

# Psychological Disorders

## Chapter Preview

Mental health workers label behavior as psychologically disordered when there is a significant dysfunction in a person's thoughts, feelings, or behaviors. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) provides an authoritative classification scheme. Whether we use a medical model or a biopsychosocial approach affects our understanding of psychological disorders. Although diagnostic labels may facilitate communication and research, they can also bias our perception of people's past and present behavior and unfairly stigmatize these individuals.

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

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

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

In dissociative disorders, conscious awareness becomes separated from previous memories, thoughts, and feelings. Those afflicted with a dissociative disorder may even have two or more distinct personalities. Psychological influences on eating behavior are evident in those who are motivated to be abnormally thin. Personality disorders are characterized by inflexible and enduring behavior patterns that impair social functioning. The most common is the remorseless and fearless antisocial personality.

The U.S. National Institute of Mental Health estimates that 26 percent of adult Americans suffer from a diagnosable mental disorder in a given year. National population surveys indicate that the rates of disorder vary across the world. Most who suffer from a disorder show the first symptoms by early adulthood. Poverty is clearly a predictor of mental illness.

## Chapter Guide

- ▶ Project: Diagnosing a “Star” (p. 918)
- ▶ Lecture: Using Case Studies to Teach Psychological Disorders (p. 917)
- ▶ Feature Films and TV: Introducing Psychological Disorders (p. 917)

### Introductory Exercise: Fact or Falsehood?

The correct answers to Handout 14–1 are as follows: 1. F 2. T 3. F 4. F 5. T 6. T 7. T 8. T 9. F 10. T

### What Is a Psychological Disorder?

- ▶ Exercises: Introducing Psychological Disorders (p. 919); Defining Psychological Disorder (p. 920)
- ▶ Lecture/Lecture Break: The Self-Diagnosis Phenomenon (p. 918)
- ▶ Project: Encounters with a “Mentally Ill” Person (p. 920)

14-1. *Discuss how we draw the line between normal behavior and psychological disorder.*

A **psychological disorder** is a significant dysfunction in a person’s thoughts, feelings, or behaviors. Dysfunctional behaviors are *maladaptive*, and they are often accompanied by distress.

- ▶ Projects/Exercises: Adult ADHD Screening Test (p. 920); Normality and the Sexes (p. 921)
- ▶ Worth Video Anthology: *ADHD and the Family*

14-2. *(Thinking Critically) Discuss the controversy over the diagnosis of attention-deficit hyperactivity disorder.*

Children once regarded as fidgety, distractible, and impulsive are now being diagnosed with **attention-deficit hyperactivity disorder (ADHD)**. Critics question whether the label is being applied to healthy schoolchildren who, in more natural outdoor environments, would seem perfectly normal. Although the proportion of children treated for the disorder has increased dramatically, the pervasiveness of the diagnosis depends in part on teacher referrals. Others counterargue that the more frequent diagnoses of ADHD reflect increased awareness of the disorder, particularly in those areas where the rates are highest.

- ▶ Lectures: Tourette Syndrome (p. 921); Culture-Bound Disorders (p. 922)
- ▶ Exercise: Multiple Causation (p. 922)

14-3. *Discuss how our understanding of disorders is affected by whether we use a medical model or a biopsychosocial approach.*

The **medical model** assumes that psychological disorders are mental illnesses that need to be diagnosed on the basis of their *symptoms* and, in most cases, *cured* through *therapy*, which may include *treatment* in a psychiatric *hospital*.

Psychologists who reject the “sickness” idea typically contend that all behavior arises from the interaction of nature (genetic and physiological factors) and nurture (past and present experiences). The biopsychosocial approach assumes that disorders are influenced by genetic predispositions, physiological states, inner psychological dynamics, and social and cultural circumstances. But not all disorders are culture-bound. Depression and schizophrenia occur worldwide.

- ▶ Lecture: Mental Health as Flourishing (p. 924)
- ▶ Exercise: The Flourishing Scale (p. 925)
- ▶ Lecture/Lecture Break: Revising the DSM (p. 923)
- ▶ PsychSim 5: Mystery Client (p. 925)
- ▶ Worth Video Anthology: *Gender Identity Disorder*

14-4. *Describe how and why clinicians classify psychological disorders, and explain why some psychologists criticize the use of diagnostic labels.*

**DSM-IV-TR** is a current authoritative scheme for classifying psychological disorders. This volume is the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, updated in 2000 as “text revision.” This classification scheme assumes the medi-

cal model and will be more substantially revised as DSM-5, which will appear in 2013. The International Classification of Diseases (ICD-10) covers both medical and psychological disorders; the eleventh edition is expected in 2014. Most health insurance policies in North America require an ICD/DSM diagnosis before they will pay for therapy. The DSM describes various disorders and has high reliability. For example, two clinicians who are working independently and applying the guidelines are likely to reach the same diagnosis.

- ▶ Exercise: The Effects of Labeling (p. 925)
- ▶ Feature Film: *In Cold Blood* (p. 925)
- ▶ Worth Video Anthology: *Postpartum Psychosis: The Case of Andrea Yates*

Critics point out that labels can create preconceptions that bias our perceptions of people's past and present behavior and unfairly stigmatize these individuals. Labels can also serve as self-fulfilling prophecies. However, diagnostic labels help not only to describe a psychological disorder but also to enable mental health professionals to communicate about their cases, to comprehend the underlying causes, and to discern effective treatment programs. The insanity defense raises moral and ethical questions about how society should treat people who have disorders and have committed crimes.

## Anxiety Disorders

- ▶ Exercise: Penn State Worry Questionnaire (p. 926)
- ▶ Worth Video Anthology: *Anxiety Disorders; Three Anxiety Disorders; Experiencing Anxiety*

### 14-5. Identify the main anxiety disorders, and describe how they differ from the ordinary worries and fears we all experience.

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

- ▶ Exercise: Taylor Manifest Anxiety Scale (p. 926)

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

- ▶ Lecture: Discovery Health Channel Phobia Study (p. 927)
- ▶ Exercises: Fear Survey (p. 927); Social Phobia (p. 928)

A **phobia** is an anxiety disorder marked by a persistent, irrational fear of a specific object, activity, or situation. In contrast to the normal fears we all experience, phobias can be so severe that they are incapacitating. For example, *social phobia*, an intense fear of being scrutinized by others, is shyness taken to an extreme. The anxious person may avoid speaking up, eating out, or going to parties. If the fear is intense enough, it can lead to *agoraphobia*. Other *specific phobias* focus on animals, insects, heights, blood, or close spaces.

- ▶ Lecture: Obsessive Thoughts (p. 929)
- ▶ Exercise: Obsessive-Compulsive Disorder (p. 928)
- ▶ Worth Video Anthology: *Obsessive-Compulsive Disorder: A Young Mother's Struggle; Those Who Hoard*
- ▶ Feature Film: *As Good As It Gets* and OCD (p. 928)

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

- ▶ Lecture: Concentration Camp Survival (p. 930)
- ▶ Exercise: The Posttraumatic Cognitions Inventory (PTCI) (p. 930)
- ▶ Worth Video Anthology: *Post-Traumatic Stress Disorder: A Vietnam Combat Veteran; PTSD: Returning from Iraq*

**Post-traumatic stress disorder (PTSD)** is characterized by haunting memories, nightmares, social withdrawal, jumpy anxiety, and/or insomnia that last for four weeks or more following a traumatic experience. Many combat veterans, accident and disaster survivors, and sexual assault victims have experienced the symptoms of PTSD. Some researchers are interested in the impressive *survivor resiliency* of those who do not develop PTSD. About half of adults experience at least one traumatic experience in their lifetime, but only about 1 in 10 women and 1 in 20 men develop PTSD symptoms. For some, suffering can lead to *post-traumatic growth*.

- ▶ Worth Video Anthology: *Fear, PTSD, and the Brain*

- 14-6. Describe how conditioning, cognition, and biology contribute to the feelings and thoughts that mark anxiety disorders.

The learning perspective views anxiety disorders as a product of fear conditioning, stimulus generalization, reinforcement of fearful behaviors, and observational learning of others' fears. The biological perspective helps explain why we learn some fears more readily and why some individuals are more vulnerable. It emphasizes genetic, neural, and evolutionary influences. For example, phobias may focus on fears faced by our ancestors, genetic inheritance of a high level of emotional reactivity predisposes some to anxiety, and elevated activity in the anterior cingulate cortex appears to be linked to OCD.

## Mood Disorders

- ▶ Lecture: Bipolar Disorder (p. 933)
- ▶ Exercises: Depression Scales (p. 931); The Automatic Thoughts Questionnaire (p. 932); Depression and Memory (p. 932); Loneliness (p. 932)
- ▶ Worth Video Anthology: *Depression*

- 14-7. Define mood disorders, and contrast major depressive disorder and bipolar disorder.

**Mood disorders** are psychological disorders characterized by emotional extremes. **Major depressive disorder** occurs when at least five signs of depression (including lethargy, feelings of worthlessness, or diminished interest or pleasure in activities) last two or more weeks and are not caused by drugs or a medical condition. **Bipolar disorder** is a mood disorder in which a person alternates between the hopelessness and lethargy of depression and the overexcited state of **mania** (a hyperactive, wildly optimistic state in which dangerously poor judgment is common). Major depressive disorder is much more common than is bipolar disorder.

- ▶ Lectures: The Sadder-but-Wiser Effect (p. 934); Cognitive Errors in Depression (p. 934); Commitment to the Common Good (p. 938)
- ▶ Exercises: Attributions for an Overdrawn Checking Account (p. 935); The Body Investment Scale and Self-Mutilation (p. 936); Understanding Suicide (p. 936); The Expanded Revised Facts on Suicide Quiz (p. 937)
- ▶ Worth Video Anthology: *Suicide: Case of the "3-Star" Chef; Mood Disorders*

- 14-8. Describe how the biological and social-cognitive perspectives explain mood disorders.

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

The biological perspective emphasizes the importance of genetic, neural, and biochemical influences. Mood disorders run in families, and *linkage analysis* is being used to search for genes that put people at risk. In addition, the brains of depressed people have been found to be less active.

The left frontal lobe and an adjacent brain reward center, which are active during positive emotions, are likely to be inactive during depressed states. Also, studies show that the *hippocampus*, a memory-processing center linked to the brain's emotional circuitry, is vulnerable to stress-related damage. Finally, certain neurotransmitters, including norepinephrine and serotonin, seem to be scarce during depression.

The social-cognitive perspective suggests that self-defeating beliefs, which arise in part from learned helplessness, and a negative explanatory style feed depression. Depressed people explain bad events in terms that are *global*, *stable*, and *internal*. This perspective sees the disorder as a vicious cycle in which (1) negative, stressful events are interpreted through (2) a ruminating, pessimistic explanatory style, creating (3) a hopeless, depressed state that (4) hampers the way a person thinks and acts. This, in turn, fuels (1) negative, stressful experiences such as rejection.

- 14-9. *Discuss the factors that affect suicide and self-injuring, and identify important warning signs to watch for in suicide prevention efforts.*

Compared with people who suffer no disorder, those with alcohol dependence are roughly 100 times more likely to commit suicide. Social suggestion may trigger suicide. The elderly sometimes choose death as an alternative to current or future suffering. In people of all ages, suicide may be a way of switching off unendurable pain. Warning signs include verbal hints, giving possessions away, or withdrawal and preoccupation with death. Some people, especially adolescents and young adults, engage in *non-suicidal self-injury* as a way to ask for help and gain attention or to gain relief from intense negative thoughts, for example.

## Schizophrenia

- ▶ Lecture: Infantile Autism (p. 940)
- ▶ Exercises: Magical Ideation Scale (p. 939)
- ▶ Project: *The Eden Express* and Schizophrenia (p. 939)
- ▶ PsychSim 5: Losing Touch With Reality (p. 939)
- ▶ Worth Video Anthology: *Schizophrenia; Schizophrenia: Symptoms; John Nash: "A Beautiful Mind"*

- 14-10. *Name the schizophrenia subtypes, and describe the patterns of thinking, perceiving, feeling, and behaving that characterize schizophrenia.*

**Schizophrenia** is a group of severe disorders characterized by disorganized and delusional thinking, disturbed perceptions, and inappropriate emotions and actions. Literally, schizophrenia means "split mind," which refers to a split from reality rather than multiple personality. As such, it is the chief example of a **psychosis**.

Schizophrenia patients who are disorganized and deluded in their talk or prone to inappropriate laughter, tears, or rage are said to have *positive symptoms*. When appropriate behaviors are absent (for example, the schizophrenia patient has a toneless voice, expressionless face, and a mute or rigid body), the person is showing *negative symptoms*. The subtypes of schizophrenia include paranoid (preoccupation with delusions or hallucinations, often of persecution or grandiosity), disorganized (disorganized speech or behavior, or flat affect or inappropriate emotions), catatonic (immobility, extreme negativism, and/or parrotlike repetition of another's speech or movements), undifferentiated (many and varied symptoms), and residual (withdrawal after hallucinations and delusions have disappeared).

The thinking of people with schizophrenia may be marked by **delusions**, that is, false beliefs—often of persecution or grandeur. Disorganized thoughts may result from a breakdown in *selective attention*. Sometimes, they also experience *hallucinations*, sensory experiences without sensory stimulation. Hallucinations are usually auditory and often take the form of voices making insulting statements or giving orders.

14-11. *Contrast chronic and acute schizophrenia.*

*Chronic*, or *process*, schizophrenia develops gradually, emerging from a long history of social inadequacy. Recovery is doubtful. *Acute*, or *reactive*, schizophrenia develops rapidly in response to particular life stresses. Recovery is much more likely.

► Worth Video Anthology: *The Schizophrenic Brain*

14-12. *Describe the brain abnormalities associated with schizophrenia.*

Researchers have linked certain forms of schizophrenia with brain abnormalities such as increased receptors for the neurotransmitter *dopamine*. Modern brain-scanning techniques indicate that people with chronic schizophrenia have abnormal activity in multiple brain areas. Out-of-sync neurons may disrupt the integrated functioning of neural networks. Some patients appear to have enlarged, fluid-filled areas and a corresponding shrinkage of cerebral tissue. Persons with schizophrenia also have a smaller-than-normal thalamus.

14-13. *Identify prenatal events that are associated with increased risk of developing schizophrenia.*

A possible cause of these abnormalities is a midpregnancy viral infection that impairs fetal brain development. For example, people are at increased risk of schizophrenia if, during the middle of their fetal development, their country experienced a flu epidemic. People born in densely populated areas, where viral diseases spread more readily, also seem to be at greater risk for schizophrenia.

14-14. *Discuss how genes influence schizophrenia.*

The nearly 1-in-100 odds of any person developing schizophrenia become about 1 in 10 if a family member has it, and close to 1 in 2 if an identical twin has the disorder. Adoption studies confirm the genetic contribution to schizophrenia. An adopted child's probability of developing the disorder is greater if the biological parents have schizophrenia. A complex disorder such as schizophrenia is surely influenced by multiple genes with small effects, but identifying these genes has proven difficult. No environmental factors have been discovered that invariably produce schizophrenia in persons who are not related to a person with schizophrenia.

## Other Disorders

► Lectures: Factitious Disorder (p. 941); Sensory Processing Disorder (p. 941); Psychogenic Versus Organic Amnesia (p. 942)

► Exercise: The Curious Experiences Inventory (p. 941)

14-15. *Describe the dissociative disorders, and discuss why they are controversial.*

In **dissociative disorders**, a person appears to experience a sudden loss of memory or change in identity, often in response to an overwhelmingly stressful situation. A person may have no memory of his identity or family. Conscious awareness is said to *dissociate* or become separated from painful memories, thoughts, and feelings. Dissociation itself is not uncommon. On occasion, many people may have a sense of being unreal, of being separated from their body, or of watching themselves as if in a movie. Facing trauma, detachment may protect a person from being overwhelmed by anxiety.

► Lecture: The Dissociative Disorders Interview Schedule and Dissociative Identity Disorder (p. 942)

► Worth Video Anthology: *Multiple Personality Disorder*

**Dissociative identity disorder (DID)** is a rare disorder in which a person exhibits two or more distinct and alternating personalities, with the original personality typically denying awareness of the other(s). Skeptics question whether DID is a genuine disorder or an extension of our normal capacity for personality shifts. Or is it merely role playing by fantasy-prone individuals? They find it suspicious that the disorder became so popular in the late twentieth century and that outside North America it is much less prevalent. (In Britain, it is rare, and in India and Japan, it is essentially nonexistent.) Some argue that the condition is either contrived by fantasy-prone, emotionally

variable people or constructed out of the therapist-patient interaction. Other psychologists disagree and find support for DID as a genuine disorder in the distinct brain and body states associated with differing personalities. Even handedness sometimes switches with personality.

► Exercise: Assessing Body Image (p. 942); Motivations-to-Eat Scale (p. 942)

► Worth Video Anthology: *Beyond Perfection: Female Body Dysmorphic Disorder; Purging Food; Overcoming Anorexia Nervosa; Self-Image: Body Dissatisfaction Among Teenage Girls*

- 14-16. *Identify the three main eating disorders, and discuss how biological, psychological, and social-cultural influences make people more vulnerable to these disorders.*

**Anorexia nervosa** is an eating disorder in which a normal-weight person (usually an adolescent female) diets to become significantly (15 percent or more) underweight, yet feels fat and is obsessed with losing weight.

**Bulimia nervosa** is an eating disorder characterized by private, binge-purge episodes of overeating, usually of high-calorie foods, followed by vomiting, laxative use, fasting, or excessive exercise.

**Binge-eating disorder** is marked by significant binge-eating episodes followed by remorse but not by purging, fasting, or excessive exercise.

Challenging family settings and weight-obsessed societal pressures provide fertile ground for the growth of eating disorders. Those most vulnerable to eating disorders are also those (usually women) who most idealize thinness and have the greatest body dissatisfaction. Low self-esteem and negative emotions that interact with stressful life experiences are additional contributing factors. Twin studies suggest that eating disorders may also have a genetic component.

► Lecture: Narcissistic Personality Disorder (p. 943)

► Exercises: Schizotypal Personality Questionnaire (p. 943); Antisocial Personality Disorder (p. 944)

► Worth Video Anthology: *Trichotillomania: Pulling Out One's Hair; The Mind of the Psychopath*

- 14-17. *Contrast the three clusters of personality disorders, and describe the behaviors and brain activity that characterize the antisocial personality disorder.*

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

## Rates of Psychological Disorders

► Lecture: The Commonality of Psychological Disorders (p. 944)

- 14-18. *Discuss the prevalence of psychological disorders, and explain whether poverty is a risk factor.*

The U.S. National Institute of Mental Health estimates that 26 percent of adult Americans suffer from a diagnosable mental disorder in a given year. The three most common disorders in the United States are mood disorders, phobias of specific objects or situations, and social phobia. A twenty-first-century World Health Organization study found that the lowest rate of reported mental disorders was in Shanghai, whereas the highest rate was found in the United States. One predictor of mental disorder is poverty. Although the stresses and demoralization of poverty can precipitate disorders, especially depression in women and substance abuse in men, some disorders, such as schizophrenia, can also lead to poverty.

HANDOUT 14-1

**Fact or Falsehood?**

- |            |  |
|------------|--|
| <b>T F</b> | 1. In some cultures, depression and schizophrenia are nonexistent.   |
| <b>T F</b> | 2. Ritalin and Adderall are stimulants but help calm hyperactivity in children with ADHD.  |
| <b>T F</b> | 3. About 30 percent of psychologically disordered people are dangerous; that is, they are more likely than other people to commit a crime. |
| <b>T F</b> | 4. By age 50, emotions have become stronger and anxiety disorders more common.   |
| <b>T F</b> | 5. Identical twins who have been raised separately sometimes develop the same phobias.   |
| <b>T F</b> | 6. In North America, today's young adults are three times as likely as their grandparents to report having experienced depression.         |
| <b>T F</b> | 7. White Americans commit suicide nearly twice as often as Black Americans do.   |
| <b>T F</b> | 8. There is strong evidence for a genetic predisposition to schizophrenia.   |
| <b>T F</b> | 9. Dissociative identity disorder is a type of schizophrenia.  |
| <b>T F</b> | 10. About 1 in 4 adult Americans suffers from a diagnosable mental disorder in a given year.   |