



Key Question Chapter Outline



CORE CONCEPTS



Psychology in Your Life

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Psychological Disorders: The State of the Art



The medical model takes a “disease” view, while psychology sees psychological disorder as an interaction of biological, mental, social, and behavioral factors.



The *DSM-IV*, the most widely used system, classifies disorders by their mental and behavioral symptoms.



Ideally, accurate diagnoses lead to proper treatments, but diagnoses may also become labels that depersonalize individuals and ignore the social and cultural contexts in which their problems arise.

A Caution to Readers

If you find that you have some signs of psychological disorder, don’t jump to conclusions.

Shyness

If you have it, it doesn’t have to be permanent. (And, by the way, it’s not a mental disorder.)

The Plea of Insanity

It’s not a psychological or psychiatric term, and, contrary to popular opinion, it is a defense that is seldom used.

USING PSYCHOLOGY TO LEARN PSYCHOLOGY:
Diagnosing Your Friends and Family

Psychological Disorders

THE VOLUNTEERS KNEW they were on their own. If they managed to get into the hospital, the five men and three women could get out only by convincing the staff that they were sane. None had ever been diagnosed with a mental illness, but perhaps they were not so “normal” after all: Would a normal person lie to get into such a place? In fact, all were collaborators in an experiment designed to find out whether normality would be recognized in a mental hospital.

The experimenter, David Rosenhan—himself one of the pseudopatients—suspected that terms such as *sanity*, *insanity*, *schizophrenia*, *mental illness*, and *abnormal* might have fuzzier boundaries than the psychiatric community thought. He also suspected that some strange behaviors seen in mental patients might originate in the abnormal atmosphere of the mental hospital, rather than in the patients themselves. To test these ideas, Rosenhan and his collaborators decided to see how mental hospital personnel would deal with patients who were not mentally ill.

Individually, they applied for admission at different hospitals, complaining that they had recently heard voices that seemed to say “empty,” “hollow,” and “thud.” Aside from this, they claimed no other symptoms of disorder. All used false names, and the four who were mental health professionals gave false occupations—but apart from these fibs, the subjects answered all questions truthfully. They tried to act normally, although the prospect of entering the alien hospital environment made them feel anxious; they also worried about not being admitted and—worse yet—being exposed as frauds.



“Why doesn’t he just snap out of it.”

We wouldn’t expect someone with a serious physical illness to get better without treatment. Yet, for the victims of another disease more widespread than cancer, lung, and heart disease combined, treatment is rarely considered.

That disease is mental illness. In fact, of the over 35 million Americans afflicted, only one in five gets treatment. Because their symptoms are either ignored or misread as mere personality problems.

But, mental illness is a medical illness that requires medical attention. Many forms, including schizophrenia, depression, and Alzheimer’s disease can be caused by a biological disorder. And this new knowledge has led to real progress in the treatment of mental illness. Today, two out of three victims of mental illness can get better and lead productive lives.

If someone you love can’t seem to snap out of it, learn more. For an informative booklet, write: The American Mental Health Fund, P.O. Box 17700, Washington, D.C. 20041. Or call toll free: 1-800-433-5959.

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● Advertisements like the one shown here have gone a long way toward correcting our views of mental illness and creating sympathy for its sufferers.

CONNECTION CHAPTER 14

Social psychology has taught us about the *power of the situation*—that is, the powerful and often unrecognized influence that the social context has on our behavior.

Their concerns about fraud vanished quickly, for all readily gained admittance at 12 different hospitals (some did it twice). All but one were diagnosed with “schizophrenia,” a major psychological disorder often accompanied by hearing imaginary voices.

After admission, the pseudopatients made no further claims of hearing voices or any other abnormal symptoms. Indeed, all wanted to be on their best behavior to gain release. Their only apparent “deviance” involved taking notes on the experience—at first privately and later publicly, when they found that the staff paid little attention. The nursing records indicated that when the staff did notice, they interpreted the note-taking as part of the patient’s illness. (One comment: “Patient engages in writing behavior.”) But in spite of the absence of abnormal symptoms, it took an average of 19 days for the pseudopatients to convince the hospital staff that they were ready for discharge. One unfortunate individual wasn’t released for almost two months.

Two main findings from this classic study jarred the psychiatric community to its core. First, *no professional staff member at any of the hospitals ever realized that any of Rosenhan’s pseudopatients was a fraud*. Of course, the staff may have assumed that the patients had been ill at the time of admission and had improved during their hospitalization. But that possibility did not let the professionals off Rosenhan’s hook: Despite apparently normal behavior, not one pseudopatient was ever labeled as “normal” or

“well” while in the hospital. And upon discharge, they were still seen as having schizophrenia—but “in remission.”

The mistaken diagnosis does not suggest that the hospital staff members were unskilled or unfeeling. The fact that they did not detect the pseudopatients’ normal behavior is probably because they spent little time observing and interacting with the patients. Most of the time they kept to themselves in a glassed-in central office that patients called “the cage.” As Rosenhan (1973) said,

It could be a mistake, and a very unfortunate one, to consider that what happened to us derived from malice or stupidity on the part of the staff. Quite the contrary, our overwhelming impression of them was of people who really cared, who were committed and who were uncommonly intelligent. Where they failed, as they sometimes did painfully, it would be more accurate to attribute those failures to the environment in which they, too, found themselves than to personal callousness. Their perceptions and behavior were controlled by the situation . . . (p. 257)

A second finding tells us volumes about the patients and the nature of psychological disorder itself: *To everyone’s surprise, the hospital patients readily detected the ruse, even though the professional staff did not*. The pseudopatients reported that the other patients regularly voiced their suspicions: “You’re not crazy. You’re a journalist or a professor. . . . You’re checking up on the hospital.” In his report of this experience, entitled

"On Being Sane in Insane Places," Rosenhan (1973) noted dryly, "The fact that the patients often recognized normality when staff did not raises important questions" (p. 252). You will hear the echo of these "important questions" as we critically examine the medical view of mental disorder in this chapter.

Please note that Rosenhan did not deny the existence of psychological disorders. People do suffer the anguish of **psychopathology** (also called *mental disorder* or *mental illness*). According to a study conducted by the National Institutes of Mental Health, about 15.4% of the population suffers from diagnosable mental health problems. Another study found that during any given year, the behaviors of over 56 million Americans meet the criteria for a diagnosable psychological disorder (Carson et al., 1996; Regier et al., 1993). Over the lifespan, as many as 32% of Americans will suffer from some psychological disorder (Regier et al., 1988).

Neither did Rosenhan deny that the initial diagnoses given his pseudopatients were justified. After all, they claimed to be hearing voices—a strong indicator of abnormality. Rosenhan's interest in mental hospitals centered on the assumptions made there about people who have been diagnosed with a "mental illness." These conditions, he argued, blinded caregivers to the needs of their patients. As we look at the problem of diagnosing and describing psychological disorder in this chapter, it will be helpful to keep Rosenhan's study in mind. Even though this research was done some 30 years ago, the terms *abnormal*, *disorder*, and *mental illness* still carry meanings that can prevent us from seeing people with psychological problems as individuals.

WHAT IS PSYCHOLOGICAL DISORDER?



Distinguishing "normal" from "abnormal" is no simple task. Consider, for example, how you would classify such eccentric personalities as Robin Williams or Madonna or Marilyn Manson. And what about a soldier who risks his or her life in combat: Is that "normal"? Or consider a grief-stricken woman who is unable to return to her normal routine three months after her husband died: Does she have a psychological disorder?

More extreme disorders are more easily detected. Clinicians (specialists in the treatment of psychological problems) look for three classic symptoms of severe psychopathology: *hallucinations*, *delusions*, and extreme *affective disturbances*. **Hallucinations** are false sensory experiences, such as hearing nonexistent voices (as Rosenhan's pseudopatients said they did). **Delusions** are extreme disorders of thinking that involve persistent false beliefs. If you think you are the president of the United States (and you are not), you have a symptom of psychopathology. Or if you think people are out to "get" you, you may also have a delusional disorder. Similarly, those whose **affect** (emotion) is characteristically depressed, anxious, or manic—or those who seem to have no emotional response at all—have other possible signs of severe psychological disorder.

Beyond such extreme signs of distress, the experts do not always agree, however. What is abnormal and what is not become a judgment call, a judgment made more difficult because no sharp boundary separates normal from abnormal thought and behavior. It may be helpful to think of psychological disorder as part of a continuum ranging from the absence of disorder to severe disorder, as shown in Table 12.1. The big idea here is that people with

■ **Psychopathology** Any pattern of emotions, behaviors, or thoughts inappropriate to the situation and leading to personal distress or the inability to achieve important goals. Other terms having essentially the same meaning include *mental illness*, *mental disorder*, and *psychological disorder*.

■ **Hallucinations** False sensory experiences that may suggest mental disorder. Hallucinations can have other causes, such as drugs or sensory isolation.

■ **Delusions** Extreme disorders of thinking, involving persistent false beliefs. Delusions are the hallmark of paranoid disorders.

■ **Affect** A term referring to emotion or mood.

TABLE 12.1**The Spectrum of Mental Disorder**

Mental disorder occurs on a spectrum that ranges from the absence of signs of pathology to severe disturbances, such as are found in major depression or schizophrenia. The important point is that there is no sharp distinction that divides those with mental disorders from those who are “normal.”

No Disorder	Mild Disorder	Moderate Disorder	Severe Disorder
Absence of signs of psychological disorder	Few signs of distress or other indicators of psychological disorder	Indicators of disorder are more pronounced and occur more frequently	Clear signs of psychological disorder, which dominate the person's life
Absence of behavior problems	Few behavior problems; responses usually appropriate to the situation	More distinct behavior problems; behavior is often inappropriate to the situation	Severe and frequent behavior problems; behavior is usually inappropriate to the situation
No problems with interpersonal relationships	Few difficulties with relationships	More frequent difficulties with relationships	Many poor relationships or lack of relationships with others

psychological disorders are not in a class by themselves. Rather, their disorders are an exaggeration of normal responses.

In this section of the chapter, we will focus on two contrasting views of psychological disorder. One, coming to us from medicine, is sometimes called the medical model. It portrays mental problems much as it does physical disorders: as sickness or disease. The other view, a psychological view, sees psychological disorders as the result of multiple factors that can involve both nature and nurture. As our Core Concept puts it:



The medical model takes a “disease” view, while psychology sees psychological disorder as an interaction of biological, mental, social, and behavioral factors.

No matter how we conceptualize psychopathology, nearly everyone agrees that psychological disorder is common. It touches the daily lives of millions. It can be insidious, working its way into thoughts and feelings, diminishing its victims’ emotional and physical well-being, along with their personal and family relationships. And it can create an enormous financial burden through lost productivity, lost wages, and the high costs of prolonged treatment. Yet the way people think of psychopathology does have a consequence: As we will see, it determines how they attempt to treat it—whether with drugs, charms, rituals, talk, torture, brain surgery, hospitalization, or commitment to an “insane asylum.”

In this section of the chapter, we will find that the two main ways of looking at psychopathology, the medical model and the psychological view, are often at odds. Some of this conflict is territorial, resulting from professional infighting. But some of the conflict has historical roots, as we shall see next.

Changing Concepts of Psychological Disorder

Before December 10, 1973, homosexuality was considered an illness. But on that day the American Psychiatric Association voted to drop homosexuality from its list of officially recognized disorders. The membership had decided that this sexual orientation was not associated with mental problems, a decision that has since been shown repeatedly to be accurate—with the understandable exception of problems related to the stress of discrimination (Cochran et al., 2003; Meyer, 2003). This change, however, was only one of the most recent in a continuously evolving concept of mental disorder that stretches back thousands of years.

Historical Roots In the ancient world, people assumed that supernatural powers were everywhere, accounting for good fortune, disease, and disaster. In this context, psychopathology was believed to be caused by demons and spirits that had taken possession of the person's mind and body (Sprock & Blashfield, 1991). If you had been living in the ancient world, your daily routine would have included rituals aimed at outwitting or placating these supernatural beings.

In about 400 B.C., the Greek physician Hippocrates took humanity's first step toward a scientific view of mental disturbance when he declared that abnormal behavior has physical causes. He taught his disciples to interpret the symptoms of psychopathology as an imbalance among four body fluids called "humors": blood, phlegm (mucus), black bile, and yellow bile (see Figure 12.1). Those with an excess of black bile, for example, were inclined to melancholy or depression, while those who had an abundance of blood were sanguine, or warmhearted. With this revolutionary idea, Hippocrates incorporated mental disorder into medicine, and his view influenced educated people in the Western world until the end of the Roman Empire.

Then, in the Middle Ages, superstition eclipsed the Hippocratic model of mental disorder. Under the influence of the medieval Church, physicians and clergy reverted to the old ways of explaining abnormality in terms of demons and witchcraft. In these harsh times, the Inquisition was driven by the belief that unusual behavior was the work of the Devil. The "cure" involved attempts to drive out the demons who possessed the unfortunate victim's soul. As a

CONNECTION CHAPTER 10

Hippocrates' humor theory was a theory of *temperaments*.

Humors	Origin	Temperament
■ blood	heart	sanguine (cheerful)
■ choler (yellow bile)	liver	choleric (angry)
■ melancholer (black bile)	spleen	melancholy (depressed)
■ phlegm	brain	phlegmatic (sluggish)



● **FIGURE 12.1** Hippocrates' Humor Theory

In Hippocrates' view, mental disorder was caused by an excess of the body fluids, or "humors."



● A painting of the witchcraft trials held in Salem, Massachusetts, in 1692. Twenty people were executed before the hysteria subsided.

result, thousands of mentally disturbed people were tortured and executed all across the European continent. And in 1692, the same view of mental disorder led the young colony in Salem, Massachusetts, to convict and execute several of its residents for witchcraft (Karlsen, 1998). A group of young girls had frightened the community with a rash of convulsions and reports of sensory disturbances that were interpreted as signs of demonic possession. A modern analysis of the Salem witch trials has concluded that the girls were probably suffering from poisoning by a fungus growing on rye grain—the same fungus that produces the hallucinogenic drug LSD (Caporeal, 1976; Matossian, 1982, 1989).

The Medical Model In the latter part of the 18th century, the “disease” view that originated with Hippocrates re-emerged with the rise of science. The resulting **medical model** held that mental disorders are *diseases* of the mind

that, like ordinary physical diseases, have objective causes and require specific treatments. People began to perceive individuals with psychological problems as sick (suffering from illness), rather than as demon-possessed or immoral. And what a difference a new theory made! Treating mental disorders by torture and abuse no longer made sense. The new view of mental illness brought sweeping reforms that were implemented in “asylums” for the “insane.” In this supportive atmosphere, many patients actually improved—even thrived—on rest, contemplation, and simple but useful work (Maher & Maher, 1985). Unfortunately, political pressures eventually turned the initially therapeutic asylums into overcrowded warehouses of neglect.

Despite such problems, however, the medical model was unquestionably an improvement over the demon model. Yet modern psychologists think that the medical model has its own weaknesses. They point out that the assumption of “disease” leads to a doctor-knows-best approach in which the therapist takes all the responsibility for diagnosing the illness and prescribing treatment. Under this assumption, the patient may become a passive recipient of medication and advice, rather than an active participant in treatment. Psychologists believe that this attitude wrongly encourages dependency on the doctor, encourages unnecessary drug therapy, and does little to help the patient develop good coping skills.

Not incidentally, a doctor-knows-best approach also takes responsibility away from psychologists and gives it to psychiatrists. Psychologists bristle at the medical model’s implication that their treatment of mental “diseases” should be done under the supervision of a physician. In effect, the medical model assigns psychologists to second-class professional status. As you can see, ownership of the whole territory of psychological disorder is hotly contested.

CONNECTION: CHAPTER 1

Psychiatrists, but not psychologists, are trained in medicine.

Psychological Models What does psychology have to offer in place of the medical model? Most clinical psychologists have now turned to a combination of psychological perspectives that derive from *behaviorism*, *cognitive psychology*, *social learning*, and *biological psychology*. We will look at these more closely.

The Social-Cognitive-Behavioral Approach Modern psychologists often combine ideas from perspectives that were once considered incompatible: cognitive psychology and behaviorism. In brief, cognitive psychology looks inward, emphasizing mental processes, while behaviorism looks outward, emphasizing the influence of the environment. As we saw in the chapter on learning,

■ **Medical model** The view that mental disorders are diseases that, like ordinary physical diseases, have objective physical causes and require specific treatments.

bridges between these perspectives were built by social-learning theorists and others. As a result, a major shift in psychological thinking in recent years now views these traditions as complementary, rather than competitive. Moreover, both sides now acknowledge that cognition and behavior usually occur in a social context, requiring a *social perspective*.

The *behavioral perspective* tells us that abnormal behaviors can be acquired in the same fashion as healthy behaviors—through behavioral learning. This view focuses on our behavior and the environmental conditions, such as rewards, punishments, and social pressures, that maintain it. For example, the behavioral perspective would suggest that a fear of public speaking could result from a humiliating public speaking experience and a subsequent avoidance of any opportunity to develop public speaking skills.

The *cognitive perspective*, by contrast, suggests that we must also consider how people *perceive* or *think about* themselves and their relations with other people. Among the important cognitive variables are these: whether people believe they have control over events in their lives (an internal or external locus of control), how they cope with threat and stress, and whether they attribute behavior to situational or personal factors (Bandura, 1986).

The **social-cognitive-behavioral approach**, then, is a psychological alternative to the medical model, combining three of psychology's major perspectives. Typical of this approach is Albert Bandura's theory of *reciprocal determinism*, which proposes that behavior, cognition, and social/environmental factors all influence each other. From this viewpoint, a fear of public speaking can be understood as a product of behavioral learning, cognitive learning, and social learning.

The Biopsychology of Mental Disorder Although most psychologists have reservations about the medical model, they do not deny the influence of biology on thought and behavior. Modern biopsychology assumes that some mental disturbances involve the brain or nervous system in some way, and this view is taking an increasingly prominent position. An explosion of research in neuroscience during the past decade confirms the role of the brain as a complex organ whose mental functions depend on a delicate balance of chemicals and ever-changing circuits. Subtle alterations in the brain's tissue or in its chemical messengers—the neurotransmitters—can profoundly alter thoughts and behaviors. Genetic factors, brain injury, infection, and learning are a few factors that can tip the balance toward psychopathology.

On the heredity front, the Human Genome Project has specified the complete human genetic package. Many psychologists see this accomplishment as a ripe opportunity for specialists in behavioral genetics who are searching for genes associated with specific psychological disorders (Plomin, 2003). It won't be easy, however. So far, only a few genetic abnormalities have been linked with specific mental problems, despite the fact that some of the most severe pathologies, such as schizophrenia and bipolar disorder, do run in families. Most such disorders are likely to result from multiple genes interacting with forces in the environment (Boomsma et al., 1997). Watch the news for further developments.

Indicators of Abnormality

While clinicians sometimes disagree about the *etiology* (causes) of psychological disorders, they usually agree broadly on the indicators of abnormality (Rosenhan & Seligman, 1995). What are these indicators? Earlier we noted that hallucinations, delusions, and extreme affective changes are signs of severe mental disorder. But many psychological problems don't reveal themselves in



● Philippe Pinel was one of the first to humanely treat inmates with mental disorders. He is best known for removing the shackles from mental patients at La Bicêtre hospital in Paris in 1792. To almost everyone's amazement, the patients responded favorably.

■ **Social-cognitive-behavioral approach** A psychological alternative to the medical model that views psychological disorder through a combination of the social, cognitive, and behavioral perspectives.

such stark ways. Accordingly, clinicians also look for the following more subtle signs that may also indicate psychological disturbances, ranging from mild to severe (see Table 12.1):

- *Distress*: Does the individual show unusual or prolonged levels of unease or anxiety? For example, almost anyone will get nervous before an important test, but feeling so overwhelmed with unpleasant emotions that concentration becomes impossible for long periods is a sign of abnormality.
- *Maladaptiveness*: Does the person act in ways that make others fearful or interfere with his or her well-being? We can see this, for example, in someone who drinks so heavily that she or he cannot hold down a job or drive a car without endangering others.
- *Irrationality*: Does the person act or talk in ways that are irrational or incomprehensible to others? A woman who converses with her long-dead sister, whose voice she hears in her head, is behaving irrationally. Likewise, behavior or emotional responses that are inappropriate to the situation, such as laughing at the scene of a tragedy, show irrational loss of contact with one's social environment.
- *Unpredictability*: Does the individual behave erratically and inconsistently at different times or from one situation to another, as if experiencing a loss of control? For example, a child who suddenly smashes a fragile toy with his fist for no apparent reason is behaving unpredictably. Similarly, a manager who treats employees compassionately one day and abusively the next is acting unpredictably.
- *Unconventionality and undesirable behavior*: Does the person behave in ways that are statistically rare and violate social norms of what is legally or morally acceptable or desirable? Being merely "unusual" is not a sign of abnormality—so feel free to dye your hair red and green at Christmastime. But if you decide to act beyond the bounds of social acceptability by strolling naked in the mall, that would be considered abnormal.

Is the presence of just one indicator enough to demonstrate abnormality? It's a judgment call. Clinicians are more confident in labeling behavior as "abnormal" when two or more of the indicators are present. And the more extreme and prevalent the indicators are, the more confident psychologists can be about identifying an abnormal condition. Moreover, none of these criteria is a condition shared by all forms of disorder that we will describe later in this chapter. Different diagnoses, we shall see, include different combinations from the above list.

While these indicators may suggest a disorder, the clinician still must decide which disorder it is. This can be difficult, because psychopathology takes many forms. Some diagnoses may have a familiar ring: *depression*, *phobias*, and *panic disorder*. You may be less well acquainted with others, such as *conversion disorder* or *catatonic schizophrenia*. In all, a bewildering 300-plus specific varieties of psychopathology are described in the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition), known by clinicians and researchers as the *DSM-IV* ("DSM-four") and used by mental health professionals of all backgrounds to describe and diagnose psychopathology. So influential is this system that we will devote the entire middle section of this chapter to an explanation of it.



● Behaviors that make other people feel uncomfortable or threatened may be a sign of abnormality.



PSYCHOLOGY IN YOUR LIFE: A CAUTION TO READERS

As you read about the symptoms of psychological disorder, you are likely to wonder about your own mental health. All students studying abnormal psychology face this hazard. To see what we mean, you might answer the following questions, which are based on the indicators of abnormality discussed earlier.

1. Have you had periods of time when you felt “blue” for no apparent reason? (distress)
2. Have you ever gone to a party on a night when you knew you should be studying? (maladaptiveness)
3. Have you had an experience in which you thought you heard or saw something that wasn’t really there? (irrationality)
4. Have you had a flash of temper in which you said something that you later regretted? (unpredictability)
5. Have you had unusual thoughts that you told no one about? (unconventionality)
6. Have you made someone fearful or distressed because of something you said or did? (maladaptiveness)

The fact is that almost everyone will answer “yes” to at least one—and perhaps all—of these questions. This does not necessarily mean abnormality. Whether you, or anyone else, is normal or abnormal is a matter of degree and frequency—and clinical judgment.

So, as we take a close look at specific psychological disorders in the next section of the chapter, you will most likely find some symptoms that you have experienced. So will your classmates. Even though they may not say so, most other students will find themselves in one or more of the disorders that we will be studying. (A similar problem is common among medical students, who begin to notice that they, too, have symptoms of the physical diseases they learn about.) You should realize that *this is normal*. One reason, of course, why you may see yourself in this chapter arises from the fact that no sharp line separates psychopathology from normalcy. All psychological disorders involve exaggerations of normal tendencies. Moreover, people who are basically healthy may occasionally become depressed, for example—although they do not *stay* depressed or develop the depths of despair that clinically depressed people do. We are not suggesting that concerns about psychological disorder should be taken lightly, however. If, after reading this chapter, you suspect that you may have a problem, you should discuss it with a professional.



● Sadness or crying is not necessarily a sign of abnormality. Some occasions call for sadness and tears.

CHECK YOUR UNDERSTANDING

1. **RECALL:** In Rosenhan’s study, who discovered that the “pseudopatients” were feigning mental illness?
 - a. psychiatrists
 - b. psychologists
 - c. nurses and aides working on the ward
 - d. other patients
 - e. other physicians
2. **APPLICATION:** Which of the following symptoms most clearly suggests the presence of abnormality?
 - a. hallucinations
 - b. worries
 - c. unusual behavior
 - d. creativity
 - e. distraction

(continues)

3. **RECALL:** Hippocrates proposed that mental disorder was caused by
- possession by demons.
 - an imbalance in four body fluids.
 - a fungus growing on rye grain.
 - traumatic memories in the unconscious.
 - the taking of potions.
4. **RECALL:** The behavioral perspective emphasizes the influence of _____, while the cognitive perspective emphasizes _____.
- genetics/conscious processes
 - conscious processes/unconscious processes
 - heredity/environment
 - medical factors/psychological factors
 - the environment/mental processes
5. **UNDERSTANDING THE CORE CONCEPT:** Which of the following would be least likely to be noticed by a clinician using strictly the medical model of mental disorder?
- delusions
 - severe disturbances in affect
 - an unhealthy family environment
 - a degenerative brain disease
 - hallucinations.

ANSWERS: 1. d 2. a 3. b 4. e 5. c



HOW ARE PSYCHOLOGICAL DISORDERS CLASSIFIED?

Imagine that you have entered a music store looking for a particular CD. Anything you could possibly want is there, but the employees do not bother grouping albums by musical category: They just dump everything randomly into the bins. With so many selections, but no organization, shopping there would be impossible—which is why music stores never operate this way. Instead, they organize selections into categories, such as rock, blues, classical, rap, country, and jazz. In much the same way, the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) brings order to the more than 300 recognized mental disorders. Usually called simply the **DSM-IV**, this manual represents the most widely used system for classifying such disorders. We will use it as the scheme for organizing the disorders we have selected for discussion in this chapter.

What is the organizing pattern employed by the *DSM-IV*? It groups nearly all recognized forms of psychopathology into categories, according to mental and behavioral symptoms, such as anxiety, depression, sexual problems, and substance abuse. Our Core Concept states:



The **DSM-IV**, the most widely used system, classifies disorders by their mental and behavioral symptoms.

It would be impossible to cover all the recognized psychological disorders in this chapter. Therefore, we must focus on those that you are most likely to encounter in daily life and in the study of psychopathology in more advanced courses.

Overview of the **DSM-IV** Classification System

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, the **DSM-IV**, was published in 1994 by the American Psychiatric Association. Then, in 2000, that volume was given a midedition update, the **DSM-IV-TR** (TR means *Text Revision*). It offers practitioners a common and concise language for the description of psychopathology. It also contains criteria for diagnosing each of the disorders it covers. Even though the manual was developed primarily by psychiatrists, its terminology has been adopted by clinicians of all stripes, including psychiatrists, psychologists, and social workers. In addi-

■ **DSM-IV** The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association; the classification system most widely accepted psychiatric in the United States.

tion, most health insurance companies use *DSM-IV* standards in determining what treatments they will pay for—a fact that gives this manual enormous economic clout.

The *DSM-IV* also helps psychologists and psychiatrists look at the entire person as they make their evaluation. This process is known as *multiaxial diagnosis*. In multiaxial diagnosis, professionals consider not only the “abnormal” behavior but also general medical conditions (Axis 3, see Table 12.2), psychosocial and environmental problems (Axis 4), and global assessment of functioning (Axis 5). By looking beyond just the disorder, psychologists and psychiatrists can treat the whole person, and not just the individual’s symptoms.

The fourth edition of the *DSM* has brought with it some big changes. For example, it has banished the term *neurosis* from the official language of psychiatry (although you will frequently hear the term used in more casual conversation). Originally, a **neurosis** or *neurotic disorder* was conceived of as a relatively common pattern of subjective distress or self-defeating behavior that did not show signs of brain abnormalities or grossly irrational thinking. In short, a “neurotic” was someone who might be unhappy or dissatisfied but was not considered dangerously ill or out of touch with reality. In the *DSM-IV*, the term *neurosis* has been dropped or replaced by the term *disorder* (Carson et al., 1996; Holmes, 2001). So, for example, “obsessive-compulsive neurosis” is now simply *obsessive-compulsive disorder*.

In contrast, a **psychosis** was previously thought to differ from neurosis in both the quality and the severity of symptoms. A condition was frequently designated as *psychotic* if it involved profound disturbances in perception, rational thinking, or affect (emotion)—the three classic signs we discussed earlier. As a result, a clinician using previous editions of the *DSM* would have been more likely to diagnose severe depression, for example, as “psychotic.” In the *DSM-IV*, the term *psychotic* is restricted mainly to a loss of contact with reality, as is found in the *schizophrenic disorders*, which we shall discuss below (Carson et al., 1996; Holmes, 2001).

As you may have surmised from its origins in psychiatry, the *DSM-IV* has close ties to the medical model of mental illness. Its language is the language of medicine—symptoms, syndromes, diagnoses, and diseases—and its final form is a curious mixture of science and tradition. (Note: It contains no diagnosis of “normal.”) Yet, in contrast with early versions of the manual, which had a distinctly Freudian flavor, the *DSM-IV* manages, for the most part, to avoid endorsing theories of cause or treatment. It also differs from early versions of the *DSM* in giving extensive and specific descriptions of the symptoms of each disorder. So, while the *DSM-IV* has its critics, the need for a common language of psychological disorder has brought it wide acceptance.

Let us turn now to a sampling of disorders described in the *DSM-IV*. A look at the chart in the margin will give you an overview of the scheme the manual uses to classify these disorders. We begin with those that involve sustained extremes of emotion: the *mood disorders*.

Mood Disorders

Everyone, of course, experiences occasional strong or unpleasant emotional reactions. Emotionality is a normal part of our ability to interpret and adapt to our world. However, when moods careen out of control, soaring to extreme elation or plunging to deep depression, the diagnosis will probably be one of the **mood disorders**. The clinician will also suspect an affective disorder when



● Dutch artist Vincent Van Gogh showed signs of bipolar disorder. This problem seems to have a high incidence among very creative people.

TABLE 12.2

Multiaxial Diagnosis

Axis 1	Clinical disorders
Axis 2	Personality disorders Mental retardation
Axis 3	General medical conditions
Axis 4	Psychosocial and environmental problems
Axis 5	Global assessment of functioning

Mood Disorders: Extremes of Mood, from Mania to Depression

- Major depression
- Bipolar disorder

■ **Neurosis** Before the *DSM-IV*, this term was used as a label for subjective distress or self-defeating behavior that did not show signs of brain abnormalities or grossly irrational thinking.

■ **Psychosis** A disorder involving profound disturbances in perception, rational thinking, or affect.

■ **Mood disorders** Abnormal disturbances in emotion or mood, including bipolar disorder and unipolar disorder. Mood disorders are also called affective disorders.

■ **Major depression** A form of depression that does not alternate with mania.

an individual’s moods are consistently inappropriate to the situation. Here we will discuss the two best-known of these affective disturbances: *major depression* and *bipolar disorder*.

Major Depression If you fail an important examination, lose a job, or lose a love, it is normal to feel depressed for a while. If a close friend dies, it is also normal to feel depressed. But if you remain depressed for weeks or months, long after the depressing event has passed, then you may have the clinically significant condition called **major depression** or *major depressive disorder*, which is among the commonest of all major mental disturbances.

Novelist William Styron (1990) writes movingly about his own experience with severe depression. The pain he endured convinced him that clinical depression is much more than a bad mood: He characterized it as “a daily presence, blowing over me in cold gusts” and “a veritable howling tempest in the brain” that can begin with a “gray drizzle of horror.” Major depression does not give way to manic periods.

Incidence Psychologist Martin Seligman (1973, 1975) has called depression the “common cold” of psychological problems. Nearly everyone has, at some time, suffered either major depression or a milder form that clinicians call *dysthymia*. In the United States, depression accounts for the majority of all mental hospital admissions, but it is still believed to be underdiagnosed and undertreated (Kessler et al, 2003; Robins et al., 1991). The *Wall Street Journal* estimates that depression costs Americans about \$43 billion each year, including the costs of hospitalization, therapy, and lost productivity (Miller, 1993). But the human cost cannot be measured in dollars. Countless people in the throes of depression may feel worthless, lack appetite, withdraw from friends and family, have difficulty sleeping, lose their jobs, and become agitated or lethargic. In severe cases, they may also experience psychotic distortions of reality. You can give yourself a quick evaluation for signs of depression in the box “Do It Yourself! A Depression Check,” on the facing page.

Most worrisome of all, suicide claims one in 50 depression sufferers (Bostwick & Pankratz, 2000). Significantly, suicide is a greater risk when a depressed person is on the way down in a depressive episode—or is on the mend. That is, in the depths of depressive despair, there is usually no energy or will to do *anything*, much less carry out a plan for suicide.

Incidentally, we advise that a suicide threat always be taken seriously, even though you may think it is just a bid for attention—and even if you see no further signs of depression. Other factors may be at work. Abuse of alcohol or other drugs, for example, multiplies the likelihood of suicide, as do chronic physical diseases or brain abnormalities (Ezzell, 2003; Shneidman, 1987). You should direct any person who suggests he or she is thinking about suicide to a competent professional for help.

Cross-cultural studies indicate that depression is the single most prevalent form of disability around the globe (Holden, 2000a), although the incidence of major depression varies widely throughout the world, as Table 12.3 shows. While some of the variation may be the result of differences in reporting and in readiness or reluctance to seek help for depression, other factors seem to be at work, too. In Taiwan and Korea, for example, these factors include low rates of marital separation and divorce—factors known to be associated with high risk of depression in virtually all cultures. On the other hand, the stresses of war have undoubtedly inflated the rate of depression in the Middle East (Horgan, 1996; Weissman et al., 1996).

TABLE 12.3	Lifetime Risk of a Depressive Episode Lasting a Year or More
Taiwan	1.5%
Korea	2.9%
Puerto Rico	4.3%
United States	5.2%
Germany	9.2%
Canada	9.6%
New Zealand	11.6%
France	16.4%
Lebanon	19%

DO IT YOURSELF!

A Depression Check

Most people think that depression is marked by outward signs of sadness, such as weeping. But depression affects other aspects of thought and behavior as well. For a quick check on your own tendencies to depression, please answer “yes” or “no” to each of the following questions, all adapted from the signs of depression listed in the *DSM-IV*:

1. Do you feel deeply depressed, sad, or hopeless most of the day?
2. Do you feel you have lost interest in most or all activities?
3. Have you experienced any major change in appetite or body weight, though not from dieting?
4. Have you experienced a significant change in your sleeping patterns?

5. Do you feel more restless than usual—or more sluggish than usual?
6. Do you feel more fatigued than you ought to?
7. Do you feel persistently hopeless or inappropriately guilty?
8. Have you been finding it increasingly difficult to think or concentrate?
9. Do you have recurrent thoughts of death or suicide?

Your answers to these items do not constitute any proof that you are, or are not, depressed. While there is no “magic number” of items you must answer “yes” in order to qualify as depressed, if you answered “yes” to some of them and if you are concerned, you might want to seek a professional opinion. Remember that a diagnosis of depression is

a clinical judgment call, based on the signs listed in the *DSM-IV*. Essentially, it is the pattern and the quality of your life, your feelings, and your behavior that determine whether or not you are depressed. Remember also that self-report is always subject to some bias. If you are concerned after considering the signs of depression in your life, we recommend an examination by a competent mental health professional, who will take into account not only your self-descriptions but also your behavior, your social context, and the rewards and aversive circumstances in your life.

Causes of Depression Some cases of major depression almost certainly involve a genetic predisposition. Severe bouts with depression often run in families (Andreasen et al., 1987; Plomin et al., 1994; Weissman et al., 1986). Further indication of a biological basis for depression comes from the favorable response that many depressed patients have to drugs that affect the brain’s neurotransmitters norepinephrine, serotonin, and dopamine (Ezzell, 2004; Hirschfeld & Goodwin, 1988; Nemeroff, 1998). Evidence also indicates that depression is related to lower brain wave activity in the left frontal lobe (Davidson, 1992a, b, 2000; Robbins, 2000). In a few cases, depression may be caused by viral infection (Bower, 1995b). Such evidence leads some observers to believe that depression is really a collection of disorders having a variety of causes (Kendler & Gardner, 1998).

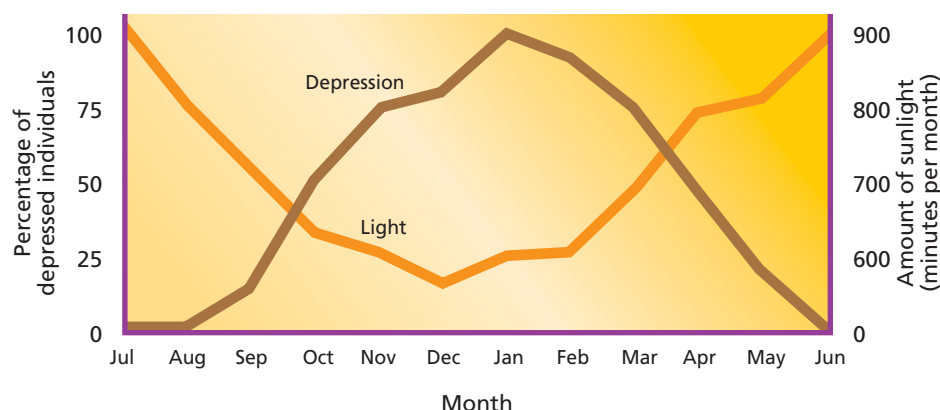
A special form of depression seems to be related to sunlight deprivation. It appears most frequently during the long, dark winter months among people who live in high latitudes (Wehr & Rosenthal, 1989). (See Figure 12.2.) This aptly named **seasonal affective disorder** (technically defined as seasonal pattern specifier), or **SAD**, is related to levels of the light-sensitive hormone melatonin, which regulates our internal biological clocks (Campbell & Murphy, 1998; Oren & Terman, 1998). Based on this knowledge, researchers have

■ Seasonal affective disorder

(SAD) Technically *Seasonal pattern specifier*, this *DSM-IV* course specifier for mood disorders is believed to be a form of depression caused by deprivation of sunlight. The term “Course Specifier” is used to describe how a disorder progresses.

CONNECTION CHAPTER 5

The “biological clock,” located in the hypothalamus, regulates our *circadian rhythms*.

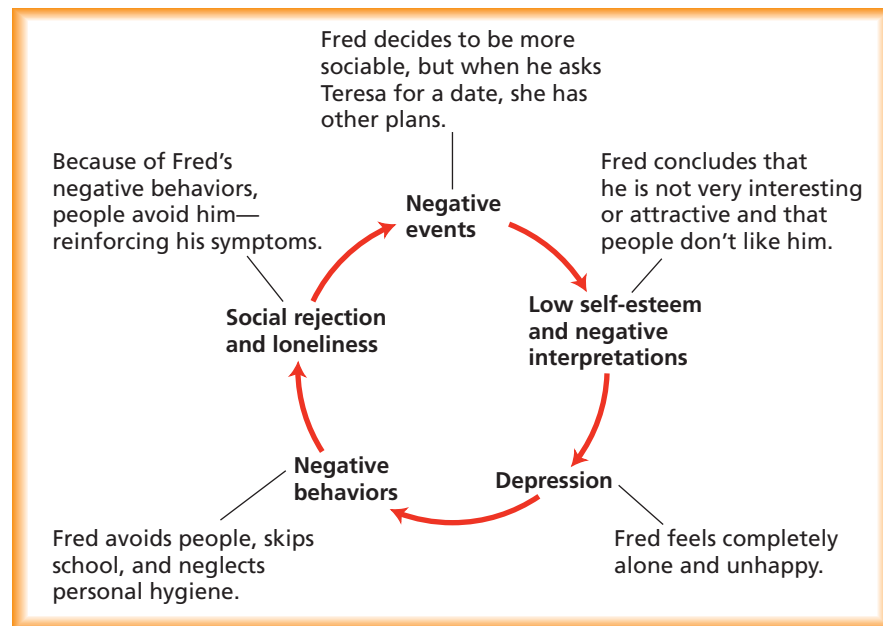


● **FIGURE 12.2** Seasonal Affective Disorder

People who suffer from seasonal affective disorder are most likely to experience symptoms of depression during months with shortened periods of sunlight. (Source: Adaptation of Fig. 1, p. 74 from “Seasonal Affective Disorder: A Description of the Syndrome and Preliminary Findings with Light Therapy” by N. E. Rosenthal et al., *Archives of General Psychiatry*, 41 (1984), pp. 72–80. American Medical Association.

● **FIGURE 12.3** The Cognitive–Behavioral Cycle of Depression

As you follow Fred around the cycle, note how his depression feeds on itself.



developed an effective therapy that regulates melatonin by exposing SAD sufferers daily to bright artificial light (Lewy et al., 1987).

Biology alone cannot entirely explain depression, however. We must also understand it as a mental, social, and behavioral condition. Initially, a negative event, such as losing a job, can make anyone feel depressed, but low self-esteem and a pessimistic attitude can fuel a cycle of depressive thought patterns (Abramson et al., 1989; Sweeney et al., 1986; Wood et al., 1990a, b). (See Figure 12.3.) Probably because of low self-esteem, depression-prone people are more likely to perpetuate the depression cycle by attributing negative events to their own personal flaws or external conditions that they feel helpless to change (Azar, 1994; Robins, 1988; Seligman, 1991; Seligman et al., 1979). Martin Seligman calls this *learned helplessness*. The resulting negative self-evaluation generates a depressed mode, which leads in turn to negative behaviors such as crying. These behaviors encourage others to avoid the depressed individual. Consequently, depressed people feel rejected and lonely, which also feeds the cycle of their despair (Coyne et al., 1991).

If you think this description of depression sounds a lot like the definition of stress that we gave in Chapter 8—you're right! One of the most promising approaches to research on this disorder sees depression as fundamentally a stress disorder (Holden, 2003b). Specifically, stress hormones adversely affect neurons, especially in the hippocampus—a part of the brain known to be a site of action for antidepressant drugs.

The cognitive approach to depression points out that negative thinking styles are learned and modifiable. This implies that if you work on changing the way you *think*, perhaps blaming yourself less and focusing more on constructive plans for doing better, you can ultimately change your feelings and your performance. Indeed, Peter Lewinsohn and his colleagues (Lewinsohn et al., 1980, 1990; Lewinsohn & Gottlib, 1995) have found that they can treat many cases of depression effectively with cognitive–behavioral techniques. Their approach intervenes at several points in the cycle of depression to teach people how to change their helpless thinking, to cope adaptively with unpleasant situations, and to build more rewards into their lives.

Who Becomes Depressed? Clinicians have noted that depression rates are higher for women than for men (Leutwyler, 1995; Strickland, 1992; Weissman et al., 1996). According to Susan Nolen-Hoeksema (1987, 1990, 2001), the difference may lie in the differing response styles of men and women who are experiencing negative moods. When women experience sadness, she says, they tend to think about the possible causes and implications of their feelings. In contrast, men attempt to distract themselves from depressed feelings, either by shifting their attention to something else or by engaging in a physical activity that will take their minds off their mood. This model suggests that the more *ruminative* response of women—characterized by a tendency to concentrate on problems—increases women’s vulnerability to depression (Shea, 1998).

The incidence of depression and the age at which it strikes are changing—at least in the United States. According to Martin Seligman, depression is between 10 and 20 times as common as it was 50 years ago (National Press Club, 1999). In the mid-1900s, most casualties of depression were middle-aged women, but now depression is more often a teenage problem—still more prevalent in females than in males (NIMH, 2000). Seligman, who has studied depression extensively, blames this increase in occurrence and decrease in age to three factors: (1) an out-of-control individualism and self-centeredness that focuses on individual success and failure, rather than group accomplishments; (2) the self-esteem movement, which has taught a generation of schoolchildren that they should feel good about themselves, irrespective of their efforts and achievements; and (3) a culture of *victimology*, which reflexively points the finger of blame at someone or something else.

Bipolar Disorder Another mood disorder also involves periods of depression—but, in addition, alternating periods of extreme elation. Formerly known as *manic-depressive disorder*, the condition is now listed in the *DSM-IV* as **bipolar disorder**. The alternating periods of *mania* (excessive elation or manic excitement) and the profound sadness of depression represent the two “poles.”

During the manic phase, the individual becomes euphoric, energetic, hyperactive, talkative, and emotionally wound tight like a spring. It is not unusual for people, swept up in mania, to spend their life savings on extravagant purchases or to engage promiscuously in a number of sexual liaisons or other potentially high-risk actions. When the mania diminishes, they are left to deal with the damage they have created during their frenetic period. Soon, in the depressive phase, a dark wave of melancholy sweeps over the mind, producing symptoms indistinguishable from the “unipolar” form of depression we discussed earlier. Biologically speaking, however, these two forms of depression differ: We know this because the antidepressant drugs that work well on major depression are not usually effective for bipolar disorder.

A genetic component in bipolar disorder is well established, although the exact genes involved have not been pinpointed (Bradbury, 2001; Plomin et al., 1994). While only 1% of the general population has bipolar attacks, having an identical twin afflicted with the problem inflates one’s chances to about 70% (Allen, 1976; Tsuang & Faraone, 1990). The fact that bipolar disorder usually responds well to medication also suggests biological factors at work.

Anxiety Disorders

Would you pick up a snake or let a tarantula rest on your shoulder? For some people the mere thought of snakes or spiders is enough to send chills of fear down their spines. Everyone, of course, has experienced anxiety or fear in threatening or dangerous situations. But pathological anxiety is far more severe than the normal anxiety associated with life’s challenges. It is also relatively

■ **Bipolar disorder** A mental abnormality involving swings of mood from mania to depression.

Anxiety Disorders: Fear, Anxiety, Panic Attacks

- Generalized anxiety disorder
- Panic disorder
- Agoraphobia
- Specific phobias
- Obsessive–compulsive disorder

common—even more common than major depression (Barlow, 2000). One estimate says that 15% of the general population has, at some time, experienced symptoms that are serious enough to qualify as one of the **anxiety disorders** recognized in the *DSM* (Regier et al., 1988).

Here we will review four major disorders that have anxiety as their main feature: (1) generalized anxiety disorder, (2) panic disorder, (3) phobic disorder, and (4) obsessive–compulsive disorder. You will note that the major differences among them have to do with the focus and duration of anxiety: Is anxiety present only occasionally or most of the time? Does the anxiety seem to come from nowhere—unrelated to the individual’s environment or behavior? Does it come from an external object or situation, such as the sight of blood or a snake? Does it involve the victim’s own ritualistic behavior, as in a person who compulsively avoids stepping on cracks in the sidewalk? (See the chart in the margin.)

Generalized Anxiety Disorder Some people spend months or years of their lives coping with anxiety. Charles, a heavy-equipment operator, says he has dizzy spells, headaches, cold sweats, and frequent feelings of anxiety. But he has no clue why he feels anxious. It’s free-floating anxiety, as clinicians sometimes call it, and they would diagnose his condition as **generalized anxiety disorder**. People with this disorder have a pervasive and persistent sense of anxiety. They are not just worried or fearful about specific situations or objects, such as heights or spiders. Nor does the anxiety come in waves, punctuated by periods of relative calm. Such patterns of anxiety signify different anxiety disorders, to which we turn next.

Panic Disorder While you are calmly eating lunch, an unexpected wave of panic sweeps over you, seemingly from nowhere. Your heart races, your body shakes, you feel dizzy, your hands become clammy and sweaty, you are afraid that you might be dying. You are having a *panic attack*.

The distinguishing feature of **panic disorder** is a strong feeling of anxiety that has no connection with present events (Barlow, 2001). As in generalized anxiety disorder, the feeling is one of “free-floating anxiety.” Attacks usually last for only a few minutes and then subside (McNally, 1994). Because of the unexpected nature of these “hit-and-run” attacks, *anticipatory anxiety* often develops as an added complication. The dread of the next attack and of being helpless and suddenly out of control can lead a person to avoid public places, and yet fear being left alone. Cognitive–behavioral theorists view panic attacks as conditioned responses to physical sensations that may have initially been learned during a period of stress (Antony et al., 1992).

Biologically, we have evidence of a genetic influence in panic disorder (Plomin et al., 1994). However, the brain mechanism responsible for this condition probably lies in the limbic system—especially in the amygdala, which appears abnormal on PET scans of many patients (Barlow, 2000, 2001; Resnick, 1992). Significantly, it is this part of the brain that houses the unconscious emotional-arousal pathway described by Joseph LeDoux (1996). Overstimulation of these circuits can produce lasting physical changes that make the individual more susceptible to anxiety attacks in the future (Rosen & Schulkin, 1998).

To complicate matters, many victims of panic disorder have additional symptoms of **agoraphobia**. This condition involves panic that develops when they find themselves in situations from which they cannot easily escape, such as crowded public places or open spaces (Antony et al., 1992; Magee et al., 1996). The term *agoraphobia* is a literal translation from the ancient Greek for “fear of the marketplace.” Victims of agoraphobia often fear that if they experience an attack in one of these locations, help might not be available or the

CONNECTION CHAPTER 8

The brain has two main *emotional pathways*; one operates mainly at an unconscious level.

■ **Anxiety disorders** Mental problems characterized mainly by anxiety. Anxiety disorders include panic disorder, specific phobias, and obsessive–compulsive disorder.

■ **Generalized anxiety disorder** A psychological problem characterized by persistent and pervasive feelings of anxiety, without any external cause.

■ **Panic disorder** A disturbance marked by panic attacks that have no obvious connection with events in the person’s present experience. Unlike generalized anxiety disorder, the victim is usually free of anxiety between panic attacks.

■ **Agoraphobia** A fear of public places and open spaces, commonly accompanying panic disorder.

situation will be embarrassing to them. These fears deprive afflicted persons of their freedom, and some become prisoners in their own homes. If the disorder becomes this extreme, they cannot hold a job or carry on normal daily activities.

You may know someone who has panic disorder or agoraphobia. These problems occur in about 2% of the population (McNally, 1994), and they are much more common in women than in men. Fortunately, the treatment outlook is good. Medical therapy involves antianxiety drugs to relieve the panic attacks. Purely psychological treatment is also effective: Studies have shown that cognitive-behavioral therapy may equal or outperform drug therapy in combating panic attacks (“Cognitive-Behavior Therapy,” 1991; Craske et al., 1991).

Phobic Disorders In contrast with panic disorder, **phobias** involve a persistent and irrational fear of a specific object, activity, or situation—a response all out of proportion to the circumstances. (These are sometimes called *specific phobias*, as contrasted with the broader fears found in agoraphobia.) Many of us respond fearfully to certain stimuli, such as spiders or snakes—or perhaps to multiple-choice tests! But these emotional responses become full-fledged phobic disorders only when they cause substantial disruption to our lives.

Phobias are relatively common. Studies suggest that 12.5% of Americans suffer from a phobic disorder at some point in their lives (Regier et al., 1988). Some specific phobias are quite rare, as in a fear of a certain type of insect. Others, such as fear of public speaking, are quite common—so common that they seem almost normal (Stein et al., 1996). (See Table 12.4.) Among the most common phobic disorders are *social phobias*, irrational fears of normal social situations (Magee et al., 1996). Phobic responses to heights (acrophobia), snakes (ophidiophobia), and closed-in spaces (claustrophobia) are also common.

What causes phobias? Long ago, John Watson and Rosalie Rayner demonstrated that fears can be learned. We also have abundant evidence that fears and phobias can be unlearned through cognitive-behavioral therapy based on conditioning. But learning may not tell the whole story. Martin Seligman (1971) has argued that humans are biologically predisposed to learn some kinds of fears more easily than others. This **preparedness hypothesis** suggests that we carry an innate biological tendency, acquired through natural selection, to respond quickly and automatically to stimuli that posed a survival threat to our ancestors (Öhman & Mineka, 2001). This explains why we develop phobias for snakes and lightning much more easily than we develop fears for automobiles and electrical outlets—objects that have posed a danger only in recent times.

Obsessive-Compulsive Disorder Seventeen-year-old Jim seemed to be a normal adolescent with many talents and interests. Then, almost overnight, he was transformed into a lonely outsider, excluded from social life by his psychological disabilities. Specifically, he developed an obsession with washing. Haunted by the notion that he was dirty—in spite of what his senses told him—Jim began to spend more and more time cleansing himself. At first his ritual ablutions were confined to weekends and evenings, but soon they consumed all his time, forcing him to drop out of school (Rapoport, 1989).

Jim had developed **obsessive-compulsive disorder**, or **OCD**, a condition characterized by patterns of persistent, unwanted thoughts and behaviors. Obsessive-compulsive disorder affects about 2.5% of Americans at some point during their lives (Regier et al., 1988). Nearly everyone has had some of its symptoms in a mild form.

The *obsession* component of OCD consists of thoughts, images, or impulses that recur or persist despite a person’s efforts to suppress them. For example, a person with an obsessive fear of germs may avoid using bathrooms outside



● A common form of social phobia involves an extreme fear of public speaking.

CONNECTION CHAPTER 6

Watson and Rayner’s infamous experiment with Little Albert showed that fears could be learned by *classical conditioning*.

■ **Phobias** A group of anxiety disorders involving a pathological fear of a specific object or situation.

■ **Preparedness hypothesis** The notion that we have an innate tendency, acquired through natural selection, to respond quickly and automatically to stimuli that posed a survival threat to our ancestors.

■ **Obsessive-compulsive disorder** A condition characterized by patterns of persistent, unwanted thoughts and behaviors.

TABLE 12.4		Phobias
DSM-IV Category	Object/Situation	Incidence
Agoraphobia	Crowds, open spaces	Common (3.5–7% of adults)
Social phobias	Fear of being observed or doing something humiliating	common (11–15%)
Specific phobias	Varies by category	(up to 16% of adults)
Animals	Cats (ailurophobia) Dogs (cynophobia) Insects (insectophobia) Spiders (arachnophobia) Birds (avisophobia) Horses (equinophobia) Snakes (ophidiophobia) Rodents (rodentophobia)	
Inanimate objects or situations	Closed spaces (claustrophobia) Dirt (mysophobia) Thunder (brontophobia) Lightning (astraphobia) Heights (acrophobia) Darkness (nyctophobia) Fire (pyrophobia)	
Bodily conditions	Illness or injury (nosophobia) Sight of blood (hematophobia) Cancer (cancerophobia) Venereal disease (venerophobia) Death (thanatophobia)	
Other specific phobias	Numbers (numerophobia) The number 13 (triskaidekaphobia) Strangers, foreigners (xenophobia) String (linonophobia) Books (bibliophobia) Work (ergophobia)	rare rare rare

Note: Hundreds of phobias have been described and given scientific names; this table provides only a sample. Some of the rare and strange-sounding phobias may have been observed only in a single patient.

his or her home or refuse to shake hands with strangers. And, because sufferers realize that their obsessive thoughts and compulsive rituals are senseless, they often go to great lengths to hide their compulsive behavior from other people. This, of course, places restrictions on their domestic, social, and work lives. Not surprisingly, OCD patients have extremely high divorce rates.

You probably have had some sort of mild obsessional experience, such as petty worries (“Did I remember to lock the door?”) or a haunting phrase or melody that kept running through your mind. Such thoughts are normal if they occur only occasionally and have not caused significant disruptions of your life. As we have noted in other disorders, it is a matter of degree.

Compulsions, the other half of obsessive–compulsive disorder, are repetitive, purposeful acts performed according to certain private “rules,” in response to an obsession. Victims feel that their compulsive behavior will reduce the tension associated with their obsessions. Typical compulsions include irresistible urges to clean, to check that lights or appliances have been turned off, and

to count objects or possessions. When they are calm, people with obsessive-compulsive disorder view the compulsion as senseless, but when their anxiety rises, they can't resist performing the compulsive behavior ritual to relieve tension. Part of the pain experienced by people with this problem is that they are frustrated by the irrationality of their obsessions and their powerlessness to eliminate them.

The tendency for OCD to run in families suggests a genetic link. Another hint comes from the finding that many people with OCD also display *tics*, unwanted involuntary movements, such as exaggerated eye blinks. In these patients, brain imaging often shows oddities in the deep motor control areas, suggesting something amiss in the brain (Resnick, 1992). OCD expert Judith Rapoport tells us to think of compulsions as "fixed software packages" programmed in the brain. Once activated, she theorizes, the patient gets caught in a behavioral "loop" that cannot be switched off (Rapoport, 1989).

Curiously, certain drugs that are commonly prescribed for depression can alleviate both the obsessions and the compulsive rituals (Poling et al., 1991). In further support of a biological basis for OCD, investigators have found that these drugs can reverse compulsive behavior in dogs that display a preoccupation with grooming themselves (Ross, 1992).

Again, however, we must note that biology cannot explain everything. Some victims of OCD have clearly *learned* that their anxiety-provoking thoughts are connected to harmful consequences (Barlow, 2000). Further evidence that learning plays a role can be seen in the results of behavioral therapy, which is effective in reducing compulsive actions. The behavioral strategy for treating compulsive hand-washing, for example, calls for a form of extinction, in which the therapist soils the patient's hands and prevents him or her from washing for progressively longer periods. Indeed, behavioral therapy can produce changes that show up in PET scans of OCD sufferers' brains (Schwartz et al., 1996). Thus, when we change behavior, we inevitably change the wiring of the obsessive-compulsive brain. This disorder shows us, once again, that biology and behavior are inseparable.



● Obsessive-compulsive disorder makes people engage in senseless, ritualistic behaviors, such as repetitive hand washing.

Somatoform Disorders

"Soma" means *body*. Thus, we use the term **somatoform disorders** for psychological problems appearing in the form of bodily symptoms or physical complaints, such as weakness or excessive worry about disease. The somatoform disorders are not especially common, occurring in about 2% of the population (Holmes, 2001). Yet despite their rarity, they have captured the popular imagination under their more common names: "hysteria" and "hypochondria." (See the chart in the margin.)

The *DSM-IV* recognizes several types of somatoform disorders, but we will cover only two: *conversion disorder* and *hypochondriasis*. And, while we're talking about somatoform disorders, please note their potential for confusion with *psychosomatic disorders*, in which mental conditions—especially stress—lead to actual physical disease. The *DSM-IV* places psychosomatic disorders under a separate heading, "Psychological Factors Affecting Medical Condition."

Conversion Disorder Paralysis, weakness, or loss of sensation—with no discernible physical cause—distinguishes **conversion disorder** (formerly called "hysteria"). Patients with this diagnosis may, for example, be blind, deaf,

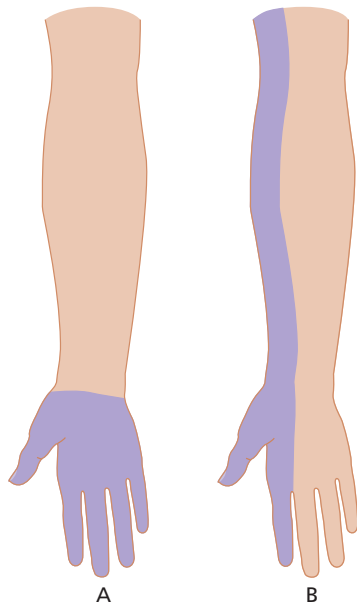
Somatoform Disorders: Physical Symptoms or Overconcern with One's Health

- Conversion disorder
- Hypochondriasis

■ **Somatoform disorders**

Psychological problems appearing in the form of bodily symptoms or physical complaints, such as weakness or excessive worry about disease. The somatoform disorders include conversion disorder and hypochondriasis.

■ **Conversion disorder** A type of somatoform disorder, marked by paralysis, weakness, or loss of sensation but with no discernible physical cause.



● **FIGURE 12.4** Glove Anesthesia

The form of conversion disorder known as “glove anesthesia” (A) involves a loss of sensation in the hand, as though the patient were wearing a thick glove. This cannot be a neurological disorder because the pattern of “anesthesia” does not correspond to the actual pattern of nerves in the hand, shown in (B).

■ **Hypochondriasis** A somatoform disorder involving excessive concern about health and disease; also called *hypochondria*.

■ **Dissociative disorders** A group of pathologies involving “fragmentation” of the personality, in which some parts of the personality have become detached, or dissociated, from other parts.

Dissociative Disorders: Non-psychotic Fragmentation of the Personality

- Dissociative amnesia
- Dissociative fugue
- Depersonalization disorder
- Dissociative identity disorder

unable to walk, or insensitive to touch in part of their bodies. Yet they have no organic disease that shows up on neurological examinations, laboratory tests, or X rays. In conversion disorder, the problem really is “all in the mind.”

“Glove anesthesia” represents a classic form of conversion disorder. As you can see in Figure 12.4, the pattern of insensitivity to touch or pain fits the patient “like a glove.” The tip-off that the problem is *psychogenic*, not physical, comes from the pattern of the patient’s symptoms: They do not match any possible pattern of nerve impairment. Other cases, however, are not always so clear-cut. Some physicians may rush too quickly to diagnose conversion disorder when they are confronted with baffling symptoms or especially difficult patients. Concluding that the problem is “all in their heads” conveniently tosses it into somebody else’s lap. Women, particularly, have charged that physicians dismiss their physical complaints as “just a hysterical reaction” and refer the patient to a psychiatrist.

We should point out that the term *conversion disorder* carries with it some baggage from our Freudian past. Originally, the term implied an unconscious displacement (or *conversion*) of anxiety into physical symptoms—although many clinicians no longer subscribe to that explanation. Some cases of conversion disorder are now thought to be physical stress responses.

Mysteriously, conversion disorder was much commoner a century ago in Europe and the United States. The problem has declined in industrialized countries, probably due to increased public understanding of physical and mental disorders (American Psychiatric Association, 1994; Nietzel et al., 1998). It is still relatively common in economically undeveloped regions, such as China (Spitzer et al., 1989) and Africa (Binitie, 1975) and among poorly educated persons in the United States (Barlow & Durand, 2005).

Hypochondriasis “Hypochondriacs” worry about getting sick. Every ache and pain signals a disease. Because of their exaggerated concern about illness, patients with **hypochondriasis** often bounce from physician to physician until they find one who will listen to their complaints and prescribe some sort of treatment—often minor tranquilizers or placebos. Naturally, these individuals represent easy marks for health fads and scams. They also find their way to the fringes of the medical community, where they may buy extensive treatment packages from disreputable practitioners.

The other side of the problem is a mistaken diagnosis of hypochondriasis (similar to the problem we found with conversion disorder). Clinicians may sometimes be too ready to conclude that the patient’s concerns are imaginary. This can have disastrous consequences, such as overlooking the symptoms of very real and very serious physical diseases, such as cancer or a chronic infection.

Dissociative Disorders

The common denominator for all the **dissociative disorders** is “fragmentation” of the personality—a sense that parts of the personality have detached (dissociated) from others. Among the dissociative disorders we find some of the most fascinating forms of mental pathology, including dissociative fugue, depersonalization disorder, and the controversial dissociative identity disorder (formerly called “multiple personality”), made famous by the fictional Dr. Jekyll and Mr. Hyde. Unfortunately, the underlying causes of dissociative disorders remain unclear. (See the chart in the margin.)

Dissociative Amnesia Sometimes memory loss is too extensive or too specific to be explained by normal forgetting. In some such cases we

call it *amnesia*. You may know an amnesia victim who has suffered a memory loss as the result of a severe blow to the head, perhaps in an auto accident. Sometimes, however, people may sustain a purely psychological form of amnesia, known as **dissociative amnesia**, as the result of a traumatic or highly stressful experience. In this disorder, the memory loss involves a specific event or series of events—usually a threatening experience in childhood.

You can see that dissociative amnesia is closely related to *posttraumatic stress disorder*, which we discussed in Chapter 8. In both cases, memory loss is related to a stressful incident or period in the person's life. We should also note, however, that dissociative amnesia can be a controversial diagnosis when it is associated with recovered memories of childhood abuse. As we discussed in Chapter 7, some psychologists have raised important questions about the accuracy of such recovered memories. And, as the *DSM-IV* states, dissociative amnesia may have “been overdiagnosed in individuals who are highly suggestible” (p. 479).

Dissociative Fugue Now consider the case of “Jane Doe,” a woman with *dissociative fugue*. She was found near death in a Florida park, where she was incoherent and suffering the effects of exposure. In contrast with victims of dissociative amnesia, discussed above, Jane Doe had a pervasive memory loss: no memory of her identity and no ability to read or write. Therapy revealed general information about the kind of past she must have had, but no good clues to her origins. After a nationwide television appeal, Jane Doe and her doctors were flooded with calls from possible relatives, the most promising of which was an Illinois couple, certain she was their daughter. They had not heard from her for over four years, since she had moved from Illinois to Florida. Despite their confidence that they had found her, she was never able to remember her past or what had happened to her (Carson et al., 1996).

Jane Doe had **dissociative fugue**, which is a combination of fugue, or “flight,” and *amnesia*. In such persons amnesia takes the form of a lost sense of identity. They also flee their homes, families, and jobs—which is why the disorder is termed *fugue*. Some victims appear disoriented and perplexed. Others may travel to distant locations and take up new lives, appearing unconcerned about the unremembered past. Usually the fugue state lasts only hours or days, followed by complete and rapid recovery. A few cases may continue for months—or, as with Jane Doe, for years.

Heavy alcohol use may predispose a person to dissociative fugue. This suggests that it may involve some brain impairment—although no certain cause has been established. Like dissociative amnesia, fugue occurs more often in those under prolonged high stress, especially in times of war and other calamities. Some psychologists also suspect that memory dissociation and repression accompany instances of sexual and physical childhood abuse (Spiegel & Cardena, 1991). As with dissociative amnesia, however, this conjecture is disputed.

Depersonalization Disorder Yet another form of dissociation involves a sensation that mind and body have separated. Patients with **depersonalization disorder** commonly report “out-of-body experiences” or feelings of being external observers of their own bodies. Some patients feel as if they are in a dream. (Fleeting, mild forms of this are common, so there is no cause for alarm!) A study of 30 such cases found that obsessive-compulsive disorder and certain personality disorders often accompany this condition (Simeon et al., 1997). The causes are unknown.

People undergoing severe physical trauma, such as a life-threatening injury in an auto accident, may also report symptoms of depersonalization. So do some patients who have had near-death experiences. Usually the sensation

CONNECTION CHAPTER 7

Compare with *anterograde amnesia* in the case of H. M.

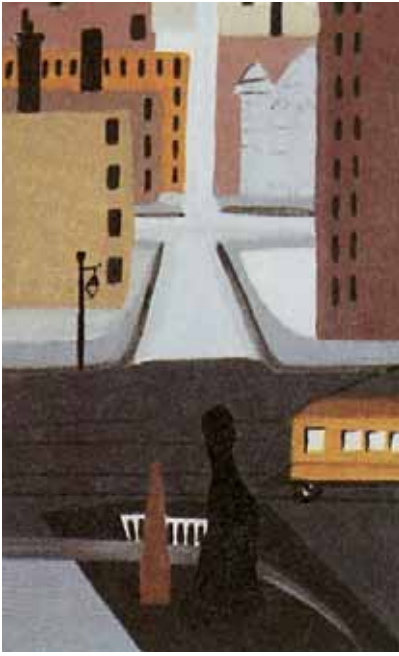
■ Dissociative amnesia

A psychologically induced loss of memory for personal information, such as one's identity or residence.

■ **Dissociative fugue** Essentially the same as dissociative amnesia, but with the addition of “flight” from one's home, family, and job. *Fugue* (pronounced *FEWG*) means “flight.”

■ Depersonalization disorder

An abnormality involving the sensation that mind and body have separated, as in an “out-of-body” experience.



● These two paintings by Sybil, a dissociative identity disorder (DID) victim, illustrate the differences among the personalities. The painting on the left was done by Peggy, Sybil's angry, fearful personality. The painting above was done by Mary, a home-loving personality.

passes quickly, although it can recur. In such individuals, investigators have attributed the disorder to hallucinations and to natural changes in the brain that occur during shock (Siegel, 1980).

Dissociative Identity Disorder Robert Louis Stevenson's famous story of Dr. Jekyll and Mr. Hyde has become a misleading stereotype of **dissociative identity disorder**. In reality, most such cases occur in women, and most display more than two identities (Ross et al., 1989). Unlike the homicidal Mr. Hyde, rarely do they pose a danger to others.

Although it was once thought to be rare, some specialists now believe that dissociative identity disorder has always been common but hidden or misdiagnosed. It usually first appears in childhood (Vincent & Pickering, 1988), and its victims frequently report having been sexually abused (Putnam et al., 1986; Ross et al., 1990). The formation of multiple identities or selves may be a form of defense by the dominant self to protect itself from terrifying events.

Dissociative identity disorder (DID) has now become a familiar diagnosis because of its portrayal in books such as *Sybil* (Schreiber, 1973) and *The Flock* (Casey & Wilson, 1991) and in films such as the 1996 production *Primal Fear*. Each emerging personality contrasts in some significant way with the original self. For example, the new personality might be outgoing if the original personality is shy, tough if the original is weak, and sexually assertive if the other is fearful and sexually naive. These alternate personalities, each with its own consciousness, emerge suddenly—usually under stress.

What lies behind this mysterious disturbance? Psychodynamic theories explain it as a fracturing of the ego, as a result of ego defense mechanisms that do not allow energy from conflicts and traumas to escape from the unconscious mind. Cognitive theories see it as a form of role-playing or mood-state dependency, a form of memory bias in which events experienced in a given mood are more easily recalled when the individual is again in that mood state (Eich et al., 1997). Others suggest that at least some cases are frauds (as in the case of a student, charged with plagiarizing a term paper, who claimed that he had multiple personalities and that one of them copied the paper without the knowledge of his dominant personality). Some observers have even sug-

■ Dissociative identity disorder

A condition in which an individual displays multiple identities, or personalities; formerly called "multiple personality disorder."

gested that the disorder exists only in the minds of a few therapists (Piper, 1998). In this view, patients may initially be led by the suggestive questioning of their therapists, who seek to uncover what they suspect are repressed memories of trauma and molestation (Loftus, 1993; Loftus & Ketcham, 1994; Ofshe & Watters, 1994).

In an unfortunate choice of terms, dissociative identity disorder is sometimes called “split personality.” This causes confusion because schizophrenia (which literally means “split mind”) has no relationship to dissociative identity disorder. In schizophrenia, the “split” refers to a psychotic split from reality, not to a fracturing of one personality into many personalities. Dissociative identity disorder, on the other hand, is *not* a psychotic disorder. We suggest that the reader avoid confusion by entirely avoiding the term “split personality.”

Eating Disorders

Like a drug addiction, Carla’s eating disorder is so powerful that she cannot resume healthy eating patterns without great difficulty. She (it is usually a she) has always felt overweight, and recently she has put herself on a severe diet—a starvation diet. Little does Carla realize that she has become the victim of an eating disorder that will ultimately alter her body in undesirable, and even lethal, ways. After some months, she may become dangerously underweight. Food has become repugnant. She feels “full” after eating only a bite or two. The original motivation may have been the same with Carla’s friend Jennifer, but Jennifer has resorted to another extreme method of weight control: She often overeats, but she makes herself vomit after a meal. Eventually, her teeth and the tissues in her mouth and esophagus come under attack by the action of refluxed stomach acid. And she, like Carla, may become dangerously malnourished.

Significantly, such eating disorders are most prevalent in Western cultures in which hunger is not widespread. They are especially likely to develop among middle- and upper-middle-class young women. Here we examine the two best-known eating disorders, exemplified above: *anorexia nervosa* and *bulimia nervosa*. (See the chart in the margin at the bottom of the page.)

Anorexia Nervosa The condition called *anorexia* (persistent lack of appetite) may develop as a consequence of certain physical diseases or conditions, such as shock, nausea, or allergic reactions. However, when loss of appetite that endangers an individual’s health stems from emotional or psychological causes, the syndrome is called **anorexia nervosa** (“nervous anorexia”). A person suffering from anorexia nervosa may act as though she is unconcerned with her condition, although she is emaciated. Commonly, anorexia nervosa is associated with extreme dieting, as in Carla’s case. (Most dieters, by contrast, have an increased desire for food.)

What causes anorexia nervosa? A strong hint comes from the finding that most anorectic persons are young white females from middle-class American homes. They typically have backgrounds of good behavior and academic success, but they starve themselves, hoping to become acceptably thin and attractive (Grice et al., 2002; Kaye et al, 2004; Keel & Klump, 2003). While cultural ideals of feminine beauty change over time, in recent decades the mass media—including fashion magazines and MTV—have promoted extremely slim models and celebrities (Andersen & DiDomenico, 1992; Rolls et al., 1991). Especially during adolescence, when people tend to evaluate themselves in terms of physical attractiveness, they judge themselves harshly for failing to live up to cultural ideals (Conger & Petersen, 1984). A victim of anorexia typically



● Billboards, magazines, TV, the fashion world, and the movies promote images of body shapes that are unrealistic for most people—yet people often judge themselves against these standards.

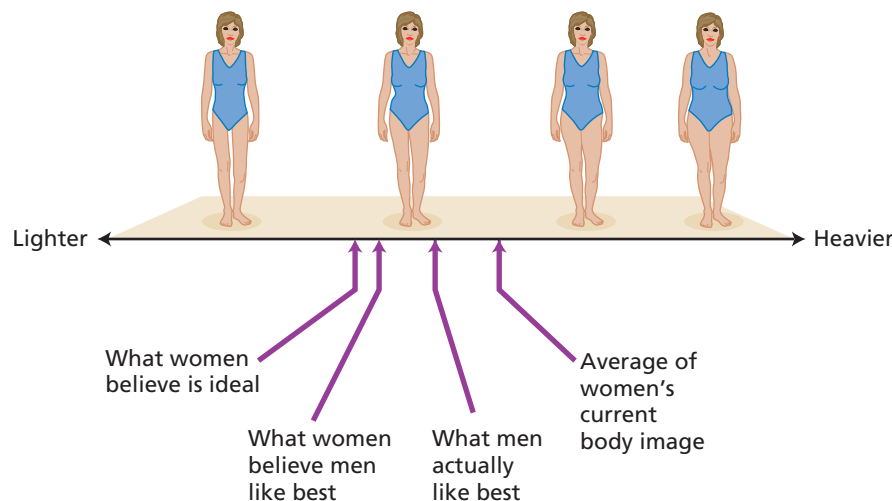
■ **Anorexia nervosa** An eating disorder that involves persistent loss of appetite that endangers an individual’s health and stems from emotional or psychological reasons rather than from organic causes.

Eating Disorders

- Anorexia nervosa
- Bulimia nervosa

● FIGURE 12.5 Women's Body Images

April Fallon and Paul Rozin (1985) asked female college students to give their current weight, their ideal weight, and the weight they believed men would consider ideal. The results showed that the average woman felt that her current weight was significantly higher than her ideal weight—and higher than the weight she thought men would like. To make matters worse, women also see their bodies as looking larger than they actually are (Thompson, 1986). When men were asked to rate themselves on a similar questionnaire, Fallon and Rozin found no such discrepancies between ideal and actual weights. But when asked what they saw as the ideal weight for women, they chose a higher weight than women did. No wonder women go on diets more often than men and are more likely to have a major eating disorder (Mintz & Betz, 1986; Striegel-Moore et al., 1993).



CONNECTION CHAPTER 8

Genetic factors may also be at work in anorexia nervosa and bulimia nervosa.

embraces a distorted body image, believing herself to be unattractively fat, and rejects others' reassurances that she is not overweight (Bruch, 1978; Fallon & Rozin, 1985). In an effort to lose imagined "excess" weight, the anorectic victim rigidly suppresses her appetite, feeling rewarded for such self-control when she does lose pounds and inches—but never feeling quite thin enough. (See Figure 12.5.)

Bulimia In the "binge-and-purge" syndrome known as **bulimia nervosa**, the sufferer overeats (binges) and then attempts to lose weight (purges) by means of self-induced vomiting, laxative use, or fasting (Rand & Kulda, 1992). Those who suffer from bulimia usually keep their disorder inconspicuous and may even be supported in their behavior patterns by peers and by competitive norms in their academic, social, and athletic lives (Polivy & Herman, 1993; Rodin et al., 1985; Squire, 1983; Striegel-Moore et al., 1993).

Eating disorders are commonly associated with other forms of psychopathology. For example, bulimia nervosa is a predictor of depression (Walters et al., 1992). It has been observed that anorectic and bulimic individuals apparently take little joy in their thinner profiles, even though their original rationale might have been to lose weight. Further, while hungry normal people look forward to eating and enjoying a good meal, eating-disordered individuals do not associate pleasure with food and may even dread having to eat. Corroborating this observation, bulimic patients in one study took longer to begin eating a scheduled meal, ate more slowly, and reported significantly more negative moods during eating than did control subjects (Hetherington et al., 1993).

Cognitive explanations for eating disorders analyze how the individual sees herself and thinks about food, eating, and weight. Accordingly, many successful treatments of eating disorders employ strategies that alter self-perception and boost feelings of self-efficacy (Baell & Wertheim, 1992).

Schizophrenia

Literally, the word *schizophrenia* means "split or broken mind"—and the "split" is from reality. In psychological terms, **schizophrenia** is a severe form of psychopathology in which personality seems to disintegrate and perception is distorted. Schizophrenia is the disorder that people have in mind when they use the terms "madness," "psychosis," or "insanity."

For the victim of schizophrenia, the mind can be twisted in terrible ways. The world may become bleak and devoid of meaning, or it may become so

■ **Bulimia nervosa** An eating disorder characterized by eating binges followed by "purges" induced by vomiting or laxatives; typically initiated as a weight-control measure.

■ **Schizophrenia** (pronounced *skits-o-FRENNY-a*) A psychotic disorder involving distortions in thoughts, perceptions, and/or emotions.

filled with sensation that everything appears in a confusion of multiple realities layered with hallucinations and delusions. In schizophrenia, emotions often become blunted, thoughts turn bizarre, and language takes strange twists. Memory may also become fragmented (Danion et al., 1999). The disorder breaks the unity of the mind, sending its victims on meaningless mental detours, sometimes riding trains of “clang” associations (associations involving similar-sounding words), and producing confused verbalizations that clinicians call “word salads.” (See the chart in the margin.) Here is an example of schizophrenic speech:

The lion will have to change from dogs into cats until I can meet my father and mother and we dispart some rats. I live on the front of Whitton’s head. You have to work hard if you don’t get into bed . . . It’s all over for a squab true tray and there ain’t no squabs, there ain’t no men, there ain’t no music, there ain’t no nothing besides my mother and my father who stand alone upon the Island of Capri where is no ice. Well it’s my suitcase sir. (Rogers, 1982)

In a lifetime, more than one of every 100 Americans—more than 2 million over the age of 18—will become afflicted (Holmes, 2001; McGuire, 2000; NIMH, 2003; Regier et al., 1993). For as yet unknown reasons, the first appearance of schizophrenia typically occurs for men before they are 25 and for women between 25 and 45 years of age.

For years, schizophrenia has consistently been the primary diagnosis for about 40% of all patient admissions to public mental hospitals—far out of proportion to all other categories of mental illness (Manderscheid et al., 1985). Because schizophrenic patients require prolonged or recurrent treatment, they can be expected to occupy about half of all mental hospital beds in the nation (American Psychiatric Association, 2000; Carson et al., 2000). Most sobering, about one-third of all schizophrenic patients will never fully recover, even with the best therapy available.

Major Types of Schizophrenia Many investigators consider schizophrenia a constellation of separate disorders. Here are the five most common:

- *Disorganized type* represents everyone’s image of mental illness, featuring incoherent speech, hallucinations, delusions, and bizarre behavior. A patient who talks to imaginary people most likely has this diagnosis.
- *Catatonic type*, involving a spectrum of motor dysfunctions, appears in two forms. Persons with the more common *catatonic stupor* may remain motionless for hours—even days—sometimes holding rigid, statuelike postures. In the other form, called *catatonic excitement*, patients become agitated and hyperactive.
- *Paranoid type* features delusions and hallucinations but no catatonic symptoms and none of the incoherence of disorganized schizophrenia. The paranoid delusions of persecution or of grandiosity (highly exaggerated self-importance) found in this type of schizophrenia are less well organized—more illogical—than those of the patient with a purely delusional disorder.
- *Undifferentiated type* serves as a catchall category for schizophrenic symptoms that do not clearly meet the requirements for any of the other categories above.
- *Residual type* is the diagnosis for individuals who have suffered from a schizophrenic episode in the past but currently have no major symptoms such as

Schizophrenia: Psychotic Deterioration of the Personality, Including Disturbances in Affect, Thinking, and Socialization

- Disorganized type
- Catatonic type
- Paranoid type
- Undifferentiated type
- Residual type

hallucinations or delusional thinking. Instead, their thinking is mildly disturbed, or their emotional lives are impoverished. The diagnosis of residual type may indicate that the disease is entering remission, or becoming dormant. (This diagnosis was assumed in most of Rosenhan's pseudopatients, whom we met at the beginning of the chapter.)

Our understanding of schizophrenia suffers from the fact that most schizophrenic patients display such a hodgepodge of symptoms that they drop into the "undifferentiated" category. Trying to make more sense of the problem, many investigators now merely divide the symptoms of schizophrenia into *positive* and *negative* categories (Javitt & Coyle, 2004; Sawa & Snyder, 2002). Positive symptoms refer to active processes, such as delusions and hallucinations, while negative symptoms refer to passive processes and deficiencies, such as social withdrawal and poverty of thinking. Patient responses to drug therapy support this division: Those with positive schizophrenia usually respond to antipsychotic drugs, while those with negative schizophrenia do not (Andreasen et al., 1995; Heinrichs, 1993). But even this distinction has its problems. Negative schizophrenia often looks like major depression. In addition, both positive and negative symptoms may occur in a single patient. All these difficulties have led some researchers to conclude that schizophrenia is a name for many separate disturbances.

CONNECTION CHAPTER 13

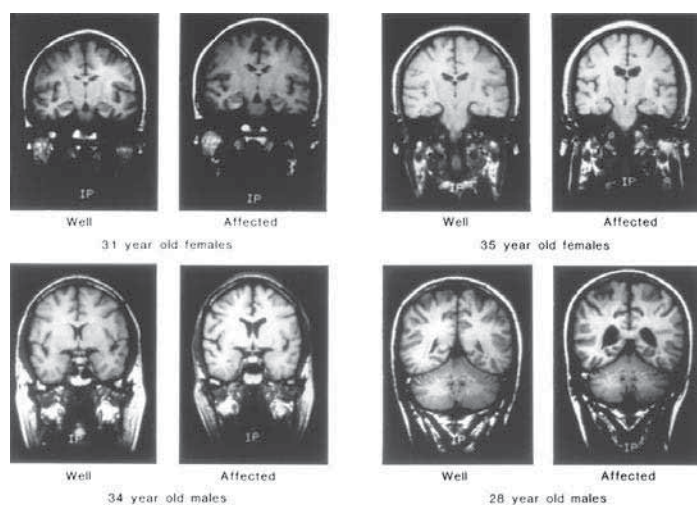
Antipsychotic drugs work by reducing the activity of the neurotransmitter dopamine in the brain.

Possible Causes of Schizophrenia No longer do most theorists look through the Freudian lens to see schizophrenia as the result of defective parenting or repressed childhood trauma (Johnson, 1989). Studies show that adopted children with *no* family history of the disorder run no increased risk of developing schizophrenia when placed in a home with a schizophrenic parent (Gottesman, 1991). Thus, an emerging consensus among psychiatrists and psychologists views schizophrenia as fundamentally a brain disorder—or a group of disorders (Sawa & Snyder, 2002).

Support for this brain disorder view comes from many quarters. As we have noted, the antipsychotic drugs (sometimes called *major tranquilizers*)—which interfere with the brain's dopamine receptors—can suppress the symptoms of positive schizophrenia (Carlsson, 1978; Snyder, 1986). On the other hand, drugs

that stimulate dopamine production (e.g., the amphetamines) can actually produce schizophrenic symptoms (Dracheva et al., 2001; Lewis et al., 2001; Smith et al., 2001). Recently, attention has turned to deficiencies in the neurotransmitter glutamate (Javitt & Coyle, 2004). Other evidence of a biological basis for schizophrenia comes in the form of brain abnormalities shown by computerized imaging techniques (Mesulam, 1990; Raz & Raz, 1990; Resnick, 1992; Suddath et al., 1990). (See Figure 12.6.)

Yet another line of evidence for the biological basis of schizophrenia comes from family studies (Holden, 2003a; Lencer et al., 2000; Plomin et al., 1994). As we found with the mood disorders, the closer one's relationship to a person with schizophrenia, the greater one's chances of developing it (Gottesman, 1991, 2001; Heston, 1970; Nicol & Gottesman, 1983). This conclusion comes from impressive studies of identical twins reared apart and from adoption studies of children having schizophrenic blood relatives. While only about



● **FIGURE 12.6** MRI Scans of a Twin with Schizophrenia and a Twin without Schizophrenia

The normal twin is on the left. Note the enlarged ventricles (fluid-filled spaces) in the brain of the schizophrenic twin on the right.

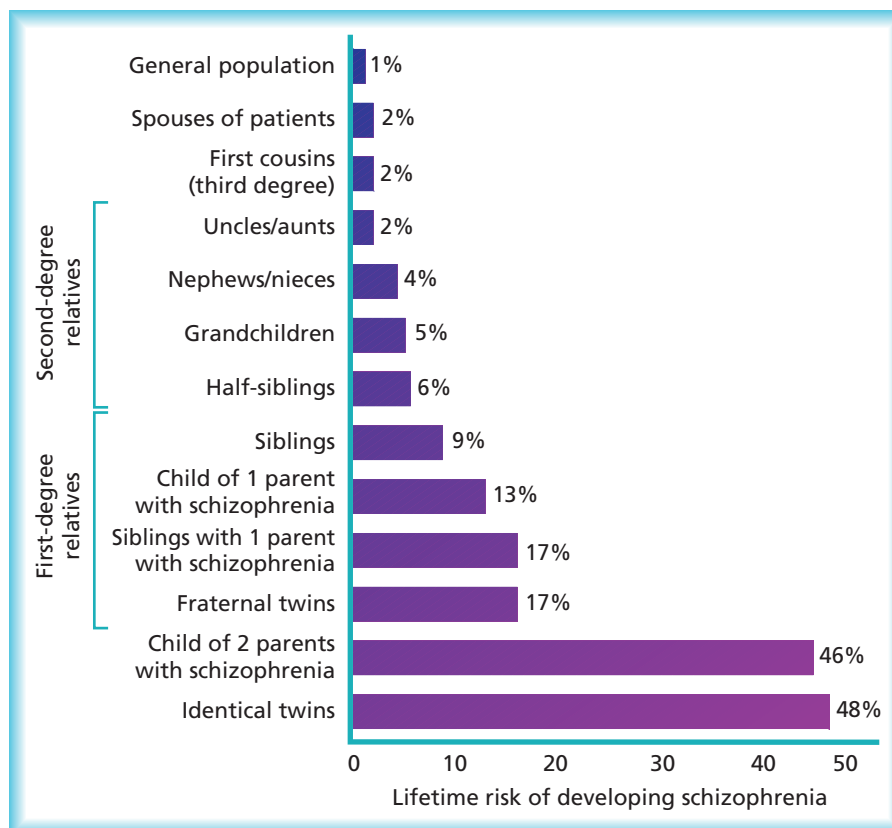
1% of us in the general population become schizophrenic, the child of a schizophrenic parent incurs a risk about 14 times higher. The worst case would be to have an identical twin who has developed the condition. In that event, the other twin's chances of becoming schizophrenic jump to nearly 50%.

As with the mood disorders, biology does not tell the whole story of schizophrenia. We can see the effect of the environment, for example, in the fact that 90% of the relatives of schizophrenic patients do not have schizophrenia (Barnes, 1987). Even in identical twins who share *exactly* the same genes, the *concordance rate* (the rate at which the disorder is shared by both) for schizophrenia is only about 50%. That is, in half the cases in which schizophrenia strikes identical twins, it leaves one twin untouched. A hopeful Finnish study found that being raised in a healthy family environment can actually lower the risk of schizophrenia in adopted children who have a genetic predisposition to the disease (Tienari et al., 1987). Apparently, schizophrenia requires a biological predisposition plus some unknown environmental agent to "turn on" the hereditary tendency (Cromwell, 1993; Iacono & Grove, 1993). This agent could be a chemical toxin, stress, or some factor we have not yet dreamed of. Taken as a whole, this research suggests that genetic factors may not themselves be sufficient for the disorder to develop (Nicol & Gottesman, 1983). (See Figure 12.7.) Despite all the biological evidence, we must remember that psychological disorder is always an interaction of biological, cognitive, and environmental factors, as our first Core Concept of the chapter suggested.

This broader perspective is often called the **diathesis–stress hypothesis**. It says that biological factors may place the individual at risk for schizophrenia (as well as many other disorders), but environmental stressors transform this potential into an actual disorder (Walker & Diforio, 1997). (The word *diathesis* refers to a predisposition or physical condition that makes one susceptible to

■ Diathesis–stress hypothesis

In reference to schizophrenia, the proposal that says that genetic factors place the individual at risk while environmental stress factors transform this potential into an actual schizophrenic disorder.



● **FIGURE 12.7** Genetic Risk of Developing Schizophrenia

The graph shows average risks for developing schizophrenia in persons with a schizophrenic relative. Data were compiled from family and twin studies conducted in European populations between 1920 and 1987; the degree of risk correlates highly with the degree of genetic relatedness. (Source: Fig. 10, p. 96, "Genetic Risk of Developing Schizophrenia," from *SCHIZOPHRENIA GENESIS: The Origins of Madness* by Irving Gottesman. Copyright © 1991. Reprinted by permission of W. H. Freeman and Company/Worth Publishers.)

disease.) Thus schizophrenia can be seen as a stress response by one who is predisposed to the disorder. In this view, then, susceptible individuals may never develop schizophrenia if they are spared certain damaging conditions or stressors that might push them “over the edge.”

Personality Disorders: Chronic Patterns of Maladjustment That May Extend through the Whole Personality

- Narcissistic personality disorder
- Antisocial personality disorder
- Borderline personality disorder

Personality Disorders

The **personality disorders** show themselves in a chronic history of poor judgment, disordered thinking, emotional disturbances, disrupted social relationships, or lack of impulse control. The key is that the condition derives from a personality pattern of long standing. These patterns can seriously impair an individual's ability to function in social or work settings.

Ten types of personality disorder are recognized in the *DSM-IV* (see the chart in the margin). Here we will consider three of the better known: *narcissistic personality disorder*, *antisocial personality disorder*, and *borderline personality disorder*.

People with a **narcissistic personality disorder** have an exaggerated sense of self-importance, a need for constant attention or admiration, and often a preoccupation with fantasies of success or power. These people often respond inappropriately to criticism or minor defeat, either by acting indifferent or by overreacting. They have problems in interpersonal relationships, feel entitled to favors without obligations, exploit others selfishly, and have difficulty understanding how others feel. For example, an individual with narcissistic personality disorder might express annoyance—but not empathy—when a friend has to cancel a date because of a death in the family.

Another personality disorder, **antisocial personality disorder**, is marked by a long-standing pattern of irresponsible or harmful behavior that indicates a lack of conscience and a diminished sense of responsibility to others. Chronic lying, stealing, and fighting are common signs. People with antisocial personality disorder may not experience anxiety, shame, or any other sort of intense emotion. They can “keep cool” in situations that would arouse and upset normal people. Violations of social

norms begin early in their lives—disrupting class, getting into fights, and running away from home. Individuals who show a criminal pattern of antisocial personality disorder, such as committing murders and other serious crimes, are popularly referred to as “psychopaths” or “sociopaths.”

Although carriers of the antisocial type of personality disorder can be found among street criminals and con artists, they are also well represented among successful politicians and businesspeople who put career, money, and power above everything and everyone. Two to three percent of the population in the United States may have antisocial personality disorder. Men are four times more likely to be so diagnosed than women (Regier et al., 1988, 1993).

The main signs of **borderline personality disorder** are instability and impulsivity (Carson et al., 2000; Holmes, 2001). People with this diagnosis have unpredictable moods and stormy interpersonal relationships, often becoming upset and abusive in response to perceived slights. They also have little tolerance for frustration. Their impulsivity may be seen in a tendency for substance abuse, gambling, sexual promiscuity, binge eating, reckless driving, self-mutilation, or suicide attempts. As with the other personality disorders, the treatment outlook for borderline personality disorder is guarded. (See Table 12.5.)



● The films *Silence of the Lambs* and *Hannibal* portray an extreme antisocial personality in the character of Hannibal Lecter.

■ **Personality disorders** Conditions involving a chronic, pervasive, inflexible, and maladaptive pattern of thinking, emotion, social relationships, or impulse control.

■ **Narcissistic personality disorder** Characterized by a grandiose sense of self-importance, a preoccupation with fantasies of success or power, and a need for constant attention or admiration.

■ **Antisocial personality disorder** Characterized by a long-standing pattern of irresponsible behavior indicating a lack of conscience and a diminished sense of responsibility to others.

■ **Borderline personality disorder** An unstable personality given to impulsive behavior.

TABLE 12.5

Types of Personality Disorders

Type clusters*	Dominant feature
Odd or eccentric	
Paranoid personality disorder	Unwarranted suspicion and mistrust of people
Schizoid personality disorder	Lack of interest in people or social relationships
Schizotypal personality disorder	Symptoms of schizophrenia, but not severe enough to be considered psychotic
Erratic or Emotional	
Borderline personality disorder	Instability and impulsivity
Histrionic personality disorder	Need for attention; shallow social relationships
Narcissistic personality disorder	Preoccupation with self; exaggerated sense of self-importance
Antisocial personality disorder	Antisocial behavior, without anxiety or guilt
Anxious or Fearful	
Avoidant personality disorder	Hypersensitivity to social rejection
Dependent personality disorder	Excessive reliance on others; reluctance to make independent decisions
Obsessive–compulsive personality disorder	Rigid need for perfection, order, and control; preoccupation with details

*Based on categories in the *DSM-IV*, with cluster names suggested by Holmes (2001).

Developmental Disorders

Developmental problems can appear at any age, but several common ones are first seen in childhood, including *autism*, *attention-deficit hyperactivity disorder (ADHD)*, and *dyslexia*. Here we will give you a brief description of these disorders, because you have already encountered them in earlier chapters. (See the chart in the margin.)

Autism A complex and poorly understood disorder, **autism** involves an impoverished ability to “read” other people, use language, and interact socially. To illustrate, imagine the following situation: Sally and Anne are playing together, when Sally puts a piece of candy in a box and then leaves the room. While Sally is gone, Anne opens the box, removes the candy, and stashes it in her purse. When Sally comes back, where will she look for the candy? Normal children will say that Sally will look in the box. Autistic children are most likely to say (if they communicate at all) that Sally will look in the purse. Thus, the autistic child lacks a *theory of mind* (Frith, 1993). Severely autistic children cannot imagine themselves in Sally’s place, believing something they know is not the case. As a result of this deficit, the autistic child has difficulty in social relationships, usually existing in a world of extreme social isolation.

Besides the theory-of-mind deficiencies and social isolation, most autistic persons also have language difficulties. In fact, many never achieve functional language at all. Perhaps because of all these difficulties, many are classified as mentally retarded (although most mentally retarded persons are *not* autistic). In severe cases, such children may engage in destructive self-stimulation, such as head-banging. Often they will also display repetitive behavior, such as rocking, for extended periods.

Developmental Disorders: Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

- Autism
- Dyslexia
- Attention-Deficit Hyperactivity Disorder (ADHD)

CONNECTION CHAPTER 1

Facilitated communication was a discredited attempt to communicate with autistic individuals.

■ **Autism** A developmental disorder marked by disabilities in language, social interaction, and the ability to understand another person’s state of mind.

Autism occurs in about 1 in 500 children and often is first suspected at about 1½ to 2 years of age, when the child fails to develop language (Kabot, Masi, & Segal, 2003). Most experts believe that autism is fundamentally a brain disorder, with a genetic basis. At present there is no cure, although there are treatment programs that can improve socialization and speech—but they are intensive and relatively expensive.

Dyslexia Reading is a key that opens many doors in a modern, information-driven society. But those doors can remain closed for people who have difficulty in reading—people with **dyslexia**. The disorder affects about 1 of 5 children to some degree, often leading to poor school performance. And, because school is so important in our society, it often leads to diminished self-esteem and eventually to lost career opportunities (Shaywitz, 1996).

Contrary to popular presumption, dyslexia is not a visual disorder. It doesn't cause letters and words to "jump around" or reverse themselves. Research over the last 15 years suggests, instead, that the disorder involves the abnormalities in the brain's language-processing circuits (Breier et al., 2003). Ironically, another "cause" may be language itself: Speakers of English—with its bizarre spelling menagerie, containing some 1120 ways to spell only 40 different sounds—are much more likely to be dyslexic than are Italian speakers, who must contend with only 33 combinations of letters for 25 sounds (Helmuth, 2001c; Paulesu et al., 2001).

In a sense, dyslexia may not even be a distinct disorder. Researcher Sally Shaywitz and her colleagues have made a case that there is no marker that sets dyslexic individuals entirely apart from others who are merely average readers. She argues that dyslexia is simply the diagnosis we give to an arbitrarily defined group of people occupying the lower end of the reading-abilities spectrum (Shaywitz et al., 1990).

Everyone does agree that dyslexia involves reading difficulties. Everyone also agrees that recent years have seen great strides made in understanding the neurological basis of the disorder, debunking some of the myths surrounding dyslexia (smart people, like Einstein, *can* have dyslexia), and developing treatments. Currently, the most effective treatments are special reading programs that emphasize the matching of sounds to letter combinations.

Attention-Deficit Hyperactivity Disorder (ADHD) Some children have more trouble than others sitting still and focusing attention on a task, such as solving a math problem or listening to directions from the teacher. Many things can cause these symptoms, including distracting problems at home, abuse from peers, or merely a cultural tradition that places low value on the tasks that demand quiet attention. Besides those, there seems to be a brain-based condition, known as **attention-deficit hyperactivity disorder (ADHD)**, that can interfere with even the best of intentions to focus attention and sit quietly (Barkley, 1998). The disorder is estimated to affect some 3 to 5% of school-age children (Brown, 2003b). (Contrary to a belief widely held among the general public, hyperactivity is *not* caused by eating sugar [Wolraich et al., 1995].)

ADHD is a controversial diagnosis, and its treatment is even more controversial (Sax & Kautz, 2003). Critics have claimed that ADHD is overdiagnosed, often being used to describe normal rambunctiousness or to blame children for the mistakes made by unskilled parents and teachers. In addition, drug treatment consisting of stimulant drugs strikes many people as being wrongheaded. On the other hand, many careful studies have demonstrated that properly administered drug therapy, along with behavioral therapy, can improve attention and diminish hyperactivity in a majority (about 70%) of

■ **Dyslexia** A reading disability, thought by some experts to involve a brain disorder.

■ **Attention-deficit hyperactivity disorder (ADHD)** A developmental disability involving short attention span, distractibility, and extreme difficulty in remaining inactive for any period.

individuals diagnosed with ADHD (Daley, 2004; MTA Cooperative Treatment Group, 2004).

Adjustment Disorders and Other Conditions

Although the large majority of everyday psychological problems involve making choices and dealing with confusion, frustration, and loss, the *DSM-IV* gives these problems short shrift under *adjustment disorders* and under the awkwardly named category *other conditions that may be a focus of clinical attention*. Together, these categories represent a catch basin for relatively mild problems that do not fit well under other headings. They span a diverse range of conditions that include mild depression, physical complaints, marital problems, academic problems, job problems, parent-child problems, bereavement, and even *malin-gering* (faking an illness). Consequently, the largest group of people suffering from mental problems may fit these headings—even though the *DSM-IV* devotes disproportionately little space to them. Ironically, because these adjustment difficulties are so prevalent, sufferers who turn to psychologists and psychiatrists account for a large proportion of the patient load seen by professionals in private practice.



"Wait! Come back! I was just kidding about wanting to be happy."



PSYCHOLOGY IN YOUR LIFE: SHYNESS

Being shy is a common problem, but it is not a *DSM-IV* disorder. Rather, *shyness* is a distressing pattern of avoiding or withdrawing from social contact. At the extreme, shy behavior may resemble a social phobia or avoidant personality disorder, as afflicted individuals seek to limit or escape from social interactions. As we have seen many times before, it is a matter of degree. Shy people are not utterly incapacitated by fear, yet they may suffer from loneliness and from lost opportunities to pursue interests and relationships.

What are the origins of this painful problem? For some people it may begin at birth: Shyness is one of three basic temperaments that have been observed among infants and traced through adult life (Kagan et al., 1988, 1994a). Jerome Kagan has also recently proposed that shyness may have its origin in an overly excitable amygdala (Kagan, 2001). But shyness and other forms of social anxiety are also *learned* responses, so that even those who are not "born shy" can acquire shy behavior patterns.

On a hopeful note, shyness does not have to be a permanent condition. Many people overcome it on their own. Organizations such as Toastmasters help people build verbal skills and confidence in social situations. And many others have found the help they need in cognitive-behavioral therapy groups. If you suffer from shyness, we recommend Phil Zimbardo's (1990) book *Shyness* as a good place to look for help.



● Shyness may be painful, but it is not a *DSM-IV* disorder.

CHECK YOUR UNDERSTANDING

- RECALL:** The *DSM-IV* is based on the
 - cognitive perspective.
 - behavioral perspective.
 - eclectic view.
 - psychoanalytic view.
 - medical model.
- RECALL:** Which disorder involves extreme swings of mood from elation to depression?
 - panic disorder
 - bipolar disorder
 - schizophrenia
 - unipolar depression
 - PTSD
- APPLICATION:** According to the preparedness hypothesis, which one of the following phobias would you expect to be most common?
 - fear of snakes (ophidiophobia)
 - fear of books (bibliophobia)
 - fear of horses (equinophobia)
 - fear of the number 13 (triskaidekaphobia)
 - fear of water (aquaphobia)
- RECALL:** Which of the following disorders involves a deficiency in memory?
 - phobia
 - antisocial personality
 - dissociative fugue
 - obsessive-compulsive disorder
 - schizophrenia
- RECALL:** Which of the following is a disorder in which the individual displays more than one distinct personality?
 - schizophrenia
 - depersonalization disorder
 - bipolar disorder
 - phobia
 - dissociative identity disorder
- RECALL:** Which of the following is primarily a disorder of young American women?
 - bipolar disorder
 - schizophrenia
 - anorexia nervosa
 - antisocial personality disorder
 - phobia
- RECALL:** Hallucinations and delusions are symptoms of
 - schizophrenia.
 - somatoform disorders.
 - anxiety disorders.
 - depersonalization disorder.
 - panic disorders.
- RECALL:** Which category of disorder is most common?
 - schizophrenia
 - dissociative disorders
 - eating disorders
 - the adjustment disorders and "other conditions that may be a focus of clinical attention"
 - mood disorders
- UNDERSTANDING THE CORE CONCEPT:** The *DSM-IV* groups most mental disorders by their
 - treatments.
 - causes.
 - symptoms.
 - theoretical basis.
 - cures.

ANSWERS: 1. e, 2. b, 3. a, 4. c, 5. e, 6. c, 7. a, 8. d, 9. c

DO IT YOURSELF!

The Insanity Plea: How Big Is the Problem?

How often is the plea of insanity used? Before you read about the insanity defense in the next part of the chapter, try to guess the approximate percentage of accused criminals

in the United States who use a plea of insanity in court: ____%. You will find the correct answer in the "Psychology in Your Life" section on p. 516. (An answer within 10%

indicates that you have an exceptionally clear grasp of reality!)

Hint: Research shows that the public has an exaggerated impression of the problem.



WHAT ARE THE CONSEQUENCES OF LABELING PEOPLE?

"Mad." "Maniac." "Mentally ill." "Crazy." "Insane." "Disturbed." "Neurotic." These, along with all the official diagnostic terms that appear in the *DSM-IV*, are labels used by the public, the courts, and mental health professionals to describe people who display mental disturbances. Ideally, an accurate diagnosis leads to an effective treatment program for the afflicted individual. Sometimes, however, labels create confusion and hurt. They can turn people into

stereotypes, masking their personal characteristics and the unique circumstances that contribute to their disorders. And, if that is not enough, labels can provoke prejudices and social rejection.

In this section we will begin with the problem of labeling as it affects the individual. Then we will pursue the issue of labeling in a larger context: Does psychological disorder mean the same thing in all cultures? Finally, we will look critically at the label “insanity” as used by the courts. The Core Concept, around which all of this is organized, says:

Ideally, accurate diagnoses lead to proper treatments, but diagnoses may also become labels that depersonalize individuals and ignore the social and cultural contexts in which their problems arise.



Diagnostic Labels Can Compound the Problem

Labeling a person as mentally disturbed can have both serious and long-lasting consequences, aside from the mental disturbance itself. A person may suffer a broken leg or an attack of appendicitis, but when one recovers, the diagnosis moves into the past. Not so with mental disorders. A label of “depression” or “mania” or “schizophrenia” can be a stigma that follows a person forever (Farina et al., 1996; Wright et al., 2000). But what about a mistaken diagnosis? As Rosenhan pointed out, a mistaken diagnosis of cancer is cause for celebration, but almost never is a diagnosis of mental disorder found to be wrong. As you will recall in the “pseudopatient” study, discussed at the beginning of the chapter, the glaring fact of normalcy never emerged, in part, because of the label *schizophrenia*.

The diagnostic label may also become part of a cycle of neglect resulting from the inferior status accorded people with mental disorders. Sadly, in our society, to be mentally disordered is to be devalued. This, of course, lowers self-esteem and reinforces disordered behavior. Thus, society extracts costly penalties from those who deviate from its norms—and in the process it perpetuates the problem of mental disorder.

Perhaps the most extreme reaction against labeling has come from radical psychiatrist Thomas Szasz, who claimed that mental illness is a “myth” (1961, 1977). Szasz argued that the symptoms used as evidence of mental illness are merely medical labels that give professionals an excuse to intervene in what are really social problems: deviant people violating social norms. Once labeled, these people can be treated for their “problem of being different,” with no threat of disturbing the existing order.

We must keep in mind, therefore, that the goal of diagnosis is not simply to fit a person into a diagnostic box. Instead, a diagnosis should initiate a process that leads to a greater understanding of a person and to the development of a plan to help. A diagnosis should be a beginning, not an end.

The Cultural Context of Psychological Disorder

Few other clinicians would go as far as Thomas Szasz, but many advocate an *ecological model* that takes the individual’s external world into account (Levine & Perkins, 1987). In this model, abnormality is viewed as an interaction between individuals and the social and cultural context. Disorder results from a mismatch between a person’s behavior and the needs of the situation. If you are a private investigator, for example, it might pay to have a slightly suspicious, or “paranoid,” complexion to your personality, but if you are a nurse, this same characteristic might be called “deviant.”

In support of an ecological model, studies show that culture influences both the prevalence of psychological disorders and the symptoms that disturbed people display (Jenkins, 1994; Manson, 1994; Matsumoto, 1996). For example, work done by the World Health Organization (1973, 1979) in Colombia, Czechoslovakia, Denmark, India, Nigeria, Taiwan, Britain, the United States, and the then-USSR established that the incidence of schizophrenia varies substantially from culture to culture. It also showed that schizophrenic symptoms, such as auditory hallucinations, show cultural variability.

Psychiatry, too, is beginning to note the effects of culture on psychopathology. The *DSM-IV*, in fact, has a section devoted to culture-specific disorders (although this section recognizes no disorders that are found specifically in the United States). According to psychiatrists Arthur Kleinman and Alex Cohen (1997), psychiatry has clung too long to three persistent myths:

1. The myth that psychological disorders have a similar prevalence in all cultures
2. The myth that biology creates psychological disorder, while culture merely shapes the way a person experiences it
3. The myth that culture-specific disorders occur only in exotic places, rather than here at home

But are cultural differences so great that a person who hallucinates might be labeled schizophrenic in our culture but visionary or shaman (a healer or seer) in another? Jane Murphy (1976) set out to answer this question in a study of two non-Western groups, the Eskimos of northwest Alaska and the Yorubas of rural tropical Nigeria, societies selected because of their wide geographic separation and cultural dissimilarity. In both groups she found separate terms and distinct social roles for the shaman and for the psychotic individual. Similar findings have since come from studies of cultures all over the world (Draguns, 1980). If mental illness is a socially defined myth, as psychiatrist Thomas Szasz asserts, it is a myth nurtured by cultures everywhere.

Still, the incidence of specific psychological disorders varies among cultures. Abundant evidence shows that, even though schizophrenia, for example, can be found everywhere, American clinicians use the diagnosis far more frequently than their counterparts in other countries. In the United States we apply the schizophrenic label to nearly all patients with psychotic symptoms (Sprock & Blashfield, 1991).



PSYCHOLOGY IN YOUR LIFE: THE PLEA OF INSANITY

Now let's look at a closely related issue: the plea of insanity. What is your opinion: Does the insanity plea really excuse criminal behavior and put thousands of dangerous people back on the streets? Let's look at the facts.

In 1843, Daniel M'Naughten, a deranged woodcutter from Glasgow, thought he had received "instructions from God" to kill the British Prime Minister, Robert Peel. Fortunately for Peel, this would-be assassin struck down his secretary by mistake. Apprehended and tried, M'Naughten was found "not guilty by reason of insanity." The court reasoned that M'Naughten's mental condition prevented him from knowing right from wrong. The public responded with outrage. Neither did the public like the modern-day insanity ruling involving John Hinckley, the young man who shot and wounded then-President Ronald Reagan.

Such infamous cases have molded a low public opinion of the insanity defense. The citizenry blames psychologists and psychiatrists for clogging the

courts with insanity pleas, allowing homicidal maniacs back on the streets, and letting criminals go to hospitals for “treatment” instead of prisons for punishment. But this public image of insanity has several problems.

For one thing, “insanity” appears nowhere among the *DSM-IV* listing of disorders recognized by psychologists and psychiatrists. Technically, **insanity** is neither a psychological nor a psychiatric term. It is a *legal* term, which only a court—not psychologists or psychiatrists—can officially apply. By law, insanity can include not only psychosis, but jealous rage, mental retardation, and a wide variety of other conditions in which a person might not be able to control his or her behavior or distinguish right from wrong (Thio, 1995).

Why, then, can we not simply abolish the laws that allow this technicality? The answer to that question turns on the definition of a crime. Legally, a crime requires two elements: (a) an illegal act (just wanting to commit a crime is not enough) and (b) the *intent* to commit the act. Merely wishing your boss dead is no crime (because you committed no illegal act). Neither is flattening the boss who accidentally steps in front of your moving car in the parking lot (assuming you had not planned the deed). But if you plot and plan and then lie in wait to willfully run over the boss, you have committed an intentional and illegal act—and the courts can convict you of murder. From this example, you can see why no one wants to give up the legal requirement of intent. But you can also see why this safeguard leaves the door open for the controversial plea of insanity.

With these things in mind, take a moment to recall your estimate of the percentage of accused criminals who use the insanity plea. (See the earlier “Do It Yourself!” box.) In reality, accused criminals use the insanity defense far less often than the public realizes. According to David Rosenhan (1983), it occurs in only about two of 1000 criminal cases, and of this tiny number, only a fraction are successful. Also contrary to popular belief, most successful insanity pleas do not occur in murder cases. Still, public concern about abuses of the insanity plea have led several states to experiment with alternatives. Some now require separate verdicts on the act and the intent, allowing a jury to reach a verdict of “guilty but mentally ill” (Savitsky & Lindblom, 1986).



● The plea of insanity is rare—and it is usually unsuccessful.

■ **Insanity** A legal term, not a psychological or psychiatric one, referring to a person who is unable, because of a mental disorder or defect, to conform his or her behavior to the law.

C H E C K Y O U R U N D E R S T A N D I N G

- RECALL:** Which one of the following statements is true?
 - Mental disorders have a similar prevalence in all cultures.
 - In general, biology creates mental disorder, while culture merely shapes the way a person experiences it.
 - Culture-specific stressors occur primarily in developing countries.
 - Cultures around the world seem to distinguish between people with mental disorders and people who are visionaries or prophets.
 - Mental disorders are more prevalent in Eastern cultures.
- RECALL:** *Insanity* is a
 - psychological term.
 - psychiatric term, found in the *DSM-IV* under “psychotic disorders.”
 - legal term.
 - term that refers either to “neurotic” or “psychotic” symptoms.
 - a classification for those seeking treatment.
- UNDERSTANDING THE CORE CONCEPT:** Which unfortunate consequence of diagnosing mental disorders is emphasized in this section of the chapter?
 - the inaccuracy of diagnosis
 - stigmatizing those with mental disorders
 - adding to the already overcrowded conditions in mental hospitals
 - that some cultures do not recognize mental disorders
 - the importance of the insanity defense

ANSWERS: 1. d 2. c 3. b

PSYCHOLOGICAL DISORDERS: THE STATE OF THE ART

We have seen that our understanding of psychological disorders has some huge gaps. In particular, there are fundamental pieces missing from the puzzles of depression and schizophrenia. Certain other disorders, such as phobias, are reasonably well understood.

Much of the confusion centers on the *DSM-IV*, which classifies some disorders by symptom and some by presumed cause. This is not to fault the developers of this highly influential manual. Rather, we are, in the beginning of the 21st century, just starting to develop a scientific understanding around which the next editions of the *DSM* can be organized.

By the way, don't rush out to buy a copy of the *DSM-IV*. The next edition, the *DSM-V*, is due off the presses in 2011.

USING PSYCHOLOGY TO LEARN PSYCHOLOGY

Diagnosing Your Friends and Family

Don't do it! Don't use your new knowledge of psychological disorders to diagnose your family and friends. This is a common source of grief among psychology students.

We realize how tempting it is to apply what you are learning to the people in your life. Some of the disorders that we have considered here are common, so it would be surprising if they sounded completely alien. As you go through this chapter, you will almost certainly notice signs of anxiety, paranoia, depression, mania, and various other impairments of perception, memory, or emotion in your friends and relatives. It is a variation on the tendency, discussed earlier, to see signs of psychological disorder in oneself. You should recognize this as a sign that you are acquiring some new knowledge about psychological disorder. But we suggest that you keep these thoughts to yourself.

You must remember that reading one chapter does not make you an expert on psychopathology, so you should be cautious about making amateur diagnoses. What you especially should *not* do is to tell someone that you think he or she is schizophrenic, bipolar, obsessive-compulsive—or any other diagnostic label.

Having said that, we should also note that erring too far in the opposite direction by ignoring signs of pathology could also be hazardous. If someone you know is struggling with significant mental problems—and if he or she asks for your opinion—you should refrain from putting a label on the problem, but you can encourage that person to see a competent professional for diagnosis and possible treatment. We will discuss more about how that is done—in the next chapter.

CHAPTER SUMMARY

● WHAT IS PSYCHOLOGICAL DISORDER?

Three classic signs suggest severe psychological disorder: hallucinations, delusions, and severe affective disturbances. But beyond these, the signs of disorder are more subtle, and a diagnosis depends heavily on clinical judgment.

Our modern conception of abnormality has evolved from attributing disorders to demon possession or imbalances of humors to the current medical model, which sees psychopathology as “illness” and with which many psychologists dis-

agree. The broader psychological model includes mental, behavioral, and social factors as well as biological ones. Aside from the three classic signs of disorder, psychopathology is usually judged by the degree to which a person exhibits distress, maladaptiveness, irrationality, unpredictability, and unconventionality.

It is normal to experience symptoms of psychological disorders on occasion, so psychology students are often unjustifiably concerned that they have a mental disorder. Frequent signs of



abnormality, however, should prompt a consult with a mental health professional.

● The medical model takes a “disease” view, while psychology sees psychological disorder as an interaction of biological, mental, social, and behavioral factors.

● HOW ARE PSYCHOLOGICAL DISORDERS CLASSIFIED?

The most widely used system for classifying mental disorders is the *DSM-IV*, which derives from psychiatry and has a bias toward the medical model. The *DSM-IV* recognizes more than 300 specific disorders, categorized by symptom patterns, but it has no category for “normal” functioning.

Among the *DSM-IV* categories are the *mood disorders*, which involve emotional disturbances. *Major depression* is the most common affective disorder, while *bipolar disorder* occurs less commonly. The *anxiety disorders* include *generalized anxiety disorder*, *panic disorder*, *phobic disorders*, and *obsessive–compulsive disorder*. The *somatoform disorders* involve the mind–body relationship in various ways. Those with *conversion disorder* have physical symptoms but no organic disease, while those with *hypochondriasis* suffer from exaggerated concern about illness. The *dissociative disorders* include *dissociative amnesia*, *dissociative fugue*, *depersonalization disorder*, and *dissociative identity disorder*. All disrupt the integrated functioning of memory, consciousness, or personal identity. Two patterns of *eating disorder* are common: *anorexia nervosa* (self-starvation) and *bulimia nervosa* (binging and purging). Both are related to unrealistic, negative body images and are difficult to treat. *Schizophrenia* is a psychotic disorder characterized by extreme distortions in perception, thinking, emotion, behavior, and language. Schizophrenia takes five forms: *disorganized*, *catatonic*, *paranoid*, *undifferentiated*, and *residual* types. Evidence for the causes of schizophrenia has been found in a variety of factors, including genetics, abnormal brain structure, and biochemistry. *Personality disorders* are patterns of

perception, thinking, or behavior that are long-standing and inflexible and that impair an individual's functioning. They include the *narcissistic*, *antisocial*, and *borderline personality disorders*. The *DSM-IV* also lists a variety of *developmental disorders*, including *autism*, *dyslexia*, and *attention-deficit hyperactivity disorder*.

The most common forms of disorder are classified in the *DSM-IV* as the *adjustment disorders* and “*other conditions that may be a focus of clinical attention*.” These include a wide range of problems in living. *Shyness* is a widespread problem—and a treatable one—but it is not officially a disorder, unless it goes to the extreme of a social phobia or avoidant personality disorder.

● The *DSM-IV*, the most widely used system, classifies disorders by their mental and behavioral symptoms.

● WHAT ARE THE CONSEQUENCES OF LABELING PEOPLE?

Labeling someone as psychologically or mentally disordered is ultimately a matter of human judgment. Yet even professional judgments can be biased by prejudices. Those labeled with psychological disorders may be depersonalized in ways that most physically ill people are not. Culture has an effect on whether a behavior is called normal, abnormal, or merely unusual. Cross-cultural research suggests that people everywhere distinguish between psychotic individuals and those whom they label shamans, prophets, or visionaries.

“Insanity” is a special sort of label that is awarded by the courts. Insanity, however, is not a psychological or psychiatric term. In fact, the insanity defense is not often used, much less used successfully—although a few high-profile cases have captured public attention.

● Ideally, accurate diagnoses lead to proper treatments, but diagnoses may also become labels that depersonalize individuals and ignore the social and cultural contexts in which their problems arise.

REVIEW TEST

For each of the following items, choose the single correct or best answer. The answer key appears at the end.

1. The medical model views mental disorder as
 - a. a character defect.
 - b. a disease or illness.
 - c. an interaction of biological, cognitive, behavioral, social, and cultural factors.
 - d. normal behavior in an abnormal context.
 - e. maladaptive contingencies of reinforcement.
2. Which of the following is *not* one of the six indicators of possible abnormality agreed upon by psychologists?
 - a. distress
 - b. observer discomfort
 - c. unconventionality
 - d. irrationality
 - e. chronic physical illness
3. The *DSM-IV* is
 - a. a personality inventory.
 - b. the most widely used classification system for mental disorders.
 - c. the neurochemical implicated in anxiety disorders.
 - d. a class of psychoactive drugs effective in the treatment of schizophrenia.
 - e. a pattern specifier for depression.
4. A long-standing pattern of irresponsible behavior that hurts others without causing feelings of guilt or remorse is typical of
 - a. an obsessive–compulsive disorder.
 - b. an antisocial personality disorder.
 - c. a narcissistic personality disorder.
 - d. paranoid schizophrenia.
 - e. dissociative fugue.

5. A young woman wanders into a hospital, claiming not to know who she is, where she came from, or how she got there. Her symptoms indicate that she might be suffering from a(n) _____ disorder.
 - a. anxiety
 - b. affective
 - c. personality
 - d. dissociative
 - e. mood
6. Which of the following statements about phobic disorders is true?
 - a. Any extreme and irrational fear of a situation or thing, such as of spiders, is considered a phobia.
 - b. The preparedness hypothesis suggests that some people learn their fears from their parents at an early age.
 - c. Phobias represent one form of affective disorders.
 - d. They are rarely diagnosed outside the United States.
 - e. All of the above are true.
7. _____ has been called the “common cold of psychopathology,” because it occurs so frequently and because almost everyone has experienced it, at least briefly, at some time.
 - a. Obsessive–compulsive disorder
 - b. Bipolar disorder
 - c. Depression
 - d. Paranoid schizophrenia
 - e. Autism
8. A person who suffers from _____ cannot eat normally but engages in a ritual of “binging”—periodic binges of overeating—followed by “purging” with induced vomiting or use of laxatives.
 - a. anorexia nervosa
 - b. bulimia nervosa
 - c. inhibition
 - d. mania
 - e. depression
9. The _____ type of schizophrenia is characterized by delusions.
 - a. residual
 - b. catatonic
 - c. paranoid
 - d. undifferentiated
 - e. disorganized
10. Rosenhan believes that his “pseudopatients” were not recognized as normal because
 - a. the staff members in the mental hospitals were incompetent.
 - b. the staff members in the mental hospitals were just as disturbed as the patients.
 - c. mental illness is a myth.
 - d. staff members did not expect patients to be normal.
 - e. he denied the existence of psychological disorders.

ANSWERS: 1. b 2. e 3. b 4. b 5. d 6. a 7. c 8. b 9. c 10. d

KEY TERMS

Psychopathology (p. 485)

Hallucinations (p. 485)

Delusions (p. 485)

Affect (p. 485)

Medical model (p. 488)

Social–cognitive–behavioral approach (p. 489)

DSM-IV (p. 492)

Neurosis (p. 493)

Psychosis (p. 493)

Mood disorders (p. 493)

Major depression (p. 494)

Seasonal pattern specifier
or (**SAD**) (p. 495)

Bipolar disorder (p. 497)

Anxiety disorders (p. 498)

Generalized anxiety disorder (p. 498)

Panic disorder (p. 498)

Agoraphobia (p. 498)

Phobias (p. 499)

Preparedness hypothesis (p. 499)

Obsessive–compulsive disorder (p. 499)

Somatoform disorders (p. 501)

Conversion disorder (p. 501)

Hypochondriasis (p. 502)

Dissociative disorders (p. 502)

Dissociative amnesia (p. 503)

Dissociative fugue (p. 503)

Depersonalization disorder (p. 503)

Dissociative identity disorder (p. 504)

Anorexia nervosa (p. 505)

Bulimia nervosa (p. 506)

Schizophrenia (p. 506)

Diathesis–stress hypothesis (p. 509)

Personality disorders (p. 510)

Narcissistic personality disorder (p. 510)

Antisocial personality disorder (p. 510)

Borderline personality disorder (p. 510)

Autism (p. 511)

Dyslexia (p. 512)

Attention-deficit hyperactivity disorder (ADHD) (p. 512)

Insanity (p. 517)

AP* REVIEW: VOCABULARY

Match each of the following vocabulary terms to its definition.

- | | |
|----------------------|------------------------------------|
| 1. Hallucinations | 6. Somatoform disorders |
| 2. Delusions | 7. Dissociative disorders |
| 3. Medical model | 8. Diathesis–stress hypothesis |
| 4. Mood disorders | 9. Borderline personality disorder |
| 5. Anxiety disorders | 10. Autism |

- _____ a. Extreme disorders of thinking, involving persistent false beliefs.
- _____ b. A developmental disorder marked by disabilities in language and in social interaction.
- _____ c. A class of disorders including bipolar disorder.

- _____ d. A class of disorders including panic disorder.
- _____ e. A disorder characterized by an unstable personality given to impulsive behavior.
- _____ f. A class of disorders including depersonalization disorder.
- _____ g. A class of disorders including conversion disorder.
- _____ h. False sensory experiences that may suggest a mental disorder.
- _____ i. The view that mental disorders are diseases that have objective physical causes and require specific treatments.
- _____ j. The proposal that genetic factors place the individual at risk while environmental stress factors transform this potential into schizophrenic disorder.

AP* REVIEW: ESSAY

Use your knowledge of the chapter concepts to answer the following essay question.

Dissociative disorders and personality disorders are two relatively common forms of abnormality. Compare and contrast them, being sure to include the following for each abnormality:

- a. characterization of the abnormalities involved
- b. diagnostic criteria
- c. axis of diagnosis

OUR RECOMMENDED BOOKS AND VIDEOS

BOOKS

- Casey, N. (Ed.). (2002). *Unholy ghost: Writers on depression*. New York: Perennial. In this “reader on depression”—including observations and stories by writers including Russell Banks, Susanna Kay-sen, William Styron, and Anne Beattie—the selections offer vivid descriptions of how depression feels, the behaviors it causes, its effects on others, and the wide-ranging treatments of depression.
- Gregory, J. (2003). *Sickened: A memoir of a Munchausen by proxy childhood*. New York: Bantam. In search of attention, excitement, or purpose, Julie Gregory’s disordered mother made and kept her sick, then dragged her to doctors and hospitals in search of drugs and surgery for nonexistent ailments. Even as an adult, Gregory never recognized she had been abused until she heard a lecture on MBP.
- Porter, R. (2003). *Madness: A brief history*. Oxford, U.K.: Oxford University Press. Today the attitude is widespread that most people struggle with some degree of mental illness at some point in life. But for most of history, the mentally ill have been ostracized as unacceptably different, persecuted, imprisoned, “treated” with torture, or at best dismissed as “sick.” This engaging account traces how attitudes shifted over centuries of recognizing and responding to mental illness in human societies.
- Torrey, E. F., & Miller, J. (2002). *The invisible plague: The rise and fall of mental illness from 1750 to the present*. Rutgers, NJ: Rutgers University Press. Here is a comprehensive and well-presented history of mental illness in the Western world, with no pat answers about causes or treatment, with a lighter and more literary tone than you’d expect in a sad history.

VIDEOS

- A Beautiful Mind*. (2001, color, 135 min.). Directed by Ron Howard; starring Russell Crowe, Jennifer Connelly, Ed Harris. This absorbing,

Oscar-winning film is based on the true story of the early career of Nobel Prize–winning mathematician John Forbes Nash, who suffered life-long from paranoid schizophrenia. (Rating PG-13)

- As Good as It Gets*. (1997, color, 138 min.). Directed by James Brooks; starring Jack Nicholson, Helen Hunt, Greg Kinnear, Cuba Gooding, Jr., Shirley Knight. An obsessive–compulsive writer becomes entangled, much against his will and inclinations, in the lives of a neighbor, a waitress, and their families, in his efforts to keep his world predictable and protected. For all its funny as well as tragic moments, the film makes clear the struggle of those who suffer from anxiety disorders. (Rating PG-13)

K-Pax. (2001, color, 120 min.). Directed by Iain Softley; starring Kevin Spacey, Jeff Bridges. A mental hospital patient, claiming actually to be visitor from another planet, baffles his psychiatrist, whose own life is touched by the “alien’s” abilities as he searches for clues to the patient’s true past. (Rating PG-13)

The Three Faces of Eve. (1957, black-and-white, 91 min.). Directed by Nunnally Johnson; starring Joanne Woodward, Lee J. Cobb, David Wayne. This classic film is based on the true story of a woman found to have at least three distinct personalities and the efforts she and her therapists made to find the source—and the resolution—of her dissociative disorder. Woodward won an Oscar for her astonishing performance. (Not rated)

Vertigo. (1958, color, 128 min.). Directed by Alfred Hitchcock; starring James Stewart, Kim Novak, Barbara Bel Geddes. A police detective with a fear of heights (acrophobia) is lured first into a mysterious romance and then into a crime in this dramatic cinematic portrayal of anxiety and terror. (Rating PG)