- Han, X., Chen, M., Wang, F., Windrem, M., Wang, S., Shanz, S., ... Nedergaard, M. (2013). Forebrain engraftment by human glial progenitor cells enhances synaptic plasticity and learning in adult mice. *Cell Stem Cell*, 12(3), 342–353. doi: 10.1016/j.stem.2012.12.015
- Hargittai, E. (2007). Whose space? Differences among users and non-users of social network sites. *Journal of Computer-Mediated Communication*, 13(1), article 14. Retrieved from <http://jcmc.indiana.edu/vol13/issue1/hargittai.html>
- Harlow, H. F. (1958). The nature of love. *American Psychologist*, 13, 573–685.
- Harman, G. (1999). Moral philosophy meets social psychology: Virtue ethics and the fundamental attribution error. *Proceedings of the Aristotelian Society*, 1998–99, 99, 315–331.
- Harmon-Jones, E. (2000). Cognitive dissonance and experienced negative affect: Evidence that dissonance increases experienced negative affect even in the absence of aversive consequences. *Personality and Social Psychology Bulletin*, 26, 1490–1501.
- Harmon-Jones, E. (2004). Insights on asymmetrical frontal brain activity gleaned from research on anger and cognitive dissonance. *Biological Psychology*, 67, 51–76.
- Harmon-Jones, E. (2006). Integrating cognitive dissonance theory with neurocognitive models of control. *Psychophysiology*, 43, S16.
- Harmon-Jones, E., Harmon-Jones, C., Fearn, M., Sigelman, J. D., & Johnson, P. (2008). Action orientation, relative left frontal cortical activation, and spreading of alternatives: A test of the action-based model of dissonance. *Journal of Personality and Social Psychology*, 94(1), 1–15.
- Harrison, P. J. (1999). The neuropathology of schizophrenia: A critical review of the data and their interpretation. *Brain*, 122, 593–624.
- Harrison, T. L., Shipstead, Z., Hicks, K. L., Hambrick, D. Z., Redick, T. S., & Engle, R. W. (2013). Working memory training may increase working memory capacity but not fluid intelligence. *Psychological Science*. doi: 10.1177/0956797613492984

- Hart, P. (1998). Preventing groupthink revisited: Evaluating and reforming groups in government. *Organizational Behavior & Human Decision Processes*, 73(2-3), 306-326.
- Hartfield, E. (1987). Passionate and companionate love. In R. J. Sternberg & M. L. Barnes (Eds.), *The psychology of love* (pp. 191-217). New Haven, CT: Yale University Press.
- Hartfield, E., & Rapson, R. L. (1992). Similarity and attraction in intimate relationships. *Communication Monographs*, 59, 209-212.
- Harvard Mental Health Letter (2010). Experts urge caution in using deep brain stimulation. *Harvard Mental Health Letter*, 26(8), 6-7.
- Harvey, S., & Keashly, L. (2003). Predicting the risk for aggression in the workplace: Risk factors, self-esteem and time at work. *Social Behaviour & Personality: An International Journal*, 31(8), 807-814.
- Hassan, S., Karpova, Y., Baiz, D., Yancey, D., Pullikuth, A., Flores, A., Register, T., Cline, J. M., D'Agostino, R., Danial, N., Datta, S. R., & Kulik, G. (2013). Behavioral stress accelerates prostate cancer development in mice. *Journal of Clinical Investigation*, 123(2), 874-886. doi:10.1172/JCI63324
- Hauck, S. J., & Bartke, A. (2001). Free radical defenses in the liver and kidney of human growth hormone transgenic mice. *Journal of Gerontology and Biological Science*, 56, 153-162.
- Havighurst R. J., Neugarten B. L., & Tobin S. N. S. (1968). Disengagement and patterns of aging. In B. L. Neugarten (Ed.), *Middle age and aging: A reader in social psychology* (pp. 161-172). Chicago: University of Chicago Press.
- Hawks, S. R., Madanat, H. N., Merrill, R. M., Goudy, M. B., & Miyagawa, T. (2003). A cross-cultural analysis of "motivation for eating" as a potential factor in the emergence of global obesity: Japan and the United States. *Health Promotion International*, 18(2), 153-162.
- Hay, P. (2013). A systematic review of evidence for psychological treatments in eating disorders: 2005-2012. *International Journal of Eating Disorders*, 46(5), 462-469. doi:10.1002/eat.22103
- Hayflick, L. (1977). The cellular basis for biological aging. In C. E. Finch & L. Hayflick (Eds.), *Handbook of biology of aging* (p. 159). New York: Van Nostrand Reinhold.
- Hayward, C., Killen, J. D., Kraemer, H. C., & Taylor, C. B. (2000). Predictors of panic attacks in adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39(2), 207-214.
- Hayward, C., Killen, J., & Taylor, C. B. (1989). Panic attacks in young adolescents. *American Journal of Psychiatry*, 146(8), 1061-1062.
- Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, 52, 511-524.
- Hazrati, L. N., Tartaglia, M. C., Diamandis, P., Davis, K. D., Green, R. E., Wennberg, R., ... Tator, C. H. (2013). Absence of chronic traumatic encephalopathy in retired football players with multiple concussions and neurological symptomatology. *Frontiers in Human Neuroscience*, 7, 222. doi: 10.3389/fnhum.2013.00222
- Heavey, C. L., Layne, C., & Christensen, A. (1993). Gender and conflict structure in marital interaction: A replication and extension. *Journal of Consulting and Clinical Psychology*, 61, 16-27.
- Hebb, D. O. (1955). Drives and the CNS (Conceptual Nervous System). *Psychological Review*, 62, 243-254.
- Hegeman, R. (2007). "Police: Shoppers stepped over victim." Associated Press, July 4. <http://abcnews.go.com/US/wireStory?id=3342724>.
- Heider, F. (1958). *The psychology of interpersonal relations*. New York: John Wiley & Sons.
- Heikkila, K., Nyberg, S. T., Theorell, T., Fransson, E. I., Alfredsson, L., Bjorner, J. B., Bonenfant, S., Borritz, M., Bouillon, K., Burr, H., Dragano, N., Geuskens, G. A., Goldberg, M., Hamer, M., Hooftman, W. E., Houtman, I. L., Joensuu, M., Knutsson, A., Koskenvuo, M., Koskinen, A., Kouvolanen, A., Madsen, I. E. H., Magnusson Hanson, L. L., Marmot, M. G., Nielsen, M. L., Nordin, M., Oksanen, T., Pentti, J., Salo, P., Rugulies, R., Steptoe, A., Suominen, S., Vahtera, J., Virtanen, M., Vaananen, A., Westerholm, P., Westerlund, H., Zins, M., Ferrie, J. E., Singh-Manoux, A., Batty, G. D., Kivimaki, M. (2013). Work stress and risk of cancer: Meta-analysis of 5700 incident cancer events in 116 000 European men and women. *BMJ*, 346(Feb07 1): f165. doi: 10.1136/bmj.f165
- Heil, G., Maslow, A., & Stephens, D. (1998). *Maslow on management*. New York: John Wiley and Sons.
- Heilman, K. M. (2002). *Matter of mind: A neurologist's view of brain-behavior relationships*. New York: Oxford University Press.
- Heilman, K., Watson, R., & Valenstein, E. (1993). Neglect and related disorders. In K. Heilman and E. Valenstein (Eds.), *Clinical neuropsychology*. New York: Oxford University Press.
- Heimberg, R. G., & Becker, R. E. (2002). *Cognitive-behavioral group therapy for social phobia: Basic mechanisms and clinical strategies*. New York: Guilford Press.
- Heimer, L. (1995). *The human brain and spinal cord: Functional neuroanatomy and dissection guide*. New York, NY: Springer-Verlag.
- Heinicke, C. M., Goorsky, M., Moscov, S., Dudley, K., Gordon, J., Schneider, C., & Guthrie, D. (2000). Relationship-based intervention with at-risk mothers: Factors affecting variations in outcome. *Infant Mental Health Journal*, 21, 133-155.
- Heinrich, B. (2000). Testing insight in ravens. In C. Heyes & L. Huber (Eds.), *The evolution of cognition*. Cambridge, MA: MIT Press.
- Helffrich, C., Pierau, S. S., Freitag, C. M., Roeper, J., Ziemann, U., & Bender, S. (2012). Monitoring cortical excitability during repetitive transcranial magnetic stimulation in children with ADHD: A single-blind, sham-controlled TMS-EEG study. *PLoS One*, 7(11), e50073. doi: 10.1371/journal.pone.0050073
- Helms, J. E. (1992). Why is there no study of cultural equivalence in standardized cognitive ability testing? *American Psychologist*, 47(9), 1083-1101.
- Henderson, R. K., Snyder, H. R., Gupta, T., & Banich, M. T. (2012). When does stress help or harm? The effects of stress controllability and subjective stress response on Stroop performance. *Frontiers in Psychology*, 3, 179.
- Henin, A., Mick, E., Biederman, J., Fried, R., Wozniak, J., Faraone, S. V., Harrington, K., Davis, S., & Doyle, A. E. (2007). Can bipolar disorder-specific neuropsychological impairments in children be identified? *Journal of Consulting and Clinical Psychology*, 75(2), 210-220.
- Henningfield, J. E., Clayton, R., & Pollin, W. (1990). Involvement of tobacco in alcoholism and illicit drug use. *British Journal of Addiction*, 85, 279-292.
- Henningfield, J. E., Cohen, C., Slade, J. D. (1991). Is nicotine more addictive than cocaine? *British Journal of Addiction*, 86, 565-569.
- Herberman, R. B., & Ortaldo, J. R. (1981). Natural killer cells: Their role in defenses against disease. *Science*, 214, 24-30.
- Herbst, J. H., Zonderman, A. B., McCrae, R. R., & Costa, P. T., Jr. (2000). Do the dimensions of the Temperament and Character Inventory map a simple genetic architecture? Evidence from molecular genetics and factor analysis. *American Journal of Psychiatry*, 157, 1285-1290.
- Herman, L. M., Pack, A. A., & Morrell-Samuels, P. (1993). Representational and conceptual skills of dolphins. In H. L. Roitblatt, L. M. Herman, & P. E. Nachtigall (Eds.), *Language and communication: Comparative perspectives*. Hillsdale, NJ: Erlbaum.
- Hernandez, D., & Fisher, E. M. (1996). Down syndrome genetics: Unravelling a multifactorial disorder. *Human Molecular Genetics*, 5, 1411-1416.
- Herrnstein, R. J., & Murray, C. (1994). *The bell curve: The reshaping of American life by differences in intelligence*. New York: Free Press.
- Hersh, S. M. (2004, May 10). Annals of national security: Torture at Abu Ghraib. *The New Yorker*.
- Hershberger, S. L., Plomin, R., & Pedersen, N. L. (1995, October). Traits and meta-trait: Their reliability, stability, and shared genetic influence. *Journal of Personality and Social Psychology*, 69(4), 673-685.
- Herxheimer, A., & Petrie, K. J. (2001). Melatonin for preventing and treating jet lag. *Cochrane Database of Systematic Reviews* (1), CD 001520.
- Heslegrave, R. J., & Rhodes, W. (1997). Impact of varying shift schedules on the performance and sleep in air traffic controllers. *Sleep Research*, 26, 198.
- Hetherington, A. W., & Ranson, S. W. (1940). Hypothalamic legions and adiposity in rats. *Anatomical Records*, 78, 149-172.
- Hebrick, S. E., McKenzie, J. E., Cox, G. R., Simmons, M. B., & Merry, S. N. (2012). Newer generation antidepressants for depressive disorders in children and adolescents. *Cochrane Database of Systematic Reviews (Online)*, 11, CD004851. doi: 10.1002/14651858.CD004851.pub3
- Hewlin, P. F. (2009). Wearing the cloak: Antecedents and consequences of creating facades of conformity. *Journal of Applied Psychology*, 94(3), 727-741.
- Hewstone, M., Rubin, M., & Willis, H. (2002). Intergroup bias. *Annual Review of Psychology*, 53, 575-604.
- Heyes, C. M. (1998). Theory of mind in nonhuman primates. *Behavior and Brain Science*, 21, 101-148.
- Hicklin, J., & Widiger, T. A. (2000). Convergent validity of alternative MMPI-2 personality disorder scales. *Journal of Personality Assessment*, 75(3), 502-518.
- Higgins, E. T., & Scholer, A. A. (2010). When is personality revealed? A motivated cognition approach. In O. P. John, R. W. Robins, & L. A. Pervin (Eds.), *Handbook of personality: Theory and research* (pp. 182-207). New York: Guilford Press.
- Hilgard E. R. (1965). Hypnotic susceptibility. New York: Harcourt, Brace & World.
- Hilgard, E. R. (1991). A neodissociation interpretation of hypnosis. In S. J. Lynn & J. W. Rhue (Eds.), *Theories of hypnosis* (pp. 83-104). New York: Guilford Press.

- Hilgard, E. R., & Hilgard, J. R. (1994). *Hypnosis in the relief of pain* (Rev. ed.). New York: Brunner/Mazel.
- Hill, D. (1990). Causes of smoking in children. In B. Durston & K. Jamrozik, *Smoking and health 1990—The global war. Proceedings of the 7th World Conference on Smoking and Health*, 1–5 April. Perth: Health Department of Western Australia, 205–209.
- Hill, J. A. (1998). Miscarriage risk factors and causes: What we know now. *OBG Management*, 10, 58–68.
- Hill, P. C., & Butter E. M. (1995). The role of religion in promoting physical health. *Journal of Psychology and Christianity*, 14(2), 141–155.
- Hillman, C. H., Pontifex, M. B., Raine, L. B., Castelli, D. M., Hall, E. E., & Kramer, A. F. (2009). The effect of acute treadmill walking on cognitive control and academic achievement in preadolescent children. *Neuroscience*, 159(3), 1044–1054.
- Hilton, J. L., & von Hippel, W. (1996). Stereotypes. *Annual Review of Psychology*, 47, 237–271.
- Hilts, P. J. (August 2, 1998). Is nicotine addictive? It depends on whose criteria you use. *New York Times*, p. C3.
- Hines, T. (2003). *Pseudoscience and the paranormal: A critical examination of the evidence*. Amherst, NY: Prometheus.
- Hintze, J. M. (2002). Interventions for fears and anxiety problems. In M. R. Shinn, H. R. Walker, & G. Stoner (Eds.), *Interventions for academic and behavior problems II: Preventive and remedial approaches* (pp. 939–954). Bethesda, MD: National Association of School Psychologists.
- Hnasko, T. S., Chuhma, N., Zhang, H., Goh, G. Y., Sulzer, D., Palmiter, R. D., Rayport, S., & Edwards, R. H. (2010). Vesicular glutamate transport promotes dopamine storage and glutamate corelease in vivo. *Neuron*, 65: 643–656.
- Hobson, J. (1988). *The dreaming brain*. New York: Basic Books.
- Hobson, J. A., & McCarley, R. (1977). The brain as a dream state generator: An activation-synthesis hypothesis of the dream process. *American Journal of Psychiatry*, 134, 1335–1348.
- Hobson, J., Pace-Schott, E., & Stickgold, R. (2000). Dreaming and the brain: Towards a cognitive neuroscience of conscious states. *Behavioral and Brain Sciences*, 23(6), 793–1121.
- Hochman, J. (1994). Buried memories challenge the law. *National Law Journal*, 1, 17–18.
- Hodges, J. R. (1994). Retrograde amnesia. In A. Baddeley, B. A. Wilson, & F. Watts (Eds.), *Handbook of memory disorders* (pp. 81–107). New York: Wiley.
- Hodgson, B. (2001). *In the arms of Morpheus: The tragic history of laudanum, morphine, and patent medicines*. New York: Firefly Books.
- Hodson, D. S., & Skeen, P. (1994). Sexuality and aging: The hammerlock of myths. *The Journal of Applied Gerontology*, 13, 219–235.
- Hoebel, B. G., & Teitelbaum, P. (1966). Weight regulation in normal and hypothalamic hyperphagic rats. *Journal of Comparative Physiological Psychology*, 61, 189–193.
- Hoeft, F., Gabrieli, J. D. E., Whitfield-Gabrieli, S., Haas, B. W., Bammer, R., Menon, V., & Spiegel, D. (2012). Functional brain basis of hypnotizability. *Archives of General Psychiatry*, 69(10): 1064.
- Hoffer, T. B., Hess, M., Welch, V., Jr., & Williams, K. (2007). *Doctorate Recipients from United States Universities: Summary Report 2006*. Chicago: National Opinion Research Center.
- Hoffrage, U., Hertwig, R., & Gigerenzer, G. (2000). Hindsight bias: A by-product of knowledge updating? *Journal of Experimental Psychology: Learning, Memory, and Cognition*, 26, 566–581.
- Hofstede, G. H. (1980). *Culture's consequences, international differences in work-related values*. Beverly Hills, CA: Sage.
- Hofstede, G. J., Pedersen, P. B., & Hofstede, G. H. (2002). *Exploring culture: Exercises, stories, and synthetic cultures*. Yarmouth, ME: Intercultural Press.
- Hoge, C. W., McGurk, D., Thomas, J. L., Cox, A. L., Engel, C. C., & Castro, C. A. (2008). Mild traumatic brain injury in U.S. soldiers returning from Iraq. *The New England Journal of Medicine*, 358(5), 453–463.
- Hogg, M. A., & Hains, S. C. (1998). Friendship and group identification: A new look at the role of cohesiveness in groupthink. *European Journal of Social Psychology*, 28(1), 323–341.
- Holahan, C. K., & Sears, R. R. (1996). *The gifted group at later maturity*. Stanford, CA: Stanford University Press.
- Holcomb, W. R. (1986). Stress inoculation therapy with anxiety and stress disorders of acute psychiatric patients. *Journal of Clinical Psychology*, 42, 864–872.
- Holden, C., & Vogel, G. (2002). Plasticity: Time for a reappraisal? *Science*, 296, 2126–2129.
- Hollon, S. D., & Beck, A. T. (1994). Cognitive and cognitive-behavioral therapies. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., p. 428). Chichester, UK: John Wiley & Sons.
- Hollon, S., These, M., & Markowitz, J. (2002). Treatment and prevention of depression. *Psychological Science in the Public Interest*, 3, 39–77.
- Holman, E. A., Silver, R. C., Poulin, M., Andersen, J., Gil-Rivas, V., & McIntosh, D. N. (2008). Terrorism, acute stress, and cardiovascular health: A 3-year national study following the September 11th attacks. *Archives of General Psychiatry*, 65, 73–80.
- Holmes, T. H., & Masuda, M. (1973). Psychosomatic syndrome: When mothers-in-law or other disasters visit, a person can develop a bad, bad cold. *Psychology Today*, 5(11), 71–72, 106.
- Holmes, T. H., & Rahe, R. H. (1967). The Social Readjustment Rating Scale. *Journal of Psychosomatic Research*, 21, 213–218.
- Holroyd, J. (1996). Hypnosis treatment of clinical pain: Understanding why hypnosis is useful. *International Journal of Clinical and Experimental Hypnosis*, 44, 33–51.
- Holt-Lunstad, J., Uchino, B. N., Smith, T. W., Cerny, C. B., & Nealey-Moore, J. B. (2003). Social relationships and ambulatory blood pressure: Structural and qualitative predictors of cardiovascular function during everyday social interactions. *Health Psychology*, 22, 388–397.
- Hong, D., Scaletta-Kent, J., & Kesler, S. (2009). Cognitive profile of Turner syndrome. *Developmental Disabilities Research Reviews*, 15(4), 270–278. doi: 10.1002/ddrr.79
- Hood, D. C. (1998). Lower-level visual processing and models of light adaptation. *Annual Review of Psychology*, 49, 503–535.
- Hootman, J. M., Dick, R., & Agel, J. (2007). Epidemiology of collegiate injuries for 15 sports: Summary and recommendations for injury prevention initiatives. *Journal of Athletic Training*, 42(2), 311–319.
- Hopfinger, J. B., Buonocore, M. H., & Mangun, G. R. (2000). The neural mechanisms of top-down attentional control. *Nature Neuroscience*, 3, 284–291.
- Horne, J. A., & Staff, C. H. (1983). Exercise and sleep: Body heating effects. *Sleep*, 6, 36–46.
- Horney, K. (1939). *New ways in psychoanalysis*. New York: W. W. Norton.
- Horney, K. (1967/1973). *Feminine psychology*. New York: W. W. Norton.
- Hornung, J. P. (2012). Raphe nuclei. In J. K. Mai & G. Paxinos (Eds.), *The human nervous system* (pp. 642–685). London, UK: Academic Press.
- Horowitz, D. L. (1985). *Ethnic groups in conflict*. Berkeley: University of California Press.
- Hortaçsu, N. (1999). The first year of family and couple initiated marriages of a Turkish sample: A longitudinal investigation. *International Journal of Psychology*, 34(1), 29–41.
- Hossain, P., Kawar, B., & El Nahas, M. (2007). Obesity and diabetes in the developing world—A growing challenge. *New England Journal of Medicine*, 356(9), 973.
- Hothersall, D. (1995). *History of psychology* (pp. 162–165). New York: McGraw-Hill, Inc.
- Hovland, C. I. (1937). The generalization of conditioned responses. I. The sensory generalization of conditioned responses with varying frequencies of tone. *Journal of General Psychology*, 17, 125–48.
- Hu, P., & Meng, Z. (August, 1996). An examination of infant-mother attachment in China. Poster session presented at the meeting of the International Society for the Study of Behavioral Development, Quebec City, Quebec, Canada.
- Hu, S., Pattatucci, A. M. L., Patterson, C., Li, L., Fulker, D. W., Cherny, S. S., Kruglyak, L., & Hamer, D. H. (1994). Linkage between sexual orientation and chromosome Xq28 in males but not in females. *Nature Genetics*, 11, 248–256.
- Hu, S., & Stern, R. M. (1999). Retention of adaptation to motion sickness eliciting stimulation. *Aviation, Space, and Environmental Medicine*, 70, 766–768.
- Hu, X., Pornpattananangkul, N., & Rosenfeld, J. P. (2013). N200 and P300 as orthogonal and integrable indicators of distinct awareness and recognition processes in memory detection. *Psychophysiology*, 50(5), 454–464. doi: 10.1111/pyps.12018
- Hubel, D. H., & Wiesel, T. N. (1959). Receptive fields of single neurons in the cat's striate cortex. *The Journal of Physiology*, 148, 574–591.
- Huesmann, L. R., & Eron, L. (1986). *Television and the aggressive child: A cross-national comparison*. Hillsdale, NJ: Erlbaum.
- Huesmann, L. R., & Miller, L. S. (1994). Long-term effects of repeated exposure to media violence in childhood. In L. R. Huesmann (Ed.), *Aggressive behavior: Current perspectives* (pp. 153–183). New York: Plenum Press.
- Huesmann, L. R., Moise, J. F., & Podolski, C. L. (1997). The effects of media violence on the development of antisocial behavior. In D. M. Stoff, J. Breiling, & J. D. Maser (Eds.), *Handbook of antisocial behavior* (pp. 181–193). New York: John Wiley.
- Huesmann, L. R., Moise-Titus, J., Podolski, C. L., & Eron, L. D. (2003). Longitudinal relations between children's exposure to TV violence and their aggressive and

- violent behavior in young adulthood: 1977–1992. *Developmental Psychology*, 39(2), 201–221.
- Huff, W., Lenartz, D., Schormann, M., Lee, S. H., Kuhn, J., Koulosakis, A., Mai, J., Daumann, J., Maarouf, M., Klosterkötter, J., & Sturm, V. (2010). Unilateral deep brain stimulation of the nucleus accumbens in patients with treatment-resistant obsessive-compulsive disorder: Outcomes after one year. *Clinical Neurology and Neurosurgery*, 112(2), 137–143.
- Hugenberg, K., & Bodenhausen, G. V. (2003). Facing prejudice: Implicit prejudice and the perception of facial threat. *Psychological Science*, 14, 640–643.
- Hughes, J. (1993). Behavior therapy. In T. R. Kratochwill & R. J. Morris (Eds.), *Handbook of psychotherapy with children and adolescents* (pp. 185–220). Boston: Allyn and Bacon.
- Hughes, S. M., Harrison, M. A., & Gallup, G. G., Jr. (2007). Sex differences in romantic kissing among college students: An evolutionary perspective. *Evolutionary Psychology* 5(3), 612–631.
- Hull, C. L. (1943). *Principles of behavior*. New York: Appleton-Century.
- Hull, J. G., Draghici, A. M., & Sargent, J. D. (2012). A longitudinal study of risk-gloryifying video games and reckless driving. *Psychology of Popular Media Culture*, 1(4), 244–253. doi: 10.1037/a0029510
- Hummer, R. A., Rogers, R. G., Nam, C. B., & Ellison, C. G. (1999). Religious involvement and U.S. adult mortality. *Demography*, 36(2), 273–285.
- Humphries, L. L. (1987). Bulimia: Diagnosis and treatment. *Comprehensive Therapy*, 13, 12–15.
- Hunsley, J., & Mash, E. J. (2008). Developing criteria for evidence-based assessment: An introduction to assessments that work. In J. Hunsley & E. J. Mash (Eds.), *A guide to assessments that work* (3rd ed.). New York: Guilford Press.
- Hunt, E. (2001). Multiple views of multiple intelligence. [Review of Intelligence reframed: Multiple intelligence in the 21st century.] *Contemporary Psychology*, 46, 5–7.
- Hunt, M. (1993). *The story of psychology*. New York: Doubleday.
- Hurlemann, R., Patin, A., Onur, O. A., Cohen, M. X., Baumgartner, T., Metzler, S., Dziobek, I., Gallinat, J., Wagner, M., Maier, W., & Kendrick, K. M. (2010). Oxytocin enhances amygdala-dependent, socially reinforced learning and emotional empathy in humans. *Journal of Neuroscience*, 30(1), 4999–5007. doi: 10.1523/JNEUROSCI.553809.2010
- Hurley, D. (1989). The search for cocaine's methadone. *Psychology Today*, 23(7/8), 54.
- Hurley, S., & Nudds, M. (Eds.). (2006). *Rational animals?* Oxford, UK: Oxford University Press.
- Hurvich, L. M., & Jameson, D. (1957). An opponent-process theory of color vision. *Psychological Review*, 64, 384–404.
- Hutcheson, J., & Snyder, H. M. (2004). Ambiguous genitalia and intersexuality. *eMedicine Journal*, 5(5). Retrieved November 17, 2004, from <http://author.emedicine.com/PED/topic1492.htm>
- Hvas, L. (2001). Positive aspects of menopause: A qualitative study. *Maturitas* 39(1), 11–17.
- Hyde, J. S., & Kling, K. C. (2001). Women, motivation, and achievement. *Psychology of Women Quarterly*, 25, 264–378.
- Hyde, J. S., & Plant, E. A. (1995). Magnitude of psychological gender differences. *American Psychologist*, 50, 159–161.
- Hygge, S. A., & Öhman, A. (1976). The relation of vicarious to direct instigation and conditioning of electrodermal responses. *Scandinavian Journal of Psychology*, 17(1), 217–222.
- Hyman, I. E., Gilstrap, L. L., Decker, K., & Wilkinson, C. (1998). Manipulating remember and know judgements of autobiographical memories. *Applied Cognitive Psychology*, 12, 371–386.
- Hyman, I. E., Jr. (1993). Imagery, reconstructive memory, and discovery. In B. Roskos-Ewoldsen, M. J. Intons-Peterson, & R. E. Anderson (Eds.), *Imagery, creativity, and discovery: A cognitive perspective* (pp. 99–121). The Netherlands: Elsevier Science.
- Hyman, I. E., Jr., & Loftus, E. F. (1998). Errors in autobiographical memories. *Clinical Psychology Review*, 18, 933–947.
- Hyman, I. E., Jr., & Loftus, E. F. (2002). False childhood memories and eyewitness memory errors. In M. L. Eisen, J. A. Quas, & G. S. Goodman (Eds.), *Memory and suggestibility in the forensic interview* (pp. 63–84). Mahwah, NJ: Erlbaum.
- Hyman, S. E., & Cohen, J. D. (2013). Disorders of mood and anxiety. In E. R. Kandel, J. H. Schwartz, T. M. Jessel, S. A. Siegelbaum, & A. J. Hudspeth (Eds.), *Principles of neural science* (5th ed., pp. 1402–1424). USA: McGraw-Hill.
- Iacoboni, M., Woods, R. P., Brass, M., Bekkering, H., Mazziotta, J. C., & Rizzolatti, G. (1999). Cortical mechanisms of human imitation. *Science*, 286, 2526–2528.
- Iber, C., Ancoli-Israel, S., Chesson Jr., A. L., & Quan, S. F. (2007). The AASM Manual for the scoring of sleep and associated events: Rules, terminology and technical specifications. Westchester, IL: American Academy of Sleep Medicine.
- Iemmola, F., & Camperio Ciani, A. (2008). New evidence of genetic factors influencing sexual orientation in men: Female fecundity increase in the maternal line. *Archives of Sexual Behavior*, 38(3), 393–399.
- Imaiizumi, Y. (1998). A comparative study of twinning and triplet rates in 17 countries, 1972–1996. *Acta Genetic Medicine & Gemellology*, 47, 101–114.
- Insel, T. R., & Wang, P. S. (2010). Rethinking mental illness. *The Journal of the American Medical Association*, 303(19), 1970–1971.
- Ioannidis, J. P. A. (1998, January 28). Effect of the statistical significance of results on the time to completion and publication of randomized efficacy trials. *Journal of the American Medical Association*, 279, 281–286.
- Irwin, A. R., & Gross, A. M. (1995). Cognitive tempo, violent video games, and aggressive behavior in young boys. *Journal of Family Violence*, 10(3), 337–350.
- Irwin, M., Cole, J., & Nicassio, P. (2006). Comparative meta-analysis of behavioral intervention for insomnia and their efficacy in middle aged adults and in older adults 55+ years of age. *Health Psychology*, 25, 3–14.
- Isabel, J. (2003). *Genetics: An introduction for dog breeders*. Loveland, CO: Alpine.
- Isenberg, D. J. (1986). Group polarization: A critical review and meta-analysis. *Journal of Personality and Social Psychology*, 50(6), 1141–1151.
- Iwakabe, S. (2008). Psychotherapy integration in Japan. *Journal of Psychotherapy Integration*, 18(1), 103–125.
- Iwamoto, E. T., & Martin, W. (1988). A critique of drug self-administration as a method for predicting abuse potential of drugs. *National Institute on Drug Abuse Research Monograph*, 104, 81457–81465.
- Izard, C. (1988). Emotion-cognition relationships and human development. In C. Izard, J. Kagan, & R. Zajonc (Eds.), *Emotions, cognition, and behavior*. New York: Cambridge University Press.
- Jackson, L. A., & Wang, J.-L. (2013). Cultural differences in social networking site use: A comparative study of China and the United States. *Computers in Human Behavior*, 29(3), 910. doi: 10.1016/j.chb.2012.11.024
- Jackson, M. L., Gunzelmann, G., Whitney, P., Hinson, J. M., Belenky, G., Rabat, A., & Van Dongen, H. P. (2013). Deconstructing and reconstructing cognitive performance in sleep deprivation. *Sleep Medicine Reviews*, 17(3), 215–225. doi: 10.1016/j.smrv.2012.06.007
- Jackson, T., Iezzi, T., Gunderson, J., Fritch, A., & Nagasaki, T. (2002). Gender differences in pain perception: The mediating role of self-efficacy beliefs. *Sex Roles*, 47, 561–568.
- Jacobson, S. G., Cideciyan A. V., Regunath, G., et al. (1995). Night blindness in Sorsby's fundus dystrophy reversed by vitamin A. *Nature Genetics*, 11, 27–32.
- Jaeggi, S. M., Buschkuhl, M., Jonides, J., & Perrig, W. J. (2008). Improving fluid intelligence with training on working memory. *Proceedings of the National Academy of Sciences, USA*, 105(19), 6829–6833.
- James, W. (1884). What is an emotion? *Mind*, 9, 188–205.
- James, W. (1890, 2002). *The principles of psychology* (Vols. 1 and 2). Cambridge, MA: Harvard University Press.
- James, W. (1890). *Principles of psychology*. New York: Henry Holt.
- James, W. (1894). The physical basis of emotion. *Psychological Review*, 1, 516–529.
- Jameson, M., Diehl, R., & Danso, H. (2007). Stereotype threat impacts college athletes' academic performance. *Current Research in Social Psychology*, 12(5), 68–79.
- Jang, K. L., Livesley, W. J., & Vernon, P. A. (1996). Heritability of the Big Five personality dimensions and their facets: A twin study. *Journal of Personality*, 64, 577–591.
- Jang, K. L., McCrae, R. R., Angleitner, A., Riemann, R., & Livesley, W. J. (1998). Heritability of facet-level traits in a cross-cultural twin sample: Support for a hierarchical model of personality. *Journal of Personality and Social Psychology*, 74, 1556–1565.
- Janis, I. (1972). *Victims of groupthink*. Boston: Houghton-Mifflin.
- Janis, I. (1982). *Groupthink* (2nd ed.). Boston: Houghton-Mifflin.
- Janos, P. M. (1987). A fifty-year follow-up of Terman's youngest college students and IQ-matched agemates. *Gifted Child Quarterly*, 31, 55–58.
- Janowitz, H. D. (1967). Role of gastrointestinal tract in the regulation of food intake. In C. F. Code (Ed.), *Handbook of physiology: Alimentary canal 1*. Washington, DC: American Physiological Society.

- January, D., & Kako, E. (2007). Re-evaluating evidence for linguistic relativity: Reply to Boroditsky (2001). *Cognition*, 104(2), 417–426.
- Janus, S. S., & Janus, C. L. (1993). *The Janus report on sexual behavior*. New York: John Wiley & Sons.
- Jay, S. M., & Elliot, C. H. (1990). A stress inoculation program for parents whose children are undergoing medical procedures. *Journal of Consulting and Clinical Psychology*, 58, 799–804.
- Jeih, K., Northcraft, G., & Neale, M. (1999). Why differences make a difference: A field study of diversity, conflict, and performance in workgroups. *Administrative Science Quarterly*, 44, 741–763.
- Jensen, A. R. (1969). How much can we boost IQ and scholastic achievement? *Harvard Educational Review*, 39, 1–123.
- Jensen, M. P., Gertz, K. J., Kupper, A. E., Braden, A. L., Howe, J. D., Hakimian, S., & Sherlin, L. H. (2013). Steps toward developing an EEG biofeedback treatment for chronic pain. *Applied Psychophysiology and Biofeedback*. doi: 10.1007/s10484-013-9214-9
- Ji, K., Akgul, G., Wollmuth, L. P., & Tsirka, S. E. (2013). Microglia actively regulate the number of functional synapses. *PLoS ONE*, 8(2), e56293. doi: 10.1371/journal.pone.0056293
- Johnson, C. P., & Myers, S. M. (Council on Children with Disabilities). (2007). Identification and evaluation of children with autism spectrum disorders. *Pediatrics*, 120(5), 1183–1215.
- Johnson, D., Johnson, R., & Smith, K. (1991). *Active learning: Cooperation in the college classroom*. Edna, MN: Interaction Book Company.
- Johnson, G. (1995, June 6). Chimp talk debate: Is it really language? *New York Times*.
- Johnson, J., Cohen, P., Pine, D. S., Klein, D. F., Kasen, S., & Brook, J. S. (2000). Association between cigarette smoking and anxiety disorders during adolescence and early adulthood. *Journal of the American Medical Association*, 284(18), 2348–2351.
- Johnson, M. E., Brems, C., Mills, M. E., Neal, D. B., & Houlihan, J. L. (2006). Moderating effects of control on the relationship between stress and change. *Administration and Policy in Mental Health and Mental Health Services Research*, 33(4), 499–503.
- Johnson, W., Bouchard, T. J., Jr., McGue, M., Segal, N. L., Tellegen, A., Keyes, M., & Gottesman, I. I. (2007). Genetic and environmental influences on the Verbal-Perceptual-Image Rotation (VPR) model of the structure of mental abilities in the Minnesota Study of Twins Reared Apart. *Intelligence*, 35(6), 542–562.
- Johnston, L. D., O'Malley, P. M., Bachman, J. G., Schulenberg, J. E. (2007). *Monitoring the Future national survey results on drug use, 1975–2006: Vol. 1. Secondary school students 2006*. Bethesda, MD: National Institute on Drug Abuse; September 2007.
- Jones, E. E., & Harris, V. A. (1967). The attribution of attitudes. *Journal of Experimental Social Psychology*, 3, 1–24.
- Jones, E., Fear, N. T., & Wessely, S. (2007). Shell shock and mild traumatic brain injury: A historical review. *The American Journal of Psychiatry*, 164(11), 1641–1645.
- Jones, E. J., Krupnick, J. L., & Kerig, P. K. (1987). Some gender effects in a brief psychotherapy. *Psychotherapy*, 24, 336–352.
- Jones, G. W. (1997). Modernization and divorce: Contrasting trends in Islamic Southeast Asia and the West. *Population and Development Review*, 23(1), 95–113.
- Jones, M. C. (1924). A laboratory study of fear: The case of Peter. *Pedagogical Seminary*, 31, 308–315.
- Jones, M. K., & Menzies, R. G. (1995). The etiology of fear of spiders. *Anxiety, Stress and Coping*, 8, 227–234.
- Judelsohn, R. G. (2007). Vaccine Safety: Vaccines are one of public health's great accomplishments. *Skeptical Inquirer*, 31.6 (November/December), Retrieved June 13, 2010, from http://www.csicop.org/si/show/vaccine_safety_vaccines_are_one_of_public_healthrsquos_great_accomplishment/
- Juffer, F., & Rosenboom, L. G. (1997). Infant–mother attachment of internationally adopted children in the Netherlands. *International Journal of Behavioral Development*, 20(1), 93–107.
- Jung, C. (1933). *Modern man in search of a soul*. New York: Harcourt Brace.
- Kabat-Zinn, J., Lipworth, L., & Burney, R. (1985). The clinical use of mindfulness meditation for the self-regulation of chronic pain. *Journal of Behavioral Medicine*, 8, 163–190.
- Kabat-Zinn, J., Lipworth, L., Burney, R., & Sellers, W. (1986). Four year follow-up of a meditation-based program for the self regulation of chronic pain: Treatment outcomes and compliance. *Clinical Journal of Pain*, 2, 159–173.
- Kable, J. A., Coles, C. D., Lynch, M. E., & Platzman, K. (2008). Physiological responses to social and cognitive challenges in 8-year olds with a history of prenatal cocaine exposure. *Developmental Psychobiology*, 50(3), 251–265.
- Kagan, J. (1998). *Galen's prophecy: Temperament in human nature*. (pp. 237–260, 270–274). New York: Basic Books.
- Kagan, J. (2010). *The temperamental thread*. New York: Dana Press.
- Kagan, J., Snidman, N., Kahn, V., & Towsley, S. (2007). The preservation of two infant temperaments into adolescence. *SRCD Monographs*, 72(2), 76–80.
- Kahan, M., & Sutton, N. (1998). Overview: Methadone treatment for the opioid-dependent patient. In B. Brands & J. Brands (Eds.), *Methadone maintenance: A physician's guide to treatment* (pp. 1–15). Toronto, ON: Addiction Research Foundation.
- Kahneman, D. (2011). *Thinking, fast and slow*. New York: Farrar, Straus and Giroux.
- Kahneman, D., Slovic, P., & Tversky, A. (1982). *Judgment under uncertainty: Heuristics and biases*. New York: Cambridge University Press.
- Kahneman, D., & Tversky, A. (1973). On the psychology of prediction. *Psychological Review*, 80, 237–251.
- Kail, R., & Hall, L. K. (2001). Distinguishing short-term memory from working memory. *Memory & Cognition*, 29(1), 1–9.
- Kakko, J., Svartberg, K. D., Kreek, M. J., & Heilig, M. (2003). 1-year retention and social function after buprenorphine-associated relapse prevention treatment for heroin dependence in Sweden: A randomised, placebo-controlled trial. *Lancet*, 361, 662–668.
- Kales, A., Soldatos, C., Bixler, E., Ladda, R. L., Charney, D. S., Weber, G., & Schweitzer, P. K. (1980). Hereditary factors in sleepwalking and night terrors. *British Journal of Psychiatry*, 137, 111–118.
- Kam, D. (2010, June 29). Valdez expert: Psychological impact of Gulf oil spill won't fully emerge for years. *The Palm Beach Post*. Retrieved July 9, 2010, from <http://www.palmbeachpost.com/news/valdez-expert-psychological-impact-of-gulf-oil-spill-776588.html>
- Kamau, C., & Harorimana, D. (2008). Does knowledge sharing and withholding of information in organizational committees affect quality of group decision making? *Proceedings of the 9th European Conference on Knowledge Management* (pp. 341–348). Reading, PA: Academic.
- Kamin, L. J. (1995, February). Behind the curve. *Scientific American*, 99–103.
- Kandel, E. R., & Schwartz, J. H. (1982). Molecular biology of learning: Modulation of transmitter release. *Science*, 218, 433–443.
- Kandel, E. R., & Siegelbaum, S. A. (2013). Cellular mechanisms of implicit memory storage and the biological basis of individuality. In E. R. Kandel, J. H. Schwartz, T. M. Jessell, S. A. Siegelbaum, & A. J. Hudspeth (Eds.), *Principles of neural science* (5th ed., pp. 1461–1486). USA: McGraw-Hill.
- Kaplan, M. F., & Miller, C. E. (1987). Group decision making and normative versus informational influence: Effects of type of issue and assigned decision rule. *Journal of Personality and Social Psychology*, 53(2), 306–313.
- Karau, S. J., & Williams, K. D. (1993). Social loafing: A meta-analytic review and theoretical integration. *Journal of Personality and Social Psychology*, 65, 681–706.
- Karau, S. J., & Williams, K. D. (1997). The effects of group cohesiveness on social loafing and social compensation. *Group Dynamics: Theory, Research and Practice*, 1, 156–168.
- Karney, B. R., & Bradbury, T. N. (2000). Attributions in marriage: State or trait? A growth curve analysis. *Journal of Personality and Social Psychology*, 78, 295–309.
- Karpicke, J. D. (2012). Retrieval-based learning: Active retrieval promotes meaningful learning. *Current Directions in Psychological Science*, 21(3), 157–163. doi: 10.1177/0963721412443552
- Karpicke, J. D., & Blunt, J. R. (2011). Retrieval practice produces more learning than elaborative studying with concept mapping. *Science*, DOI: 10.1126/science/1199327.
- Kastenbaum, R., & Costa, P. T., Jr. (1977). Psychological perspective on death. *Annual Review of Psychology*, 28, 225–249.
- Katz, V. L. (2007). Spontaneous and recurrent abortion: Etiology, diagnosis, treatment. In V. L. Katz, G. M. Lentz, R. A. Lobo, & D. M. Gershenson (Eds.), *Comprehensive Gynecology* (5th ed.). Philadelphia: Mosby Elsevier.
- Kaufman, J., & Zigler, E. (1993). The intergenerational transmission of abuse is overstated. In R. J. Gelles & D. R. Loseke (Eds.), *Current controversies on family violence*. Newbury Park, CA: Sage.
- Kaveny, M. C. (2001). The case of conjoined twins: Embodiment, individuality, and dependence. *Theological Studies*, 62.

- Kaye, W. H., Fudge, J. L., & Paulus, M. (2009). New insights into symptoms and neurocircuit function of anorexia nervosa. *Nature Reviews Neuroscience*, 10(8), 573–584. doi: 10.1038/nrn2682
- Kaye, W. H., Wierenga, C. E., Bailer, U. F., Simmons, A. N., & Bischoff-Grethe, A. (2013). Nothing tastes as good as skinny feels: The neurobiology of anorexia nervosa. *Trends in Neurosciences*, 36(2), 110–120. doi: 10.1016/j.tins.2013.01.003
- Kazdin, A. E. (1980). Acceptability of time out from reinforcement procedures for disruptive behavior. *Behavior Therapy*, 11(3), 329–344.
- Kazdin, A. E. (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American Psychologist*, 63(3), 146–159. doi: 10.1037/0003-066x.63.3.146
- Kazmierczak, M., Kielbratowska, B., & Pastwa-Wojciechowska, B. (2013). Couvade syndrome among polish expectant fathers. *Medical Science Monitor*, 19, 132–138. doi: 10.12659/msm.883791
- Kearney, C. A., & Silverman, W. K. (1998). A critical review of pharmacotherapy for youth with anxiety disorders: Things are not as they seem. *Journal of Anxiety Disorders*, 12, 83–102.
- Keel, P. K., & Fornay, K. J. (2013). Psychosocial risk factors for eating disorders. *The International Journal of Eating Disorders*, 46(5), 433–439. doi: 10.1002/eat.22094
- Keillor, J., Barrett, A., Crucian, G., Kortenkamp, S., & Heilman, K. (2002). Emotional experience and perception in the absence of facial feedback. *Journal of the International Neuropsychological Society*, 8(1), 130–135.
- Keirsey, D. (1998). *Please understand me ii: Temperament character intelligence*. Del Mar, CA: Prometheus Nemesis Book Company.
- Keller, M. B., McCullough, J. P., Klein, D. N., Arnow, B., Dunner, D., Gelenberg, A., Markowitz, J. C., Nemeroff, C. B., Russell, J. M., Thase, M. E., Trivedi, M. H., & Zajecka, J. (2000). A comparison of nefazodone, the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression. *New England Journal of Medicine*, 342(20), 1462–1470.
- Kellermann, T., Regenbogen, C., De Vos, M., Mößnang, C., Finkelmeyer, A., & Habel, U. (2012). Effective connectivity of the human cerebellum during visual attention. *The Journal of Neuroscience*, 32(33), 11453–11460. doi: 10.1523/jneurosci.0678-12.2012
- Kelly, I. (1980). The scientific case against astrology. *Mercury*, 10(13), 135.
- Kelly, J. A., McAuliffe, T. L., Sikkema, K. J., Murphy, D. A., Somlai, A. M., Mulry, G., Miller, J. G., Stevenson, L. Y., & Fernandez, M. I. (1997). Reduction in risk behavior among adults with severe mental illness who learned to advocate for HIV prevention. *Psychiatric Services*, 48(10), 1283–1288.
- Kempf, L., & Weinberger, D. R. (2009). Molecular genetics and bioinformatics: An outline for neuropsychological genetics. In T. E. Goldberg & D. R. Weinberger (Eds.), *The genetics of cognitive neuroscience* (pp. 3–26). Cambridge, MA: MIT Press.
- Kendall, P. (1983). Stressful medical procedures: Cognitive-behavioral strategies for stress management and prevention. In D. Meichenbaum & M. Jaremko (Eds.), *Stress reduction and prevention*. (pp. 159–190). New York: Plenum Press.
- Kendall, P. C., Hudson, J. L., Gosch, E., Flannery-Schroeder, E., & Suveg, C. (2008). Cognitive-behavioral therapy for anxiety disordered youth: A randomized clinical trial evaluating child and family modalities. *Journal of Consulting and Clinical Psychology*, 76(2), 282–297.
- Kandler, K. S. (1985). Diagnostic approaches to schizotypal personality disorders: A historical perspective. *Schizophrenia Bulletin*, 11, 538–553.
- Kandler, K. S., Czajkowski, N., Tambs, K., Torgersen, S., Aggen, S. H., Neale, M. C., & Reichborn-Kjennerud, T. (2006). Dimensional representations of DSM-IV cluster A personality disorders in a population-based sample of Norwegian twins: A multivariate study. *Psychological Medicine*, 36(11), 1583–1591. doi: 10.1017/s0033291706008609
- Kandler, K. S., & Prescott, C. A. (1999). A population-based twin study of lifetime major depression in men and women. *Archives of General Psychiatry*, 56(1), 39–44.
- Kenny, A. (1968). Mind and body, In *Descartes: A study of his philosophy* (p. 279). New York: Random House.
- Kenny, A. (1994). Descartes to Kant. In A. Kenny (Ed.), *The Oxford history of western philosophy* (pp. 107–192). Oxford, England: Oxford University Press.
- Kenrick, D. T., Griskevicius, V., Neuberg, S. L., & Schaller, M. (2010). Renovating the pyramid of needs: Contemporary extensions built upon ancient foundations. *Perspectives on Psychological Science*, 5(3), 292–314.
- Kensinger, E. A., Shearer, D. K., Locascio, J. J., Growdon, J. H., & Corkin, S. (2003). Working memory in mild Alzheimer's disease and early Parkinson's disease. *Neuropsychology*, 17(2), 230–239.
- Keromoian, R., & Leiderman, P. H. (1986). Infant attachment to mother and child caretaker in an East African community. *International Journal of Behavioral Development*, 9, 455–469.
- Kerwin, D. R., Zhang, Y., Kotchen, J. M., Espeland, M. A., Van Horn, L., McTigue, K. M., Robinson, J. G., Powell, L., Kooperberg, C., Coker, L. H., & Hoffmann, R. (2010). The cross-sectional relationship between body mass index, waist-hip ratio, and cognitive performance in postmenopausal women enrolled in the women's health initiative. *Journal of the American Geriatric Society*, 58, 1427–1432. [Article first published online July 14, 2010]. doi: 10.1111/j.1532-5415.2010.02969.x
- Kesebir, S., Graham, J., & Oishi, S. (2010). A theory of human needs should be human-centered, not animal-centered. *Perspectives on Psychological Science*, 5(3), 315–319.
- Kessler, R. C., Galea, S., Jones, R. T., Parker, H. A., & Hurricane Katrina Community Advisory Group. (2006). Mental illness and suicidality after Hurricane Katrina. *Bulletin of the World Health Organization*, 84(12): 930–939.
- Kessler, R. C., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Wittchen, H. U. (2012). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research*, 21(3), 169–184. doi: 10.1002/mpr.1359
- Kety, S. S., Wender, P. H., Jacobsen, B., Ingaham, L. J., Jansson, L., Faber, B., & Kinney, D. K. (1994). Mental illness in the biological and adoptive relatives of schizophrenic adoptees. *Archives of General Psychiatry*, 51, 442–455.
- Kiecolt-Glaser, J. K. (2009). Psychoneuroimmunology: Psychology's gateway to the biomedical future. *Perspectives on Psychological Science*, 4(4), 367.
- Kiecolt-Glaser, J. K., Fisher, L. D., Ogracki, P., Stout, J. C., Speicher, C. E., & Glaser, R. (1987). Marital quality, marital disruption, and immune function. *Psychosomatic Medicine*, 49, 13–34.
- Kiecolt-Glaser, J. K., Glaser, R., Gravenstein, S., Malarkey, W. B., & Sheridan, J. (1996). Chronic stress alters the immune response to influenza virus vaccine in older adults. *Proceedings of the National Academy of Sciences USA*, 93(7), 3043–3047.
- Kiecolt-Glaser, J. K., Marucha, P. T., Malarkey, W. B., & Marcado, A. M. (1995). Slowing of wound healing by psychological stress. *Lancet*, 346, 1194–1196.
- Kiecolt-Glaser, J. K., McGuire, L., Robles, T., & Glaser, R. (2002). Psychoneuroimmunology: Psychological influences on immune function and health. *Journal of Consulting and Clinical Psychology*, 70, 537–547.
- Kihlstrom, J. F. (1985). Hypnosis. *Annual Review of Psychology*, 36, 385–418.
- Kihlstrom, J. F. (1987). The cognitive unconscious. *Science*, 237, 1445–1452.
- Kihlstrom, J. F. (1999). Conscious and unconscious cognition. In R. J. Sternberg (Ed.), *The nature of cognition* (pp. 173–203). Cambridge, MA: MIT Press.
- Kihlstrom, J. F. (2001). Hypnosis and the psychological unconscious. In Howard S. Friedman (Ed.), *Assessment and therapy: Specialty articles from the encyclopedia of mental health* (pp. 215–226). San Diego, CA: Academic Press.
- Kihlstrom, J. F. (2002). Memory, autobiography, history. *Proteus: A Journal of Ideas*, 19(2), 1–6.
- Kihlstrom, J. F. (2002). To honor Kraepelin ...: From symptoms to pathology in the diagnosis of mental illness. In L. E. Beutler & M. L. Malik (Eds.), *Rethinking the DSM: A psychological perspective* (pp. 279–303). Washington, DC: American Psychological Association.
- Kihlstrom, J., Mulvaney, S., Tobias, B., & Tobias, I. (2000). The emotional unconscious. In E. Eich, J. Kihlstrom, G. Bower, J. Forgas, & P. Niedenthal (Eds.), *Cognition and emotion* (pp. 30–86). New York: Oxford University Press.
- Kim, H., & Markus, H. R. (1999). Deviance or uniqueness, harmony or conformity? A cultural analysis. *Journal of Personality and Social Psychology*, 77, 785–800.
- Kimura, D. (1999). *Sex and cognition*. Cambridge, MA: MIT Press.
- Kimura, R., Mactavish, E., Yang, J., Westaway, D., & Jhamandas, J. H. (2012). Beta amyloid-induced depression of hippocampal long-term potentiation is mediated through the amylin receptor. *Journal of Neuroscience*, 32(48), 17401–17406. doi: 10.1523/JNEUROSCI.3028-12.2012
- King, M. W., Street, A. E., Gradus, J. L., Vogt, D. S., & Resick, P. A. (2013). Gender differences in posttraumatic stress symptoms among OEF/OIF veterans: An item response theory analysis. *Journal of Traumatic Stress*, 26(2), 175–183. doi: 10.1002/jts.21802
- Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. Philadelphia: W. B. Saunders.

- Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. H. (1953). *Sexual behavior in the human female*. New York: W. B. Saunders.
- Kirby, J. S., Chu, J. A., & Dill, D. L. (1993). Correlates of dissociative symptomatology in patients with physical and sexual abuse histories. *Comprehensive Psychiatry*, 34, 250–263.
- Kirchengast, S. (2009). Teenage-pregnancies—a biomedical and a sociocultural approach to a current problem. *Current Women's Health Reviews*, 5, 1–7.
- Kirmayer, L. J. (1991). The place of culture in psychiatric nosology: *Taijin kyofusho* and the *DSM-III-TR*. *Journal of Nervous and Mental Disease*, 179, 19–28.
- Kirsch, I. (2000). The response set theory of hypnosis. *American Journal of Clinical Hypnosis*, 42 (3/42), 4, 274–292.
- Kirsch, I., & Lynn, S. J. (1995). The altered state of hypnosis: Changes in the theoretical landscape. *American Psychologist*, 50, 846–858.
- Kitamura, T., Saitoh, Y., Takashima, N., Murayama, A., Niibori, Y., Ageta, H., Sekiguchi, M., Sugiyama, H., & Inokuchi, K. (2009). Adult neurogenesis modulates the hippocampus-dependent period of associative fear memory. *Cell*, 139(4), 814–827.
- Kitayama, S., & Markus, H. R. (1994). Introduction to cultural psychology and emotion research. In S. Kitayama & H. R. Markus (Eds.), *Emotion and culture: Empirical studies of mutual influence* (pp. 1–22). Washington, DC: American Psychological Association.
- Klaver, C. C., Wolfs, R. C., Vingerling, J. R., Hofman, A., & de Jong, P. T. (1998). Age-specific prevalence and causes of blindness and visual impairment in an older population: The Rotterdam Study. *Archives of Ophthalmology*, 116, 653–658.
- Kleim, B., Ehring, T., & Ehlers, A. (2012). Perceptual processing advantages for trauma-related visual cues in post-traumatic stress disorder. *Psychological Medicine*, 42(1), 173–181. doi: 10.1017/s0033291711001048
- Kleinot, M. C., & Rogers, R. W. (1982). Identifying effective components of alcohol misuse prevention programs. *Journal of Studies on Alcohol*, 43, 802–811.
- Klein, R. G., Mannuzza, S., Olazagasti, M. A., Roizen, E., Hutchison, J. A., Lashua, E. C., & Castellanos, F. X. (2012). Clinical and functional outcome of childhood attention-deficit/hyperactivity disorder 33 years later. *Archives of General Psychiatry*, 69(12), 1295–1303. doi: 10.1001/archgenpsychiatry.2012.271
- Klein, S. B., & Mowrer, R. R. (1989). *Contemporary learning theories: Pavlovian conditioning and the status of traditional learning theory*. Hillsdale, NJ: Lawrence Erlbaum.
- Kligman, A. M., & Balin, A. K. (1989). Aging of human skin. In A. K. Balin & A. M. Kligman (Eds.), *Aging and the skin* (pp. 1–42). New York: Raven Press.
- Klorman, R., Hilpert, P. L., Michael, R., LaGana, C., & Sveen, O. B. (1980). Effects of coping and mastery modeling on experienced and inexperienced pedodontic patients' disruptiveness. *Behavior Therapy*, 11, 156–168.
- Kluft, R. P. (1984). Introduction to multiple personality disorder. *Psychiatric Annals*, 14, 19–24.
- Klüver, H., & Bucy, P. C. (1939). Preliminary analysis of functions of the temporal lobes in monkeys. *Archives of Neurological Psychiatry*, 42, 979–1000.
- Knight, A. (1996). *The life of the law: The people and cases that have shaped our society, from King Alfred to Rodney King*. New York: Crown Publishing Group.
- Knight, J. A. (1998). Free radicals: Their history and current status in aging and disease. *Annals of Clinical and Laboratory Science*, 28, 331–346.
- Kobasa, S. (1979). Stressful life events, personality, and health: An inquiry into hardiness. *Journal of Personality and Social Psychology*, 37(1), 1–11.
- Koch, C., & Mormann, F. (2010). The neurobiology of consciousness. In G. Mashour (Ed.), *Consciousness, awareness, and anesthesia* (pp. 24–46). New York: Cambridge University Press.
- Koenig, H. G., Hays, J. C., Larson, D. B., George, L. K., Cohen, H. J., McCullough, M. E., Meador, K. G., & Blazer, D. G. (1999). Does religious attendance prolong survival? A six-year follow-up study of 3,968 older adults. *Journal of Gerontology*, 54A, M370–M377.
- Koenig, H. G., McCullough, M. E., & Larson, D. B. (2001). *Handbook of religion and health*. Oxford, UK: Oxford University Press.
- Koh, J. K. (1996). A guide to common Singapore spiders. *BP Guide to Nature series*. Singapore: Singapore Science Center.
- Kohlberg, L. (1973). Continuities in childhood and adult moral development revisited. In P. Baltes & K. W. Schaie (Eds.), *Life-span development psychology: Personality and socialization*. San Diego, CA: Academic Press.
- Köhler, W. (1925, 1992). *Gestalt psychology: An introduction to new concepts in modern psychology (reissue)*. New York: Liveright.
- Kok, B. E., Coffey, K. A., Cohn, M. A., Catalino, L. I., Vacharkulksemsuk, T., Algoe, S. B., Brantley, M., & Fredrickson, B. L. (2013). How positive emotions build physical health: Perceived positive social connections account for the upward spiral between positive emotions and vagal tone. *Psychological Science*, 24(5), ePub ahead of print. doi: 10.1177/0956797612470827
- Kolodny, R. C. (2001, August). In memory of William H. Masters. *Journal of Sex Research*.
- Konowal, N. M., Van Dongen, H. P. A., Powell, J. W., Mallis, M. M., & Dinges, D. F. (1999). Determinants of microsleeps during experimental sleep deprivation. *Sleep*, 22 (Suppl. 1), 328.
- Koob, G. F., & Le Moal, M. (2005). Plasticity of reward neurocircuitry and the 'dark side' of drug addiction. *Nature Neuroscience*, 8(11): 1442–1444.
- Korn, S. (1984). Continuities and discontinuities in difficult/easy temperament: Infancy to young adulthood. *Merrill Palmer Quarterly*, 30, 189–199.
- Kosslyn, S. M. (1983). Mental imagery. In Z. Rubin (Ed.), *The psychology of being human*. New York: Harper & Row.
- Kosslyn, S. M., Alpert, N. M., Thompson, W. L., Maljkovic, V., Weise, S. B., Chabris, C. F., Hamilton, S. E. and Buonano, F. S. (1993). Visual mental imagery activates topographically organized visual cortex: PET investigations. *Journal of Cognitive Neuroscience* 5, 263–287.
- Kosslyn, S. M., Ball, T. M., & Reiser, B. J. (1978). Visual images preserve metric spatial information: Evidence from studies of image scanning. *Journal of Experimental Psychology: Human Perception and Performance*, 4, 47–60.
- Kosslyn, S. M., Ganis, G., & Thompson, W. L. (2001). Neural foundations of imagery. *Nature Reviews Neuroscience* 2, 635–642.
- Kosslyn, S. M., Pascual-Leone, A., Felician, O., Camposano, S., Keenan, J. P., Thompson, W. L., Ganis, G., Sukel, K. E., & Alpert, N. M. (1999). The role of area 17 in visual imagery: Convergent evidence from PET and rTMS. *Science* 284, 167–170.
- Kosslyn, S. M., Thompson, W. L., Wrager, M. J., & Alpert, N. M. (2001). Imagining rotation by endogenous and exogenous forces: Distinct neural mechanisms for different strategies. *Neuroreport*, 12, 2519–2525.
- Kotkin, M., Daviet, C., & Gurin, J. (1996). The *Consumer Reports* mental health survey. *American Psychologist*, 51(10), 1080–1082.
- Kovacs, K., Lajtha, A., & Sershen, H. (2010). Effect of nicotine and cocaine on neurofilaments and receptors in whole brain tissue and synaptoneurosome preparations. *Brain Research Bulletin*, 82(1–2): 109–117.
- Kozberg, M., Chen, B. R., De Leo, S. E., Bouchard, M. B., & Hillman, E. M. C. (2013). Resolving the transition from negative to positive blood oxygen level-dependent responses in the developing brain. *Proceedings of the National Academy of Sciences of the United States of America (PNAS)*. Published online ahead of print, February 20, 2013. doi: 10.1073/pnas.1212785110
- Kratofil, P. H., Baberg, H. T., & Dimsdale, J. E. (1996). Self-mutilation and severe self-injurious behavior associated with amphetamine psychosis. *General Hospital Psychiatry*, 18, 117–120.
- Kreipe, R. E. (1992). Normal somatic adolescent growth and development. In E. McAnarney, R. E. Kreipe, D. Orr, & G. Comerci (Eds.), *Textbook of adolescent medicine* (pp. 44–68). Philadelphia: W.B. Saunders & Co.
- Kriegstein, A., & Alvarez-Buylla, A. (2009). The glial nature of embryonic and adult neural stem cells. *Annual Review of Neuroscience*, 32(1), 149–184.
- Kristensen, P., & Bjerkedal, T. (2007). Explaining the relation between birth order and intelligence. *Science*, 316(5832), 1717.
- Kroenke, C. H., Quesenberry, C., Kwan, M. L., Sweeney, C., Castillo, A., & Caan, B. J. (2012). Social networks, social support, and burden in relationships, and mortality after breast cancer diagnosis in the Life After Breast Cancer Epidemiology (LACE) study. *Breast Cancer Research and Treatment*, 137(1), 261. doi: 10.1007/s10549-012-2253-8
- Krüttner, S., Stepien, B., Noordermeer, J. N., Mommaas, M. A., Mechteder, K., Dickson, B. J., & Keleman, K. (2012). Drosophila CPEB Orb2A mediates memory independent of its RNA-binding domain. *Neuron*, 76(2), 383. doi: 10.1016/j.neuron.2012.08.028
- Kryger, M., Lavie, P., & Rosen, R. (1999). Recognition and diagnosis of insomnia. *Sleep*, 22, S421–S426.
- Kubicki, M., Niznikiewicz, M., Connor, E., Nestor, P., Bouix, S., Dreusicke, M., Kikinis, R., McCarley, R., & Shenton, M. (2009). Relationship between white matter integrity, attention, and memory in schizophrenia: A diffusion tensor imaging study. *Brain Imaging and Behavior*, 3(2), 191–201.
- Kübler-Ross, E. (1997). *The wheel of life: A memoir of living and dying*. New York: Touchstone.

- Kuhn, H. W., & Nasar, S. (Eds.). (2001). *The essential John Nash*. Princeton, NJ: Princeton University Press.
- Kuhn, J., Gründler, T. O. J., Lenartz, D., Sturm, V., Klosterkötter, J., & Huff, W. (2010). Deep brain stimulation for psychiatric disorders. *Deutsches Ärzteblatt International*, 107 (7), 105–113.
- Kulik, J. A., & Mahler, H. I. M. (1989). Social support and recovery from surgery. *Health Psychology*, 8, 221–238.
- Kulik, J. A., & Mahler, H. I. M. (1993). Emotional support as a moderator of adjustment and compliance after coronary bypass surgery: A longitudinal study. *Journal of Behavioral Medicine*, 16, 45–63.
- Kulmala, J., von Bonsdorff, M. B., Stenholm, S., Tormakangas, T., von Bonsdorff, M. E., Nygard, C.-H., Klockars, M., Seitsamo, J., Ilmarinen, J., & Rantanen, T. (2013). Perceived stress symptoms in midlife predict disability in old age: A 28-year prospective cohort study. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, doi: 10.1093/gerona/gls339
- Kumar, S., & Oakley-Browne, M. (2002). Panic disorder. *Clinical Evidence*, 7, 906–912.
- Küntay, A., & Slobin, D. I. (2002). Putting interaction back into child language: Examples from Turkish. *Psychology of Language and Communication*, 6, 5–14.
- Kuo, B. C. H. (2011). Culture's consequences on coping: Theories, evidences, and dimensionalities. *Journal of Cross-Cultural Psychology*, 42, 1084. doi: 10.1177/0022022110381126
- Kupfer, D. J., & Reynolds, C. F. III. (1997). Management of insomnia. *New England Journal of Medicine*, 336(5), 341–346.
- Kuriki, I., Ashida, H., Murakami, I., & Kitaoka, A. (2008). Functional brain imaging of the Rotating Snakes illusion by fMRI. *Journal of Vision*, 8(10), 16 11–10.
- Kvavilashvili, L., Mirani, J., Schlagman, S., Foley, K., & Dornbrot, D. E. (2009). Consistency of flashbulb memories of September 11 over long delays: Implications for consolidation and wrong time slice hypotheses. *Journal of Memory and Language*, 61(4), 556–572.
- LaBar, K. S., LeDoux, J. E., Spencer, D. D., & Phelps, E. A. (1995). Impaired fear conditioning following unilateral temporal lobectomy in humans. *Journal of Neuroscience*, 15, 6846–6855.
- LaBerge, D. (1980). Unitization and automaticity in perception. In J. H. Flowers (Ed.), *Nebraska Symposium on Motivation* (pp. 53–71). Lincoln: University of Nebraska Press.
- Labouvie-Vief, G. (1980). Beyond formal operations: Uses and limits of pure logic in lifespan development. *Human Development*, 23, 114–146.
- Labouvie-Vief, G. (1992). A neo-Piagetian perspective on adult cognitive development. In R. Sternberg & C. Berg (Eds.), *Intellectual development* (pp. 197–228). Cambridge, UK: Cambridge University Press.
- Lacayo, A. (1995). Neurologic and psychiatric complications of cocaine abuse. *Neuropsychiatry, Neuropsychology, and Behavioral Neurology*, 8(1), 53–60.
- LaFromboise, T., Coleman, H. L. K., & Gerton J. (1993). Psychological impact of biculturalism: Evidence and theory. *Psychological Bulletin*, 114, 395–412.
- Lagopoulos, J., Xu, J., Rasmussen, I., Vik, A., Malhi, G. S., Eliassen, C. F., Arntsen, I. E., Sæther, J. G., Hollup, S., Holen, A., Davanger, S., & Ellingsen, Ø. (2009). Increased theta and alpha EEG activity during nondirective meditation. *The Journal of Alternative and Complementary Medicine*, 15(11), 1187.
- Lal, S. (2002). Giving children security: Mamie Phipps Clark and the radicalization of child psychology. *American Psychologist*, 57(1), 20–28.
- Lalancette, M.-F., & Standing, L. G. (1990). Asch fails again. *Social Behavior and Personality*, 18(1), 7–12.
- Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (5th ed.) (pp. 139–193). New York: Wiley.
- Lambert, N., Fincham, F. D., Dewall, N. C., Pond, R., & Beach, S. R. (2013). Shifting toward cooperative tendencies and forgiveness: How partner-focused prayer transforms motivation. *Personal Relationships*, 20(1), 184. doi: 10.1111/j.1475-6811.2012.01411.x
- Lance, C. J., LaPointe, J. A., & Fisicaro, S. (1994). Tests of three causal models of halo rater error. *Organizational Behavior and Human Decision Performance*, 57, 83–96.
- Landrum, R. E. (2009). Finding jobs with a psychology bachelor's degree. Washington, DC: American Psychological Association.
- Landrum, R. E., & Davis, S. F. (2007). *The psychology major: Career options and strategies for success*, 3rd ed. Upper Saddle River, NJ: Prentice Hall.
- Lane, R. D., Kivley, L. S., DuBois, M. A., Shamasundara, P., & Schwartz, G. E. (1995). Levels of emotional awareness and the degree of right hemisphere dominance in the perception of facial emotion. *Neuropsychologia*, 33, 525–538.
- Lang, J. W. B., & Lang, J. (2010). Priming competence diminishes the link between cognitive test anxiety and test performance. *Psychological Science*, 21(6), 811–819.
- Lange, C. (1885). The emotions. Reprinted in C. G. Lange & W. James (Eds.), *The emotions*. New York: Harner.
- Langer, E. J., & Rodin, J. (1976). The effects of enhanced personal responsibility for the aged: A field experiment in an institutional setting. *Journal of Personality and Social Psychology*, 34, 191–198.
- Langone, M. C. (1996). Clinical update on cults. *Psychiatric Times*, 13(7), 1–3.
- Lamphear, B. P., Dietrich, K., Auinger, P., & Cox, C. (2000). Cognitive deficits associated with blood lead concentrations <10 micrograms/dL in U.S. children and adolescents. *Public Health Reports*, 115(6), 521–529.
- Lapierre, M. A., Vaala, S. E., & Linebarger, D. L. (2011). Influence of licensed spokescharacters and health cues on children's ratings of cereal taste. *Archives of Pediatric & Adolescent Medicine*, 135(3), 229–234. doi: 10.1001/archpediatrics.2010.300
- Lapsley, D. K., Milstead, M., Quintana, S. M., Flannery, D., & Buss, R. R. (1986). Adolescent egocentrism and formal operations: Tests of a theoretical assumption. *Developmental Psychology*, 22, 800–807.
- Larsen, J. T., Berntson, G. G., Poehlmann, K. M., Ito, T. A., & Cacioppo, J. T. (2008). The psychophysiology of emotion. In M. Lewis, J. M. Haviland-Jones, & L. F. Barrett (Eds.), *Handbook of Emotions* (3rd ed., pp. 180–195). New York: Guilford Press.
- Larzelere, R. (1986). Moderate spanking: Model or deterrent of children's aggression in the family? *Journal of Family Violence*, 1(1), 27–36.
- Lashley, K. S. (1938). The thalamus and emotion. *The Psychological Review*, 45, 21–61.
- Lasnik, H. (1990). Metrics and morphophonemics in early English verse. *University of Connecticut Working Papers in Linguistics: Vol. 3* (pp. 29–40). Storrs: University of Connecticut.
- Latané, B., & Darley, J. M. (1969). Bystander "apathy." *American Scientist*, 57(2), 244–268.
- Latané, B., Williams, K., & Harkins, S. (1979). Many hands make light the work: The causes and consequences of social loafing. *Journal of Personality & Social Psychology*, 37(6), 822–832.
- Laumann, E. O., Gagnon, J. H., Michael, R. T., and Michaels, S. (1994). *The social organization of sexuality: Sexual practices in the United States* (pp. 77–145). Chicago: University of Chicago Press.
- Launer, L., Masaki, K., Petrovitch, H., Foley, D., & Havlik, R. (1995). The association between midlife blood pressure levels and late-life cognitive function. *Journal of the American Medical Association*, 272(23), 1846–1851.
- Lavergne, G. M. (1997). *A sniper in the tower: The true story of the Texas Tower massacre*. New York: Bantam.
- Laviolette, S. R., Lauzon, N. M., Bishop, S. F., Sun, N. & Tan, H. (2008). Dopamine signaling through D1-like versus D2-like receptors in the nucleus accumbens core versus shell differentially modulates nicotine reward sensitivity. *Journal of Neuroscience* Aug 6; 28(32): 8025–8033.
- Laws, G., Davies, I., & Andrews, C. (1995). Linguistic structure and nonlinguistic cognition: English and Russian blues compared. *Language and Cognitive Processes*, 10, 59–94.
- Lay, C., & Nguyen, T. T. I. (1998). The role of acculturation-related and acculturation non-specific daily hassles: Vietnamese-Canadian students and psychological distress. *Canadian Journal of Behavioural Science*, 30(3), 172–181.
- Lazarus, R. S. (1991). *Emotion and adaptation*. New York: Oxford University Press.
- Lazarus, R. S. (1993). From psychological stress to the emotions: A history of changing outlooks. *Annual Review of Psychology*, 44, 1–22.
- Lazarus, R. S. (1999). *Stress and emotion: A new synthesis*. New York: Springer.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.
- Leary, M. R., & Forsyth, D. R. (1987). Attributions of responsibility for collective endeavors. *Review of Personality and Social Psychology*, 8, 167–188.
- Leask, J., Haber, R. N., & Haber, R. B. (1969). Eidetic imagery in children: II. Longitudinal and experimental results. *Psychonomic Monograph Supplements*, 3, 25–48.
- Leccece, A. P., Pennings, E. J. M., & De Wolff, F. A. (2000). *Combined use of alcohol and psychotropic drugs. A review of the literature*. Leiden, The Netherlands: Academic Ziekenhuis Leiden (AZL).
- Leclerc, C. M., & Hess, T. M. (2007). Age differences in the bases for social judgments: Tests of a social expertise perspective. *Experimental Aging Research*, 33(1), 95–120.
- LeDoux, J. (1994). Emotion, memory and the brain. *Scientific American*, 270, 32–39.

- LeDoux, J. (2003). The emotional brain, fear, and the amygdala. *Cellular and Molecular Neurobiology*, 23(4–5), 727–738.
- LeDoux, J. E. (1996). *The emotional brain: The mysterious underpinnings of emotional life*. New York: Simon & Schuster.
- LeDoux, J. E. (2007). The amygdala. *Current Biology*, 17(20), R868–R874.
- LeDoux, J. E., & Damasio, A. R. (2013). Emotions and feelings. In E. R. Kandel, J. H. Schwartz, T. M. Jessell, S. A. Siegelbaum, & A. J. Hudspeth (Eds.), *Principles of neural science* (5th ed., pp. 1079–1094). USA: McGraw-Hill.
- LeDoux, J. E., & Phelps, E. A. (2008). Emotional networks in the brain. In M. Lewis, J. M. Haviland-Jones, & L. F. Barrett (Eds.), *Handbook of emotions* (3rd ed., pp. 159–179). New York: Guilford Press.
- Lee, F., Hallahan, M., & Herzog, T. (1996). Explaining real life events: How culture and domain shape attributions. *Personality and Social Psychology Bulletin*, 22, 732–741.
- Lee, M., & Shlain, B. (1986). *Acid dreams: The complete social history of LSD: The sixties, and beyond*. New York: Grove Press.
- Lee, P. A. (1995). Physiology of puberty. In K. L. Becker (Ed.), *Principles and practice of endocrinology and metabolism* (pp. 822–830). Philadelphia: J.B. Lippincott.
- Lee, S. H., Kim, E. Y., Kim, S., & Bae, S. M. (2010). Event-related potential patterns and gender effects underlying facial affect processing in schizophrenia patients. *Neuroscience Research*, 7, 7.
- Lehnert, B. (2007). Joint wave-particle properties of the individual photon. *Progress in Physics*, 4(10), 104–108.
- Lehr, U., & Thomae, H. (1987). Patterns of psychological aging. *Results from the Bonne Aging Longitudinal Study (BOLS)*. Stuttgart, Germany: Enke.
- Leibel, R. L., Rosenbaum, M., & Hirsch, J. (1995). Changes in energy expenditure resulting from altered body weight. *The New England Journal of Medicine*, 332, 621–628.
- Leon, P., Chedraui, P., Hidalgo, L., & Ortiz, F. (2007). Perceptions and attitudes toward the menopause among middle-aged women from Guayaquil, Ecuador. *Maturitas*, 57(3), 233–238.
- Leonard, L. (1997). *Children with specific language impairment*. Cambridge, MA: MIT Press.
- Leong, F. T. L., Hartung, P. J., Goh, D., & Gaylor, M. (2001). Appraising birth order in career assessment: Linkages to Holland's and Super's models. *Journal of Career Assessment*, 9, 25–39.
- LePort, A. K., Mattfeld, A. T., Dickinson-Anson, H., Fallon, J. H., Stark, C. E., Kruggel, F., Cahill, L., & McGaugh, J. L. (2012). Behavioral and neuroanatomical investigation of Highly Superior Autobiographical Memory (HSAM). *Neurobiology of Learning and Memory*, 98(1), 78. doi: 10.1016/j.nlm.2012.05.002
- Leroy, C., & Symes, B. (2001). Teachers' perspectives on the family backgrounds of children at risk. *McGill Journal of Education*, 36(1), 45–60.
- Leslie, M. (2000, July/August). The vexing legacy of Louis Terman. *Stanford Magazine*. Retrieved on August 12, 2010, from <http://www.stanfordalumni.org/news/magazine/2000/julaug/articles/terman.html>
- Levenson, R. W. (1992). Autonomic nervous system differences among emotions. *Psychological Sciences*, 3, 23–27.
- Levenson, R. W., Ekman, P., Heider, K., & Friesen, W. V. (1992). Emotion and autonomic nervous system activity in the Minangkabau of West Sumatra. *Journal of Personality and Social Psychology*, 62, 972–988.
- Levy, B. R., Slade, M. D., Kunkel, S. R., & Kasl, S. V. (2002). Longevity increased by positive self-perceptions of aging. *Journal of Personality and Social Psychology*, 83, 261–269.
- Lewis, D. K. (1996, June). A cross-cultural model for psychotherapy: Working with the African-American client. *Perspectives on Multiculturalism and Cultural Diversity*, VI(2).
- Lewis, J. R. (1995). *Encyclopedia of afterlife beliefs and phenomenon*. Detroit, MI: Visible Ink Press.
- Lewis, R. W., Fugl-Meyer, K. S., Corona, G., Hayes, R. D., Laumann, E. O., Moreira, E. D., Jr., ... Segraves, T. (2010). Definitions/epidemiology/risk factors for sexual dysfunction. *The Journal of Sexual Medicine*, 7(4pt2), 1598–1607. doi: 10.1111/j.1743-6109.2010.01778.x
- Liechti, M. E., & Vollenweider, F. X. (2001). Which neuroreceptors mediate the subjective effects of MDMA in humans? A summary of mechanistic studies. *Human Psychopharmacology* 16: 589–598.
- Light, K. R., Kolata, S., Wass, C., Denman-Brice, A., Zagalsky, R., & Matzel, L. D. (2010). Working memory training promotes general cognitive abilities in genetically heterogeneous mice. *Current Biology*, 20(8), 777–782.
- Like, R., Steiner, P., & Rubel, A. (1996). Recommended core curriculum guidelines on culturally sensitive and competent care. *Family Medicine*, 27, 291–297.
- Lilienfeld, S. O. (1999). Projective measures of personality and psychopathology: How well do they work? *Skeptical Inquirer*, 23(5), 32–39.
- Lilienfeld, S. O., Lynn, S. J., & Lohr, J. M. (2004). Science and pseudoscience in clinical psychology: Initial thoughts, reflections, and considerations. In S. O. Lilienfeld, S. J. Lynn, & J. M. Lohr (Eds.), *Science and pseudoscience in clinical psychology* (p. 2). New York: Guilford Press.
- Lilienfeld, S. O., Wood, J. M., & Garb, H. N. (2000). The scientific status of projective techniques. *Psychological Science in the Public Interest*, 1(2), 27–66. doi: 10.1111/1529-1006.002
- Lim, J., Choo, W. C., & Chee, M. W. L. (2007). Reproducibility of changes in behavior and fMRI activation associated with sleep deprivation in a working memory task. *Sleep*, 30, 61–70.
- Lim, M. M., & Young, L. J. (2006). Neuropeptidergic regulation of affiliative behavior and social bonding in animals. *Hormones and Behavior*, 50(4), 506–517. doi: 10.1016/j.yhbeh.2006.06.028
- Lim, Y. Y., Ellis, K. A., Pietrzak, R. H., Ames, D., Darby, D., Harrington, K., Martins, R. N., Masters, C. L., Rowe, C., Savage, G., Szoek, C., Villemagne, V. L., & Maruff, P. (2012). Stronger effect of amyloid load than APOE genotype on cognitive decline in healthy older adults. *Neurology*, 79(16), 1645. doi: 10.1212/WNL.0b013e31826e9ae6
- Lin, C. S., Lyons, J. L., and Berkowitz, F. (2007). Somatotopic identification of language-SMA in language processing via fMRI. *Journal of Scientific and Practical Computing* 1(2), 3–8.
- Lin, P. J., & Schwanenflugel, P. J. (1995). Cultural familiarity and language factors in the structure of category knowledge. *Journal of Cross-Cultural Psychology*, 26, 153–168.
- Lin, P. J., Schwanenflugel, P. J., & Wisenbaker, J. M. (1990). Category typicality, cultural familiarity, and the development of category knowledge. *Developmental Psychology*, 26, 805–813.
- Lindau, S. T., Schumm, P., Laumann, E. O., Levinson, W., O'Muircheartaigh, C. A., & Waite, L. J. (2007). A study of sexuality and health among older adults in the United States. *New England Journal of Medicine*, 357(8), 762–764.
- Lindemann, B. (1996). Taste reception. *Physiological Review*, 76, 719–766.
- Lindsey, E. W., Cremeens, P. R., & Caldera, Y. M. (2010). Gender differences in mother–toddler and father–toddler verbal initiations and responses during a caregiving and play context. *Sex Roles*, 62(11–12), 746–759.
- Lindsey, E. W., Cremeens, P. R., & Caldera, Y. M. (2010). Gender Differences in mother–toddler and father–toddler verbal initiations and responses during a caregiving and play context. *Sex Roles*. Retrieved June 21, 2010, from <http://www.springerlink.com/content/q261154773764443/>
- Linn, M. C., & Petersen, A. C. (1985). Emergence and characterization of sex differences in spatial ability: A meta-analysis. *Child Development*, 56(6), 1479–1498.
- Lipsman, N., Woodside, D. B., Giacobbe, P., Hamani, C., Carter, J. C., Norwood, S. J., . . . Lozano, A. M. (2013). Subcallosal cingulate deep brain stimulation for treatment-refractory anorexia nervosa: A phase 1 pilot trial. *Lancet*, 381(9875), 1361–1370. doi: 10.1016/s0140-6736(12)62188-6
- Lisanby, S. H., Maddox, J. H., Prudic, J., Devanand, D. P., & Sackeim, H. A. (2000). The effects of electroconvulsive therapy on memory of autobiographical and public events. *Archives of General Psychiatry*, 57, 581–590.
- Livesley, J. W. (Ed.). (1995). *The DSM-IV Personality disorders*. New York: Guilford Press.
- Lizkowski, U., Carpenter, M., Striano, T., & Tomasello, M. (2006). 12- and 18-month-olds point to provide information for others. *Journal of Cognition and Development*, 7, 173–187.
- Lock, M. (1994). Menopause in cultural context. *Experimental Gerontology*, 29(3–4), 307–317.
- Loehlin, J. C. (1992). *Genes and environment in personality development*. Newbury Park, CA: Sage.
- Loehlin, J. C., McCrae, R. R., Costa, P. T., Jr., & John, O. P. (1998). Heritabilities of common and measure-specific components of the Big Five personality factors. *Journal of Research in Personality*, 32, 431–453.
- Loehlin, J. C., Willerman, L., & Horn, J. M. (1985). Personality resemblances in adoptive families when the children are late-adolescent or adult. *Journal of Personality and Social Psychology*, 48, 376–392.
- Loftus, E. (1975). Leading questions and the eyewitness report. *Cognitive Psychology*, 7, 560–572.

- Loftus, E. (1987, June 29). Trials of an expert witness. *Newsweek*, 109: 10–11.
- Loftus, E. F., & Loftus, G. R. (1980). On the permanence of stored information in the human brain. *American Psychologist*, 35, 409–420.
- Loftus, E. F., Miller, D. G., & Burns H. J. (1978). Semantic integration of verbal information into a visual memory. *Journal of Experimental Psychology: Human Learning*, 4, 19–31.
- Loftus, J. (2001). America's liberalization in attitudes toward homosexuality, 1973 to 1998. *American Sociological Review*, 66(5), 762–782.
- Loo, S. K., Hale, T. S., Macion, J., Hanada, G., McGough, J. J., McCracken, J. T., et al. (2009). Cortical activity patterns in ADHD during arousal, activation and sustained attention. *Neuropsychologia*, 47(10), 2114–2119.
- Lord, T. R. (2001). 101 reasons for using cooperative learning in biology teaching. *The American Biology Teacher*, 63(1), 30–38.
- Lorenz, K. (1966). *On Aggression* (p. ix). (Marjorie Kerr Wilson, Trans.) New York: Harcourt, Brace & World, Inc.
- Lorenzo, G. L., Biesanz, J. C., & Human, L. J. (2010). What is beautiful is good and more accurately understood: Physical attractiveness and accuracy in first impressions of personality. *Psychological Science*, 21, 1777–1782.
- Lovaas, O. I. (1964). Cue properties of words: The control of operant responding by rate and content of verbal operants. *Child Development*, 35, 245–256.
- Lovaas, O. I. (1987). Behavioral treatment and normal educational and intellectual functioning in young autistic children. *Journal of Consulting and Clinical Psychology*, 55, 3–9.
- Lovaas, O. I., Berberich, J. P., Perloff, B. F., & Schaffer, B. (1966). Acquisition of imitative speech by schizophrenic children. *Science*, 151, 705–707.
- Lu, S., & Ende, N. (1997). Potential for clinical use of viable pluripotent progenitor cells in blood bank stored human umbilical cord blood. *Life Sciences*, 61, 1113–1123.
- Lubinski, D. (2000). Scientific and social significance of assessing individual differences: "Sinking shafts at a few critical points." *Annual Review of Psychology*, 51, 405–444.
- Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "everyone has won and all must have prizes"? *Archives of General Psychiatry*, 32, 995–1008.
- Luby, J. L. (2010). Preschool depression: The importance of identification of depression early in development. *Current Directions in Psychological Science*, 19(2), 91–95.
- Luchins, A. S. (1957). Primacy-recency in impression formation. In C. Hovland (Ed.), *The order of presentation in persuasion* (pp. 33–40, 55–61). New Haven, CT: Yale University Press.
- Luck, S. J., & Gold, J. M. (2008). The construct of attention in schizophrenia. *Biological Psychiatry*, 64(1), 34–39.
- Lucy, J. A., & Shweder, R. A. (1979). Whorf and his critics: Linguistic and nonlinguistic influences on color memory. *American Anthropologist*, 81, 581–615.
- Luria, A. R. (1965). Two kinds of motor perseveration in massive injury of the frontal lobes. *Brain*, 88, 1–10.
- Luria, A. R. (1968). *The mind of a mnemonist* (pp. 24, 25). New York: Basic Books.
- Lurito, J. T., Dzemidzic, M., Mathews, V. P., Lowe, M. J., Karenken, D. A., Phillips, M. D., & Wang, Y. (2000). Comparison of hemispheric lateralization using four language tasks. *Neuroimage*, 11, S358.
- Lutkenhaus, P., Grossmann, K. E., & Grossman, K. (1985). Infant–mother attachment at twelve months and style of interaction with a stranger at the age of three years. *Child Development*, 56, 1538–1542.
- Lydiard, R. B. (2003). The role of GABA in anxiety disorders. *The Journal of Clinical Psychiatry*, 64(Suppl. 3), 21–27.
- Lykken, D. T. (1995). *The antisocial personalities*. Hillsdale, NJ: Laurence Erlbaum.
- Lykken, D. T., & Tellegen, A. (1996). Happiness is a stochastic phenomenon. *Psychological Science*, 7, 186–189.
- Lynott, P. P., & Roberts, R. (1997). The developmental stake hypothesis and changing perceptions of intergenerational relations, 1971–1985. *The Gerontologist*, 37, 394–405.
- Lyttton, H., & Romney, D. M. (1991). Parents' sex-differentiated socialization of boys and girls: A meta-analysis. *Psychological Bulletin*, 109, 267–296.
- Lyvers, M. (2003). The neurochemistry of psychedelic experiences. *Science & Consciousness Review*, 1, 1–5.
- Lyznicki, J. M., Doege, T. C., Davis, R. M., & Williams, M. A. (Council on Scientific Affairs, American Medical Association). (1998). Sleepiness, driving, and motor-vehicle crashes. *Journal of the American Medical Association*, 279(23), 1908–1913.
- Ma, J., Han, Y., Grogan-Kaylor, A., Delva, J., & Castillo, M. (2012). Corporal punishment and youth externalizing behavior in Santiago, Chile. *Child Abuse & Neglect*, 36(6), 481–490. doi: 10.1016/j.chab.2012.03.006
- Maccoby, E. E. (1998). The two sexes: Growing up apart: Coming together. Cambridge, MA: Belknap Press.
- MacCoun, R. J., & Kerr, N. L. (1988). Asymmetric influence in mock jury deliberation: Jurors' bias for leniency. *Journal of Personality and Social Psychology*, 54, 21–33.
- MacDonald, A. P. (1970). Internal-external locus of control and the practice of birth control. *Psychological Reports*, 27, 206.
- MacDonald, D., Kabani, N., Avis, D., & Evens, A. C. (2000). Automated 3D extraction of inner and outer surfaces of cerebral cortex from MRI. *NeuroImage*, 12, 340–356.
- Macdonald, I., Amos, J., Crone, T., Wereley, S. (2010, May 21). The measure of an oil disaster. [Electronic version]. New York Times. Retrieved June 9, 2010, from <http://www.nytimes.com/2010/05/22/opinion/22macdonald.html>
- Maciejewski, P. K., Zhang, B., Block, S. D., & Prigerson, H. G. (2007). An empirical examination of the stage theory of grief. *The Journal of the American Medical Association*, 297(7), 716–723. doi:10.1001/jama.297.7.716
- MacKenzie, S. B., Lutz, R. J., & Belch, G. E. (1986, May). The role of attitude toward the ad as a mediator of advertising effectiveness: A test of competing explanations. *Journal of Marketing Research*, 23, 130–143.
- Mack, J. E. (1994). *Abduction*. New York: Scribner.
- Macknik, S. L., King, M., Randi, J., Robbins, A., Teller, Thompson, J., & Martinez-Conde, S. (2008). Attention and awareness in stage magic: Turning tricks into research. *Nature Reviews: Neuroscience*, 9(11), 871–879.
- Macknik, S. L., & Martinez-Conde, S. (2009). Real magic: Future studies of magic should be grounded in neuroscience. *Nature reviews: Neuroscience*, 10(3), 241–241.
- Macquet, P., & Franck, G. (1996). Functional neuroanatomy of human rapid eye movement sleep and dreaming. *Nature*, 383, 163–166.
- Macrae, C. N., & Bodenhausen, G. V. (2000). Social cognition: Thinking categorically about others. *Annual Review of Psychology*, 51, 93–120.
- Macrae, C. N., & Quadflieg, S. (2010). Perceiving people. In S. Fiske, D. T. Gilbert, & G. Lindzey (Eds.), *The handbook of social psychology* (5th ed., pp. 428–463). New York: McGraw-Hill.
- Madsen, K. M., Hvilstedt, A., Vestergaard, M., Schendel, D., Wohlfahrt, J., Thorsen, P., Olsen, J., & Melbye, M. (2002). A population-based study of measles, mumps, rubella vaccine and autism. *New England Journal of Medicine*, 347, 1477–1482.
- Mahoney, M. J. (2005). Constructivism and positive psychology. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 745–750). New York: Oxford University Press.
- Mahowald, M. W., & Schenck, C. H. (1996). NREM sleep parasomnias. *Neurologic Clinics*, 14, 675–696.
- Maier, S. F., Amat, J., Baratta, M. V., Paul, E., & Watkins, L. R. (2006). Behavioral control, the medial prefrontal cortex, and resilience. *Dialogues in Clinical Neuroscience*, 8(4), 397–406.
- Maier, S. F., & Watkins, L. R. (1998). Cytokines for psychologists: Implications of bidirectional immune-to-brain communication for understanding behavior, mood, and cognition. *Psychological Review*, 105, 83–107.
- Maier, S. F., & Watkins, L. R. (2005). Stressor controllability and learned helplessness: The roles of the dorsal raphe nucleus, serotonin, and corticotropin-releasing factor. *Neuroscience & Biobehavioral Reviews*, 29(4–5), 829–841.
- Main, M., & Cassidy, J. (1988). Categories of response to reunion with the parent at age 6: Predictable from infant attachment classifications and stable over a 1 month period. *Developmental Psychology*, 24, 415–426.
- Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behaviour the linking mechanism? In M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years: Theory, research and intervention* (pp. 161–182). Chicago: University of Chicago Press.
- Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years: Theory, research and intervention* (pp. 121–160). Chicago: University of Chicago Press.
- Maletic, V., Robinson, M., Oakes, T., Iyengar, S., Ball, S. G., & Russell, J. (2007). Neurobiology of depression: An integrated view of key findings. *The International Journal of Clinical Practice*, 61(12), 2030–2040.

- Mandler, G. (1967). Organization and memory. In K. W. Spence & J. T. Spence (Eds.), *The psychology of learning and motivation, Vol. 1* (pp. 327–372). New York: Academic Press.
- Mangalindan, J. P. (2012). Google: The king of perks – CNN Money. Retrieved May 30, 2013, from <http://money.cnn.com/galleries/2012/technology/1201/gallery-best-companies-google-perks.fortune/index.html>
- Manusov, V., & Patterson, M. L. (Eds.). (2006). *The Sage handbook of nonverbal communication* (p. 289). Thousand Oaks, CA: Sage.
- Maquet, P., Schwartz, S., Passingham, R., & Frith, C. (2003). Sleep-related consolidation of a visuomotor skill: Brain mechanisms as assessed by functional magnetic resonance imaging. *The Journal of Neuroscience*, 23(4), 1432.
- March of Dimes Foundation, 2009. Organization of Teratology Information Specialists, 2011.
- Marcus, G. F. (2001). *The algebraic mind: Integrating connectionism and cognitive science (learning, development, and conceptual change)*. Cambridge, MA: MIT Press.
- Maren, S., & Fanselow, M. S. (1996). The amygdala and fear conditioning: Has the nut been cracked? *Neuron*, 16, 237–240.
- Margolin, S., & Kubic, L. S. (1944). An apparatus for the use of breath sounds as a hypnagogic stimulus. *American Journal of Psychiatry*, 100, 610.
- Marik, P. E. (2000). Leptin, obesity, and obstructive sleep apnea. *Chest*, 118, 569–571.
- Markowitz, J. H., Lewis, C. E., Sanders, P. W., Tucker, D., & Warnock, D. G. (1997). Relationship of diastolic blood pressure with cyclic GMP excretion among young adults (the CARDIA study): Influence of a family history of hypertension. *Journal of Hypertension*, 15(9), 955–962.
- Marks, D. F., Murray, M., Evans, B., Willig, C., Sykes, C. M., & Woodall, C. (2005). *Health Psychology: Theory, research & practice* (pp. 3–25). London: Sage.
- Marks, K. (2010). Round-the-world teenage sailor Jessica Watson gets hero's welcome in Australia. *The Christian Science Monitor*, May 16, 2010. Retrieved June 27, 2010, from <http://www.csmonitor.com/World/Asia-Pacific/2010/0516/Round-the-world-teenage-sailor-Jessica-Watson-gets-hero-s>Welcome-in-Australia>
- Mars, A. E., Mauk, J. E., & Dowrick, P. (1998). Symptoms of pervasive developmental disorders as observed in prediagnostic home videos of infants and toddlers. *Journal of Pediatrics*, 132, 500–504.
- Martin, C. L. (2000). Cognitive theories of gender development. In T. Eckes & H. M. Trautner (Eds.), *The developmental social psychology of gender* (pp. 91–121). Mahwah, NJ: Lawrence Erlbaum.
- Martin, J. A., & Buckwalter, J. J. (2001). Telomere erosion and senescence in human articular cartilage chondrocytes. *Journal of Gerontology and Biological Science*, 56(4), 172–179.
- Martin, L. (2004). Can sleepwalking be a murder defense? Retrieved October 19, 2004, from <http://www.lakesidepress.com/pulmonary/Sleep/sleep-murder.htm>
- Martínez-Frías, M. L., Bermejo, E., Mendioroz, J., Rodríguez-Pinilla, E., Blanco, M., Egüés, J., Félix, V., García, A., Huertas, H., Nieto, C., López, J. A., López, S., Paísán, L., Rosa, A., & Vázquez, M. S. (2009). Epidemiological and clinical analysis of a consecutive series of conjoined twins in Spain. *Journal of Pediatric Surgery*, 44(4), 811–820. doi: 10.1016/j.jpedsurg.2008.07.002
- Martinussen, R., Hayden J., Hogg-Johnson, S., & Tannock, R. (2005). A meta-analysis of working memory components in children with Attention-Deficit/Hyperactivity Disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, 44(4), 377–384.
- Martyn, A. C., De Jaeger, X., Magalhaes, A. C., Kesarwani, R., Goncalves, D. F., Raulic, S., Guzman, M. S., Jackson, M. F., Izquierdo, I., MacDonald, J. F., Prado, M. A. M., & Prado, V. F. (2012). Elimination of the vesicular acetylcholine transporter in the forebrain causes hyperactivity and deficits in spatial memory and long-term potentiation. *Proceedings of the National Academy of Sciences*, 109(43), 17651–17656. doi: 10.1073/pnas.1215381109
- Maruta, T., Colligan, R. C., Malinchoc, M., & Offord, K. P. (2002, August). Optimism-pessimism assessed in the 1960s and self-reported health status 30 years later. *Mayo Clinic Proceedings*, 77, 748–753.
- Mary Ann Liebert, Inc./Genetic Engineering News. (2010). Virtual Reality and Other Technologies Offer Hope for More Effective Treatment of Posttraumatic Stress Disorder.
- Maslow, A. (1943). A theory of human motivation. *Psychological Review*, 50, 370–396.
- Maslow, A. (1971). *The farther reaches of human nature*. New York: Viking Press.
- Maslow, A. (1987). *Motivation and personality* (3rd ed.). New York: Harper & Row.
- Maslow, A. H. (1954). *Motivation and personality*. New York: Harper & Row.
- Maslow, A., & Lowery, R. (Eds.). (1998). *Toward a psychology of being* (3rd ed.). New York: Wiley & Sons.
- Massaro, D. W., & Cowan, N. (1993). Information processing models: Microscopes of the mind. *Annual Review of Psychology*, 44, 383–426.
- Masson, J. M. (1984). *The assault on truth: Freud's suppression of the seduction theory*. New York: Farrar, Straus & Giroux.
- Masters, J. C., Burish, T. G., Holton, S. D., & Rimm, D. C. (1987). *Behavior therapy: Techniques and empirical finding*. San Diego, CA: Harcourt Brace Jovanovich.
- Masters, W. H., & Johnson, V. E. (1970). *Human sexual inadequacy*. Boston: Little, Brown.
- Masters, W., & Johnson, V. (1966). *Human sexual response*. Boston: Little, Brown.
- Masters, W., Johnson, V., & Kolodny, R. (1995). *Human sexuality* (5th ed.). New York: HarperCollins.
- Masuda, T., & Kitayama, S. (2004). Perceiver-induced constraint and attitude attribution in Japan and the U.S.: A case for the cultural dependence of the correspondence bias. *Journal of Experimental Social Psychology*, 40, 409–416.
- Matsumoto, D. (1994). *People: Psychology from a cultural perspective* (pp. 144–147). Pacific Grove, CA: Brooks-Cole.
- Matthew, N., & Dallery, J. (2007). Mercury rising: Exploring the vaccine–autism myth. *Skeptic*, 13(3), Retrieved May 3, 2010, from <http://www.skeptic.com/eskeptic/07-06-20/#feature>
- Matthews, K. A., Dahi, R. E., Owens, J. F., Lee, L., & Hall, M. (2012). Sleep duration and insulin resistance in healthy black and white adolescents. *Sleep*, 35(10): 1353–1358.
- Matthews, K. A., Gump, B. B., Harris, K. F., Haney, T. L., & Barefoot, J. C. (2004). Hostile behaviors predict cardiovascular mortality among men enrolled in the Multiple Risk Factor Intervention trial. *Circulation*, 109, 66–70.
- Maurer, D., & Young, R. (1983). Newborns' following of natural and distorted arrangements of facial features. *Infant Behaviour and Development*, 6, 127–131.
- Mavromatis, A. (1987). *Hypnagogia: The unique state of consciousness between wakefulness and sleep*. London: Routledge & Kegan Paul.
- Mavromatis, A., & Richardson, J. T. E. (1984). Hypnagogic imagery. *International Review of Mental Imagery*, 1, 159–189.
- Maxmen, J. S., Ward, N. G., & Kilgus, M. D. (2009). *Essential psychopathology and its treatment*. New York: W. W. Norton.
- Mayer, J. D., & Geher, G. (1996). Emotional intelligence and the identification of emotion. *Intelligence*, 22, 89–113.
- Mayer, J. D., Roberts, R. D., & Barsade, S. G. (2008). Human abilities: Emotional intelligence. *Annual Review of Psychology*, 59(1), 507–536. doi: 10.1146/annurev.psych.59.103006.093646
- Mayer, J. D., & Salovey, P. (1997). What is emotional intelligence? In P. Salovey & D. Sluyter (Eds.), *Emotional development and emotional intelligence: Educational implications* (pp. 3–31). New York: Basic Books.
- Mayer, J. D., Salovey, P., & Caruso, D. R. (2000). Models of emotional intelligence. In R. J. Sternberg (Ed.), *Handbook of human intelligence* (2nd ed., pp. 396–420). New York: Cambridge University Press.
- Mayer, J. D., Salovey, P., & Caruso, D. R. (2008). Emotional intelligence: New ability or eclectic traits? *American Psychologist*, 63(6), 503–517. doi: 10.1037/0003-066x.63.6.503
- Maziade, M., Bissonnette, L., Rouillard, E., Martinez, M., Turgeon, M., Charron, L., Pouliot, V., Boutin, P., Cliché, D., Dion, C., Fournier, J. P., Garneau, Y., Lavallee, J. C., Montgrain, N., Nicole, L., Pires, A., Ponton, A. M., Potvin, A., Wallot, H., Roy, M. A., & Merette, C. (Le Groupe IREP). (1997). 6p24–22 region and major psychoses in the Eastern Quebec population. *American Journal of Medical Genetics*, 74, 311–318.
- Mazzoni, G. A. L., Loftus, E. F., & Kirsch, I. (2001). Changing beliefs about implausible autobiographical events: A little plausibility goes a long way. *Journal of Experimental Psychology: Applied*, 7(1), 51–59.
- McAdams, D. P., & Olson, B. D. (2010). Personality development: Continuity and change over the life course. *Annual Review of Psychology*, 61, 517–542. doi: 10.1146/annurev.psych.093008.100507
- McBurney, D. H., Zapp, D., & Streeter, S. (2005). Preferred number of sexual partners: Tails of distributions and tales of mating systems. *Evolution and Human Behavior*, 26(3), 271–278.
- McCann, S. J. H., & Stewin, L. L. (1988). Worry, anxiety, and preferred length of sleep. *Journal of Genetic Psychology*, 149, 413–418.
- McCarty, C. A., Weisz, J. R., Wanitromanee, K., Eastman, K. L., Suwanlert, S., Chaiyasit, W., & Band, E. B. (1999). Culture, coping, and context: Primary and secondary control among Thai and American youth. *Journal of Child Psychology and Psychiatry*, 40, 809–818.

- McCauley, C. (1998). Group dynamics in Janis's theory of groupthink: Backward and forward. *Organizational Behavior & Human Decision Processes*, 73(2-3), 142-162.
- McClelland, D. C. (1961). *The achieving society*. Princeton, NJ: Van Nostrand.
- McClelland, D. C. (1987). *Human motivation*. Cambridge, MA: Cambridge University Press.
- McClelland, J. L., & Rumelhart, D. E. (1988). Explorations in parallel distributed processing. Cambridge, MA: MIT Press.
- McConaghay, N., Hadzi-Pavlovic, D., Stevens, C., Manicavasagar, V., Buhrich, N., & Vollmer-Conna, U. (2006). Fraternal birth order and ratio of heterosexual/homosexual feelings in women and men. *Journal of Homosexuality*, 51(4), 161-174.
- McCrae, R. R., & Costa, P. T. (1990). *Personality in adulthood*. New York: Guilford Press.
- McCrae, R. R., & Costa, P. T., Jr. (1996). Toward a new generation of personality theories: Theoretical contexts for the five-factor model. In J. S. Wiggins (Ed.), *The five-factor model of personality: Theoretical perspectives* (pp. 51-87). New York: Guilford.
- McCrae, R. R., Costa Jr, P. T., & Martin, T. A. (2005). The NEO-PI-3: A more readable revised NEO Personality Inventory. *Journal of Personality Assessment*, 84(3), 261-270. doi: 10.1207/s15327752jpa8403_05
- McCrae, R. R., Martin, T. A., & Costa, P. T., Jr. (2005). Age trends and age norms for the NEO Personality Inventory-3 in adolescents and adults. *Assessment*, 12(4), 363-373. doi: 10.1177/1073191105279724
- McCrae, R. R., & Terracciano, A. (2005). Universal features of personality traits from the observer's perspective: Data from 50 cultures. *Journal of Personality and Social Psychology*, 88(3), 547-561. doi: 10.1037/0022-3514.88.3.547.
- McDaniel, M. A., Howard, D. C., & Einstein, G. O. (2009). The read-recite-review study strategy: Effective and portable. *Psychological Science*, 20(4), 516-522.
- McDermott, J. F. (2001). Emily Dickinson revisited: A study of periodicity in her work. *American Journal of Psychiatry*, 158(5), 686-690.
- McDougall, T. (2009). Nursing children and adolescents with bipolar disorder. *Journal of Child and Adolescent Psychiatric Nursing*, 22, 33-39.
- McDougall, W. (1908). *An introduction to social psychology*. London: Methuen & Co.
- McEwen, B. S. (2000). The neurobiology of stress: From serendipity to clinical relevance. *Brain Research*, 886, 172-189.
- McGaugh, J. L. (2004). The amygdala modulates the consolidation of memories of emotionally arousing experiences. *Annual Review Neuroscience*, 27, 1-28.
- McGinnis, J. M., & Foege, W. H. (1993). Actual causes of death in the United States. *Journal of the American Medical Association*, 270(18), 2207-2212.
- McGinn, L. K. (2000). Cognitive behavioral therapy of depression: Theory, treatment, and empirical status. *American Journal of Psychotherapy*, 54, 254-260.
- McGrath, E., Keita, G. P., Strickland, B. R., & Russo, N. F. (1992). *Women and depression: Risk factors and treatment issues*. Washington, DC: American Psychological Association.
- McGrath, R. E., & Carroll, E. J. (2012). The current status of 'projective' 'tests'. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol 1: Foundations, planning, measures, and psychometrics*. (pp. 329-348). Washington, DC US: American Psychological Association.
- McGregor, D. (1960). *The human side of enterprise*. New York: McGraw-Hill.
- McGuire, F. (1994). Army alpha and beta tests of intelligence. In R. J. Sternberg (Ed.), *Encyclopedia of intelligence* (Vol. 1, pp. 125-129.) New York: Macmillan.
- McKee, A. C., Cantu, R. C., Nowinski, C. J., Hedley-Whyte, E. T., Gavett, B. E., Budson, A. E., Santini, V. E., Lee, H. S., Kubilus, C. A., & Stern, R. A. (2009). Chronic traumatic encephalopathy in athletes: Progressive tauopathy after repetitive head injury. *Journal of Neuropathology and Experimental Neurology*, 68(7), 709-735.
- McLaughlin, S. K. & Margolskee, R. F. (1994). Vertebrate taste transduction. *American Scientist*, 82, 538-545.
- McMahon, F. J., Akula, N., Schulze, T. G., Muglia, P., Tozzi, F., Detera-Wadleigh, S. D., ... Rietschel, M. (2010). Meta-analysis of genome-wide association data identifies a risk locus for major mood disorders on 3p21.1. *Nature Genetics*, 42(2), 128-131. doi: 10.1038/ng.523
- McMillan, H. L., Boyle, M. H., Wong, M. Y., Duku, E. K., Fleming, J. E., & Walsh, C. A. (1999). Slapping and spanking in childhood and its association with lifetime prevalence of psychiatric disorders in a general population sample. *Canadian Medical Association Journal*, 161, 805-809.
- McMonagle, T., & Sultana, A. (2002). Token economy for schizophrenia (Cochrane Review). In *The Cochrane Library*, Issue 2. Oxford: Update Software.
- McPherson, J. M., Smith-Lovin, L., Cook, J. M., (2001). Birds of a feather: Homophily in social networks. *Annual Review of Sociology* 27, 415-444.
- Meador, B. D., & Rogers, C. R. (1984). Person-centered therapy. In R. J. Corsini (Ed.), *Current psychotherapies* (3rd ed., pp. 142-195). Itasca, IL: Peacock.
- Medical Economics Staff. (1994). *PDR family guide to women's health & prescription drugs*. Montvale, NJ: Medical Economics Company.
- Medicine, B. (2002). Directions in gender research in American Indian societies: Two spirits and other categories. In W. J. Lonner, D. L. Dinnel, S. A. Hayes, & D. N. Sattler (Eds.), *Online Readings in Psychology and Culture* (Unit 3, Chapter 2) (www.wvu.edu/~culture), Center for Cross-Cultural Research, Western Washington University, Bellingham, WA.
- Mehrabian, A. (2000). Beyond IQ: Broad-based measurement of individual success potential or "emotional intelligence." *Genetic, Social, and General Psychology Monographs*, 126, 133-239.
- Meichenbaum, D. (1996). Stress inoculation training for coping with stressors. *The Clinical Psychologist*, 49, 4-7.
- Meikle, J., & Boseley, S. (2010, May 24). MMR row doctor Andrew Wakefield struck off register. *The Guardian* (London). Retrieved April 26, 2013, from <http://www.guardian.co.uk/society/2010/may/24/mmr-doctor-andrew-wakefield-struck-off>
- Meineri, S. & Guégan N. (2008). An Application of the Foot-in-the-Door Strategy in the Environmental Field. *European Journal of Social Sciences*, 7, 71-74.
- Mejia, O. L., & McCarthy, C. J. (2010). Acculturative stress, depression, and anxiety in migrant farmwork college students of Mexican heritage. *International Journal of Stress Management*, 17(1), 1-20.
- Melzack, R., & Wall, P. D. (1965). Pain mechanisms: A new theory. *Science*, 150, 971-979.
- Melzack, R., & Wall, P. D. (1996). *The challenge of pain*. London: Penguin Books.
- Mendez, M. F., & Fras, I. A. (2011). The false memory syndrome: Experimental studies and comparison to confabulations. *Medical Hypotheses*, 76(4), 492-496. doi: 10.1016/j.mehy.2010.11.033
- Mennella, J. A., & Trabulsi, J. C. (2012). Complementary foods and flavor experiences: Setting the foundation. *Ann Nutr Metab*, 60 Suppl 2, 40-50. doi: 10.1159/000335337
- Menon, T., Morris, M., Chiu, C. Y., & Hong, Y. I. (1999). Culture and the construal of agency: Attribution to individual versus group dispositions. *Journal of Personality and Social Psychology*, 76, 701-727.
- Merikle, M. P. (2000). Subliminal perception. In A. E. Kazdin (Ed.), *Encyclopedia of Psychology* (Vol. 7, pp. 497-499). New York: Oxford University Press.
- Mervis, C. B., & Rosch, E. (1981). Categorization of natural objects. *Annual Review of Psychology*, 32, 89-115.
- Mesgarani, N., & Chang, E. F. (2012). Selective cortical representation of attended speaker in multi-talker speech perception. *Nature*, 485, 233-236. doi: 10.1038/nature11020
- Meyer, G. J., & Kurtz, J. E. (2006). Advancing personality assessment terminology: Time to retire 'objective' and 'projective' as personality test descriptors. *Journal of Personality Assessment*, 87(3), 223-225. doi: 10.1207/s15327752jpa8703_01
- Meyrick, J. (2001). Forget the blood and gore: An alternative message strategy to help adolescents avoid cigarette smoking. *Health Education*, 101(3), 99-107.
- Michaels, J. W., Blommel, J. M., Brocato, R. M., Linkous, R. A., & Rowe, J. S. (1982). Social facilitation and inhibition in a natural setting. *Replications in Social Psychology*, 2, 21-24.
- Michalski, D., Mulvey, T., & Kohout, J. (2010). *2008 American Psychological Association survey of psychology health service providers*. Retrieved April 5, 2010, from <http://www.apa.org/workforce/publications/08-hsp/report.pdf>
- Mikami, A. Y., Szwedo, D. E., Allen, J. P., Evans, M. A., & Hare, A. L. (2010). Adolescent peer relationships and behavior problems predict young adults' communication on social networking websites. *Developmental Psychology*, 46, 46-56.
- Miles, D. R., & Carey, G. (1997). Genetic and environmental architecture of human aggression. *Journal of Personality and Social Psychology*, 72, 207-217.
- Milgram, S. (1963). Behavioral study of obedience. *The Journal of Abnormal and Social Psychology*, 67(4), 371-378. doi: 10.1037/h0040525
- Milgram, S. (1964). Issues in the study of obedience: A reply to Baumrind. *American Psychologist*, 19, 848-852.
- Milgram, S. (1974). *Obedience to authority: An experimental view*. New York: Harper & Row.
- Miller, G. (2009). Neuropathology. A late hit for pro football players. *Science*, 325(5941), 670-672.
- Miller, G. (2013). Neuroscience. The promise and perils of oxytocin. *Science*, 339(6117), 267-269. doi: 10.1126/science.339.6117.267

- Miller, G. A. (1956). The magical number seven, plus or minus two: Some limits on our capacity for processing information. *Psychological Review*, 63, 81–97.
- Miller, J. G. (1984). Culture and the development of everyday social explanation. *Journal of Personality and Social Psychology*, 46, 961–978.
- Miller, K., & Doman, J. M. R. (1996, April). Together forever. *Life Magazine*, 46–56.
- Miller, K. E., & Graves, J. C. (2000). Update on the prevention and treatment of sexually transmitted diseases. *American Family Physician*, 61, 379–386.
- Miller, L. H., & Smith, A. D. (1993). *The stress solution*. New York: Pocket Books.
- Miller, M. E., & Bowers, K. S. (1993). Hypnotic analgesia: Dissociated experience or dissociated control? *Journal of Abnormal Psychology*, 102, 29–38.
- Miller, M. N., & Pumariega, A. (1999). Culture and eating disorders. *Psychiatric Times*, 16(2), 1–4.
- Miller, M., & Rahe, R. H. (1997). Life changes scaling for the 1990s. *Journal of Psychosomatic Research*, 43(3), 279–292.
- Miller, N. E., Sears, R. R., Mowrer, O. H., Doob, L. W., & Dollard, J. (1941). The frustration-aggression hypothesis. *Psychological Review*, 48, 337–342.
- Miller, T. Q., Smith, T. W., Turner, C. W., Guijarro, M. L., & Hallet, A. J. (1996). A meta-analytic review of research on hostility and physical health. *Psychological Bulletin*, 119, 322–348.
- Miller, T. Q., Turner, C. W., Tindale, R. S., Posavac, E. J., & Dugoni, B. L. (1991). Reasons for the trend toward null findings in research on Type A behavior. *Psychological Bulletin*, 110, 469–485.
- Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.
- Mills, M. A., Edmondson, D., & Park, C. L. (2007). Trauma and stress response among Hurricane Katrina evacuees. *American Journal of Public Health*, 97(1), 116–123.
- Milner, B., Corkin, S., & Teuber, H. L. (1968). Further analysis of the hippocampal syndrome: 14-year follow-up study of H. M. *Neuropsychologia*, 6, 215–234.
- Milner, J. (1992, January). Risk for physical child abuse: Adult factors. *Violence Update*, pp. 9–11.
- Mintz, L. B., & Betz, N. E. (1988). Prevalence and correlates of eating disordered behaviors among undergraduate women. *Journal of Counseling Psychology*, 35, 463–471.
- Mischel, W. (1966). A social learning view of sex differences in behaviour. In E. E. Maccoby (Ed.), *The development of sex differences* (pp. 56–81). Stanford, CT: Stanford University Press.
- Mischel, W., & Shoda, Y. (1995). A cognitive-affective system theory of personality: Reconceptualizing situations, dispositions, dynamics, and invariances in personality structure. *Psychological Review*, 102(2), 246–268.
- Mishell, D. R. (2001). Menopause. In M. A. Stenchever et al. (Eds.), *Comprehensive gynecology* (4th ed., pp. 1217–1258). St. Louis, MO: Mosby.
- Missonnier, P., Hasler, R., Perroud, N., Herrmann, F. R., Millet, P., Richiardi, J., ... Baud, P. (2013). EEG anomalies in adult ADHD subjects performing a working memory task. *Neuroscience*, 241, 135–146. doi: 10.1016/j.neuroscience.2013.03.011
- Mitchell, J. E., Pyle, R. L., Eckert, E. D. (1981). Frequency and duration of binge-eating episodes in patients with bulimia. *American Journal of Psychiatry*, 138, 835–836.
- Mitchell, J. E., Roerig, J., & Steffen, K. (2013). Biological therapies for eating disorders. *International Journal of Eating Disorders*, 46(5), 470–477. doi: 10.1002/eat.22104
- Mitchell, S. A., & Black, M. J. (1996). *Freud and beyond: A history of modern psychoanalytic thought* [Reprint ed.]. New York: HarperCollins.
- Miyatake, A., Morimoto Y., Oishi, T., Hanasaki, N., Sugita, Y., Iijima, S., Teshima, Y., Hishikawa, Y., & Yamamura, Y. (1980). Circadian rhythm of serum testosterone and its relation to sleep: Comparison with the variation in serum luteinizing hormone, prolactin, and cortisol in normal men. *Journal of Clinical Endocrinology and Metabolism*, 51(6), 1365–1371.
- Moffat, S. D., Hampson, E. , & Hatzipantelis, M. (1998). Navigation in a “virtual” maze: Sex differences and correlation with psychometric measures of spatial ability in humans. *Evolution and Human Behavior*, 19(2), 73–87.
- Moffic, H. S. (2003). Seven ways to improve “cultural competence.” *Current Psychiatry*, 2(5), 78.
- Mogil, J. S. (1999). The genetic mediation of individual differences in sensitivity to pain and its inhibition. *Proceedings of the National Academy of Sciences, USA*, 96(14), 7744–7751.
- Mokdad, A. H., Bowman, B. A., Ford, E. S., Dietz, W. H., Vinicor, F., Bales, V. S., & Marks, J. S. (2001). Prevalence of obesity, diabetes, and obesity related health risk factors. *Journal of the American Medical Association*, 289, 76–79.
- Moldofsky, H. (1995). Sleep and the immune system. *International Journal of Immunopharmacology*, 17(8), 649–654.
- Möller, A., & Hell, D. (2002). Eugen Bleuler and forensic psychiatry. *International Journal of Law and Psychiatry*, 25, 351–360.
- Moll, H., & Tomasello, M. (2007). How 14- and 18-month-olds know what others have experienced. *Developmental Psychology*, 43, 309–317.
- Money, J. (1994). *Sex errors of the body and related syndromes*. Baltimore: Paul H. Brookes.
- Money, J., & Mathews, D. (1982). Prenatal exposure to virilizing progestins: An adult follow-up study of 12 women. *Archives of Sexual Behavior*, 11(1), 73–83.
- Money, J., & Norman, B. F. (1987). Gender identity and gender transposition: Longitudinal outcome study of 24 male hermaphrodites assigned as boys. *Journal of Sex and Marriage Therapy*, 13, 75–79.
- Montgomery, C., & Fisk, J. E. (2008). Ecstasy-related deficits in the updating component of executive processes. *Human Psychopharmacology*, 23(6): 495–511.
- Moody, R., & Perry, P. (1993). *Reunions: Visionary encounters with departed loved ones*. London: Little, Brown.
- Moore-Ede, M. C., Sulzman, F. M., & Fuller, C. A. (1982). *The clocks that time us*. Cambridge, MA: Harvard University Press.
- Moore, T. E. (1988). The case against subliminal manipulation. *Psychology and Marketing*, 5, 297–316.
- Moore, T. H., Zammit, S., Lingford-Hughes, A., Barnes, T. R., Jones, P. B., Burke, M., & Lewis, G. (2007). Cannabis use and risk of psychotic or affective mental health outcomes: A systematic review. *Lancet*, 370, 293–294, 319–328.
- Moorhead, G., Neck, C. P., & West, M. S. (1998). The tendency toward defective decision making within self-managing teams: The relevance of groupthink for the 21st century. *Organizational Behavior & Human Decision Processes*, 73(2–3), 327–351.
- Mora, G. (1985). History of psychiatry. In H. I. Kaplan & B. J. Sadock (Eds.), *Comprehensive textbook of psychiatry* (pp. 2034–2054). Baltimore: Williams & Wilkins.
- Moreland, R. L., & Zajonc, R. B. (1982). Exposure effects in person perceptions: Familiarity, similarity, and attraction. *Journal of Experimental Social Psychology*, 18(5), 395–415.
- Morgan, C. A., Rasmusson, A., Pietrzak, R. H., Coric, V., Southwick, S. M. (2009). Relationships among plasma dehydroepiandrosterone and dehydroepiandrosterone sulfate, cortisol, symptoms of dissociation, and objective performance in humans exposed to underwater navigation stress. *Biological Psychiatry*, 66(4), 334–340.
- Morgan, C. D., & Murray, H. A. (1935). A method for investigating fantasies: The Thematic Apperception Test. *Archives of Neurology and Psychiatry*, 34, 298–306.
- Morin, C. M., Bootzin, R. R., Buysse, D. J., Edinger, J. D., Espie, C. A., & Lichstein, K. L. (2006). Psychological and behavioral treatment of insomnia: Update of the recent evidence (1998–2004). *Sleep*, 29(11), 1398–1414.
- Morishima, Y., Schunk, D., Bruhin, A., Ruff, C. C., & Fehr, E. (2012). Linking brain structure and activation in temporoparietal junction to explain the neurobiology of human altruism. *Neuron*, 75(1), 73–79. doi: 10.1016/j.neuron.2012.05.021
- Morris, J. S., Friston, K. J., Buche, L. C., Frith, C. D., Young, A. W., Calder, A. J., & Dolan, R. J. (1998). A neuromodulatory role for the human amygdala in processing emotional facial expressions. *Brain*, 121, 47–57.
- Morris, M., Nisbett, R. E., & Peng, K. (1995). Causal understanding across domains and cultures. In D. Sperber, D. Premack, & A. J. Premack (Eds.), *Causal cognition: A multidisciplinary debate* (pp. 577–612). Oxford, UK: Oxford University Press.
- Morris, M. W., & Peng, K. (1994). Culture and cause: American and Chinese attributions social and physical events. *Journal of Personality and Social Psychology*, 67, 949–971.
- Morris, S. (2009, November 20). Devoted husband who strangled wife in his sleep walks free from court. Retrieved April 9, 2010, from <http://www.guardian.co.uk/uk/2009/nov/20/brian-thomas-dream-strangler-tragedy>
- Morrow, C. E., Culbertson, J. L., Accornero, V. H., Xue, L., Anthony, J. C., & Bandstra, E. S. (2006). Learning disabilities and intellectual functioning in school-aged children with prenatal cocaine exposure. *Developmental Neuropsychology*, 30(3), 905–931.
- Moruzzi, G., & Magoun, H. W. (1949). Brainstem reticular formation and activation of the EEG. *Electroencephalographs in Clinical Neurophysiology*, 1, 455–473.
- Moscovici, S., & Zavalloni, M. (1969). The group as a polarizer of attitudes. *Journal of Personality and Social Psychology* 12, 125–135.
- Mosher, W. D., Chandra, A., & Jones, J. (2005). Sexual behavior and selected health measures: Men and women 15–44 years of age, United States, 2002. *Advance data from vital and health statistics; no 362*. Hyattsville, MD: National Center for Health Statistics.

- Motraghi, T. E., Seim, R. W., Meyer, E. C., & Morissette, S. B. (2013). Virtual reality exposure therapy for the treatment of posttraumatic stress disorder: A methodological review using consort guidelines. *Journal of Clinical Psychology*. doi: 10.1002/jclp.22051
- Mowat, F. (1988). *Woman in the mists: The story of Dian Fossey and the mountain gorillas of Africa*. New York: Warner Books.
- Mroczek, D. K., Spiro, A., & Turiano, N. A. (2009). Do health behaviors explain the effect of neuroticism on mortality? Longitudinal findings from the VA Normative Aging Study. *Journal of Research in Personality*, 43(4), 653.
- Mueser, K. T., Rosenberg, St. D., Xie, H., Jankowski, M. K., Bolton, E. E., Lu, E., Hamblen, J. L., Rosenberg, H. J., McHugo, G. J., & Wolfe, R. (2008). A randomized controlled trial of cognitive-behavioral treatment for posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology*, 76(2), 259–271.
- Mufson, L. H., Dorta, K. P., Olfson, M., Weissman, M. M., & Hoagwood, K. (2004). Effectiveness research: Transporting interpersonal psychotherapy for depressed adolescents (IPT-A) from the lab to school-based health clinics. *Clinical Child and Family Psychology Review*, 7(4), 251–261.
- Muhlberger, A., Herrmann, M. J., Wiedemann, G. C., Ellgring, H., & Pauli, P. (2001). Repeated exposure of flight phobics to flights in virtual reality. *Behaviour Research and Therapy*, 39(9), 1033–1050.
- Mukamel, R., Ekstrom, A. D., Kaplan, J., Iacoboni, M., & Fried, I. (2010). Single-neuron responses in humans during execution and observation of actions. *Current Biology*, 20, 750–756.
- Muller-Oerlinghausen, B., Berghofer, A., & Bauer, M. (2002). Bipolar disorder. *Lancet*, 359, 241–247.
- Munoz, Daniel (15 May 2010). Australian teenager finishes round-world solo sail. *Reuters*. Retrieved May 15, 2010, from <http://www.reuters.com/article/idUSTRE64E0D920100515>.
- Münsterberg, H. (1908). *On the witness stand*. New York: Clark, Boardman.
- Münsterberg, H. (1913). *Psychology and industrial efficiency*. Boston & New York: Houghton Mifflin.
- Murdock, B. B., Jr. (1962). The serial position effect in free recall. *Journal of Experimental Psychology*, 64, 482–488.
- Murphy, C. C., Boyle, C., Schendel, D., Decoufle, P., & Yeargin-Alsopp, M. (1998). Epidemiology of mental retardation in children. *Mental Retardation and Developmental Disabilities Research Reviews*, 4, 6–13.
- Murphy, L. R. (1995). Managing job stress: An employee assistance/human resource management partnership. *Personnel Review*, 24(1), 41–50.
- Murray, S. L., Holmes, J. G., MacDonald, G., & Ellsworth, P. C. (1998). Through the looking glass darkly? When self-doubts turn into relationship insecurities. *Journal of Personality and Social Psychology*, 75, 1459–1480.
- Muter, P. (1978). Recognition failure of recallable words in semantic memory. *Memory & Cognition*, 6(1), 9–12.
- Nadeau, K. G., Quinn, P., & Littman, E. (2001). *AD/HD self-rating scale for girls*. Springfield, MD: Advantage Books.
- Naitoh, P., Kelly, T. L., & Englund, C. E. (1989). *Health effects of sleep deprivation* (Naval Health Research Centre, Rep. No. 89-46), San Diego, CA: NHRC.
- Najavits, L. M. (2007). Psychosocial treatments for posttraumatic stress disorder. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (3rd ed., pp. 513–530). New York: Oxford University Press.
- Nasar, S. (1998). *A beautiful mind: A biography of John Forbes Nash, Jr., winner of the Nobel Prize in economics 1994*. New York: Simon & Schuster.
- Nathan, P. E., & Gorman, J. M. (2007). *Psychosocial treatments for posttraumatic stress disorder* (3rd ed.). New York: Oxford University Press.
- National Academy of Neuropsychology. (May, 2001). NAN definition of a clinical neuropsychologist [Electronic version]. Retrieved April 13, 2010, from <http://www.nanonline.org/NAN/Files/PAIC/PDFs/NANPositionDefNeuro.pdf>
- National Collegiate Athletic Association (2002). 2002 NCAA graduation rates report. Retrieved September 21, 2007, from NCAA—The National Collegiate Athletic Association: The online resource for the National Collegiate Athletic Association Web site: http://web1.ncaa.org/web_files/grad_rates/2002/index.html
- National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. (2006). Fetal viability and death: United States. Accessed April 26, 2013, from https://scholarworks.iupui.edu/bitstream/handle/1805/583/OS76-127_VII.pdf?sequence=1
- National Institute of Mental Health. (2008). Suicide in the U.S.: Statistics and Prevention (NIH Publication No. 06-4594), from <http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml>
- National Institute of Mental Health. (2013). Statistics Retrieved 5/14/2013, from <http://www.nimh.nih.gov/statistics/index.shtml>
- National Institute of Mental Health (NIMH) (2010). The numbers count: Mental disorders in America. Retrieved from <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml>
- National Institute of Mental Health (NIMH) Genetics Workgroup. (1998). *Genetics and mental disorders* (NIH Publication No. 98-4268). Rockville, MD: National Institute of Mental Health.
- National Institute on Alcoholism and Alcohol Abuse (NIAAA) (2007). Data/Statistical Tables. Retrieved July 25, 2007, from <http://www.niaaa.nih.gov/Resources/DatabaseResources/QuickFacts/default.htm>
- National Institute on Drug Abuse. (2006, May). NIDA InfoFacts: MDMA (Ecstasy). Retrieved May 5, 2010, from <http://www.nida.nih.gov/Infofacts/ecstasy.html>
- National Institute on Drug Abuse (NIDA). (2002). Research report series—Prescription drugs: Abuse and addiction. National Institutes of Health (NIH). Retrieved July 19, 2008, from www.drugabuse.gov/ResearchReports/Prescription/prescription5.html
- National Institutes of Health. (1998). *Understanding vaccines*. NIH Publication #98-4219.
- National Institutes of Health; National Heart, Lung and Blood Institute. (2011). *Your guide to healthy sleep*. NIH Publication No. 06-5271.
- National Safety Council. (2010). National safety council estimates that at least 1.6 million crashes are caused each year by drivers using cell phones and texting. Retrieved March 3, 2010, from <http://www.nsc.org/Pages/NSCEstimates16millioncrashescalledbydriversusingcellphonesandtexting.aspx>
- National Sleep Foundation (2009). Can't sleep? What to know about insomnia. Retrieved May 5, 2010, from <http://www.sleepfoundation.org/article/sleep-related-problems/insomnia-and-sleep>
- Neale, M. C., Rushton, J. P., & Fulker, D. W. (1986). The heritability of items from the Eysenck Personality Questionnaire. *Personality and Individual Differences*, 7, 771–779.
- Neary, N. M., Goldstone, A. P., & Bloom, S. R. (2004). Appetite regulations: From the gut to the hypothalamus. *Clinical Endocrinology*, 60(2), 153–160.
- Neimark, J. (1996). The diva of disclosure, memory researcher Elizabeth Loftus. *Psychology Today*, 29(1), 48–80.
- Neimeyer, R. A., & Mitchell, K. A. (1998). Similarity and attraction: A longitudinal study. *Journal of Social and Personality Relationships*, 5, 131–148.
- Neisser, U. (1982). Snapshots or benchmarks? In U. Neisser (Ed.), *Memory observed: Remembering in natural contexts* (pp. 43–48). San Francisco: W. H. Freeman.
- Neisser, U., Boodoo, G., Bouchard, T. J., Boykin, A. W., Brody, N., Ceci, S. J., Halpern, D. F., Loehlin, J. C., Perloff, R., Sternberg, R. J., & Urbina, S. (1996). Intelligence: Knowns and unknowns. *American Psychologist*, 51, 77–101.
- Neisser, U., & Harsch, N. (1992). Phantom flashbulbs: False recollections of hearing the news about Challenger. In E. Winograd & U. Neisser (Eds.), *Affect and accuracy in recall: Studies of "flashbulb memories"* (pp. 9–31). New York: Cambridge University Press.
- Nelson, C. A. (2011). Brain development and behavior. In A. M. Rudolph, C. Rudolph, L. First, G. Lister, & A. A. Gershon (Eds.), *Rudolph's pediatrics* (22nd ed.). New York: McGraw-Hill.
- Nelson, K. (1993). The psychological and social origins of autobiographical memory. *Psychological Science*, 4, 7–14.
- Nelson, L. J., Padilla-Walker, L. M., Badger, S., Barry, C. M., Carroll, J., & Madsen, S. (2008). Associations between shyness and internalizing behaviors, externalizing behaviors, and relationships during emerging adulthood. *Journal of Youth and Adolescence*, 37, 605–615.
- Nestor, P. G., Kubicki, M., Niznikiewicz, M., Gurrera, R. J., McCarley, R. W., & Shenton, M. E. (2008). Neuropsychological disturbance in schizophrenia: A diffusion tensor imaging study. *Neuropsychology*, 22(2), 246–254.
- Neto, F. (1995). Conformity and independence revisited. *Social Behavior and Personality*, 23(3), 217–222.
- Neumarker, K. (1997). Mortality and sudden death in anorexia nervosa. *International Journal of Eating Disorders*, 21, 205–212.
- Neville, H. J., & Bavelier, D. (2000). Specificity and plasticity in neurocognitive development in humans. In M. S. Gazzaniga (Ed.), *The New Cognitive Neurosciences* (2nd ed., pp. 83–99). Cambridge, MA: MIT Press.

- New Rochelle: New York. Retrieved from the Internet at <http://www.liebertpub.com/global/pressrelease/virtual-reality-and-other-technologies-offer-hope-for-more-effective-treatment-of-posttraumatic-stress-disorder/769>.
- Nicholson, N., Cole, S., & Rocklin, T. (1985). Conformity in the Asch situation: A comparison between contemporary British and U.S. students. *British Journal of Social Psychology*, 24, 59–63.
- Nickell, J. (1995). Crop circle mania wanes: An investigative update. *Skeptical Inquirer* 19(3), 41–43.
- Nickerson, R. S., & Adams, J. J. (1979). Long-term memory for a common object. *Cognitive Psychology*, 11, 287–307.
- Niedermeyer, E. (2005). Historical aspects. In E. Niedermeyer & F. Lopes da Silva (Eds.), *Electroencephalography: Basic principles, clinical applications, and related fields* (5th ed., pp. 1–15). Philadelphia: Lippincott, Williams & Wilkins.
- Nielsen, M., Suddendorf, T., & Slaughter, V. (2006). Mirror self-recognition beyond the face. *Child Development*, 77(1), 176–185. doi: 10.1111/j.1467-8624.2006.00863.x
- Nieto, F., Young, T. B., Lind, B. K., Shahar, E., Samet, J. M., Redline, S., D'Agostino, R. B., Newman, A. B., Lebowitz, M. D., & Pickering, T. G. (2000). Association of sleep-disordered breathing, sleep apnea, and hypertension in a large, community-based study. *Journal of the American Medical Association*, 283(14), 1829–1836.
- Nigg, J. T. (2006). *What causes ADHD? Understanding what goes wrong and why*. New York, NY: The Guilford Press.
- Nigg, J. T. (2010). Attention-Deficit/Hyperactivity Disorder: Endophenotypes, structure, and etiological pathways. *Current Directions in Psychological Science*, 19(1), 24–29.
- Nijenhuis, E. R. (2000). Somatoform dissociation: Major symptoms of dissociative disorders. *Journal of Trauma and Dissociation*, 1(4), 7–29.
- Nikolajsen, L., & Jensen, T. S. (2001). Phantom limb pain. *British Journal of Anaesthesia*, 87, 107–116.
- Nisbett, R. E. (1972). Hunger, obesity, and the ventromedial hypothalamus. *Psychological Review*, 79, 433–453.
- Nisbett, R. E., Aronson, J., Blair, C., Dickens, W., Flynn, J., Halpern, D. F., & Turkheimer, E. (2012). Intelligence: New findings and theoretical developments. *American Psychologist*, 67(2), 130–159. doi: 10.1037/a0026699
- Nitsche, M. A., Boggio, P. S., Fregni, F., & Pascual-Leone, A. (2009). Treatment of depression with transcranial direct current stimulation (tDCS): A review. *Experimental Neurology*, 219(1), 14–19.
- Nolen-Hoeksema, S. (1990). *Sex differences in depression*. Palo Alto, CA: Stanford University Press.
- Nolen-Hoeksema, S. (2012). Emotion regulation and psychopathology: The role of gender. *Annual Review of Clinical Psychology*, 8, 161–187. doi: 10.1146/annurev-clinpsy-032511-143109
- Nooyens, A. C. J., Baan, C. A., Spijkerman, A. M. W., & Verschuren, W. M. M. (2010). *Type 2 diabetes mellitus and cognitive decline in middle-aged men and women—The Doetinchem Cohort Study*. American Diabetes Association: Diabetes Care.
- Norcross, J. C. (2005). A primer on psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 3–23). New York, Oxford University Press.
- Nordenskjold, A., von Knorring, L., & Engstrom, I. (2011). Predictors of time to relapse/recurrence after electroconvulsive therapy in patients with major depressive disorder: A population-based cohort study. *Depression Research and Treatment*, 2011, 470985. doi: 10.1155/2011/470985
- Norenzayan, A., Choi, I., & Nisbett, R. E. (1999). Eastern and Western perceptions of causality for social behavior: Lay theories about personalities and situations. In D. A. Prentice & D. T. Miller (Eds.), *Cultural divides* (pp. 239–272). New York: Russell Sage Foundation.
- Norrbrink Budh, C., Lund, I., Hultling, C., Levi, R., Werhagen, L., Ertzgaard, P., & Lundeberg, T. (2003). Gender-related differences in pain in spinal cord injured individuals. *Spinal Cord*, 41, 122–128.
- Nosek, B. A., Greenwald, A. G., & Banaji, M. R. (2007). The Implicit Association Test at age 7: A methodological and conceptual review. In J. A. Bargh (Ed.), *Automatic processes in social thinking and behavior* (pp. 265–292). New York: Psychology Press.
- Nosich, G. M. (2008). Learning to think things through: A guide to critical thinking across the curriculum (3rd ed., pp. 2–16). Upper Saddle River, NJ: Prentice-Hall.
- Novak, J. D. (1995). Concept maps to facilitate teaching and learning. *Prospects*, 25, 95–11.
- Novak, M., Björck, L., Giang, K. W., Heden-Ståhl, C., Wilhelmsson, L., & Rosengren, A. (2013). Perceived stress and incidence of Type 2 diabetes: A 35-year follow-up study of middle-aged Swedish men. *Diabetic Medicine*, 30(1), e8. doi: 10.1111/dme.12037
- Novella, S. (2007, November/December). The Anti-Vaccination Movement. *Skeptical Inquirer*. Retrieved May 21, 2010, from http://www.csicop.org/si/show/anti-vaccination_movement/www.guardian.co.uk/science/2007/feb/24/badscience.uknews
- Novotney, A. (2013, March). I/O psychology goes to Mars. *Monitor on Psychology*, 44(3), 38.
- Nyberg, L., & Tulving, E. (1996). Classifying human long-term memory: Evidence from converging dissociations. *European Journal of Cognitive Psychology*, 8(2), 163–183.
- Oberman, L. M., & Ramachandran, V. S. (2007). The simulating social mind: The role of simulation in the social and communicative deficits of autism spectrum disorders. *Psychological Bulletin*, 133, 310–327.
- Ocholla-Ayayo, A. B. C., Wekesa, J. M., & Ottieno, J. A. M. (1993). *Adolescent pregnancy and its implications among ethnic groups in Kenya*. In International Population Conference, Montreal, Canada: International Union for the Scientific Study of Population, 1: 381–395.
- Ochsner, K., & Kosslyn, S. M. (1994). Mental imagery. In V. S. Ramachandran (Ed.), *Encyclopedia of human behavior*. New York: Academic Press.
- O'Connor, R. D. (1972). Relative efficacy of modeling, shaping, and the combined procedures for modification of social withdrawal. *Journal of Abnormal Psychology*, 79, 327–334.
- Offit, P. A., & Bell, L. M. (1998). *What every parent should know about vaccines*. New York: Macmillan.
- Ohayon, M. M., Priest, R. G., Caulet, M., & Guilleminault, C. (1996). Hypnagogic and hypnopompic hallucinations: pathological phenomena? *British Journal of Psychiatry*, 169, 459–67.
- Öhman, A. (2008). Fear and anxiety. In M. Lewis, J. M. Haviland-Jones & L. F. Barrett (Eds.), *Handbook of emotion* (3rd ed., pp. 709–729). New York: Guilford Press.
- Okami, P., & Shackelford, T. K. (2001). Human sex differences in sexual psychology and behavior. *Annual Review of Sex Research*, 12, 186–241.
- O'Keefe, D. J. (2009). Theories of persuasion. In R. L. Nabi & M. B. Oliver (Eds.), *The Sage handbook of media processes and effects* (pp. 277–278). Los Angeles: Sage.
- Okie, S. (2005). Traumatic brain injury in the war zone. *The New England Journal of Medicine*, 352(20), 2043–2047.
- Olin, B. R., (Ed.). (1993). Central nervous system drugs, sedatives and hypnotics, barbiturates. In *Facts and comparisons drug information* (pp. 1398–1413). St. Louis, MO: Facts and Comparisons.
- Oliver, J. E. (1993). Intergenerational transmission of child abuse: Rates, research, and clinical interpretations. *American Journal of Psychiatry*, 150, 1315–1324.
- Ollendick, T. H., & King, N. J. (1998). Empirically supported treatments for children with phobic and anxiety disorders: Current status. *Journal of Clinical Child Psychology*, 27(2), 156–167.
- Olsen, P. (1975). *Emotional flooding*. Baltimore: Penguin Books.
- Olson, H. C., & Burgess, D. M. (1997). Early intervention for children prenatally exposed to alcohol and other drugs. In M. J. Guralnick (Ed.), *The effectiveness of early intervention* (pp. 109–146). Baltimore: Brookes.
- Oman, C. M. (1990). Motion sickness: A synthesis and evaluation of the sensory conflict theory. *Canadian Journal of Physiological Pharmacology*, 68, 294–303.
- Onken, L. S., Blaine, J. D., & Battjes, R. J. (1997). Behavioral therapy research: A conceptualization of a process. In S. W. Henggeler & A. B. Santos (Eds.), *Innovative approaches for difficult-to-treat populations* (pp. 477–485). Washington, DC: American Psychiatric Press.
- Ophir, E., Nass, C., & Wagner, A. D. (2009). Cognitive control in media multitaskers. *Proceedings of the National Academy of Sciences of the United States of America*, 106(37): 15583–15587.
- Osborne, J. W. (2007). Linking stereotype threat and anxiety. *Educational Psychology*, 27, 135–154.
- Osshera, L., Flegala, K. E., & Lustiga, C. (2012). Everyday memory errors in older adults. *Aging, Neuropsychology, and Cognition*, 20(2), 220–242. doi: 10.1080/13825585.2012.690365
- Oster, J.R. (1987). The binge-purge syndrome: A common albeit unappreciated cause of acid-base and fluid-electrolyte disturbances. *Southern Medical Journal*, 80, 58–67.
- Oswald, I. (1959). Sudden bodily jerks on falling asleep. *Brain*, 82, 92–103.

- Oudiette, D., Antony, J. W., Creery, J. D., & Paller, K. A. (2013). The role of memory reactivation during wakefulness and sleep in determining which memories endure. *Journal of Neuroscience*, 33(15), 6672. doi: 10.1523/JNEUROSCI.5497-12.2013
- Overeem, S., Mignot, E., Gert van Dijk, J., & Lammers, G. J. (2001). Narcolepsy: Clinical features, new pathophysiological insights, and future perspectives. *Journal of Clinical Neurophysiology*, 18(2), 78–105.
- Overmier, J. B., & Seligman, M. E. P. (1967). Effects of inescapable shock on subsequent escape and avoidance behavior. *Journal of Comparative Physiology and Psychology*, 63, 23–33.
- Owen, A. M., Hampshire, A., Grahn, J. A., Stenton, R., Dajani, S., Burns, A. S., Howard, R. J., & Ballard, C. G. (2010). Putting brain training to the test [Electronic version]. *Nature*. DOI 10.1038/nature09042
- Owen, M. T., Easterbrooks, M. A., Chase-Lansdale, L., & Goldberg, W. A. (1984). The relation between maternal employment status and the stability of attachments to mother and to father. *Child Development*, 55, 1894–1901.
- Pajonk, F. G., Wobrock, T., Gruber, O., Scherk, H., Berner, D., Kaizl, I., Kierer, A., Muller, S., Oest, M., Meyer, T., Backens, M., Schneider-Axmann, T., Thornton, A. E., Honer, W. G., & Falkai, P. (2010). Hippocampal plasticity in response to exercise in schizophrenia. *Archives of General Psychiatry*, 67(2), 133–143.
- Palmer, S. E. (1992). Common region: A new principle of perceptual grouping. *Cognitive Psychology*, 24(3), 436–447.
- Palva, J. M., Monto, S., Kulashekhar, S., & Palva, S. (2010). Neuronal synchrony reveals working memory networks and predicts individual memory capacity. *Proceedings of the National Academy of Sciences, USA*, 107(16), 7580–7585.
- Pan, A. S. (2000). Body image, eating attitudes, and eating behaviors among Chinese, Chinese-American and non-Hispanic White women. *Dissertation Abstracts International, Section B: The Sciences and Engineering*, 61(1-B), 544.
- Paparelli, A., Di Forti, M., Morrison, P. D., & Murray, R. M. (2011). Drug-induced psychosis: How to avoid star gazing in schizophrenia research by looking at more obvious sources of light. *Frontiers in Behavioral Neuroscience*, 5: 1. doi: 10.3389/fnbeh.2011.00001
- Parent, A., Teilmann, G., Juul, A., Skakkebaek, N. E., Toppari, J., & Bourguignon, J. P. (2003). The timing of normal puberty and age limits of sexual precocity: Variations around the world, secular trends, and changes after migration. *Endocrine Reviews*, 24(5), 668–693.
- Pargament, K. I. (1997). *The psychology of religion and coping: Theory, research, and practice*. New York: Guilford Press.
- Paris, J. (2004). Gender differences in personality traits and disorders. *Current Psychiatry Reports*, 6, 71–74.
- Park, J., Turnbull, A. P., & Turnbull, H. R. (2002). Impacts of poverty on quality of life in families of children with disabilities. *Exceptional Children*, 68, 151–170.
- Parkes, C. M., Laungani, P., & Young, W. (1997). *Death and bereavement across cultures*. Routledge: New York.
- Parkinson, W. L., & Weingarten, H. P. (1990). Dissociative analysis of ventromedial hypothalamic obesity syndrome. *American Journal of Physiology: Regulatory, Integrative, and Comparative Physiology*, 259, R829–R835.
- Parsons, H. M. (1992). Hawthorne: An early OBM experiment. *Journal of Organizational Behavior Management*, 12(1), 27–43.
- Partonen, T., & Lonnqvist, J. (1998). Seasonal affective disorder. *Lancet*, 352(9137), 1369–1374.
- Paul, B. M., ElvevÅg, B., Bokat, C. E., Weinberger, D. R., & Goldberg, T. E. (2005). Levels of processing effects on recognition memory in patients with schizophrenia. *Schizophrenia Research*, 74(1), 101–110.
- Pavlov, I. P. (1906). The scientific investigation of the psychical faculties or processes in the higher animals. *Science*, 24, 613–619.
- Pavlov, I. P. (1926). *Conditioned reflexes*. London: Oxford University Press.
- Pavlov, I. P. (1927). *Conditioned Reflexes: An Investigation of the Physiological Activity of the Cerebral Cortex*. Translated and Edited by G. V. Anrep. London: Oxford University Press.
- Peng, K., Ames, D. R., & Knowles, E. D. (2000). Culture and human inference: Perspectives from three traditions. In D. Matsumoto (Ed.) (2001). *The handbook of culture and psychology* (pp. 245–264). New York: Oxford University Press.
- Peplau, L. A., & Fingerhut, A. W. (2007). The close relationships of lesbians and gay men. *Annual Review of Psychology*, 58, 10.1–10.20.
- Peplau, L. A., & Taylor, S. E. (1997). *Sociocultural perspectives in social psychology: Current readings*. Upper Saddle River, NJ: Prentice-Hall.
- Pepperberg, I. M. (1998). Talking with Alex: Logic and speech in parrots. *Scientific American Presents: Exploring Intelligence*, 9(4), 60–65.
- Pepperberg, I. M. (2007). Grey parrots do not always “parrot”: The roles of imitation and phonological awareness in the creation of new labels from existing vocalizations. *Language Sciences*, 29(1), 1–13.
- Perls, F. (1951). *Gestalt therapy*. New York: Julian Press.
- Perls, F. (1969). *Gestalt therapy verbatim*. Moab, UT: Real People Press.
- Perrine, D. M. (1997). *The chemistry of mind-altering drugs*. Washington, DC: American Chemical Society.
- Perrin, S., & Spencer, C. (1980). The Asch effect—A child of its time. *Bulletin of the British Psychological Society*, 33, 405–406.
- Perrin, S., & Spencer, C. P. (1981). Independence or conformity in the Asch experiment as a reflection of cultural and situational factors. *British Journal of Social Psychology*, 20(3), 205–209.
- Perry, W. G., Jr. (1970). *Forms of intellectual and ethical development in the college years: A scheme*. New York: Holt, Rinehart, and Winston.
- Petanjek, Z., Judas, M., Simic, G., Rasin, M. R., Uylings, H. B., Rakic, P., & Kostovic, I. (2011). Extraordinary neoteny of synaptic spines in the human prefrontal cortex. *Proceedings of the National Academy of Sciences of the United States of America*, 108(32), 13281–13286. doi: 10.1073/pnas.1105108108
- Peters, W. A. (1971). *A class divided*. Garden City, NY: Doubleday.
- Peterson, C., & Park, N. (2010). What happened to self-actualization? *Perspectives on Psychological Science*, 5(3), 320–322.
- Peterson, D. R. (1976). Need for the Doctor of Psychology degree in professional psychology. *American Psychologist*, 31, 792–798.
- Peterson, D. R. (1982). Origins and development of the Doctor of Psychology concept. In G. R. Caddy, D. C. Rimm, N. Watson, & J. H. Johnson (Eds.), *Educating professional psychologists* (pp. 19–38). New Brunswick, NJ: Transaction Books.
- Peterson, L. R., & Peterson, M. J. (1959). Short-term retention of individual items. *Journal of Experimental Psychology*, 58, 193–198.
- Petitto, L. A., Holowka, S., Sergio, L. E., & Ostry, D. (2001). Language rhythms in baby hand movements. *Nature*, 413, 35.
- Petitto, L. A., & Marentette, P. F. (1991). Babbling in the manual mode: Evidence for the ontogeny of language. *Science*, 251, 1493–1496.
- Petri, H. (1996). *Motivation: Theory, research and application* (4th ed.), Belmont, CA: Wadsworth.
- Petrides, G., Tobias, K. G., Kellner, C. H., & Rudorfer, M. V. (2011). Continuation and maintenance electroconvulsive therapy for mood disorders: A review of the literature. *Neuropsychobiology*, 64(3), 129–140. doi: 10.1159/000328943
- Petrova, P. K., Cialdini, R. B., & Sills S., J. (2007). Compliance, consistency, and culture: Personal consistency and compliance across cultures. *Journal of Experimental Social Psychology*, 43: 104–111.
- Pettigrew, T. F., & Tropp, L. R. (2000). Does intergroup contact reduce prejudice? Recent meta-analytic findings. In S. Oskamp (Ed.), *Reducing prejudice and discrimination: Social psychological perspectives* (pp. 93–114). Mahwah, NJ: Erlbaum.
- Petty, R., & Cacioppo, J. (1986). *Communication and persuasion: Central and peripheral routes to attitude change*. New York: Springer-Verlag.
- Petty, R., & Cacioppo, J. (1996). *Attitudes and persuasion: Classic and contemporary approaches* (reprint). Boulder, CO: Westview Press.
- Petty, R. E. (1995). Attitude change. In A. Tesser (Ed.), *Advances in social psychology* (pp. 194–255). New York: McGraw-Hill.
- Petty, R. E., Wheeler, S. C., & Tormala, Z. L. (2003). Persuasion and attitude change. In T. Millon & M. J. Lerner (Eds.), *Handbook of psychology: Volume 5: Personality and social psychology* (pp. 353–382). Hoboken, NJ: John Wiley & Sons.
- Pezdek, K., Finger, K., & Hodge, D. (1997). Planting false childhood memories: The role of event plausibility. *Psychological Science*, 8, 437–441.
- Pezdek, K., & Hodge, D. (1999). Planting false childhood memories in children: The role of event plausibility. *Child Development*, 70, 887–895.
- Pfeiffer, W. M. (1982). Culture-bound syndromes. In I. Al-Issa (Ed.), *Culture and psychopathology* (pp. 201–218). Baltimore: University Park Press.
- Phan, T., & Silove, D. (1999). An overview of indigenous descriptions of mental phenomena and the range of traditional healing practices amongst the Vietnamese. *Transcultural Psychiatry*, 36, 79–94.
- Piaget, J. (1926). *The language and thought of the child*. New York: Harcourt Brace.
- Piaget, J. (1952). *The origins of intelligence in children*. New York: W. W. Norton.
- Piaget, J. (1962). *Play, dreams and imitation in childhood*. New York: W. W. Norton.
- Piaget, J. (1983). Piaget's theory. In W. Kessen (Ed.), *Handbook of child psychology: Volume 1. Theoretical models of human development* (pp. 103–128). New York: Wiley.
- Pilkington, J. (1998). “Don't try and make out that I'm nice”: The different strategies women and men use when gossiping. In J. Coates (Ed.), *Language and gender: A reader* (pp. 254–269). Oxford, UK: Blackwell.

- Pilon, M., Montplaisir, J., & Zadra A. (2008). Precipitating factors of somnambulism: Impact of sleep deprivation and forced arousals. *Neurology*, 70: 2284–90.
- Pinker, S. (1995). Language acquisition. In Gleitman et al. (Eds.), *An invitation to cognitive science* (2nd ed., pp. 135–182). Cambridge: MIT Press.
- Pinker, S., & Bloom, P. (1990). Natural language and natural selection. *Behavioral and Brain Sciences*, 13(4), 707–784.
- Pinsof, W. M., & Wynne, L. C. (1995). The efficacy of marital and family therapy: An empirical overview, conclusions, and recommendations. *Journal of Marital and Family Therapy*, 21, 585–613.
- Plaut, D. C., & McClelland, J. L. (2010). Locating object knowledge in the brain: A critique of Bowers' (2009) attempt to revive the grandmother cell hypothesis. *Psychological Review*, 117, 284–288.
- Plomin, R. (1994). The nature of nurture: The environment beyond the family. In R. Plomin (Ed.), *Genetics and experience: The interplay between nature and nurture* (pp. 82–107). Thousand Oaks, CA: Sage.
- Plomin, R., & DeFries, J. C. (1998, May). Genetics of cognitive abilities and disabilities. *Scientific American*, 62–69.
- Plomin, R. N. L., Pederson, G. E., McClearn, J. R., Nesselroade, C. S., & Bergman, H. F. (1988). EAS temperaments during the last half year of the life span: Twins reared apart and twins raised together. *Psychology of Aging*, 4, 43–50.
- Plomin, R., Owen, M. J., & McGuffin, P. (1994). The genetic basis of complex human behaviors. *Science*, 264(5166), 1733–1739.
- Plomin, R., & Spinath, F. M. (2004). Intelligence: Genetics, genes, and genomics. *Journal of Personality and Social Psychology*, 86(1), 112–129.
- Plug, C., & Ross, H. E. (1994). The natural moon illusion: A multi-factor angular account. *Perception*, 23, 321–333.
- Plum, F., & Posner, J. B. (1985). *The diagnosis of stupor and coma*. Philadelphia: F. A. Davis.
- Poe, G. R., Walsh, C. M., & Bjorness, T. E. (2010). Cognitive neuroscience of sleep. In G. A. Kerkhof and H. P. A. van Dongen (Eds.), *Human Sleep and Cognition*, 185, 1–19. Oxford: Elsevier Science.
- Pogue-Geile, M. F., & Yokley, J. L. (2010). HYPERLINK “<http://cdp.sagepub.com/content/19/4/214.abstract>”. Current Research on the Genetic Contributors to Schizophrenia. *Current Directions in Psychological Science*, 19, 214–219. doi: 10.1177/0963721410378490.
- Polce-Lynch, M., Myers, B. J., Kilmartin, C. T., Forssmann-Falck, R., & Kliewer, W. (1998). Gender and age patterns in emotional expression, body image, and self-esteem: A qualitative analysis. *Sex Roles*, 38, 1025–1050.
- Polewan, R. J., Vigorito, C. M., Nason, C. D., Block, R. A., & Moore, J. W. (2006). A cartesian reflex assessment of face processing. *Behavioral and Cognitive Neuroscience Reviews*, 3(5), 3–23.
- Pollack, M. H., Simon, N. M., Fagiolini, A., Pitman, R., McNally, R. J., Nierenberg, A. A., Miyahara, S., Sachs, G. S., Perlman, C., Ghaemi, S. N., Thase, M. E., & Otto, M. W. (2006). Persistent posttraumatic stress disorder following September 11 in patients with bipolar disorder. *Journal of Clinical Psychiatry*, 67(3), 394–399.
- Pollitt, E., & Mathews, R. (1998). Breakfast and cognition: An integrative summary. *The American Journal of Clinical Nutrition*, V67: 804S–813S.
- Pompili, M., Lester, D., Dominici, G., Longo, L., Marconi, G., Forte, A., ... Girardi, P. (2013). Indications for electroconvulsive treatment in schizophrenia: A systematic review. *Schizophrenia Research*, 146(1–3), 1–9. doi: 10.1016/j.schres.2013.02.005
- Pope, H. G., Poliakoff, M. B., Parker, M. P., Boynes, M., & Hudson, J. I. (2007). Is dissociative amnesia a culture-bound syndrome? Findings from a survey of historical literature. *Psychological Medicine*, 37(2), 225–233.
- Pomerleau, C. S., & Pomerleau, O. F. (1994). Euphoriant effects of nicotine. *Tobacco Control*, 3, 374.
- Posthuma, D., de Geus, E. J. C., & Deary, I. J. (2009). The genetics of intelligence. In T. E. Goldberg & D. R. Weinberger (Eds.), *The Genetics of Cognitive Neuroscience*. Cambridge, MA: MIT Press.
- Postman, L. (1975). Tests of the generality of the principle of encoding specificity. *Memory & Cognition*, 3, 663–672.
- Poulin, M. J., Holman, E. A., & Buffone, A. (2012). The neurogenetics of nice: Receptor genes for oxytocin and vasopressin interact with threat to predict prosocial behavior. *Psychological Science*, 23(5), 446–452. doi: 10.1177/0956797611428471
- Powers, M. H. (1984). A computer-assisted problem-solving method for beginning chemistry students. *The Journal of Computers in Mathematics and Science Teaching*, 4(1), 13–19.
- Pratkanis, A. R. (1992). The cargo-cult science of subliminal persuasion. *Skeptical Inquirer*, 16, 260–272.
- Pratkanis, A. R., & Greenwald, A. G. (1988). Recent perspectives on unconscious processing: Still no marketing applications. *Psychology and Marketing*, 5, 337–353.
- Pratt, J. A. (1991). Psychotropic drug tolerance and dependence: Common underlying mechanisms? In E. Pratt (Ed.), *The biological bases of drug tolerance and dependence* (pp. 2–28). London: Academic Press/Harcourt Brace Jovanovich.
- Preston, J. D., O’Neal, J. H., & Talaga, M. C. (2008). *Handbook of clinical psychopharmacology for therapists* (5th ed.). Oakland, CA: New Harbinger.
- Priester, J. M., & Petty, R. E. (1995). Source attributions and persuasion: Perceived honesty as a determinant of message scrutiny. *Personality and Social Psychology Bulletin*, 21, 637–654.
- Prigerson, H. G., Bierhals, A. J., Kasi, S. V., Reynolds, C. F., Shear, M. K., Day, N., Beery, L. C., Newsome, J. T., & Jacobs, S. (1997). Traumatic grief as a risk factor for mental and physical morbidity. *American Journal of Psychiatry*, 154I, 616–623.
- Pritchard, T. C. (2012). Gustatory system. In J. K. Mai & G. Paxinos (Eds.), *The human nervous system* (pp. 1187–1218). London, UK: Academic Press.
- Prochaska, J. O., & Norcross, J. C. (2003). *Systems of psychotherapy* (5th ed.). Belmont, CA: Wadsworth.
- Prochaska, J. O., & Norcross, J. C. (2009). *Systems of psychotherapy: A transtheoretical analysis*. Belmont, CA: Brooks/Cole, Cengage Learning.
- Pullum, G. K. (1991). *The great Eskimo vocabulary hoax: And other irreverent essays on the study of language*. Chicago: University of Chicago Press.
- Pumariega, A. J., & Gustavson, C. R. (1994). Eating attitudes in African-American women: The essence. *Eating Disorders: Journal of Treatment and Prevention*, 2, 5–16.
- Purcell, S. (1985, August). *Relation between religious orthodoxy and marital sexual functioning*. Paper presented at the meeting of the American Psychological Association, Los Angeles.
- Purdy, D., Eitzen, D., & Hufnagel, R. (1982). Are athletes also students? The educational attainment of college athletes. *Social Problems*, 29, 439–448.
- Putnam, S. P., & Stifter, C. A. (2002). Development of approach and inhibition in the first year: Parallel findings for motor behavior, temperament ratings and directional cardiac response. *Developmental Science*, 5, 441–451.
- Puts, D. A., Jordan, C. L., & Breedlove, S. M. (2006). O brother, where art thou? The fraternal birth-order effect on male sexual orientation. *Proceedings of the National Academy of Sciences, USA*, 103(28), 10531–10532.
- Quintero, J. E., Kuhlman, S. J., & McMahon, D. G. (2003). The biological clock nucleus: A multiphasic oscillator network regulated by light. *Journal of Neuroscience*, 23, 8070–8076.
- Raijmakers, J. G. W., & Shiffrin, R. M. (1992). Models for recall and recognition. *Annual Review of Psychology*, 43, 205–234.
- Rabins, P., Appleby, B. S., Brandt, J., DeLong, M. R., Dunn, L. B., Gabriels, L., et al. (2009). Scientific and ethical issues related to deep brain stimulation for disorders of mood, behavior, and thought. *Archives of General Psychiatry*, 66(9), 931–937.
- Rachman, S. (1990). The determinants and treatments of simple phobias. *Advances in Behavioral Research and Therapy*, 12(1), 1–30.
- Rachman, S. J., & Hodgson, R. J. (1980). *Obsessions and compulsions*. Englewood Cliffs, NJ: Prentice Hall.
- Racsmány, M., Conway, M. A., & Demeter, G. (2010). Consolidation of episodic memories during sleep: Long-term effects of retrieval practice. *Psychological Science*, 21: 80–85.
- Rahman, Q., & Hull, M. S. (2005). An empirical test of the kin selection hypothesis for male homosexuality. *Archives of Sexual Behavior*, 34, 461–467.
- Raikkonen, K., Matthews, K. A., & Salomon, K. (2003). Hostility predicts metabolic syndrome risk factors in children and adolescents. *Health Psychology*, 22, 279–286.
- Rainforth, M. V., Schneider, R. H., Niclitch, S. I., Gaylord-King, C., Salerno, J. W., & Anderson, J. W. (2007). Stress reduction programs in patients with elevated blood pressure: A systematic review and meta-analysis. *Current Hypertension Reports*, 9, 520–528.
- Ramachandran, V. S., & Blakeslee, S. (1998). *Phantoms in the brain*. New York: Quill William Morrow.
- Ramón y Cajal, S. (1995.) *Histology of the nervous system of man and vertebrates*. New York: Oxford University Press. English translation by N. Swanson and L. M. Swanson.
- Ranke, M. B., & Saenger, P. (2001, July 28). Turner's syndrome. *Lancet*, 358(9278), 309–314.
- Rao, S. C., Rainer, G., & Miller, E. K. (1997). Integration of what and where in the primate prefrontal cortex. *Science*, 276, 821–824.
- Rapoport, J. L., Addington, A. M., Frangou, S., & Psych, M. R. (2005). The neurodevelopmental model of schizophrenia: Update 2005. *Molecular Psychiatry*, 10(5), 434–449. doi: 10.1038/sj.mp.4001642
- Rapoport, J. L., Giedd, J. N., & Gogtay, N. (2012). Neurodevelopmental model of schizophrenia: Update 2012. *Molecular Psychiatry*, 17(12), 1228–1238. doi: 10.1038/mp.2012.23

- Rasenberger, J. (2006). Nightmare on Austin Street. *American Heritage Magazine*, 57(5), Retrieved July 8, 2010, from http://www.americanheritage.com/articles/magazine/ah/2006/5/2006_5_65.shtml
- Ratey, J. J., & Hagerman, E. (2008). *Spark: The revolutionary new science of exercise and the brain*. New York: Little, Brown.
- Rauch, S. L., Shin, L. M., & Wright, C. I. (2003). Neuroimaging studies of amygdala function in anxiety disorders. *Annals of the New York Academy of Sciences*, 985, 389–410.
- Raynor, H. A., & Epstein, L. H. (2001). Dietary variety, energy regulation and obesity. *Psychological Bulletin*, 127(3), 325–341.
- Reason, J. T., & Brand, J. J. (1975). *Motion sickness*. London: Academic Press.
- Rechtschaffen, A., & Kales, A. (1968). *A manual of standardized terminology, techniques, and scoring system for sleep stages of human subjects*. U.S. Department of Health, Education, and Welfare Public Health Service - NIH/NIND.
- Reichborn-Kjennerud, T. (2008). Genetics of personality disorders. *Psychiatric Clinics of North America*, 31, 421.
- Reichborn-Kjennerud, T., Czajkowski, N., Neale, M. C., Orstavik, R. E., Torgersen, S., Tambs, K., ... Kendler, K. S. (2007). Genetic and environmental influences on dimensional representations of DSM-IV cluster C personality disorders: A population-based multivariate twin study. *Psychological Medicine*, 37(5), 645–653. doi: 10.1017/s003291706009548
- Reicher, S. D., Haslam, S. A., & Smith, J. R. (2012). Working toward the experimenter: Reconceptualizing obedience within the Milgram paradigm as identification-based followership. *Perspectives on Psychological Science*, 7(4), 315–324. doi: 10.1177/1745691612448482
- Reilly, D., & Neumann, D. L. (2013). Gender-role differences in spatial ability: A meta-analytic review. *Sex Roles*, 68, 521. doi: 10.1007/s11199-013-0269-0
- Reinders, A., Quak, J., Nijenhuis, E. R., Korf, J., Paans, A. M., Willemsen, A. T., & den Boer, J. A. (2001, June). *Identity state-dependent processing of neutral and traumatic scripts in dissociative identity disorder as assessed by PET*. Oral presentation at the 7th Annual Meeting of the Organisation for Human Brain Mapping, Brighton, UK. *NeuroImage* 13(Suppl.), S1093.
- Reiner, W. G. (1999). Assignment of sex in neonates with ambiguous genitalia. *Current Opinions in Pediatrics*, 11(4), 363–365.
- Reiner, W. G. (September 29, 2000). *The genesis of gender identity in the male: Prenatal androgen effects on gender identity and gender role*. Oral presentation at New York University Child Study Center, Grand Rounds Summary.
- Reisenzein, R. (1983). The Schachter theory of emotion: Two decades later. *Psychological Bulletin*, 94, 239–264.
- Reisenzein, R. (1994). Pleasure-arousal theory and the intensity of emotions. *Journal of Personality and Social Psychology*, 7(6), 1313–1329.
- Renchler, R. (1993). Poverty and learning. *ERIC Digest No. 83*, Eugene, OR: ERIC Clearinghouse on Educational Management. (ERIC Document Reproduction Service No. ED 357 433).
- Renner, M. J., & Mackin, R. S. (1998). A life stress instrument for classroom use. *Teaching of Psychology*, 25, 47.
- Rescorla, R. (1988). Pavlovian conditioning—It's not what you think. *American Psychologist*, 43, 151–160.
- Rescorla, R. A. (1968). Probability of shock in the presence and absence of CS in fear conditioning. *Journal of Comparative and Physiological Psychology*, 66, 1–5.
- Resick, P. A., Monson, C. M., & Rizvi, S. (2008). Posttraumatic stress disorder. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (pp. 65–122). New York: Guilford Press.
- Reynolds, C. F.; Frank, E.; Perel, J. M.; Imber, S. D.; Cornes, C.; Miller, M. D.; Mazumdar, S.; Houck, P. R.; Dew, M. A.; Stack, J. A.; Pollock, B. G.; & Kuper, D. J. (1999). Nortriptyline and interpersonal psychotherapy as maintenance therapies for recurrent depression: A randomized controlled trial in patients older than 59 years. *Journal of the American Medical Association* 281 (1), 39–45.
- Reynolds, J. A. (2002). *Succeeding in college: study skills and strategies*, 2e. Needham Heights: Allyn and Bacon.
- Reynolds, R. M., Strachan, M. Frier, B. M., Fowkes, F. G., Mitchell, R., Seckl, J. R., Deary, I. J., Walker, B. R., & Prices, J. F. (2010). Morning cortisol levels and cognitive abilities in people with Type 2 diabetes. *American Diabetes Association: Diabetes Care*, 33(4), 714–720.
- Rezvani, A. H., & Levin, E. D. (2001). Cognitive effects of nicotine. *Biological Psychiatry*, 49, 258–267.
- RIA Novosti. (2010, January 7). Some 80 people die from drug abuse in Russia every day—minister. Retrieved June 30, 2010, from <http://en.rian.ru/russia/20100616/159443005.html>
- Rice, W. R., Friberg, U., & Gavrilets, S. (2012). Homosexuality as a consequence of epigenetically canalized sexual development. *The Quarterly Review of Biology*, 87(4), 344–368.
- Richards, C. F., & Lowe, R. A. (2003). Researching racial and ethnic disparities in emergency medicine. *Academic Emergency Medicine*, 10(11), 1169–1175.
- Richardson, J., & Morgan, R. (1997). *Reading to learn in the content areas*. Belmont, CA: Wadsworth.
- Rideout, V. J., Foehr, U. G., & Roberts, D. F. (2010). *Generation M2: Media in the lives of 8- to 18-year-olds*. Menlo Park, CA: Henry J. Kaiser Family Foundation.
- Ridley, M. (1999). *Genome: The autobiography of a species in 23 chapters*. London: Fourth Estate.
- Ridley, M. (2002). Crop Circle Confession. *Scientific American*. Retrieved February 17, 2010, from <http://www.sciam.com/article.cfm?chanID=sa006&articleID=0038B16-ED5F-1D29-97CA809EC588EEDF>
- Rieber, R. W., & Robinson, D. K. (2001). *Wilhelm Wundt in history: The making of a scientific psychology*. New York: Kluwer Academic.
- Rijdsdijk, F. V., Gottesman, I. I., McGuffin, P., & Cardno, A. G. (2011). Heritability estimates for psychotic symptom dimensions in twins with psychotic disorders. *American Journal of Medical Genetics Part B, Neuropsychiatric Genetics*, 156B(1), 89–98. doi: 10.1002/ajmg.b.31145
- Ritchey, M., LaBar, K. S., & Cabeza, R. (2011). Level of processing modulates the neural correlates of emotional memory formation. *Journal of Cognitive Neuroscience*, 4, 757–775.
- Ritts, V. (1999). Infusing culture into psychopathology: A supplement for psychology instructors. Retrieved from the Internet on June 19, 2004, at www.stlcc.cc.mo.us/mc/users/vritts/psypath.htm.
- Rizzolatti, G., Fabbri-Destro, M., & Cattaneo, L. (2009). Mirror neurons and their clinical relevance. *Nature Clinical Practice Neurology*, 5(1), 24–34.
- Ro, E., & Clark, L. A. (2009). Psychosocial functioning in the context of diagnosis: Assessment and theoretical issues. *Psychological Assessment*, 21(3), 313–324.
- Roberto, C. A., Baik, J., Harris, J. L., & Brownell, K. D. (2010). Influence of licensed characters on children's taste and snack preferences. *Pediatrics*. Retrieved from <http://pediatrics.aappublications.org/cgi/content/abstract/peds.2009-3433v1>. doi:10.1542/peds.2009-3433
- Robins, L. N. (1996). *Deviant children grown up*. Baltimore: Williams & Wilkins.
- Robinson, F. P. (1946). *Effective study*. New York: Harper & Bros.
- Robinson, J. W., & Preston, J. D. (1976). Equal status contact and modification of racial prejudice: A reexamination of the contact hypothesis. *Social Forces*, 54, 911–924.
- Robinson, P. (1993). *Freud and his critics*. Berkeley: University of California Press.
- Rosch, T., Theberge, J., Frewen, P. A., Kluiters, R., Densmore, M., Calhoun, V. D., & Lanius, R. A. (2013). Mind over chatter: Plastic up-regulation of the fMRI salience network directly after EEG neurofeedback. *Neuroimage*, 65, 324–335. doi: 10.1016/j.neuroimage.2012.09.046
- Roche, A. F. (1979). Secular trends in human growth, maturation, and development. *Monographs of the Society for Research in Child Development*, 44(3–4), 1–120.
- Rodgers, J. E. (1992). *Psychosurgery: Damaging the brain to save the mind*. New York: HarperCollins.
- Rodin, J. (1981). Current status of the internal-external hypothesis for obesity. *American Psychologist*, 36, 361–372.
- Rodin, J. (1985). Insulin levels, hunger, and food intake: An example of feedback loops in body weight regulation. *Health Psychology*, 4, 1–24.
- Rodin, J., & Langer, E. J. (1977). Long-term effects of a control-relevant intervention among the institutionalized aged. *Journal of Personality and Social Psychology*, 35, 275–282.
- Roediger, H. L. (1990). Implicit memory: Retention without remembering. *American Psychologist*, 45, 1043–1056.
- Roediger, H. L., III (2000). Why retrieval is the key process to understanding human memory. In E. Tulving (Ed.), *Memory, consciousness and the brain: The Tallinn Conference* (pp. 52–75). Philadelphia: Psychology Press.
- Roediger, H. L., III, & Guynn, M. J. (1996). Retrieval processes. In E. L. Bjork & R. A. Bjork (Eds.), *Memory* (pp. 197–236). New York: Academic Press.
- Roethlisberger, F. J. & Dickson, W. J. (1939) *Management and the Worker*. Cambridge, MA: Harvard University Press.
- Roffman, R. A., Stephens, R. S., Simpson, E. E., & Whitaker, D. L. (1988). Treatment of marijuana dependence: Preliminary results. *Journal of Psychoactive Drugs*, 20(1), 129–137.
- Roffwarg, H. P., Muzio, J. N., & Dement, W. C. (1966). Ontogenetic development of the human sleep-dream cycle. *Science*, 152(3722), 604–619.
- Rogers, C. R. (1951). *Client-centered therapy*. Boston: Houghton Mifflin Co.

- Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy*. Boston: Houghton Mifflin Co.
- Rogers, R. W., & Mewborn, C. R. (1976). Fear appeals and attitude change: Effects of a threat's noxiousness, probability of occurrence, and the efficacy of the coping responses. *Journal of Personality and Social Psychology*, 34, 54–61.
- Rogoff, B. (1994). Developing understanding of the idea of communities of learners. *Mind, Culture, and Activity*, 1(4), 209–229.
- Rohde, P., Silva, S. G., Tonev, S. T., Kennard, B. D., Vitiello, B., Kratochvil, C. J., Reinecke, M. A., Curry, J. F., Simons, A. D., March, J. S. (2008). Achievement and maintenance of sustained improvement during TADS continuation and maintenance therapy. *Archives of General Psychiatry*, 65(4), 447–455.
- Roid, G. H. (2003). *Stanford-Binet intelligence scales* (5th ed.). Itasca, IL: Riverside.
- Roos, P. E., & Cohen, L. H. (1987). Sex roles and social support as moderators of life stress adjustment. *Journal of Personality and Social Psychology*, 53, 576–585.
- Roper, G., Rachman, S., & Marks, I. (1975). Passive and participant modeling in exposure treatment of obsessive-compulsive neurotics. *Behaviour Research and Therapy*, 13, 271–279.
- Ros, T., Theberge, J., Frewen, P. A., Kluetsch, R., Densmore, M., Calhoun, V. D., & Lanus, R. A. (2013). Mind over chatter: Plastic up-regulation of the fMRI salience network directly after EEG neurofeedback. *Neuroimage*, 65, 324–335. doi: 10.1016/j.neuroimage.2012.09.046
- Rosch, E. (1973). On the internal structure of perceptual and semantic categories. In T. E. Moore (Ed.), *Cognitive development and the acquisition of language* (pp. 111–144). New York: Academic Press.
- Rosch, E. (1977). Human categorization. In N. Warren (Ed.), *Advances in cross-cultural psychology*, 1 (pp. 1–72). London: Academic Press.
- Rosch, E., & Mervis, C. (1975). Family resemblances: Studies in the internal structures of categories. *Cognitive Psychology*, 7, 573–605.
- Rosch-Heider, E. (1972). Universals in color naming and memory. *Journal of Experimental Psychology*, 93, 10–20.
- Rosch-Heider, E., & Olivier, D. C. (1972). The structure of the color space in naming and memory for two languages. *Cognitive Psychology*, 3, 337–354.
- Rosenbloom, T., Shahar, A., Perlman, A., Estreich, D., & Kirzner, E. (2007). Success on a practical driver's license test with and without the presence of another testee. *Accident Analysis & Prevention*, 39(6), p. 1296–1301.
- Rosenfeld, J. P., Labkovsky, E., Winograd, M., Lui, M. A., Vandenboom, C., & Chedid, E. (2008). The Complex Trial Protocol (CTP): A new, countermeasure-resistant, accurate, P300-based method for detection of concealed information. *Psychophysiology*, 45(6), 906–919.
- Rosenhan, D. L. (1973). On being sane in insane places. *Science*, 179, 250–258.
- Rosenman, R. H., Brand, R. I., Jenkins, C. D., Friedman, M., Straus, R., & Wurm, M. (1975). Coronary heart disease in the Western Collaborative Group Study, final follow-up experience of 2 years. *Journal of the American Medical Association*, 233, 812–817.
- Rosenthal, A. M. (1964). *Thirty-eight witnesses: The Kitty Genovese case*. New York: McGraw-Hill.
- Rosenthal, R., & Jacobson, L. (1968). *Pygmalion in the classroom*. New York: Holt, Rinehart & Winston.
- Rose, S., Kamin, L. J., & Lewontin, R. C. (1984). *Not in our genes: Biology, ideology and human nature*. Harmondsworth, UK: Penguin.
- Ross, H. E., & Ross, G. M. (1976). Did Ptolemy understand the moon illusion? *Perception*, 5, 377–385.
- Rossini, P. M., Altamura, C., Ferreri, F., Melgari, J. M., Tecchio, F., Tombini, M., Pasqualetti, P., & Vernieri, F. (2007). Neuroimaging experimental studies on brain plasticity in recovery from stroke. *Eura Medicophys*, 43(2), 241–254.
- Rothbaum, B. O., Hodges, L. F., Kooper, R., Opdyke, D., Williford, J. S., & North, M. (1995). Effectiveness of computer-generated (virtual reality) graded exposure in the treatment of acrophobia. *American Journal of Psychiatry*, 152, 626–628.
- Rothbaum, F., Morelli, G., & Rusk, N. (2010). Attachment, learning and coping: The interplay of cultural similarities and differences. In C. Y. Chiu, Y. Y. Hong, & M. Gelfand (Eds.), *Advances in culture and psychology* (Vol. 1, pp. 153–215). New York: Oxford University Press.
- Rothbaum, R., Weisz, J., Pott, M., Miyake, K., & Morelli, G. (2000). Attachment and culture: Security in Japan and the U.S. *American Psychologist*, 55, 1093–1104.
- Rothenberg, A. (2001). Bipolar illness, creativity, and treatment. *Psychiatric Quarterly*, 72(2), 131–147.
- Rotter, J. B. (1966). Generalized expectancies for internal versus external control of reinforcements. *Psychological Monographs*, 80 [Whole no. 609].
- Rotter, J. B. (1978). Generalized expectancies for problem solving and psychotherapy. *Cognitive Therapy and Research*, 2, 1–10.
- Rotter, J. B. (1981). The psychological situation in social learning theory. In D. Magnusson (Ed.), *Toward a psychology of situations: An interactional perspective*. Hillsdale, NJ: Lawrence Erlbaum.
- Rotter, J. B. (1990). Internal versus external control of reinforcement: A case history of a variable. *American Psychologist*, 45, 489–493.
- Rotton, J., & Frey, J. (1985). Air pollution, weather, and violent crime: Concomitant time-series analysis of archival data. *Journal of Personality and Social Psychology*, 49, 1207–1220.
- Rotton, J., Frey, J., Barry, T., Milligan, M., & Fitzpatrick, M. (1979). The air pollution experience and physical aggression. *Journal of Applied Social Psychology*, 9, 397–412.
- Roura, J., Wesnes, K., Hänninen, J., Murphy, M., Riordan, H., & Rinne, J. (2013, March 16–23). Safety and efficacy of ORM-12741 on cognitive and behavioral symptoms in patients with Alzheimer's disease: A randomized, double-blind, placebo-controlled, parallel group, multicenter, proof-of-concept 12 week study. Paper presented at American Academy of Neurology 65th Annual Meeting, San Diego, CA.
- Rouse, B. A. (1998). *Substance and mental health statistics source book*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA).
- Rovet, J. (1993). The psychoeducational characteristics of children with Turner's syndrome. *Journal of Learning Disabilities*, 26, 333–341.
- Rowan, J. (2001). *Ordinary ecstasy*. Hove, UK: Brunner-Routledge.
- Rowe, D. C., Almeida, D. A., & Jacobson, K. C. (1999). School context and genetic influences on aggression in adolescence. *Psychological Science*, 10, 277–280.
- Roysircar-Sadowsky, G. R., & Maestas, M. V. (2000). Acculturation, ethnic identity, and acculturative stress: Evidence and measurement. In R. H. Dana (Ed.), *Handbook of cross-cultural and multicultural assessment* (pp. 131–172). Mahwah, NJ: Lawrence Erlbaum.
- Rozeske, R. R., Evans, A. K., Frank, M. G., Watkins, L. R., Lowry, C. A., & Maier, S. F. (2011). Uncontrollable, but not controllable, stress desensitizes 5-HT1A receptors in the dorsal raphe nucleus. *The Journal of Neuroscience*, 31(40), 14107–14115. doi: 10.1523/jneurosci.3095-11.2011
- Ruble, D., Alvarez, J., Bachman, M., Cameron, J., Fuligni, A., Garcia Coll, C., & Rhee, E. (2004). The development of a sense of "we": The emergence and implications of children's collective identity. In M. Bennett & F. Sani (Eds.), *The development of the social self*. New York: Psychology Press.
- Rudd, P., & Osterberg, L. G. (2002). Hypertension: Context, pathophysiology, and management. In E. J. Topol (Ed.), *Textbook of cardiovascular medicine* (pp. 91–122). Philadelphia: Lippincott Williams & Wilkins.
- Ruff, R. M., Iverson, G. L., Barth, J. T., Bush, S. S., & Broshek, D. K. (2009). Recommendations for diagnosing a mild traumatic brain injury: A National Academy of Neuropsychology education paper. *Archives of Clinical Neuropsychology*, 24(1), 3–10.
- Ruhe, H. G., Mason, N. S., & Schene, A. H. (2007). Mood is indirectly related to serotonin, norepinephrine and dopamine levels in humans: A meta-analysis of monoamine depletion studies. *Molecular Psychiatry*, 12(4), 331–359.
- Ruiz, S., Lee, S., Soekadar, S. R., Caria, A., Veit, R., Kircher, T., ... Sitaram, R. (2013). Acquired self-control of insula cortex modulates emotion recognition and brain network connectivity in schizophrenia. *Human Brain Mapping*, 34(1), 200–212. doi: 10.1002/hbm.21427
- Rumelhart, D. E., Hinton, G. E., & McClelland, J. L. (1986). A general framework for parallel distributed processing. In D. E. Rumelhart, J. L. McClelland, & the PDP Research Group (Eds.), *Parallel distributed processing: Explorations in the microstructure of cognition: Vol. 1. Foundations* (pp. 45–76). Cambridge, MA: MIT Press.
- Rundus, D. (1971). An analysis of rehearsal processes in free recall. *Journal of Experimental Psychology*, 89, 63–77.
- Ruscio, A. M., Borkovec, T. D., & Ruscio, J. (2001). A taxometric investigation of the latent structure of worry. *Journal of Abnormal Psychology*, 110, 413–422.
- Russell, D. E. (1986). *The secret trauma: Incest in the lives of girls and women*. New York: Basic Books.
- Rutherford, A. (2000). Mary Cover Jones (1896–1987). *The Feminist Psychologist*, 27(3), 25.
- Ryan, R. M., Chirkov, V. I., Little, T. D., Sheldon, K. M., Timoshina, E. L., Deci, E. L. (1999). The American dream in Russia: Extrinsic aspirations and well-being in two cultures. *Personality and Social Psychology Bulletin*, 25, 1509–1524.
- Ryan, R. M., & Deci, E. L. (2000). Intrinsic and extrinsic motivations: Classic definitions and new directions. *Contemporary Educational Psychology*, 25, 54–67.
- Rydell, R. J., & Boucher, K. L. (2010). Capitalizing on multiple social identities to prevent stereotype threat: The moderating role of self-esteem. *Personality and Social Psychology Bulletin*, 36(2), 239–250.

- Sabatini, E., Della Penna, S., Franciotti, R., Ferretti, A., Zoccolotti, P., Rossini, P. M., Romani, G. L., & Gainotti, G. (2009). Brain structures activated by overt and covert emotional visual stimuli. *Brain Research Bulletin*, 79(5), 258–264.
- Sackett, P. R., Borneman, M. J., & Connelly, B. S. (2008). High stakes testing in higher education and employment: Appraising the evidence for validity and fairness. *American Psychologist*, 63(4), 215–227. doi: 10.1037/0003-066X.63.4.215
- Sacks, O. (1990). *The man who mistook his wife for a hat and other clinical tales*. New York: HarperPerennial.
- Sadker, M., & Sadker, D. (1994). *Failing at fairness: How America's schools cheat girls*. New York: Scribner.
- Sadock, B. J., Kaplan, H. I., & Sadock, V. A. (2007). *Kaplan & Sadock's synopsis of psychiatry: Behavioral sciences/clinical psychiatry* (10th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Sagan, C. (1977). *The dragons of Eden: Speculations on the evolution of human intelligence*. New York: Random House.
- Saha, S., Chant, D., Welham, J., & McGrath, J. (2005). A systematic review of the prevalence of schizophrenia. *PLoS Medicine*, 2(5), e141.
- Salamone, J. D., & Correa, M. (2012). The mysterious motivational functions of mesolimbic dopamine. *Neuron*, 76(3): 470–485.
- Salend, S. J. (1987). Contingency management systems. *Academic Therapy*, 22, 245–253.
- Salovey, P., & Mayer, J. D. (1990). Emotional intelligence. *Imagination, cognition, and personality*, 9, 185–211.
- Salthouse, T. A. (1984). The skill of typing. *Scientific American*, 250(2), 128–135.
- Sanbonmatsu, D. M., Strayer, D. L., Medeiros-Ward, N., & Watson, J. M. (2013). Who multi-tasks and why? Multi-tasking ability, perceived multi-tasking ability, impulsivity, and sensation seeking. *PLoS ONE* 8(1): e54402. doi:10.1371/journal.pone.0054402
- Sanders, L. D., Weber-Fox, C. M., & Neville, H. J. (2008). Varying degrees of plasticity in different subsystems within language. In J. R. Pomerantz & M. Crair (Eds.), *Topics in integrative neuroscience: From cells to cognition*. New York: Cambridge University Press.
- Sanders, S., Hill, B., Yarber, W., Graham, C., Crosby, R., & Milhausen, R. (2010). Misclassification bias: Diversity in conceptualisations about having "had sex." *Sexual Health*, 7(1), 31–34.
- Sands, L. P., & Meredith, W. (1992). Intellectual functioning in late midlife. *Journal of Gerontological and Psychological Science*, 47, 81–84.
- Sanes, J. R., & Jessell, T. M. (2013a). Experience and the refinement of synaptic connections. In E. R. Kandel, J. H. Schwartz, T. M. Jessell, S. A. Siegelbaum, & A. J. Hudspeth (Eds.), *Principles of neural science* (5th ed., pp. 1259–1283). USA: McGraw-Hill.
- Sanes, J. R., & Jessell, T. M. (2013b). Repairing the damaged brain. In E. R. Kandel, J. H. Schwartz, T. M. Jessell, S. A. Siegelbaum, & A. J. Hudspeth (Eds.), *Principles of neural science* (5th ed., pp. 1284–1305). USA: McGraw-Hill.
- Santhakumar, V., Wallner, M., & Otis, T. S. (2007). Ethanol acts directly on extrasynaptic subtypes of GABA_A receptors to increase tonic inhibition. *Alcohol*, 41(3): 211–221.
- Sanz, C., Andrieu, S., Sinclair, A., Hanaire, H., & Vellas, B. (2009). Diabetes is associated with a slower rate of cognitive decline in Alzheimer disease. *Neurology*, 73, 1359–1366.
- Saper, C. B., Chou, T. C., & Scammell, T. E. (2001). The sleep switch: Hypothalamic control of sleep and wakefulness. *Trends in Neurosciences*, 24, 726–731.
- Sapir, E. S. (1921). *Language: An introduction to the study of speech*. New York: Harcourt, Brace.
- Sapolsky, R. M. (2004). *Why zebras don't get ulcers* (3rd ed., pp. 1, 144–145). New York: Owl Books.
- Sarbin, T. R., & Coe, W. C. (1972). *Hypnosis: A social psychological analysis of influence communication*. New York: Holt, Rinehart, & Winston.
- Sartory, G., Cwik, J., Knuppertz, H., Schürholz, B., Lebents, M., Seitz, R. J., & Schulze, R. (2013). In search of the trauma memory: A meta-analysis of functional neuroimaging studies of symptom provocation in posttraumatic stress disorder (PTSD). *PLoS ONE*, 8(3), e58150. doi: 10.1371/journal.pone.0058150
- Sastray, K. S., Karpova, Y., Prokopovich, S., Smith, A. J., Essau, B., Gersappe, A., Carson, J. P., Weber, M. J., Register, T. C., Chen, Y. Q., Penn, R. B., & Kulik, G. (2007). Epinephrine protects cancer cells from apoptosis via activation of cAMP-dependent protein kinase and BAD phosphorylation. *Journal of Biological Chemistry*, 282(19), 14094–14100.
- Satterly, D. (1987). Piaget and education. In R. L. Gregory (Ed.), *The Oxford companion to the mind* (pp. 110–143). Oxford: Oxford University Press.
- Sattler, J. M. (1977). The effects of therapist-client racial similarity. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapy: A handbook of research* (pp. 252–290). Elmsford, NY: Pergamon.
- Savage-Rumbaugh, S., & Lewin, R. (1994). *Kanzi*. New York: Wiley.
- Savage-Rumbaugh, S., Shanker, S., & Taylor, T. J. (1998). *Apes, language and the human mind*. Oxford, UK: Oxford University Press.
- Savic, I., Berglund, H., & Lindstrom, P. (2005). Brain response to putative pheromones in homosexual men. *Proceedings of the National Academy of Sciences, USA*, 102(20), 7356–7361.
- Savic, I., & Lindstrom, P. (2008). PET and MRI show differences in cerebral asymmetry and functional connectivity between homo- and heterosexual subjects. *Proceedings of the National Academy of Sciences, USA*, 105(27), 9403–9408.
- Scarpa, A., Raine, A., Venables, P. H., & Mednick, S. A. (1995). The stability of inhibited/uninhibited temperament from ages 3 to 11 years in Mauritian children. *Journal of Abnormal Child Psychology*, 23, 607–618.
- Schachter, S., & Singer, J. E. (1962). Cognitive, social and physiological determinants of emotional states. *Psychological Review*, 69, 379–399.
- Schacter, D. L., & Wagner, A. D. (2013). Learning and memory. In E. R. Kandel, J. H. Schwartz, T. M. Jessell, S. A. Siegelbaum, & A. J. Hudspeth (Eds.), *Principles of neural science* (5th ed., pp. 1441–1460). USA: McGraw-Hill.
- Schafer, M., & Crichlow S. (1996). Antecedents of groupthink: A quantitative study. *Journal of Conflict Resolution*, 40, 415–435.
- Schaeie, K. W., & Willis, S. L. (2010). The Seattle longitudinal study of adult cognitive development. *Bulletin of the International Society for the Study of Behavioral Development*, 37, 24–29.
- Schalock, R. L., Borthwick-Duffy, S. A., Buntinz, W. H. E., Coulter, D. L., & Craig, E. M. P. (2010). *Intellectual disability: Definition, classification, and systems of supports* (11th ed.): American Association on Intellectual and Developmental Disabilities.
- Schapiro, A. C., & McClelland, J. L. (2009). A connectionist model of a continuous developmental transition in the balance scale task. *Cognition*, 110(1), 395–411.
- Scharnowski, F., Hutton, C., Josephs, O., Weiskopf, N., & Rees, G. (2012). Improving visual perception through neurofeedback. *The Journal of Neuroscience*, 32(49), 17830–17841. doi: 10.1523/jneurosci.6334-11.2012
- Scheele, D., Striepens, N., Güntürkün, O., Deutschländer, S., Maier, W., Kendrick, K. M., & Hurlemann, R. (2012). Oxytocin modulates social distance between males and females. *The Journal of Neuroscience*, 32(46), 16074–16079. doi: 10.1523/jneurosci.2755-12.2012
- Schiller, P. H., & Carvey, C. E. (2005). The Hermann grid illusion revisited. *Perception*, 34(11), 1375–1397.
- Schmitt, D. P. (2002). Personality, attachment and sexuality related to dating relationship outcomes: Contrasting three perspectives on personal attribute interaction. *British Journal of Social Psychology*, 41(4), 589–610.
- Schmitt, D. P., Allik, J., McCrae, R. R., & Benet-Martínez, V. (2007). The geographic distribution of big five personality traits: Patterns and profiles of human self-description across 56 nations. *Journal of Cross-Cultural Psychology*, 38(2), 173–212. doi: 10.1177/0022022106297299
- Schmitt, K. C., & Reith, M. E. A. (2010). Regulation of the dopamine transporter. *Annals of the New York Academy of Sciences*, 1187: 316.
- Schmitz, C., Wagner, J., & Menke, E. (2001). The interconnection of childhood poverty and homelessness: Negative impact/points of access. *Families in Society*, 82(1), 69–77.
- Schnabel, J. (1994). *Round in circles* (pp. 267–277). London: Hamish Hamilton.
- Schneider, K. J., Bugental, J. F. T., & Fraser, J. F. (Eds.). (2001). *Handbook of humanistic psychology*. Thousand Oaks, CA: Sage.
- Schneider R, Grim C, Rainforth M, Kotchen T, Nidich S, Gaylord-King C, Salerno J, Morley Kotchen J, Alexander C. Stress Reduction in the Secondary Prevention of Cardiovascular Disease: Randomized Controlled Trial of Transcendental Meditation and Health Education in Blacks. *Circulation: Cardiovascular Quality and Outcomes*. 5:750–758, 2012
- Schneider, R. H., Staggers, F., Alexander, C. N., Sheppard, W., Rainforth, M., Kondwani, K., Smith, S., & King, C. G. (1995). A randomized controlled trial of stress reduction for hypertension in older African Americans. *Hypertension*, 26(5), 820–827.
- Schneider, R., Nidich, S., Kotchen, J. M., Kotchen, T., Grim, C., Rainforth, M., King, C. G., & Salerno, J. (2009). Abstract 1177: Effects of stress reduction on clinical

- events in African Americans with coronary heart disease: A randomized controlled trial. *Circulation*, 120, S461.
- Schneider, W., Dumais, S., & Shriffrrin, R. (1984). *Automatic and control processing and attention*. London: Academic Press.
- Schneidman, E. (1983). *Death of man*. New York: Jason Aronson.
- Schneidman, E. (1994). *Death: Current perspectives*. New York: McGraw-Hill.
- Schöls, L., Haan, J., Riess, O., Amoiridis, G., & Przuntek, H. (1998). Sleep disturbance in spinocerebellar ataxias: Is the SCA3 mutation a cause of restless legs syndrome? *Neurology*, 51, 1603–1607.
- Schroeder, S. R. (2000). Mental retardation and developmental disabilities influenced by environmental neurotoxic insults. *Environmental Health Perspectives*, 108(Suppl. 3), 395–399.
- Schroth, M. L., & McCormack, W. A. (2000). Sensation seeking and need for achievement among study-abroad students. *The Journal of Social Psychology*, 140, 533–535.
- Schultz, D. P., & Schultz, S. E. (2004). *A History of Modern Psychology*, pp. 239–242. Belmont, CA: Wadsworth.
- Schutzwohl, A., Fuchs, A., McKibbin, W. F., & Shackelford, T. K. (2009). How willing are you to accept sexual requests from slightly unattractive to exceptionally attractive imagined requestors? *Human Nature*, 20(3), 282–293.
- Schwanenflugel, P., & Rey, M. (1986). Interlingual semantic facilitation: Evidence from common representational system in the bilingual lexicon. *Journal of Memory and Language*, 25, 605–618.
- Schwartz, C. E., Kunwar, P. S., Greve, D. N., Moran, L. R., Viner, J. C., Covino, J. M., Kagan, J., Stewart, S. E., Snidman, N. C., Vangel, M. G., & Wallace, S. R. (2010). Structural differences in adult orbital and ventromedial prefrontal cortex predicted by infant temperament at 4 months of age. *Archives of General Psychiatry*, 67(1), 78–84. doi: 10.1001/archgenpsychiatry.2009.171
- Schwartz, J. H., Barres, B. A., & Goldman, J. E. (2013). The cells of the nervous system. In E. R. Kandel, J. H. Schwartz, T. M. Jessell, S. A. Siegelbaum, & A. J. Hudspeth (Eds.), *Principles of neural science* (5th ed., pp. 71–99). USA: McGraw-Hill.
- Schwartz, J. H., & Javitch, J. A. (2013). Neurotransmitters. In E. R. Kandel, J. H. Schwartz, T. M. Jessell, S. A. Siegelbaum, & A. J. Hudspeth (Eds.), *Principles of neural science* (5th ed., pp. 289–306). USA: McGraw-Hill.
- Schwartz, S. K. (2000). *Working your degree*. Retrieved March 6, 2010, from http://cnnfn.cnn.com/2000/12/08/career/q_degreespsychology/
- Schweickert, R. (1993). A multinomial processing tree model for degradation and redintegration in immediate recall. *Memory and Cognition*, 21, 168–175.
- Schwitzgebel, E. (1999). Representation and desire: A philosophical error with consequences for theory-of-mind research. *Philosophical Psychology*, 12, 157–180.
- Scott, S. K., Young, A. W., Calder, A. J., Hellawell, D. J., Aggleton, J. P., & Johnson, M. (1997). Impaired auditory recognition of fear and anger following bilateral amygdala lesions. *Nature*, 385(6613), 254–257.
- Scott, W. D. (1908). *The theory and practice of advertising*. Boston, MA: Small, Maynard, & Company.
- Security Director's Report (2008). Experts identify four trends in workplace violence. *Institute of Management and Administration, Inc.*, 8(6), 1–15.
- Segal, S. K., Cotman, C. W., & Cahill, L. F. (2012). Exercise-induced noradrenergic activation enhances memory consolidation in both normal aging and patients with amnestic mild cognitive impairment. *Journal of Alzheimer's Disease*, 32(4), 1011–1018. doi: 10.3233/JAD-2012-121078
- Segall, M. H., Campbell, D. T., & Herskovits, M. J. (1966). *The influence of culture on perception*. Indianapolis, IN: Bobbs-Merrill.
- Segerstrom, S.C., & Sephton, S.E. (2010). Optimistic expectancies and cell-mediated immunity: The role of positive affect. *Psychological Science*, 21(3), 448–455.
- Segerstrom, S. C., Taylor, S. E., Kemeny, M. E., & Fahey, J. L. (1998). Optimism is associated with mood, coping, and immune change in response to stress. *Journal of Personality and Social Psychology*, 74(6), 1646–1655.
- Seligman, M. (1970). On the generality of the laws of learning. *Psychological Review*, 77, 406–418.
- Seligman, M. (1975). *Helplessness: Depression, development and death*. New York: W. H. Freeman.
- Seligman, M. (1989). *Helplessness*. New York: W. H. Freeman.
- Seligman, M. (1995). The effectiveness of psychotherapy: The *Consumer Reports* study. *American Psychologist*, 50, 965–975.
- Seligman, M. (1998). *Learned optimism: How to change your mind and your life* (2nd ed.). New York: Pocket Books.
- Seligman, M. (2002). *Authentic happiness*. New York: Free Press.
- Seligman, M. E. P. (2005). Positive psychology, positive prevention, and positive therapy. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 3–9). New York: Oxford University Press.
- Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, 55(1), 5–14. doi: 10.1037/0003-066x.55.1.5
- Seligman, M., & Maier, S. F. (1967). Failure to escape traumatic shock. *Journal of Experimental Psychology*, 74, 1–9.
- Selye, H. (1956). *The stress of life*. New York: McGraw-Hill.
- Selye, H. (1976). *The stress of life* (Rev. ed.). New York: McGraw-Hill.
- Selye, H. A. (1936). Syndrome produced by diverse noxious agents. *Nature*, 138, 32.
- Shackelford, T. K., Buss, D. M., & Bennett, K. (2002). Forgiveness or breakup: Sex differences in responses to a partner's infidelity. *Cognition and Emotion*, 16(2), 299–307.
- Shadish, R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and quasi-experimental designs for generalized causal inferences*. New York: Houghton Mifflin.
- Shafiro, M. V., Himelein, M. J., & Best, D. L. (2003). Ukrainian and U.S. American females: Differences in individualism/collectivism and gender attitudes. *Journal of Cross-Cultural Psychology*, 34(3), 297–303.
- Shafton, A. (1995). *Dream reader: Contemporary approaches to the understanding of dreams* (SUNY series in dream studies) (pp. 40–46). New York: State University of New York Press.
- Shah, P. M. (1991). Prevention of mental handicaps in children in primary health care. *Bulletin of the World Health Organization*, 69, 779–789.
- Shapiro, A. K., & Shapiro, E. (1997). *The powerful placebo*. Baltimore: Johns Hopkins University Press.
- Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York: Guilford Press.
- Shapiro, F. (2012). *Getting past your past: Take control of your life with self-help techniques from EMDR therapy*. New York: Rodale.
- Shapiro, K. L., Jacobs, W. J., & LoLordo, V. M. (1980). Stimulus relevance in Pavlovian conditioning in pigeons. *Animal Learning and Behavior*, 8, 586–594.
- Sharif, Z., Bradford, D., Stroup, S., & Lieberman, J. (2007). Pharmacological treatment of schizophrenia. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (3rd ed., pp. 203–241). New York: Oxford University Press.
- Sharot, T., Delgado, M. R., & Phelps, E. A. (2004). How emotion enhances the feeling of remembering. *Nature Neuroscience*, 7(12), 1376–1380.
- Shaw, N. D., Butler, J. P., McKinney, S. M., Nelson, S. A., Ellenbogen, J. M., & Hall, J. E. (2012). Insights into puberty: the relationship between sleep stages and pulsatile LH secretion. *Journal of Clinical Endocrinology & Metabolism*, 97:11, E2055–E2062.
- Shean, R. E., de Klerk, N. H., Armstrong, B. K., & Walker, N. R. (1994). Seven-year follow-up of a smoking-prevention program for children. *Australian Journal of Public Health*, 18, 205–208.
- Shekelle, P. G., Hardy, M. L., Morton, S. C., Maglione, M., Mojica, W. A., Suttorp, M. J., Rhodes, S. L., Jungvig, L., & Gagné, J. (2003). Efficacy and safety of ephedra and ephedrine for weight loss and athletic performance: A metaanalysis. *Journal of the American Medical Association*, 289(12), 1537–1545.
- Sheldon, K. M. (2012). The self-determination theory perspective on positive mental health across cultures. *World Psychiatry*, 11(2), 101–102.
- Sheldon, S. H. (2002). Sleep in infants and children. In T. L. Lee-Chiong, M. J. Sateia, & M. A. Carskadon (Eds.), *Sleep medicine* (pp. 99–103). Philadelphia: Hanley & Belfus.
- Shepard, R. N., & Metzler, J. (1971). Mental rotation of three-dimensional objects. *Science*, 171, 701–703.
- Shepard, T. H. (2001). *Catalog of teratogenic agents* (10th ed.). Baltimore: Johns Hopkins University Press.
- Shepherd, G. M. (2012). *Neurogastronomy: How the brain creates flavor and why it matters*. New York, NY: Columbia University Press.
- Sherif, M. (1936). *The psychology of social norms*. New York: Harper & Row.
- Sherif, M., Harvey, O. J., White, B. J., Hood, W. R., & Sherif, C. W. (1961). *Intergroup conflict and cooperation: The Robber's Cave experiment*. Norman: University of Oklahoma Book Exchange.
- Sherlin, L. H., Arns, M., Lubar, J., Heinrich, H., Kerson, C., Strehl, U., & Sterman, M. B. (2011). Neurofeedback and basic learning theory: Implications for research and practice. *Journal of Neurotherapy: Investigations in Neuromodulation, Neurofeedback and Applied Neuroscience*, 15(4), 292–304.

- Sherry, P., Gaa, A., Thurlow-Harrison, S., Gruber, K., Clemons, J., & Bobulinski, M. (2003). *Traffic accidents, job stress, and supervisor support in the trucking industry*. Paper presented at the International Institute for Intermodal Transportation, University of Denver, CO.
- Shields, B. J., & Smith, G. A. (2009). Cheerleading-related injuries in the United States: A prospective surveillance study. *Journal of Athletic Training*, 44(6), 567–577.
- Shively, S., Scher, A. I., Perl, D. P., & Diaz-Arrastia, R. (2012). Dementia resulting from traumatic brain injury: What is the pathology? *Archives of Neurology*, 69(10), 1245–1251. doi: 10.1001/archneuro.2011.3747
- Shore, L. A. (1990). Skepticism in light of scientific literacy. *Skeptical Inquirer*, 15(1), 3–4.
- Shorey, G. (2001). Bystander non-intervention and the Somalia incident. *Canadian Military Journal*, 19–27.
- Shorter, E. (1997). *A history of psychiatry: From the era of the asylum to the age of Prozac*. New York: John Wiley & Sons.
- Showalter, E. (1997). *Hystories: Hysterical epidemics and modern culture*. New York: Columbia University Press.
- Shuglin, A. (1986). The background chemistry of MDMA. *Journal of Psychoactive Drugs*, 18(4), 291–304.
- Shweder, R. A., Haidt, J., Horton, R., & Joseph, C. (2008). The cultural psychology of the emotions. In M. Lewis, J. M. Haviland-Jones & L. F. Barrett (Eds.), *Handbook of emotions* (3rd ed., pp. 409–427). New York: Guilford Press.
- Siegel, J. M. (2001). The REM sleep-memory consolidation hypothesis. *Science*, 294, 1058–1063.
- Siegel, J. M. (2011). Neural control of sleep in mammals. In M. H. Kryger, T. Roth & W. C. Dement (Eds.), *Principles and practice of sleep medicine*. St. Louis, MO: Elsevier Saunders.
- Siegel, R. K., & West, L. J., Eds. (1975). *Hallucinations: Behavior, experience, and theory* (2nd ed.). New York: Wiley.
- Siegel, S. (1969). Effects of CS habituation on eyelid conditioning. *Journal of Comparative and Physiological Psychology*, 68(2), 245–248.
- Siegelbaum, S. A., Kandel, E. R., & Yuste, R. (2013). Synaptic integration in the central nervous system. In E. R. Kandel, J. H. Schwartz, T. M. Jessell, S. A. Siegelbaum, & A. J. Hudspeth (Eds.), *Principles of neural science* (5th ed., pp. 210–235). USA: McGraw-Hill.
- Siegler, I. C., Costa, P. T., Brummett, B. H., Helms, M. J., Barefoot, J. C., Williams, R. B., Dahlstrom, G., Kaplan, B. H., Vitaliano, P. P., Nichaman, M. Z., Day, S., & Rimer, B. K. (2003). Patterns of change in hostility from college to midlife in the UNC alumni heart study predict high-risk status. *Psychosomatic Medicine*, 65, 738–745.
- Siegler, R. S. (1996). *Emerging minds: The process of change in children's thinking*. New York: Oxford University Press.
- Simeon, D., Guralnik, O., Hazlett, E. A., Spiegel-Cohen, J., Hollander, E., & Buchsbaum, M. S. (2000). Feeling unreal: A PET study of depersonalization disorder. *American Journal of Psychiatry*, 157, 1782–1788.
- Simon, D. A., & Bjork, R. A. (2001). Metacognition in motor learning. *Journal of Experimental Psychology: Learning, memory, and cognition*, 27(4), 907–912.
- Simpson, D. (2005). Phrenology and the neurosciences: Contributions of F.J. Gall and J. G. Spurzheim. *ANZ Journal of Surgery*, 75(6), 475–482.
- Singer, M. T., & Lalich, J. (1995). *Cults in our midst*. San Francisco: Jossey-Bass.
- Singh-Manoux, A., Richards, M., & Marmot, M. (2003). Leisure activities and cognitive function in middle age: Evidence from the Whitehall II study. *Journal of Epidemiology and Community Health*, 57, 907–913.
- Skinner, B. F. (1938). *The behavior of organisms: An experimental analysis*. New York: Appleton-Century-Crofts.
- Skinner, B. F. (1956). A case history in scientific method. *American Psychologist*, 11, 221–233.
- Skinner, B. F. (1961). *Cumulative record: Definitive edition*. New York: Appelton-Century-Crofts.
- Skinner, B. F. (1971). *Beyond freedom and dignity*. New York: Alfred A. Knopf.
- Skinner, B. F. (1974). *About behaviorism*. New York: Alfred A. Knopf.
- Skinner, B. F. (1989). The origins of cognitive thought. *Recent Issues in the Analysis of Behavior*, Princeton, NC: Merrill Publishing Company.
- Skolnick, A. (1986). Early attachment and personal relationships across the life course. In P. B. Baltes, D. L. Featherman, & R. M. Lerner (Eds.), *Life-span development and behavior* (vol. 7). Hillsdale, NJ: Erlbaum.
- Slater, A. (2000). Visual perception in the young infant: Early organisation and rapid learning. In D. Muir & A. Slater (Eds.), *Infant development: The essential readings*. Oxford, UK: Blackwell.
- Slater, M., Antley, A., Davison, A., Swapp, D., Guger, C., Barker, C., Pistrang, N., & Sanchez-Vives, M. V. (2006). A virtual reprise of the Stanley Milgram obedience experiments. *PLoS ONE* 1(1), e39. doi:10.1371/journal.pone.0000039
- Sleddens, E. F., Gerards, S. M., Thijs, C., de Vries, N. K., & Kremers, S. P. (2011). General parenting, childhood overweight and obesity-inducing behaviors: A review. *International Journal of Pediatric Obesity* 6(2–2), e12–27.
- Slipp, S. (1993). *The Freudian mystique: Freud, women and feminism*. New York: New York University Press.
- Sloan, D. M., & Mizes, J. S. (1999). Foundations of behavior therapy in the contemporary healthcare context. *Clinical Psychology Review*, 19, 255–274.
- Smith, D. (2001). Shock and disbelief. *Atlantic Monthly*, 2, 79–90.
- Smith, J. D., & Mitchell, A. (2001). "Me? I'm not a drooler. I'm the assistant": Is it time to abandon mental retardation as a classification? *Mental Retardation*, 39(2), 144–146.
- Smith, M. A., Roediger, H. L., & Karpicke, J. D. (2013). Covert retrieval practice benefits retention as much as overt retrieval practice. *Journal of Experimental Psychology: Learning, Memory, and Cognition*. doi: 10.1037/a0033569
- Smith, T. C., Ryan, M. A. K., Wingard, D. L., Sallis, J. F., & Kritz-Silverstein, D. (2008). New onset and persistent symptoms of post-traumatic stress disorder self-reported after deployment and combat exposures: Prospective population-based U.S. military cohort study. *British Medical Journal*, 336(7640), 366–371.
- Smolen, P., Baxter, D. A., Byrne, J. H., (2006). A model of the roles of essential kinases in the induction and expression of late long-term potentiation. *Biophysical Journal*, 90, 2760–2775.
- Snarey, J. R. (1985). Cross-cultural universality of social-moral development: A critical review of Kohlbergian research. *Psychological Bulletin*, 97(2), 202–232.
- Snyder, C. R., & Lopez, S. J. (2005). The future of positive psychology. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 751–767). New York: Oxford University Press.
- Snyder, D. J., & Bartoshuk, L. M. (2009). Epidemiological studies of taste function: Discussion and perspectives. *Annals of the New York Academy of Sciences*, 1170, 574–580.
- Snyder, M., Tanke, E. D., & Berscheid, E. (1977). Social perception and interpersonal behavior: On the self-fulfilling nature of social stereotypes. *Journal of Personality and Social Psychology*, 35, 656–666.
- Snyder, S. H. (2002). Forty years of neurotransmitters. *Archives of General Psychiatry*, 59, 983–994.
- Snyder, T. D., & Dillow, S. A. (2010). Digest of education statistics 2009 (NCES Publication No. NCES 2010-013). Washington, DC: National Center for Education Statistics, Institute of Education Sciences, U.S. Department of Education.
- Söderlund, J., Schröder, J., Nordin, C., Samuelsson, M., Walther-Jallow, L., Karlsson, H., Erhardt, S., & Engberg, G. (2009). Activation of brain interleukin-1 β in schizophrenia. *Molecular Psychiatry*, 14(12), 1069.
- Sodowsky, G. R., Lai, E. W., & Plake, B. S. (1991). Moderating effects of socio-cultural variables on acculturation attitudes of Hispanics and Asian Americans. *Journal and Counseling and Development*, 70, 194–204.
- Soomro, G. M. (2001). Obsessive-compulsive disorder. *Clinical Evidence*, 6, 754–762.
- Sorkhabi, N. (2005). Applicability of Baumrind's parent typology to collective cultures: Analysis of cultural explanations of parent socialization effects. *International Journal of Behavioral Development*, 29(6), 552–563. doi: 10.1177/01650250500172640
- Spangler, W. D. (1992). Validity of questionnaire and TAT measures of need for achievement: Two meta-analyses. *Psychological Bulletin*, 112, 140–154.
- Spangler, W. J., Cosgrove, G. R., Ballantine, H. T., Jr., Cassem, E. H., Rauch, S. L., Nierenberg, A., & Price, B. H. (1996). Magnetic resonance image-guided stereotactic cingulotomy for intractable psychiatric disease. *Neurosurgery*, 38, 1071–1076.
- Sparling, R., Mottaghay, F., Ganis, G., Thompson, W. L., Toepper, R., Kosslyn, S. M., & Pascual-Leone, A. (2002). Visual cortex excitability increases during visual mental imagery—A TMS study in healthy human subjects. *Brain Research*, 938, 92–97.
- Spearman, C. (1904). "General intelligence" objectively determined and measured. *American Journal of Psychology*, 15, 201–293.
- Speca, M., Carlson, L. E., Goodey, E., & Angen, E. (2000). A randomized wait-list controlled clinical trial: The effects of a mindfulness meditation-based stress reduction program on mood and symptoms of stress in cancer outpatients. *Psychosomatic Medicine*, 62, 2613–2622.

- Sperling, G. (1960). The information available in brief visual presentations. *Psychological Monographs*, 74(11), 1–29.
- Speroff, L., Glass, R. H., & Kase, N. G. (1999). Recurrent early pregnancy loss. In *Clinical Gynecologic endocrinology and infertility* (pp. 1042–1055). Philadelphia: Lippincott Williams & Wilkins.
- Sperry, R. W. (1968). Mental unity following surgical disconnection of the cerebral hemispheres. *The Harvey Lectures*. Series 62, 293–323. New York: Academic Press.
- Spiegel, D., Bloom, J. R., & Gottheil, E. (1989). Effects of psychosocial treatment on survival of patients with metastatic breast cancer. *Lancet*, 2, 888–891.
- Springer, S. P., & Deutsch, G. (1998). *Left brain, right brain: Perspectives from cognitive neuroscience* (5th ed.). New York: Freeman.
- Squire, L., & Kandel, E. (1999). *Memory: From mind to molecule*. New York: Scientific American Library.
- Squire, L. R., & Kandel, E. R. (2009). *Memory: From mind to molecules*. Greenwood Village, CO: Roberts and Company Publishers.
- Squire, L. R., Knowlton, B., & Musen, G. (1993). The structure and organization of memory. *Annual Review of Psychology*, 44, 453–495.
- Squire, L. R., & Slater, P. C. (1978). Anterograde and retrograde memory impairment in chronic amnesia. *Neuropsychologia*, 16, 313–322.
- Squire, L. R., Slater, P. C., & Chace, P. M. (1975). Retrograde amnesia: Temporal gradient in very long-term memory following electroconvulsive therapy. *Science*, 187, 77–79.
- Stahl, S. M. (2013). *Stahl's essential psychopharmacology: Neuroscientific basis and practical applications* (4th ed.). New York: Cambridge University Press.
- Standing, L., Conezio, J., & Haber, R. N. (1970). Perception and memory for pictures: Single-trial learning of 2500 visual stimuli. *Psychonomic Science*, 19, 73–74.
- Stanovich, K. E., & West, R. F. (2000). Individual differences in reasoning: Implications for the rationality debate? *Behavioral and Brain Sciences*, 23(5), 645–665; discussion 665–726.
- Steele, C. M. (1992). Race and the schooling of Black Americans. *The Atlantic Monthly*, 269(4), 68–78.
- Steele, C. M. (1997). A threat in the air: How stereotypes shape intellectual identity and performance. *American Psychologist*, 52, 613–629.
- Steele, C. M. (1999, August). Thin ice: "stereotype threat" and Black college students. *The Atlantic Monthly*, 284, 44–54.
- Steele, C. M., & Aronson J. (1995). Stereotype threat and the intellectual test performance of African Americans. *Journal of Personality and Social Psychology*, 69, 797–811.
- Steele, J., James, J. B., & Barnett, R. C. (2002). Learning in a man's world: Examining the perceptions of undergraduate women in male-dominated academic areas. *Psychology of Women Quarterly*, 26, 46–50.
- Stein, H. T. (2001). Adlerian overview of birth order characteristics. Alfred Adler Institute of San Francisco. Retrieved June 16, 2004, at <http://pws.cablespeed.com/~htstein/birthord.htm>
- Stein, S. (1984). *Girls and boys: The limits of non-sexist rearing*. London: Chatto & Windus.
- Stein-Behrens, B., Mattson, M. P., Chang, I., Yeh, M., & Sapolsky, R. (1994). Stress exacerbates neuron loss and cytoskeletal pathology in the hippocampus. *Journal of Neuroscience*, 14, 5373–5380.
- Steinberg, L., & Silverberg, S. B. (1987). Influences on marital satisfaction during the middle stages of the family life cycle. *Journal of Marriage and the Family*, 49, 751–760.
- Steriade, M., & McCarley, R. W. (1990). *Brainstem control of wakefulness and sleep*. New York: Plenum.
- Stern, W. (1912). *The psychological methods of testing intelligence* (G. M. Whipple, Trans.) (Educational Psychology Monograph No. 13). Baltimore, MD: Warwick & York, Inc.
- Sternberg, R. J. (1986). A triangular theory of love. *Psychological Review*, 93, 119–135.
- Sternberg, R. J. (1988a). *The triarchic mind: A new theory of human intelligence*. New York: Viking-Penguin.
- Sternberg, R. J. (1988b). Triangulating love. In R. Sternberg & M. Barnes (Eds.), *The psychology of love* (pp. 119–138). New Haven, CT: Yale University Press.
- Sternberg, R. J. (1996). *Successful intelligence: How practical and creative intelligence determine success in life*. New York: Simon & Schuster.
- Sternberg, R. J. (1997a). Construct validation of a triangular love scale. *European Journal of Social Psychology*, 27, 313–335.
- Sternberg, R. J. (1997b). The triarchic theory of intelligence. In P. Flannagan, J. L. Genshaft, & P. L. Harrison (Eds.), *Contemporary intellectual assessment: Theories, tests, and issues* (pp. 92–104). New York: Guilford Press.
- Sternberg, R. J. (2005). The triarchic theory of successful intelligence. In *Contemporary Intellectual Assessment: Theories, Tests, and Issues*. New York: Guilford Press.
- Sternberg, R. J., & Grigorenko, E. L. (2006). Cultural intelligence and successful intelligence. *Group Organization Management*, 31, 27–39.
- Sternberg, R. J., & Kaufman, J. C. (1998). Human abilities. *Annual Review of Psychology*, 49, 479–502.
- Sternberger, R. R., et al. (1995). Social phobia: An analysis of possible developmental factors. *Journal of Abnormal Psychology*, 194, 526–531.
- Stevenson, M. B., Roach, M. A., Leavitt, L. A., Miller, J. F., & Chapman, R. S. (1988). Early receptive and productive language skills in preterm and full-term 8-month-old infants. *Journal of Psycholinguistic Research*, 17(2), 169–183.
- Stewart, S. (2012). Hurricane Sandy discussion number 25? (report). National Hurricane Center. Retrieved May 28, 2013, from <http://www.nhc.noaa.gov/archive/2012/al18/al182012.discus.025.shtml>
- Stickgold, R., Hobson, J. A., Fosse, R., & Fosse, M. (2001). Sleep, learning and dreams: Off-line memory reprocessing. *Science*, 294, 1052–1057.
- Stiff, J. B., & Mongeau, P. A. (2002). *Persuasive communication* (2nd ed.). New York: Guilford Press.
- Stipek, D. J., Gralinski, J. H., & Kopp, C. B. (1990). Self-concept development in the toddler years. *Developmental Psychology*, 26(6), 972–977.
- Stockhorst, U., Gritzmann, E., Klopp, K., Schottenfeld-Naor, Y., Hübinger, A., Berresheim, H., Steingrüber, H., & Gries, F. A. (1999). Classical conditioning of insulin effects in healthy humans. *Psychosomatic Medicine*, 61, 424–435.
- Stoesz, B. M., Hare, J. F., & Snow, W. M. (2013). Neurophysiological mechanisms underlying affiliative social behavior: Insights from comparative research. *Neuroscience and Biobehavioral Reviews*, 37(2), 123–132. doi: 10.1016/j.neubiorev.2012.11.007
- Stoodley, C. J., & Schmahmann, J. D. (2009). Functional topography in the human cerebellum: A meta-analysis of neuroimaging studies. *NeuroImage*, 44(2), 489–501. doi: 10.1016/j.neuroimage.2008.08.039
- Stoodley, C. J., Valera, E. M., & Schmahmann, J. D. (2012). Functional topography of the cerebellum for motor and cognitive tasks: An fMRI study. *NeuroImage*, 59(2), 1560–1570. doi: 10.1016/j.neuroimage.2011.08.065
- Storey, A. E., Walsh, C. J., Quinton, R. L., & Wynne-Edwards, K. E. (2000). Hormonal correlates of paternal responsiveness in new and expectant fathers. *Evolution and Human Behavior*, 21, 79–95.
- Stowell, J. R., Kiecolt-Glaser, J. K., & Glaser, R. (2001). Perceived stress and cellular immunity: When coping counts. *Journal of Behavioral Medicine*, 24(4), 323–339.
- Stratton, K., Gable, A., & McCormick, M. C. (Eds.). (2001a). *Immunization safety review: Thimerosal-containing vaccines and neurodevelopmental disorders*. Washington, DC: National Academies Press.
- Stratton, K., Wilson, C. B., & McCormick, M. C. (Eds.). (2001b). *Immunization safety review: Measles-mumps-rubella vaccine and autism*. Washington, DC: National Academies Press.
- Straus, M. A. (2000). Corporal punishment of children and adult depression and suicidal ideation. *Beating the devil out of them: Corporal punishment in American families and its effects on children* (pp. 60–77). New York: Lexington Books.
- Strauss, A. S. (2004). The meaning of death in Northern Cheyenne culture. In A. C. G. M. Robben (Ed.), *Death, mourning, and burial: A cross-cultural reader* (pp. 71–76). Malden, MA: Blackwell.
- Strawbridge, W. J., Cohen, R. D., Shema, S. J., & Kaplan, G. A. (1997). Frequent attendance at religious services and mortality over 28 years. *American Journal of Public Health*, 87, 957–961.
- Strayer, D. L., & Drews, F. A. (2007). Cell-phone-induced driver distraction. *Current Directions in Psychological Science*, 16, 128–131.
- Strayer, D. L., Drews, F. A., & Crouch, D. J. (2006). A comparison of the cell phone driver and the drunk driver. *Human Factors*, 48, 381–391.
- Strayer, D. L., & Johnston, W. A. (2001). Driven to distraction: Dual-task studies of simulated driving and conversing on a cellular phone. *Psychological Science*, 12, 462–466.
- Strick, P. L., Dum, R. P., & Fiez, J. A. (2009). Cerebellum and nonmotor function. *Annual Review of Neuroscience*, 32, 413–434. doi: 10.1146/annurev.neuro.31.060407.125606
- Stromeyer, C. F., III, & Psotka, J. (1971). The detailed texture of eidetic images. *Nature*, 237, 109–112.
- Stroth, S., Hille, K., Spitzer, M., & Reinhardt, R. (2009). Aerobic endurance exercise benefits memory and affect in young adults. *Neuropsychological Rehabilitation*, 19(2), 223–243.

- Strunk, D. R., Brotman, M. A., & DeRubeis, R. J. (2010). The process of change in cognitive therapy for depression: Predictors of early inter-session symptom gains. *Behaviour Research and Therapy*, 48(7), 599–606.
- Stubbs, R. J., van Wyk, M. C., Johnstone, A. M., & Harbron, C. G. (1996). Breakfasts high in protein, fat or carbohydrate: Effect on within-day appetite and energy balance. *European Journal of Clinical Nutrition*, 50(7), 409–417.
- Stuss, D. T., Binns, M. A., Murphy, K. J., & Alexander, M. P. (2002). Dissociations within the anterior attentional system: Effects of task complexity and irrelevant information on reaction time speed and accuracy. *Neuropsychology*, 16, 500–513.
- Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse*. Hoboken, NJ: John Wiley & Sons.
- Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist*, 32, 616–624.
- Sue, S. (1992). Ethnicity and mental health: Research and policy issues. *Journal of Social Issues*, 48(2), 187–205.
- Sue, S., Zane, N., & Young, K. (1994). Research on psychotherapy in culturally diverse populations. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 783–817). New York: Wiley.
- Suleiman, J., & Watson, R. T. (2008). Social loafing in technology-supported teams. *Computer Supported Cooperative Work*, 17, 291–309.
- Sullivan, D. R., Liu, X., Corwin, D. S., Verceles, A. C., McCurdy, M. T., Pate, D. A., ... Netzer, G. (2012). Learned helplessness among families and surrogate decision-makers of patients admitted to medical, surgical, and trauma ICUs. *Chest*, 142(6), 1440–1446. doi: 10.1378/chest.12-0112
- Sullivan, P. F. (2005). The genetics of schizophrenia. *PLoS Med*, 2(7), e212. doi: 05-PLME-RIT-0198R1
- Sullivan, P. F., Neale, M. C., & Kendler, K. S. (2000). Genetic epidemiology of major depression: Review and meta-analysis, *American Journal of Psychiatry*, 157, 1552–1562.
- Sulloway, F. J. (1996). *Born to rebel: Birth order, family dynamics, and creative lives*. New York: Pantheon.
- Sulzer, J., Sitaram, R., Blefari, M. L., Kollias, S., Birbaumer, N., Stephan, K. E., ... Gassert, R. (2013). Neurofeedback-mediated self-regulation of the dopaminergic midbrain. *Neuroimage*, 75C, 176–184. doi: 10.1016/j.neuroimage.2013.02.041
- Suryani, L., & Jensen, S. (1993). *Trance and possession in Bali: A window on western multiple personality, possession disorder, and suicide*. New York: Oxford University Press.
- Sutcliffe, N., Clarke, A. E., Levinton, C., Frost, C., Gordon, C., & Isenberg, D. A. (1999). Associates of health status in patients with systemic lupus erythematosus. *Journal of Rheumatology*, 26, 2352–2356.
- Sutherland, P. (1992). *Cognitive development today: Piaget and his critics*. London: Paul Chapman.
- Swaab, D. F., Bao, A.-M., Garcia-Falgueras, A., Hofman, M. A., & Ishunina, T. A. (2012). Sex differences in the forebrain. In J. K. Mai & G. Paxinos (Eds.), *The human nervous system* (pp. 739–758). London, UK: Academic Press.
- Swann, J. (1998). Talk control: An illustration from the classroom of problems in analyzing male dominance of conversation. In J. Coates (Ed.), *Language and gender: A reader* (pp. 185–196). Oxford, UK: Blackwell.
- Swanson, H. (1994). Index of suspicion. Case 3. Diagnosis: Failure to thrive due to psychosocial dwarfism. *Pediatric Review*, 15(1), 39, 41.
- Swayze, V. W., II. (1995). Frontal leukotomy and related psychosurgical procedures in the era before antipsychotics (1935–1954): A historical overview. *American Journal of Psychiatry*, 152(4), 505–515.
- Swenson, D. D., & Marshall, B. (2005, May 14). Flash flood: Hurricane Katrina's inundation of New Orleans, August 29, 2005. *Times-Picayune*, p. 3.
- Szalavitz, M. (2009). Popping smart pills: the case for cognitive enhancement. *Time* in partnership with CNN. Retrieved May 5, 2010, from <http://www.time.com/time/health/article/0,8599,1869435,00.html>
- Szell, M., & Thurner, S. (2013). How women organize social networks different from men. *Scientific Reports*, 3, 1214. doi: 10.1038/srep01214
- Taglialatela, J. P., Savage-Rumbaugh, E. S., & Baker, L. A. (2003). Vocal production by a language-competent bonobo (*Pan paniscus*). *International Journal of Comparative Psychology*, 24, 1–17.
- Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup behaviour. In S. Worcher & W. G. Austin (Eds.), *The psychology of intergroup relations* (Vol. 2, pp. 7–24) New York: Nelson Hall.
- Takeuchi, T., Ogilvie, R. D., Murphy, T. I., & Ferrelli, A. V. (2003). EEG activities during elicited sleep onset. REM and NREM periods reflect difference mechanisms of dream generation. *Clinical Neurophysiology*, 114(2), 210–220.
- Talbott, G. D. & Crosby, L. R. (2001). Recovery contracts: Seven key elements. In R. H. Coombs (Ed.), *Addiction recovery tools* (pp. 127–144). Thousand Oaks, CA: Sage.
- Tarrier, N. (2010). Broad minded affective coping (BMAC): A positive CBT approach to facilitating positive emotions. *International Journal of Cognitive Therapy*, 3, 65–78.
- Taylor, B., Miller, E., Farrington, C. P., Petropoulos, M. C., Favot-Mayaud, I., Li, J., & Waight, P. A. (1999). Autism and measles, mumps, and rubella vaccine: No epidemiological evidence for a causal association. *Lancet*, 353, 2026–2029.
- Taylor, C., Manganello, J. A., Lee, S. J., & Rice, J. C. (2010). Mothers' spanking of 3-year-old children and subsequent risk of children's aggressive behavior. *Pediatrics*, 125, 1057–1065.
- Taylor, D. M., & Moghaddam, F. M. (1994). *Theories of intergroup relations: International social psychological perspectives* (2nd ed.). Westport, CT: Praeger.
- Taylor, E. (2001). Positive psychology and humanistic psychology: A reply to Seligman. *Journal of Humanistic Psychology*, 41(1), 13–29. doi: 10.1177/0022167801411003
- Teigen, K. (1994). Yerkes-Dodson: A law for all seasons. *Theory & Psychology*, 4, 525–547.
- Temoshok, L., & Dreher, H. (1992). *The Type C connection: The behavioral links to cancer and your health*. New York: Random House.
- Termer, L. M. (1916). *The measurement of intelligence*. Boston: Houghton Mifflin.
- Termer, L. M. (1925). *Mental and physical traits of a thousand gifted children* (I). Stanford, CA: Stanford University Press.
- Termer, L. M., & Oden, M. H. (1947). *The gifted child grows up: 25 years' follow-up of a superior group: Genetic studies of genius* (Vol. 4). Stanford, CA: Stanford University Press.
- Termer, L. M., & Oden, M. H. (1959). *The gifted group at mid-life, thirty-five years follow-up of the superior child: Genetic studies of genius* (Vol. 3). Stanford, CA: Stanford University Press.
- Tevis, M. 1994. "George I. Sanchez." In *Lives in Education: A Narrative of People and Ideas*, 2nd ed., ed. L. Glenn Smith, Joan K. Smith, pp. 346–354. New York: St. Martin's Press.
- Thase, M. E. (1999). When are psychotherapy and pharmacotherapy combinations the treatment of choice for major depressive disorders? *Psychiatric Quarterly*, 70(4), 333–346.
- Thase, M. E., & Sachs, G. S. (2000). Bipolar depression: Pharmacotherapy and related therapeutic strategies. *Biological Psychiatry*, 48(6), 558–572.
- The College Board. (2011). Time management tips for students. Retrieved May 31, 2013, from <http://www.collegeboard.com/student/plan/college-success/116.html>
- Thiedke, C. C. (2001). Sleep disorders and sleep problems in childhood. *American Family Physician*, 63, 277–284.
- Thomas, A., & Chess, S. (1977). *Temperament and development*. New York: Brunner/Mazel.
- Thomas, M., Thorne, D., Sing, H., Redmond, D., Balkin, T., Wesensten, N., Russo, M., Welsh, A., Rowland, L., Johnson, D., Aladdin, R., Cephus, R., Hall, S., & Belenky, G. (1998). The relationship between driving accidents and microsleep during cumulative partial sleep deprivation. *Journal of Sleep Research*, 7(2), 275.
- Thomas, R. K. (1994). Pavlov's rats "dripped saliva at the sound of a bell." *Psychology*, 5(80). Retrieved May 9, 2008, from <http://www.cogsci.ecs.soton.ac.uk/cgi/newspsy?5.80>
- Thompson, W. W., Price, C., Goodson, B., Shay, D. K., Benson, P., Hinrichsen, V. L., Lewis, E., Eriksen, E., Ray, P., Marcy, S. M., Dunn, J., Jackson, L. A., Lieu, T. A., Black, S., Stewart, G., Weintraub, E. S., Davis, R. L., & DeStefano, F. (2007). Early thimerosal exposure and neuropsychological outcomes at 7 to 10 years. *The New England Journal of Medicine*, 357(13), 1281–1292.
- Thoresen, C. E., & Harris, H. S. (2002). Spirituality and health: What's the evidence and what's needed? *Annals of Behavioral Medicine*, 24, 3–13.
- Thorndike, E. L. (1911). *Animal Intelligence: Experimental studies*. New York: MacMillan.
- Thorndike, E. L. (1920). A constant error on psychological rating. *Journal of Applied Psychology*, 5, 25–29.
- Thornton, A., & Hui-Sheng, L. (1994). Continuity and change. In A. Thornton & Hui-Sheng (Eds.), *Social change and the family in Taiwan* (pp. 396–410). Chicago: University of Chicago Press.
- Thurstone, L. (1938). *Primary mental abilities*. Chicago: University of Chicago Press.
- Tienari, P., Wynne, L. C., Sorri, A., Lahti, I., Läksy, K., Moring, J., Naarala, M., Nieminen, P., & Wahlberg, K-E. (2004). Genotype-environment interaction in schizophrenia-spectrum disorder: Long-term follow-up study of Finnish adoptees. *The British Journal of Psychiatry*, 184, 216–222.

- Tobach, E. (2001). Development of sex and gender. In J. Worell (Ed.), *Encyclopedia of women and gender* (pp. 315–332). San Diego, CA: Academic Press.
- Toga, A. W., & Thompson, P. M. (2003). Mapping brain asymmetry. *Nature Reviews Neuroscience*, 4, 37–48.
- Toker, S., Shirom, A., Melamed, S., & Armon, G. (2012). Work characteristics as predictors of diabetes incidence among apparently healthy employees. *Journal of Occupational Health Psychology*, 17(3), 259. doi: 10.1037/a0028401
- Tolman, E. C., & Honzik, C. H. (1930). Introduction and removal of reward and maze learning in rats. *University of California Publications in Psychology*, 4, 257–275.
- Tomasello, M., Carpenter, M., & Lizskowski, U. (2007). A new look at infant pointing. *Child Development*, 78, 705–722.
- Torgersen, S., Czajkowski, N., Jacobson, K., Reichborn-Kjennerud, T., Roysamb, E., Neale, M. C., & Kendler, K. S. (2008). Dimensional representations of DSM-IV cluster B personality disorders in a population-based sample of Norwegian twins: A multivariate study. *Psychological Medicine*, 38(11), 1617–1625. doi: 10.1017/s0033291708002924
- Torrance, E. P. (1993). The Beyonders in a thirty-year longitudinal study of creative achievement. *Roeper Review*, 15(3), 131–135.
- Trace, S. E., Baker, J. H., Penas-Lledo, E., & Bulik, C. M. (2013). The genetics of eating disorders. *Annual Review of Clinical Psychology*, 9, 589–620. doi: 10.1146/annurev-clinpsy-050212-185546
- Trappey, C. (1996). A meta-analysis of consumer choice and subliminal advertising. *Psychology and Marketing*, 13, 517–530.
- Treisman A. [M.] (2006). How the deployment of attention determines what we see. *Visual Cognition*, 14, 411–443.
- Treisman, A. M., & Gelade, G. (1980). A feature integration theory of attention. *Cognitive Psychology*, 12, 97–136.
- Treisman, M. (1977). Motion sickness: An evolutionary hypothesis. *Science*, 197, 493.
- Tremblay, A., Doucet, E., & Imbeault, P. (1999). Physical activity and weight maintenance. *International Journal of Obesity*, 23(3), S50–S54.
- Tresniowski, A. (1999, July 12). Troubled sleep. *People Weekly*, 56–59.
- Triandis, H. (1971). *Attitude and attitude change*. New York: Wiley.
- Trivers, R. L. (1972). Parental investment and sexual selection. In B. Campbell (Ed.), *Sexual selection and the descent of man, 1871–1971* (pp. 136–179). Chicago: Aldine-Atherton.
- Trocme, N., MacLaurin, B., Fallon, B., Daciuk, J., Billingsley, D., Tourigny, M., Mayer, M., Wright, J., Barter, K., Furford, G., Hornick, J., Sullivan, R., & McKenzie, B. (2001). *Canadian incidence study of reported child abuse and neglect: Final report* (pp. 30–31). Ottawa, ON: Minister of Public Works and Government Services Canada.
- Troncoso, X. G., Macknik, S. L., Otero-Millan, J., & Martinez-Conde, S. (2008). Microsaccades drive illusory motion in the enigma illusion. *Proceedings of the National Academy of Sciences, USA*, 105(41), 16033–16038.
- Trut, L. M. (1999). Early canid domestication: The Farm-Fox experiment. *Science*, 283.
- Tsai, G. E., Condle, D., Wu, M-T., & Chang, I-W. (1999). Functional magnetic resonance imaging of personality switches in a woman with dissociative identity disorder. *Harvard Review of Psychiatry*, 7, 119–122.
- Tsai, J. L., Simeonova, D. I., & Watanabe, J. T. (2004). Somatic and social: Chinese Americans talk about emotion. *Personality and Social Psychology Bulletin*, 30(9), 1226–1238.
- Tsapogas, J. (2006). *Characteristics of Doctoral Scientists and Engineers in the United States: 2003*. NSF, 06-320. Arlington, VA: National Science Foundation, Division of Science Resources Statistics.
- Tucker, E. W., & Potocky-Tripodi, M. (2006). Changing heterosexuals' attitudes toward homosexuals: A systematic review of the empirical literature. *Research on Social Work Practice*, 16(2), 176–190.
- Tucker, M. A., Hirota, Y., Wamsley, E. J., Lau, H., Chakladar, A., & Fishbein, W. (2006). A daytime nap containing solely non-REM sleep enhances declarative but not procedural memory. *Neurobiology of Learning and Memory*, 86(2), 241–247.
- Tugade, M. M., & Fredrickson, B. L. (2004). Resilient individuals use positive emotions to bounce back from negative emotional experiences. *Journal of Personality and Social Psychology*, 86(2), 320–333.
- Tukuitonga, C. F., & Bindman, A. B. (2002). Ethnic and gender differences in the use of coronary artery revascularisation procedures in New Zealand. *New Zealand Medical Journal*, 115, 179–182.
- Tulving, E., & Thomson, D. M. (1973). Encoding specificity and retrieval processes in episodic memory. *Psychological Review*, 80, 352–373.
- Tupak, S. V., Dresler, T., Badewien, M., Hahn, T., Ernst, L. H., Herrmann, M. J., ... Fallgatter, A. J. (2013). Inhibitory transcranial magnetic theta burst stimulation attenuates prefrontal cortex oxygenation. *Human Brain Mapping*, 34(1), 150–157. doi: 10.1002/hbm.21421
- Turk, C. L., Heimberg, R. G., & Magee, L. (2008). Social anxiety disorder. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (pp. 123–163). New York: Guilford Press.
- Turner, W. J. (1995). Homosexuality, Type 1: An Xq28 phenomenon. *Archives of Sexual Behavior*, 24(2), 109–134.
- Tusel, D. J., Piotrowski, N. A., Sees, K., Reilly, P. M., Banys, P., Meek, P., & Hall, S. M. (1994). Contingency contracting for illicit drug use with opioid addicts in methadone treatment. In L. S. Harris (Ed.), *Problems of drug dependence: Proceedings of the 56th Annual Scientific Meeting*. (National Institute on Drug Abuse Research Monograph No. 153, pp. 155–160). Washington, DC: U.S. Government Printing Office.
- Tversky, A., & Kahneman, D. (1973). Availability: A heuristic for judging frequency and probability. *Cognitive Psychology*, 5(2), 207–232.
- Tversky, A., & Shafir, E. (1992). The disjunction effect in choice under uncertainty. *Psychological Science*, 3(5), 305–309.
- Ulmer, J. L., Parsons, L., Moseley, M., & Gabrieli, J. (2006). White matter in cognitive neuroscience: Advances in diffusion tensor imaging and its applications. *Annals of the New York Academy of Sciences*, 1064.
- UNAIDS. (2008). 2008 Report on the global AIDS epidemic. Retrieved June 8, 2010, from http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp
- UNAIDS. (2009). AIDS epidemic update. Retrieved June 8, 2010, from http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf
- Underwood, M. K., Beron, K. J., & Rosen, L. H. (2009). Continuity and change in social and physical aggression from middle childhood through early adolescence. *Aggressive Behavior*, 35(5), 357–375.
- Unger, R. (1979). Toward a redefinition of sex and gender. *American Psychologist*, 34, 1085–1094.
- Upthegrove, T., Roscigno, V., & Charles, C. (1999). Big money collegiate sports: Racial concentration, contradictory pressures, and academic performance. *Social Science Quarterly*, 80, 718–737.
- Vail, A. (1976). Factors influencing lower class, black patients' remaining in treatment. *Clinical Psychology*, 29, 12–14.
- Vaillant, G. E. (2002). Adaptive mental mechanisms: Their role in a positive psychology. *American Psychologist*, 55, 89–98.
- Valverde, R., Pozdnjakova, I., Kajander, T., Venkatraman, J., & Regan, L. (2007). Fragile X mental retardation syndrome: Structure of the KH1-KH2 domains of fragile X mental retardation protein. *Structure*, 9, 1090–1098.
- Van de Castle, R. (1994). *Our dreaming mind*. New York: Ballantine Books.
- Van de Garde-Perik, Markopoulos, P., de Ruyter, B., Eggen, B., IJsselsteijn, W.A., (2008). Investigating privacy attitudes and behavior in relation to personalization. *Social Science Computer Review*, Spring 2008, Vol 26, No 1, 20–44.
- Van den Hout, M. A., Bartelski, N., & Engelhard, I. M. (2013). On EMDR: Eye movements during retrieval reduce subjective vividness and objective memory accessibility during future recall. *Cognition & Emotion*, 27(1), 177–183. doi: 10.1080/02699931.2012.691087
- VandenBos, G. R., & Bulatao, E. Q. (Eds.). (1996). *Violence on the job: Identifying risks and developing solutions*. Washington DC: American Psychological Association.
- van der Merwe, A., & Garuccio, A. (Eds.). (1994). *Waves and particles in light and matter*. New York: Plenum Press.
- van der Stelt, O., van der Molen, M., Boudeijn Gunning, W., & Kok, A. (2010). Neuroelectrical signs of selective attention to color in boys with attention-deficit hyperactivity disorder. *Cognitive Brain Research*, 12(2), 245–264.
- Van Dongen, H. P. A., Maislin, G., Mullington, J. M., & Dinges, D. F. (2003). The cumulative cost of additional wakefulness: Dose-response effects on neurobehavioral functions and sleep physiology from chronic sleep restriction and total sleep deprivation. *Sleep*, 26, 117–126.
- Van Horn, J. D., Irimia, A., Torgerson, C. M., Chambers, M. C., Kikinis, R., & Toga, A. W. (2012). Mapping connectivity damage in the case of Phineas Gage. *PLoS One*, 7(5), e37454. doi: 10.1371/journal.pone.0037454
- Varela, J. A., Wang, J., Christianson, J. P., Maier, S. F., & Cooper, D. C. (2012). Control over stress, but not stress per se increases prefrontal cortical pyramidal neuron excitability. *The Journal of Neuroscience*, 32(37), 12848–12853. doi: 10.1523/jneurosci.2669-12.2012
- Vartanian, L. R. (2000). Revisiting the imaginary audience and personal fable constructs of adolescent egocentrism: A conceptual review. *Adolescence*, 35(140), 639–661.

- Vasey, P. L. & VanderLaan, D. P. (2010). An adaptive cognitive dissociation between willingness to help kin and nonkin in Samoan *Fa'afafine*. *Psychological Science*, 21(2), 292–297.
- Vecsey, C. G., Baillie, G. S., Jaganath, D., Havekes, R., Daniels, A., Wimmer, M., Huang, T., Brown, K. M., Li, X. Y., Descalzi, G., Kim, S. S., Chen, T., Shang, Y. Z., Zhuo, M., Houslay, M. D., & Abel, T. (2009). Sleep deprivation impairs cAMP signaling in the hippocampus. *Nature*, 461 (7267), 1122–1125.
- Vernon, S. W., & Roberts, R. E. (1982). Use of RDC in a tri-ethnic community survey. *Archives of General Psychiatry*, 39, 47.
- Villani, S. (2001). Impact of media on children and adolescents: A 10-year review of the research. *Journal of the American Academy on Child and Adolescent Psychiatry*, 40(4), 392–401.
- Virkkunen, M., & Linnoila, M. (1996). Serotonin and glucose metabolism in impulsively violent alcoholic offenders. In D. M. Stoff, & R. B. Cairns (Eds.), *Aggression and violence* (pp. 87–100). Mahwah, NJ: Lawrence Erlbaum.
- Visser, P. S., & Krosnick, J. A. (1998). Development of attitude strength over the life cycle: Surge and decline. *Journal of Personality and Social Psychology*, 75(6), 1389–1410.
- Vogel, G. W. (1975). A review of REM sleep deprivation. *Archives of General Psychiatry*, 32, 749–761.
- Vogel, G. W. (1993). Selective deprivation, REM sleep. In M. A. Carskadon (Ed.), *The encyclopedia of sleep and dreaming*. New York: Macmillan.
- Vogt, B. A., & Palomero-Gallagher, N. (2012). Cingulate cortex. In J. K. Mai & G. Paxinos (Eds.), *The human nervous system* (pp. 943–987). London, UK: Academic Press.
- Voineskos, A. N., Lobaugh, N. J., Bouix, S., Rajji, T. K., Miranda, D., Kennedy, J. L., et al. (2010). Diffusion tensor tractography findings in schizophrenia across the adult lifespan. *Brain: A Journal of Neurology*, 17, 17.
- Vokey, J. R., & Read, J. D. (1985). Subliminal messages: Between the devil and the media. *American Psychologist*, 40, 1231–1239.
- Volkow, N. D., Wang, G.-J., Newcorn, J., Telang, F., Solanto, M. V., Fowler, J. S., et al. (2007). Depressed dopamine activity in caudate and preliminary evidence of limbic involvement in adults with Attention-Deficit/Hyperactivity Disorder. *Archives of General Psychiatry*, 64(8), 932–940.
- von Helmholtz, H. (1852). On the theory of compound colours. *Philosophical Magazine*, 4, 519–535.
- von Helmholtz, H. L. F. (1863). *Die Lehre von den Tonempfindungen als physiologische Grundlage für die Theorie der Musik* (1954, XX, trans. by Alexander J. Ellis). *On the sensations of tone as a physiological basis for the theory of music*. New York: Dover.
- Voogd, J., & Ruigrok, T. J. H. (2012). Cerebellum and precerebellar nuclei. In J. K. Mai & G. Paxinos (Eds.), *The human nervous system* (pp. 471–545). London, UK: Academic Press.
- Voss, M. W., Erickson, K. I., Prakash, R. S., Chaddock, L., Malkowski, E., Alves, H., Kim, J. S., Morris, K. S., White, S. M., Wojcicki, T. R., Hu, L., Szabo, A., Klamm, E., McAuley, E., & Kramer, A. F. (2010). Functional connectivity: A source of variance in the association between cardiorespiratory fitness and cognition? *Neuropsychologia*, 48(5), 1394–1406.
- Voyer, D., & Rodgers, M. (2002). Reliability of laterality effects in a dichotic listening task with nonverbal material. *Brain & Cognition*, 48, 602–606.
- Voyer, D., Voyer, S., & Bryden, M. (1995). Magnitude of sex differences in spatial abilities: A meta-analysis and consideration of critical variables. *Psychological Bulletin*, 117(2), 250–270.
- Vygotsky, L. S. (1934/1962). *Thought and language*. Cambridge, MA: MIT Press.
- Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes*. Cambridge, MA: Harvard University Press.
- Vygotsky, L. S. (1987). Thought and word. In R. W. Riebe & A. S. Carton (Eds.), *The collected works of L. S. Vygotsky: Vol. 1. Problems of general psychology* (pp. 243–288). New York: Plenum.
- Wade, T. D., Gordon, S., Medland, S., Bulik, C. M., Heath, A. C., Montgomery, G. W., & Martin, N. G. (2013). Genetic variants associated with disordered eating. *The International Journal of Eating Disorders*, doi: 10.1002/eat.22133
- Wahlsten, D. (1997). The malleability of intelligence is not constrained by heritability. In B. Devlin, S. E. Fienberg, & K. Roeder, *Intelligence, genes, and success: Scientists respond to the bell curve* (pp. 71–87). New York: Springer.
- Wakefield, A. J., Murch, S. H., Anthony, A., Linnell, J., Casson, D. M., Malik, M., Berelowitz, M., Dhillon, A. P., Thomson, M. A., Harvey, P., Valentine, A., Davies, S. E., & Walker-Smith, J. A. (1998). Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children. *The Lancet*, 351, 9103.
- Walker, L. J. (1991). Sex differences in moral reasoning. In W. M. Kurtines & J. L. Gewirtz (Eds.), *Handbook of moral behavior and development: Vol. 2. Research* (pp. 333–364). Hillsdale, NJ: Lawrence Erlbaum.
- Walker, M. P. (2005). A refined model of sleep and the time course of memory formation. *Behavioral and Brain Sciences*, 28, 51–64.
- Walter, C. (2008). Affairs of the lips. *Scientific American Mind*, 19(6), 24.
- Wampold, B. E. (1997). Methodological problems in identifying efficacious psychotherapies. *Psychotherapy Research*, 7, 21–43.
- Wang, Z., David, P., Srivastava, J., Powers, S., Brady, C., D'Angelo, J., & Moreland, J. (2012). Behavioral performance and visual attention in communication multitasking: A comparison between instant messaging and online voice chat. *Computers in Human Behavior*, 28(3): 968.
- Ward, A. S., Li, D. H., Luedtke, R. R., & Emmett-Oglesby, M. W. (1996). Variations in cocaine self-administration by inbred rat strains under a progressive-ratio schedule. *Psychopharmacology*, 127(3), 204–212.
- Ward, C., & Rana-Deuba, A. (1999). Acculturation and adaptation revisited. *Journal of Cross-Cultural Psychology*, 30, 422–442.
- Ward, I. L. (1992). Sexual behavior: The product of parinatal hormonal and prepubertal social factors. In A. A. Gerall, H. Moltz, & I. L. Ward. (Eds.), *Handbook of behavioral neurobiology: Vol. 11. Sexual differentiation* (pp. 157–178). New York: Plenum Press.
- Ward, J., Mattic, K. R. P., & Hall, W. (1999). *Methadone maintenance treatment and other opioid replacement therapies*. Sydney, Australia: Harwood Academic.
- Ward, M. M., Lotstein, D. S., Bush, T. M., Lambert, R. E., van Vollenhoven, R., & Neuwelt, C. M. (1999). Psychosocial correlates of morbidity in women with systemic lupus erythematosus. *Journal of Rheumatology*, 26, 2153–2158.
- Wartner, U. G., Grossmann, K., Fremmer-Bombik, E., & Suess, G. (1994). Attachment patterns at age six in south Germany: Predictability from infancy and implications for preschool behavior. *Child Development*, 65, 1014–1027.
- Washburn, M. F. (1908). *The animal mind: A text-book of comparative psychology*. New York: Macmillan.
- Wasserman, E. A., & Miller, R. R. (1997). What's elementary about associative learning? *Annual Review of Psychology*, 48, 573–607.
- Waterhouse, L. (2006a). Inadequate evidence for multiple intelligences, Mozart effect, and emotional intelligence theories. *Educational Psychologist*, 41(4), 247–255.
- Waterhouse, L. (2006b). Multiple intelligences, the Mozart effect, and emotional intelligence: A critical review. *Educational Psychologist*, 41, 207–225.
- Waterman, A. S. (2013). The humanistic psychology–positive psychology divide: Contrasts in philosophical foundations. *American Psychologist*, 68(3), 124–133. doi: 10.1037/a0032168
- Watkins, C. E., Campbell, V. L., Nieberding, R., & Hallmark, R. (1995). Contemporary practice of psychological assessment by clinical psychologists. *Professional Psychology: Research and Practice*, 26, 54–60.
- Watkins, C. E., Jr., & Savickas, M. L. (1990). Psychodynamic career counseling. In W. B. Walsh & S. H. Osipow (Eds.), *Career counseling: Contemporary topics in vocational psychology* (pp. 79–116). Hillsdale, NJ: Lawrence Erlbaum.
- Watson, D. L., Hagiwara, D. K., & Tenney, A. L. (1999). Skill-building exercises and generalizing psychological concepts to daily life. *Teaching of Psychology*, 26, 193–195.
- Watson, J. B. (1913). Psychology as the behaviorist views it. *Psychological Review*, 20, 158–177.
- Watson, J. B. (1924). *Behaviorism*. New York: W. W. Norton.
- Watson, J. B., & Rayner, R. (1920). Conditioned emotional responses. *Journal of Experimental Psychology*, 3, 1–14.
- Watson, J. M., & Strayer, D. L. (2010). Supertaskers: Profiles in extraordinary multitasking ability. *Psychonomic Bulletin & Review*, 17(4), 479–485.
- Watt, H. M. G. (2000). Measuring attitudinal change in mathematics and English over the 1st year of junior high school: A multi-dimensional analysis. *Journal of Experimental Education*, 68, 331–361.
- Weaver, F. M., Follett, K., Stern, M., Hur, K., Harris, C., Marks, W. J., Jr., et al. (2009). Bilateral deep brain stimulation vs. best medical therapy for patients with advanced Parkinson disease: A randomized controlled trial. *Journal of the American Medical Association*, 301(1), 63–73.
- Webb, W. B. (1992). *Sleep: The gentle tyrant* (2nd ed.). Bolton, MA: Ander.
- Wechsler, D. (1975). *The collected papers of David Wechsler*. New York: Academic Press.
- Wechsler, D. (2002). *WPPSI-III* (Wechsler Preschool and Primary Scale of Intelligence—Third Edition) *Administration and scoring manual*. San Antonio, TX: Pearson.

- Wechsler, D. (2003). *WISC-IV* (Wechsler Intelligence Scale for Children—Fourth Edition) *Administration and scoring manual*. San Antonio, TX: Pearson.
- Wechsler, D. (2008). *WAIS-IV* (Wechsler Adult Intelligence Scale—Fourth Edition) *Administration and scoring manual*. San Antonio, TX: Pearson.
- Wedding, D. (2004). Cross-cultural counseling and psychotherapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (7th ed., p. 485). Itasca, IL: Peacock.
- Weinberger, D. R. (1987). Implications of normal brain development for the pathogenesis of schizophrenia. *Archives of General Psychiatry*, 44, 660–668.
- Weiner, B. (1985). An attributional theory of achievement motivation. *Psychological Review*, 92, 548–573.
- Weiner, I. B. (1997). Current status of the Rorschach Inkblot Method. *Journal of Personality Assessment*, 68, 5–19.
- Weiner, I. B. (2013). Applying Rorschach assessment. In G. P. Koocher, J. C. Norcross & B. A. Greene (Eds.), *Psychologists' desk reference* (pp. 148–152). New York, NY: Oxford University Press.
- Weiner, R. D. (2000). Retrograde amnesia with electroconvulsive therapy: Characteristics and implications. *Archives of General Psychiatry*, 57, 591–592.
- Weiss, S., Klaver, P., Reul, J., Elger, C. E., & Fernandez, G. (2004). Temporal and cerebellar brain regions that support both declarative memory formation and retrieval. *Cerebral Cortex*, 14, 256–267.
- Weisman, A. (1972). *On dying and denying*. New York: Behavioral Publications.
- Weiss, J. M. (1972). Psychological factors in stress and disease. *Scientific American*, 226, 104–113.
- Weisse, C. S. (1992). Depression and immunocompetence: A review of the literature. *Psychological Bulletin*, 111, 475–489.
- Weissman, M. M., & Klerman, G. L. (1977). Sex differences and the epidemiology of depression. *Archives of General Psychiatry*, 34, 98–111.
- Wellings, K., Nanchahal, K., Macdowall, W., McManus, S., Erens, B., Mercer, C. H., Johnson, A. M., Copas, A. J., Korovessis, C., Fenton, K. A., & Field, J. (2001). Sexual behaviour in Britain: Early heterosexual experience. *Lancet*, 358(9296), 1843–1850.
- Wenneberg, S. R., Schneider, R. H., Walton, K. G., Maclean, C. R., Levitsky, D. K., Mandarino, J. V., Waziri, R., & Wallace, R. K. (1997). Anger expression correlates with platelet aggregation. *Behavioral Medicine*, 22(4), 174–177.
- Werker, J. F., & Lalonde, C. E. (1988). Cross-language speech perceptions: Initial capabilities and developmental change. *Developmental Psychology*, 24, 672–683.
- Wertheimer, M. (1982). *Productive thinking*. Chicago: University of Chicago Press.
- Westen, D. (2005). Cognitive neuroscience and psychotherapy: Implications for psychotherapy's second century. In G. Gabbard, J. Beck, & J. Holmes (Eds.), *Oxford textbook of psychotherapy*. Oxford, UK: Oxford University Press.
- Wetherell, J. L. (2002). Behavior therapy for anxious older adults. *Behavior Therapist*, 25, 16–17.
- Wever, E. G. (1949). *Theory of hearing*. New York: John Wiley & Sons.
- Wever, E. G., & Bray, C. W. (1930). The nature of acoustic response: The relation between sound frequency and frequency of impulses in the auditory nerve. *Journal of Experimental Psychology*, 13(5), 373–387.
- Weyant, J. M. (1996). Application of compliance techniques to direct-mail requests for charitable donations. *Psychology and Marketing*, 13, 157–170.
- White, G. L. (1980). Physical attractiveness and courtship progress. *Journal of Personality and Social Psychology*, 39, 660–668.
- White, J. N., Hutchens, T., & Lubar, J. (2005). Quantitative EEG assessment during neuropsychological task performance in adults with attention deficit hyperactivity disorder. *Journal of Adult Development*, 12(2), 113–121.
- White, S. (2000). *The transgender debate (the crisis surrounding gender identity)*. Reading, UK: Garnet.
- Whorf, B. L. (1956). *Language, thought and reality*. New York: Wiley.
- Wicker, A. W. (1971). An examination of the "other variables" explanation of attitude-behavior inconsistency. *Journal of Personality and Social Psychology*, 19, 18–30.
- Wierenga, C. E., Stricker, N. H., McCauley, A., Simmons, A., Jak, A. J., Chang, Y. L., et al. (2010). Increased functional brain response during word retrieval in cognitively intact older adults at genetic risk for Alzheimer's disease. *Neuroimage*, 15, 15.
- Wiley, J., & Jarosz, A. F. (2012). Working memory capacity, attentional focus, and problem solving. *Current Directions in Psychological Science*, 21(4), 258.
- Wilhelm, I., Rose, M., Imhof, K. I., Rasch, B., Buechel, C., & Born, J. (2013). The sleeping child outplays the adult's capacity to convert implicit into explicit knowledge. *Nature Neuroscience*, doi: 10.1038/nrn.3343.
- Willeumier, K., Taylor, D. V., & Amen, D. G. (2012). Elevated body mass in National Football League players linked to cognitive impairment and decreased prefrontal cortex and temporal pole activity. *Translational Psychiatry*, 2, e68. doi: 10.1038/tp.2011.67
- Williams, J. A., Pascual-Leone, A., & Fregni, F. (2010). Interhemispheric modulation induced by cortical stimulation and motor training. *Physical Therapy*, 90(3), 398–410.
- Williams, M. A., & Sachdev, P. S. (2010). Magnetoencephalography in neuropsychiatry: Ready for application? *Current Opinion in Psychiatry*, 4, 4.
- Williams, M. E. (1995). *The American Geriatrics Society's complete guide to aging and mental health*. New York: Random House.
- Williams, R. B. (1999). A 69-year-old man with anger and angina. *Journal of the American Medical Association*, 282, 763–770.
- Williams, R. B. (2001). Hostility: Effects on health and the potential for successful behavioral approaches to prevention and treatment. In A. Baum, T. A. Revenson, & J. E. Singer (Eds.), *Handbook of Health Psychology*. Mahwah, NJ: Erlbaum.
- Williams, R. B., Haney, T. L., Lee, K. L., Kong, Y. H., Blumenthal, J. A., & Whalen, R. E. (1980). Type A behavior, hostility, and coronary atherosclerosis. *Psychosomatic Medicine*, 42(6), 539–549.
- Winningham, R. G., Hyman, I. E., Jr., & Dinnel, D. L. (2000). Flashbulb memories? The effects of when the initial memory report was obtained. *Memory*, 8, 209–216.
- Winslow, J. T., Hastings, N., Carter, C. S., Harbaugh, C. R., & Insel, T. R. (1993). A role for central vasopressin in pair bonding in monogamous prairie voles. *Nature*, 365(6446), 545–548. doi: 10.1038/365545a0
- Winton, W. M. (1987). Do introductory textbooks present the Yerkes-Dodson law correctly? *American Psychologist*, 42(2), 202–203.
- Wise, K., Alhabash, S., & Park, H. (2010). Emotional responses during social information seeking on Facebook. *Cyberpsychology, Behavior, and Social Networking*, 13(5), 555–562.
- Wiseman, R. (2007). *Quirkology: How we discover the big truths in small things* (pp. 7–8, 28–29). New York: Basic Books.
- Witelson, S. F. (1991). Neural sexual mosaicism: Sexual differentiation of the human temporo-parietal region for functional asymmetry. *Psychoneuroendocrinology*, 16, 131–153.
- Wojcik, B. E., Stein, C. R., Bagg, K., Humphrey, R. J., & Orosco, J. (2010). Traumatic brain injury hospitalizations of U.S. army soldiers deployed to Afghanistan and Iraq. *American Journal of Preventive Medicine*, 38(Suppl. 1), S108–116.
- Wolberg, L. R. (1977). *The technique of psychotherapy*. New York: Grune & Stratton.
- Wood, J. M., Nezworski, M. T., & Stejskal, W. J. (1996). The comprehensive system for the Rorschach: A critical examination. *Psychological Science*, 7(1), 3–10, 14–17.
- Woodhouse, A. (2005). Phantom limb sensation. *Clinical and Experimental Pharmacology and Physiology*, 32(1–2), 132–134.
- World Health Organization. (2010). Guidelines on HIV and infant feeding 2010: Principles and recommendations for infant feeding in the context of HIV and a summary of evidence. Retrieved from http://www.who.int/maternal_child_adolescent/documents/9789241599535/en/
- World Health Organization. (2012). HIV/AIDS. Retrieved from <http://www.who.int/mediacentre/factsheets/fs360/en/>
- Wu, C.-C., Lee, G. C., & Lai, H.-K. (2004). Using concept maps to aid analysis of concept presentation in high school computer textbooks. *Journal of Education and Information Technologies*, 9(2), 10.1023/B:EAIT.0000027930.09631.a5
- Wyman, P. A., Moynihan, J., Eberly, S., Cox, C., Cross, W., Jin, X., & Caserta, M. T. (2007). Association of family stress with natural killer cell activity and the frequency of illnesses in children. *Archives of Pediatric and Adolescent Medicine*, 161, 228–234.
- Wynne, C. (1999). Do animals think? The case against the animal mind. *Psychology Today*, 32(6), 50–53.
- Yaffe, K., Vittinghoff, E., Lindquist, K., Barnes, D., Covinsky K. E., Neylan, T., Kluse, M., & Marmar, C. (2010). Posttraumatic stress disorder and risk of dementia among U.S. veterans. *Archives of General Psychiatry*, 67(6), 608–613.
- Yalom, I. (1995). *The theory and practice of group psychotherapy* (4th ed.). New York: Basic Books.
- Yamaguchi, S., Isejima, H., Matsuo, T., Okura, R., Yagita, K., Kobayashi, M., & Okamura, H. (2003). Synchronization of cellular clocks in the suprachiasmatic nucleus. *Science*, 302, 1408–1412.
- Yang, Y., Raine, A., & Colletti, P. (2010). Morphological alterations in the prefrontal cortex and the amygdala in unsuccessful psychopaths. *Journal of Abnormal Psychology*, 119, 546–554.
- Yerkes, R. M., & Dodson, J. D. (1908). The relation of strength of stimulus to rapidity of habit formation. *Journal of Comparative Neurology and Psychology*, 18, 459–482.

- Yerkes, R. M. (Ed.). (1921). Psychological examining in the United States Army. *Memoirs of the National Academy of Sciences*, 15, 1–890.
- Ying, Y. W. (1990). Explanatory models of major depression and implications for help-seeking among immigrant Chinese-American women. *Culture, Medicine, and Psychiatry*, 14, 393–408.
- Yip, Y. L. (2002, Autumn). Pivot-Qi. *The Journal of Traditional Eastern Health and Fitness*, 12(3).
- Yopyk, D., & Prentice, D. A. (2005). Am I an athlete or a student? Identify salience and stereotype threat in student-athletes. *Basic and Applied Social Psychology*, 27(4), 29–336.
- Young, J. E., Rygh, J. L., Weinberger, A. D., & Beck, A. T. (2008). Cognitive therapy for depression. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (pp. 250–305). New York: Guilford Press.
- Young, S. N. (Ed.) (1996). Melatonin, sleep, aging, and the health protection branch. *Journal of Psychiatry Neuroscience*, 21(3), 161–164.
- Yule, G. (1996). *Pragmatics*. Oxford: Oxford University Press.
- Zadra, A., Desautels, A., Petit, D., & Montplaisir, J. (2013). Somnambulism: Clinical aspects and pathophysiological hypotheses. *The Lancet Neurology*, 12(3): 285.
- Zadra, A., Pilon, M., & Montplaisir, J. (2008). Polysomnographic diagnosis of sleep-walking: Effects of sleep deprivation. *Annals of Neurology*, 63(4): 513–519.
- Zajonc, R. B. (1965). Social facilitation. *Science*, 149, 269–274.
- Zajonc, R. B. (1968). Attitudinal effects of mere exposure. *Journal of Personality and Social Psychology Monographs*, 9(2), 1–27.
- Zajonc, R. B. (1980). Feeling and thinking: Preferences need no inferences. *American Psychologist*, 35, 151–175.
- Zajonc, R. B. (1984). On the primacy of affect. *American Psychologist*, 39, 117–123.
- Zajonc, R. B. (1998). Emotions. In D. T. Gilbert & S. T. Fiske (Eds.), *Handbook of social psychology* (4th ed., Vol. 1, pp. 591–632). New York: McGraw-Hill.
- Zajonc, R. B., Heingartner, A., & Herman, E. M. (1970). Social enhancement and impairment of performance in the cockroach. *Journal of Social Psychology*, 13(2), 83–92.
- Zarate, C. A., Jr., Brutsche, N. E., Ibrahim, L., Franco-Chaves, J., DiazGranados, N., Cravchik, A., ... Luckenbaugh, D. A. (2012). Replication of ketamine's antidepressant efficacy in bipolar depression: A randomized controlled add-on trial. *Biological Psychiatry*, 71(11), 939–946. doi: 10.1016/j.biopsych.2011.12.010
- Zarate, C. A., Jr., Singh, J. B., Carlson, P. J., Brutsche, N. E., Ameli, R., Luckenbaugh, D. A., ... Manji, H. K. (2006). A randomized trial of an N-methyl-D-aspartate antagonist in treatment-resistant major depression. *Archives of General Psychiatry*, 63(8), 856–864. doi: 10.1001/archpsyc.63.8.856
- Zedler, Beatrice (1995). "Mary Whiton Calkins." In M. E. Waite (Ed.), *A history of women philosophers: Vol. 4* (pp. 103–123). Netherlands: Kluwer Academic Publishers.
- Zeidner, M., & Matthews, G. (2005). Evaluative anxiety. In A. Elliott & C. Dweck (Eds.), *Handbook of competence and motivation* (pp. 141–146). New York: Guilford Press.
- Zeki, S. (2001). Localization and globalization in conscious vision. *Annual Review of Neuroscience*, 24, 57–86.
- Zentall, T. R. (2000). Animal intelligence. In R. J. Sternberg (Ed.), *Handbook of intelligence*. Cambridge, MA: Cambridge University Press.
- Zhang R, Lu S, Meng L, Min Z, Tian J, Valenzuela, R. IK., Guo, T, Tian, L., Zhao, W., & Ma, J.. (2012) Genetic Evidence for the Association between the Early Growth Response 3 (*EGR3*) Gene and Schizophrenia. *PLoS ONE* 7(1): e30237.
- Zhao, Y., Montoro, R., Igartua, K., & Thombs, B. D. (2010). Suicidal ideation and attempt among adolescents reporting "unsure" sexual identity or heterosexual identity plus same-sex attraction or behavior: Forgotten groups? *Journal of the American Academy of Child & Adolescent Psychiatry*, 49(2), 104–113.
- Zhou, J. N., Hofman, M. A., Gooren, L. J. G., & Swaab, D. F. (1995). A sex difference in the human brain and its relation to transsexuality. *Nature*, 378, 68–70.
- Zilles, K. (1990). Cortex. In G. Paxinos (Ed.), *The human nervous system* (pp. 757–802). San Diego, CA: Academic.
- Zilles, K., & Amunts, K. (2012). Architecture of the cerebral cortex. In J. K. Mai & G. Paxinos (Eds.), *The human nervous system* (pp. 836–895). London, UK: Academic Press.
- Zillmann, D., Baron, R., & Tamborini, R. (1981). Social costs of smoking: Effects of tobacco smoke on hostile behavior. *Psychology Journal of Applied Social*, 11, 548–561.
- Zimbardo, P. (1971). The pathology of imprisonment. *Society*, 9(4–8), 4.
- Zimbardo, P. G. (1970). The human choice: Individuation, reason, and order versus deindividuation, impulse, and chaos. In N. J. Arnold & D. Levine (Eds.), *Nebraska Symposium on Motivation, 1969*. Lincoln: University of Nebraska Press.
- Zimbardo, P. G., & Hartley, C. F. (1985). Cults go to high school: A theoretical and empirical analysis of the initial stage in the recruitment process. *Cultic Studies Journal*, 2, 91–148.
- Zimbardo, P., Maslach, C., & Haney, C. (2000). Reflections on the Stanford Prison Experiment: Genesis, transformations, consequences. In T. Blass (Ed.), *Obedience to authority: Current perspectives on the Milgram paradigm* (pp. 193–237). London: Lawrence Erlbaum.
- Zisapel, N. (2001). Circadian rhythm sleep disorders: Pathophysiology and potential approaches to management. *CNS Drugs*, 15(4), 311–328.
- Zlatin, D. M. (1995). Life themes: A method to understand terminal illness. *Omega: Journal of Death and Dying*, 31(3), 189–206. doi: 10.2190/E4BA-ML04-E2BK-TYJE
- Zorilla, E. P., Luborsky, L., McKay, J. R., Rosenthal, R., Houldin, A., Tax, A., McCorkle, R., Seligman, D. A., & Schmidt, K. (2001). The relationship of depression and stressors to immunological assays: A meta-analytic review. *Brain, Behavior, and Immunity*, 15, 199–226.
- Zucchi, F. C. R., Kirkland, S. W., Jadavji, N. M., van Waes, L. T., Klein, A., Supina, R. D., & Metz, G. A. (2009). Predictable stress versus unpredictable stress: A comparison in a rodent model of stroke. *Behavioural Brain Research*, 205(1), 67–75.
- Zuckerman, M. (1979). *Sensation seeking: Beyond the optimal level of arousal*. Hillsdale, NJ: Lawrence Erlbaum.
- Zuckerman, M. (1994). *Behavioral expression and biosocial bases of sensation seeking*. New York: Cambridge University Press.
- Zuckerman, M. (2002). Zuckerman-Kuhlman Personality Questionnaire (ZKPQ): An alternative five-factorial model. In B. De Raad & M. Perugini (Eds.), *Big Five assessment* (pp. 377–396). Seattle, WA: Hogrefe & Huber.
- Zuo, L., & Cramond, B. (2001). An examination of Terman's gifted children from the theory of identity. *Gifted Child Quarterly*, 45(4), 251–259.
- Zuvekas, S. H., & Vitiello, B. (2012). Stimulant medication use in children: A 12-year perspective. *American Journal of Psychiatry*, 193:160–166.
- Zvolensky, M. J., Schmidt, M. B., & Stewart, S. H. (2003). Panic disorder and smoking. *Clinical Psychology: Science and Practice*, 10, 29–51.



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