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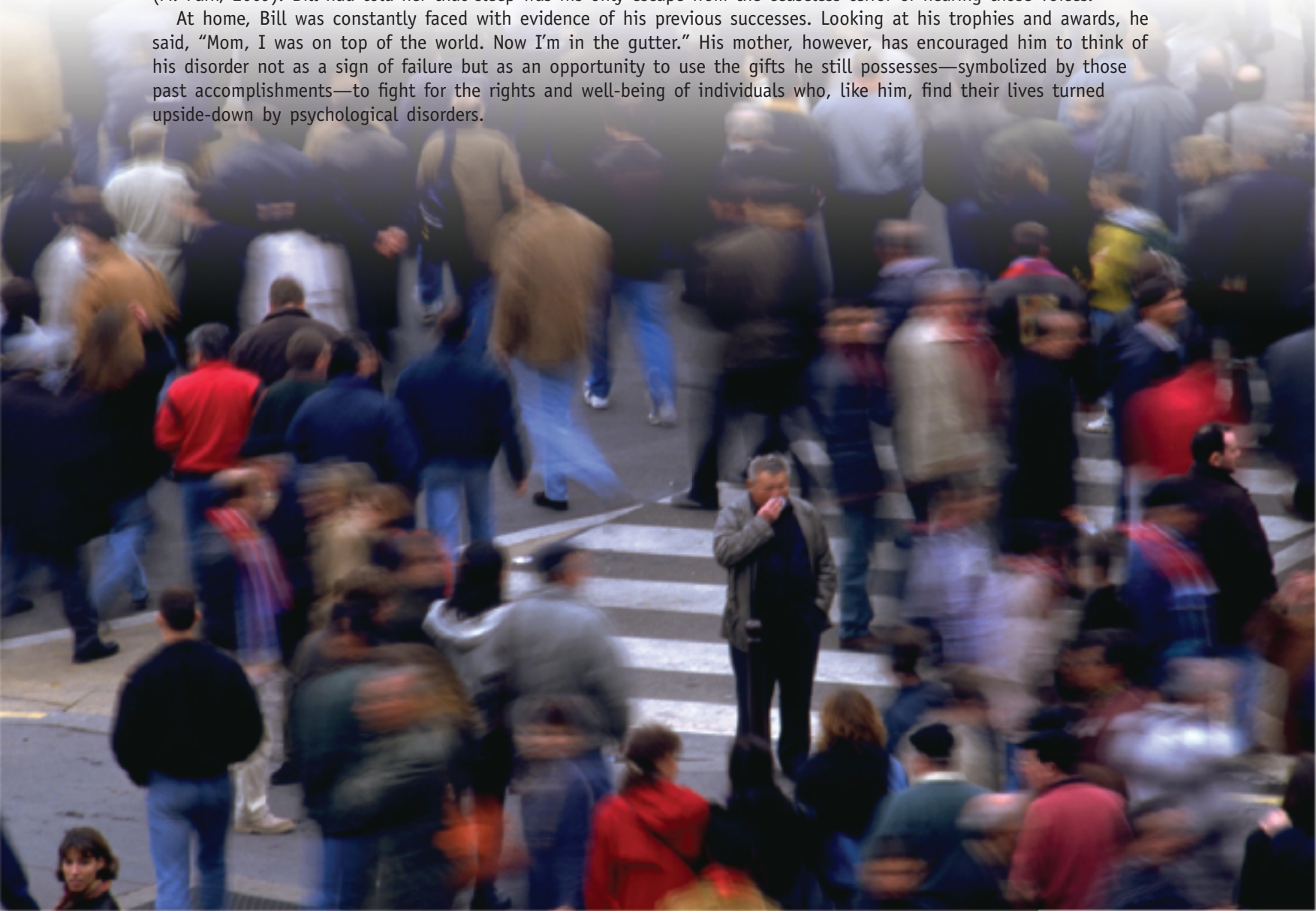
Psychological Disorders

The Courage to Wake Up Every Morning

Bill Garrett was a freshman scholarship recipient at Johns Hopkins University when he began to hear strange voices inside his head. Those voices told him profoundly disturbing things: that he was stupid and fat, that soap and shampoo were toxic, that his father had poisoned the family dog, and that his grandmother was putting human body parts in his food. Bill withdrew into this terrifying inner world. Eventually, he was diagnosed with schizophrenia, a disorder characterized by disturbed thought. Failing in his classes, this previously excellent student (and track and lacrosse star) was forced to return home.

Bill's mother understood her son's experience when she found herself at a support group for families of individuals with schizophrenia. At one point, surrounded by 10 people all speaking to her at once, she was overwhelmed by the confusing cacophony. Afterward she told her son, "You have to be the most courageous person. You wake up every morning" (M. Park, 2009). Bill had told her that sleep was his only escape from the ceaseless terror of hearing those voices.

At home, Bill was constantly faced with evidence of his previous successes. Looking at his trophies and awards, he said, "Mom, I was on top of the world. Now I'm in the gutter." His mother, however, has encouraged him to think of his disorder not as a sign of failure but as an opportunity to use the gifts he still possesses—symbolized by those past accomplishments—to fight for the rights and well-being of individuals who, like him, find their lives turned upside-down by psychological disorders.





This chapter explores the meaning of the word *abnormal* as it relates to psychology. We examine various theoretical approaches to understanding abnormal behavior and survey the main psychological disorders. We delve into how stigma plays a role in the lives of individuals struggling with psychological disorders, and we consider how even difficult, troubled lives remain valuable and meaningful.

1

Defining and Explaining Abnormal Behavior

abnormal behavior

Behavior that is deviant, maladaptive, or personally distressful over a relatively long period of time.

What makes behavior “abnormal”? The American Psychiatric Association (2001, 2006, 2013) defines abnormal behavior in medical terms: a mental illness that affects or is manifested in a person’s brain and can affect the way the individual thinks, behaves, and interacts with others. Abnormal behavior may also be defined by three criteria that distinguish it from normal behavior: **Abnormal behavior** is deviant, maladaptive, or personally distressful over a relatively long period of time. Only one of these criteria needs to be present for a behavior to be labeled “abnormal,” but typically two or all three are present.

EXPERIENCE IT!
Normal vs. Abnormal Behavior



Three Criteria of Abnormal Behavior

Let’s take a close look at what each of the three characteristics of abnormal behavior entails:


- Abnormal behavior is *deviant*. Abnormal behavior is certainly atypical or statistically unusual. However, Alicia Keys, Hope Solo, and Mark Zuckerberg are atypical in many of their behaviors, and yet we do not categorize them as abnormal. We do often consider




Accomplished individuals such as singer-songwriter Alicia Keys, champion soccer goalkeeper Hope Solo, and Facebook CEO Mark Zuckerberg are atypical but not abnormal. However, when atypical behavior deviates from cultural norms, it often is considered abnormal.

atypical behavior abnormal, though, when it deviates from what is acceptable in a culture. A woman who washes her hands three or four times an hour and takes seven showers a day is abnormal because her behavior deviates from culturally acceptable norms.

- Abnormal behavior is *maladaptive*. Maladaptive behavior interferes with one's ability to function effectively in the world. A man who believes that he can endanger others through his breathing may go to great lengths to isolate himself from people for what he believes is their own good. His belief negatively affects his everyday functioning; thus, his behavior is maladaptive. Behavior that presents a danger to the person or those around him or her is also considered maladaptive (and abnormal).
- Abnormal behavior is *personally distressful* over a long period of time. The person engaging in the behavior finds it troubling. A woman who secretly makes herself vomit after every meal may never be seen by others as deviant (because they do not know about it), but this pattern of behavior may cause her to feel intense shame, guilt, and despair.

 *Context matters! If the woman who washes her hands three or four times an hour and takes repeated showers works in a sterile lab with toxic chemicals or live viruses, her behavior might be quite adaptive.*

 *Which of these three qualities—deviation from what is acceptable, maladaptiveness, and personal distress—do you think is most important to calling a behavior abnormal? Why?*


Culture, Context, and the Meaning of Abnormal Behavior

Because culture establishes the norms by which people evaluate their own and others' behaviors, culture is at the core of what it means to be normal or abnormal (Agorastos, Haasen, & Huber, 2012). In evaluating behavior as normal or abnormal, culture matters in complex ways (Sue & others, 2013). Cultural norms provide guidance about how people should behave and what behavior is healthy or unhealthy. Importantly, however, cultural norms can be mistaken. One only has to watch an episode of *Mad Men* to recognize that at one time cigarette smoking was not only judged to be an acceptable habit but also promoted as a healthy way to relax. The point is, definitions of *normal* change as society changes.

Significant, too, is the fact that cultural norms can be limiting, oppressive, and prejudicial (Potter, 2012). Individuals who fight to change the established social order sometimes face the possibility of being labeled deviant—and even mentally ill. In the late nineteenth and early twentieth centuries, for instance, women in Britain who demonstrated for women's right to vote were widely viewed to be mentally ill. When a person's or a group's behavior challenges social expectations, we must open our minds to the possibility that such actions are in fact an adaptive response to injustice. People may justifiably challenge what everyone thinks is true and may express ideas that seem strange. They should be able to make others feel uncomfortable without being labeled abnormal.

Further, as individuals move from one culture to another, interpretations and evaluations of their behavior must take into account the norms in their culture of origin (Bourque & others, 2012; John & others, 2012). Historically, people entering the United States from other countries were examined at Ellis Island, and many were judged to be mentally impaired simply because of differences in their language and customs.

Cultural variation in what it means to be normal or abnormal makes it very difficult to compare different psychological disorders across different cultures. Many of the diagnostic categories we trace in this chapter primarily reflect Western (and often U.S.) notions of normality, and applying these to other cultures can be misleading and even inappropriate (Agorastos, Haasen, & Huber, 2012). Throughout this chapter, we will see how culture influences the experience of psychological disorders.

 *Consider, for instance, that a symptom of one of Sigmund Freud's most famous patients, Anna O., was that she was not interested in getting married.*



Spend 15 to 20 minutes observing an area with a large number of people, such as a mall, a cafeteria, or a stadium during a game. Identify and make a list of behaviors you would classify as abnormal. How does your list of behaviors compare with the definition of *abnormal* provided above? What would you change in the list if you were in a different setting, such as a church, a bar, or a library? What does this exercise tell you about the meaning of *abnormal*?

Theoretical Approaches to Psychological Disorders

What causes people to develop a psychological disorder, that is, to behave in deviant, maladaptive, and personally distressful ways? Theorists have suggested various approaches to this question.

THE BIOLOGICAL APPROACH The *biological approach* attributes psychological disorders to organic, internal causes. This perspective primarily focuses on the brain, genetic factors, and neurotransmitter functioning as the sources of abnormality.

The biological approach is evident in the **medical model**, which describes psychological disorders as medical diseases with a biological origin. From the perspective of the medical model, abnormalities are called “mental illnesses,” the afflicted individuals are “patients,” and they are treated by “doctors.”

medical model
The view that psychological disorders are medical diseases with a biological origin.

THE PSYCHOLOGICAL APPROACH The *psychological approach* emphasizes the contributions of experiences, thoughts, emotions, and personality characteristics in explaining psychological disorders. Psychologists might focus, for example, on the influence of childhood experiences, personality traits, learning experiences, or cognitions in the development and course of psychological disorders.

THE SOCIOCULTURAL APPROACH The *sociocultural approach* emphasizes the social contexts in which a person lives, including gender, ethnicity, socioeconomic status, family relationships, and culture. For instance, poverty is related to rates of psychological disorders (Jeon-Slaughter, 2012; Rosenthal & others, 2012).

The sociocultural perspective stresses the ways that cultures influence the understanding and treatment of psychological disorders. The frequency and intensity of psychological disorders vary and depend on social, economic, technological, and religious aspects of cultures (Matsumoto & Juang, 2013). Some disorders are culture-related, such as *windigo*, a disorder recognized by northern Algonquian Native American groups that involves fear of being bewitched and turned into a cannibal.

Importantly, different cultures may interpret the same pattern of behaviors in very different ways. When psychologists look for evidence of the occurrence of a particular disorder in different cultures, they must keep in mind that behaviors associated with a disorder might not be labeled as illness or dysfunction within a particular cultural context. Cultures might have their own interpretations of these behaviors, so researchers must probe whether locals ever observe these patterns of behavior, even if they are not considered illness (Draguns & Tanaka-Matsumi, 2003). For example, in one study researchers interviewed a variety of individuals in Uganda to see whether dissociative disorders, including dissociative identity disorder (which you might know as multiple personality disorder), existed in that culture (Van Duijl, Cardeña, & de Jong, 2011). They found that while most dissociative disorders were recognizable to Ugandans, the local healers consistently labeled what Westerners consider dissociative identity disorder as a spirit possession.

THE BIOPSYCHOSOCIAL MODEL Abnormal behavior can be influenced by biological factors (such as genes), psychological factors (such as childhood experiences), and sociocultural factors (such as gender). These factors can operate alone, but they often act in combination with one another.

To appreciate how these factors work together, let's back up for a moment. Consider that not everyone with a genetic predisposition to schizophrenia develops the disorder. Similarly, not everyone who experiences childhood neglect develops depression. Moreover, even women who live in cultures that strongly discriminate against them do not always develop psychological disorders. Thus, to understand the development of psychological disorders, we must consider a variety of interacting factors from each of the domains of experience.

Sometimes this approach is called *biopsychosocial*. From the biopsychosocial perspective, none of the factors considered is necessarily viewed as more important than another; rather, biological, psychological, and social factors are all significant ingredients in producing both normal and abnormal behavior. Furthermore, these ingredients may combine in unique ways, so that one depressed person might differ from another in terms of the key factors associated with the development of the disorder.

Classifying Abnormal Behavior

To understand, prevent, and treat abnormal behavior, psychiatrists and psychologists have devised systems classifying those behaviors into specific psychological disorders. Classifying psychological disorders provides a common basis for communicating. If one psychologist says that her client is experiencing depression, another psychologist understands that a particular pattern of abnormal behavior has led to this diagnosis. A classification system can also help clinicians predict how likely it is that a particular disorder will occur, which individuals are most susceptible to it, how the disorder progresses, and what the prognosis (or outcome) for treatment is (Birgegård, Norring, & Clinton, 2012a, 2012b).

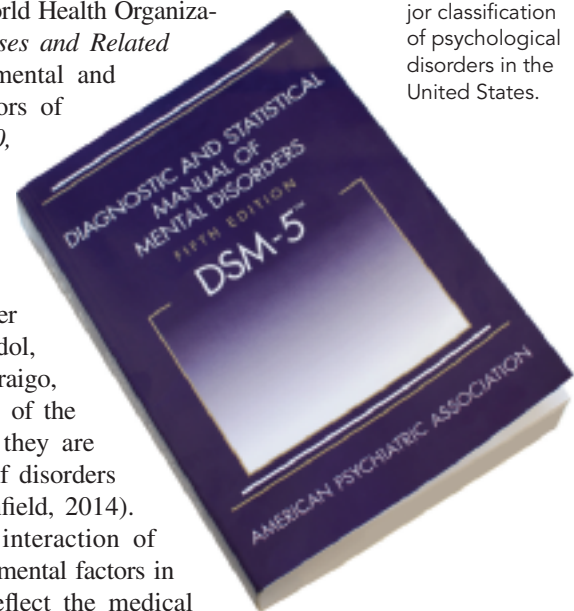
Further, a classification system may benefit the person suffering from psychological symptoms. Having a name for a problem can be a comfort and a signal that treatments are available. On the other hand, officially naming a problem can also have serious negative implications for the person because of the potential for creating *stigma*, a mark of shame that may cause others to avoid or to act negatively toward an individual. Being diagnosed with a psychological disorder can profoundly influence a person's life because of what the diagnosis means with respect to the person and his or her family and larger social world. We discuss stigma further at the end of this chapter.

THE DSM CLASSIFICATION SYSTEM In 1952, the American Psychiatric Association (APA) published the first major classification of psychological disorders in the United States, the *Diagnostic and Statistical Manual of Mental Disorders*. Its current version, **DSM-5**, was approved in 2013. This edition of the *DSM* is the product of a 14-year revision process. *DSM-5* differs in many ways from its predecessors. Throughout the history of the *DSM*, the number of diagnosable disorders has increased dramatically. For example, *DSM-5* includes new diagnoses such as binge eating disorder and gambling addiction.

The *DSM* is not the only diagnostic system. The World Health Organization devised the *International Classification of Diseases and Related Problems (ICD-10)*, which includes a chapter on mental and behavioral disorders. One of the goals of the authors of *DSM-5* was to bring diagnoses closer to the *ICD-10*, although the two manuals remain different in important ways.

CRITIQUES OF THE DSM Even before it was published, the *DSM-5* was criticized on a number of bases (British Psychological Society, 2011; Skodol, 2012a, 2012b; Spiegel & others, 2013; Widiger & Craig, 2013). A central criticism that applies to all versions of the *DSM* is that it treats psychological disorders as if they are medical illnesses, taking an overly biological view of disorders that may have their roots in social experience (Blashfield, 2014). Even as research has shed light on the complex interaction of genetic, neurobiological, cognitive, social, and environmental factors in psychological disorders, the *DSM-5* continues to reflect the medical

DSM-5
The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition; the major classification of psychological disorders in the United States.



model (British Psychological Society, 2011), neglecting factors such as poverty, unemployment, and trauma. Another general criticism of the *DSM* is that it focuses strictly on problems. Critics argue that emphasizing *strengths* as well as weaknesses might help to destigmatize psychological disorders. Identifying a person's strengths can be an important step toward maximizing his or her ability to contribute to society (Roten, 2007).

Other criticisms of the *DSM-5* include these:

- It relies too much on social norms and subjective judgments.
- Too many new categories of disorders have been added, some of which do not yet have consistent research support and whose inclusion will lead to a significant increase in the number of people being labeled as having a mental disorder.
- Loosened standards for some existing diagnoses will add to the already very high rates of these.

Figure 12.1 shows some of the changes that are part of the *DSM*'s newest formulation. In thinking about the critiques of these revisions, you might be wondering what all the fuss is about. One reason for these concerns is that U.S. insurance companies generally will reimburse patients only for treatments for diagnoses that appear in the *DSM-5*. Another reason for concern is that part of the medical model is the assumption that disorders optimally are treated through medical means. Generally, that means prescribing medications. With the loosening of diagnostic criteria, many more individuals might be given powerful psychoactive drugs, perhaps unnecessarily. Thus, it is imperative that the *DSM* gets it right, and many critics argue that it falls short in this high-stakes context (Andrews, 2014; Blashfield, 2014; Paris, 2013; Watson & others, 2013).

Concerns are about overdiagnosis and the proliferation of psychoactive drugs are well illustrated by the controversy surrounding **attention-deficit/hyperactivity disorder (ADHD)**. To read more, see Challenge Your Thinking.

EXPERIENCE IT!
Attention Deficit
Hyperactivity Disorder
(ADHD)



attention-deficit/hyperactivity disorder (ADHD)

One of the most common psychological disorders of childhood, in which individuals show one or more of the following: inattention, hyperactivity, and impulsivity.

Disorder	Change	Sources of Concern
Major Depressive Disorder	In the past, those experiencing grief due to the loss of a loved one generally have not been considered depressed. This grief exclusion has been dropped.	This change may result in those experiencing normal grief to be labeled with depression.
Attention-Deficit/Hyperactivity Disorder (ADHD)	Some of the diagnostic requirements have been loosened, and the age of diagnosis has been changed.	Overdiagnosis of ADHD is already a concern, as is the proliferation of drugs used to treat the condition.
Autism Spectrum Disorder	The diagnosis of Asperger syndrome, which was given to high-functioning individuals with autistic characteristics, has been dropped.	Those who were previously diagnosed with Asperger's may not be diagnosed at all and may not receive treatment.
Post-Traumatic Stress Disorder (PTSD)	Previously, a person had to have experienced or witnessed a trauma. Now, PTSD can be diagnosed even for those who only hear about a trauma.	The change may lead to a huge increase in those with this disorder.
Disruptive Mood Regulation Disorder	This is a new diagnosis for children with wild mood swings.	Adding diagnoses targeting children is concerning.
Mild Neurocognitive Impairment	This new diagnosis is for adults experiencing cognitive decline.	Many adults experience mild cognitive decline with age, and this diagnosis may pathologize normal aging.

FIGURE 12.1 New Features of *DSM-5* *DSM-5* has dropped some diagnostic categories, added others, and changed the criteria for still others.

Challenge

YOUR THINKING

Does Everyone Have ADHD?

Perhaps no diagnosis is more controversial these days than attention-deficit/hyperactivity disorder (ADHD), in which individuals, prior to the age of 7, show one or more of the following symptoms: inattention, hyperactivity, and impulsivity. Chances are you know someone who suffers from ADHD. You might even have it yourself.

ADHD is one of the most common psychological disorders of childhood, with diagnoses skyrocketing in recent years. In 1988 just 500,000 cases of ADHD were diagnosed, but by 2007, that number had jumped to 4 million per year (Bloom & Cohen, 2007). In 2010, 10.4 million children were diagnosed with ADHD (Garfield & others, 2012). Experts previously thought that most children “grow out of” ADHD. However, based on evidence showing that as many as 70 percent of adolescents (Sibley & others, 2012) and 66 percent of adults (Asherson & others 2010) diagnosed as children continue to experience ADHD symptoms, *DSM-5* recognizes ADHD in adults.

The sheer number of ADHD diagnoses has prompted speculation that psychiatrists, parents, and teachers are in fact labeling normal childhood behavior as psychopathology (Morrow & others, 2012). One reason for concern about overdiagnosing ADHD is that the form of treatment in well over 80 percent of cases is psychoactive drugs, including stimulants such as Ritalin and Adderall (Garfield & others, 2012). Animal research has shown that in the absence of ADHD, exposure to such stimulants can predispose individuals to later addiction problems (Leo, 2005). Those who question the diagnosis of ADHD in children find it equally problematic in adults (Marcus, Norris, & Cocco, 2012). These scholars argue that the spread of ADHD is primarily a function of overpathologizing normal behavior, confusing ADHD for other disorders, and aggressive marketing by pharmaceutical companies (Moncrieff & Timimi, 2010).

A recent study sheds some light on the controversy. Child psychologists, psychiatrists, and social workers were sent vignettes of cases of children in which symptoms were described (Brüchmiller, Margraf, & Schneider, 2012), and were asked to diagnose the children. Some of the descriptions fit the diagnostic criteria for ADHD, but others lacked key features of the disorder. In addition, in the case vignettes, the researchers varied whether the child was identified as male or female. The dependent variable was whether these professionals gave a diagnosis



of ADHD to a case. The results showed that participants *overdiagnosed* ADHD, giving an ADHD diagnosis to cases that specifically lacked important aspects of the disorder about 17 percent of the time. Further, regardless of symptoms, boys were two times more likely than girls to receive such a diagnosis. An important lesson from this study is that professionals must be vigilant in their application of diagnostic criteria as they encounter different cases. The results

also demonstrate how even professionals can fall prey to certain biases.

Certainly, individuals who experience ADHD have symptoms that make adjustment difficult, so it is critical that diagnosis of the disorder be accurate. Children diagnosed with ADHD are at heightened risk of dropping out of school, teen pregnancy, and antisocial behavior (Barkley & others, 2002; von Polier, Vloet, & Herpertz-Dahlmann, 2012). Adolescents and adults with ADHD symptoms are more likely to experience difficulties at work, while driving a car, and in interpersonal relationships; they are also more likely to have substance abuse problems (Chang, Lichtenstein, & Larsson, 2012; Kooij & others, 2010; Sibley & others, 2012).

ADHD is not the only controversial diagnosis; nor is this psychological disorder the only one given a great deal of attention by pharmaceutical companies (Mash & Wolfe, 2013). Drug companies commonly fund research that focuses on a disease model of psychological disorders. Clearly, psychological disorders are “real” in the sense that they lead to objectively negative outcomes in people’s lives. The controversy over ADHD is a reminder of the important role of psychology research in clarifying and defining diagnostic categories. Indeed, the aim of the profession is to avoid inappropriately labeling, misdiagnosing, and mistreating people who are already suffering.

What Do You Think?

- Would ADHD be as controversial if the treatment did not involve drugs? Why or why not?
- Do you think ADHD would be diagnosed as often as it is if drugs were not readily available for its treatment?
- If a teacher suggested that your child be tested for ADHD, what would you do?

Before we begin our survey of various psychological disorders, a word of caution. It is very common for individuals who are learning about psychological disorders to recognize the symptoms and behaviors of disorders in themselves or in people around them. Keep in mind that only trained professionals can diagnose a psychological disorder.

- All of the following are characteristics of abnormal behavior *except*
 - it is typical.
 - it causes distress.
 - it is maladaptive.
 - it is deviant.
 - The medical model interprets psychological disorders as medical diseases with a/an
 - environmental origin.
 - sociocultural origin.
 - biological origin.
 - biopsychosocial origin.
 - A central complaint about *DSM-5* is that it neglects factors such as
 - inherited tendencies toward particular diseases.
 - age.
 - economic and employment status.
 - All of the above.
- APPLY IT!** 4. Since she was a little girl, 19-year-old Francesca has believed that whenever she walks through a doorway, she must touch the doorframe 12 times and silently count to 12 or else her mother will die. She has never told anyone about this ritual, which she feels is harmless, similar to carrying a lucky charm. Which of the following is true of Francesca's behavior?
- Francesca's behavior is abnormal only because it is different from the norm. It is not maladaptive, nor does it cause her distress.
 - Francesca's behavior fits all three characteristics of abnormal behavior.
 - Francesca's behavior is maladaptive, but it is not abnormal because she does not feel personal distress over her ritual.
 - Francesca's behavior does not fit any of the characteristics of abnormal behavior.

2 Anxiety and Anxiety-Related Disorders

Think about how you felt before a make-or-break exam or a big presentation—or perhaps as you noticed police lights flashing behind your speeding car. Did you feel jittery and nervous and experience tightness in your stomach? These are the feelings of normal anxiety, an unpleasant feeling of fear and dread.

In contrast, **anxiety disorders** involve fears that are uncontrollable, disproportionate to the actual danger the person might be in, and disruptive of ordinary life. They feature motor tension (jumpiness, trembling), hyperactivity (dizziness, a racing heart), and apprehensive expectations and thoughts. *DSM-5* recognizes 12 types of anxiety disorders. In this section, we survey four common anxiety disorders

- Generalized anxiety disorder
- Panic disorder
- Specific phobia
- Social anxiety disorder

as well as two disorders that are not classified as anxiety disorders but are related to the experience of anxiety:

- Obsessive-compulsive disorder (categorized under Obsessive-Compulsive and Related Disorders)
- Post-traumatic stress disorder (categorized under Trauma- and Stressor-Related Disorders)

Generalized Anxiety Disorder


When you are worrying about getting a speeding ticket, you know why you are anxious; there is a specific cause. **Generalized anxiety disorder** is different from such everyday feelings of anxiety in that sufferers experience persistent anxiety for at least 6 months and are unable to specify the reasons for the anxiety (Freeman & Freeman, 2012). People with generalized anxiety disorder are nervous most of the time. They may worry

anxiety disorders

Disabling (uncontrollable and disruptive) psychological disorders that feature motor tension, hyperactivity, and apprehensive expectations and thoughts.

generalized anxiety disorder

Psychological disorder marked by persistent anxiety for at least 6 months, and in which the individual is unable to specify the reasons for the anxiety.


 Recall from Chapter 2 that GABA is the neurotransmitter that inhibits neurons from firing—it's like the brain's brake pedal. Problems with GABA are often implicated in anxiety disorders.

about their work, relationships, or health. That worry can also take a physical toll and cause fatigue, muscle tension, stomach problems, and difficulty sleeping.

What is the etiology of generalized anxiety disorder? (*Etiology* means the causes or significant preceding conditions.) Among the biological factors are genetic predisposition, deficiency in the neurotransmitter GABA, and respiratory system abnormalities (Boschen, 2012). The psychological and sociocultural factors include having harsh (or even impossible) self-standards, overly strict and critical parents, automatic negative thoughts when feeling stressed, and a history of uncontrollable traumas or stressors (such as an abusive parent).

Panic Disorder

Much like everyone else, you might sometimes have a specific experience that sends you into a panic. For example, you work all night on a paper, only to have your computer crash before you saved your last changes, or you are about to dash across a street just when you see a large truck coming right at you. Your heart races, your hands shake, and you might break into a sweat.

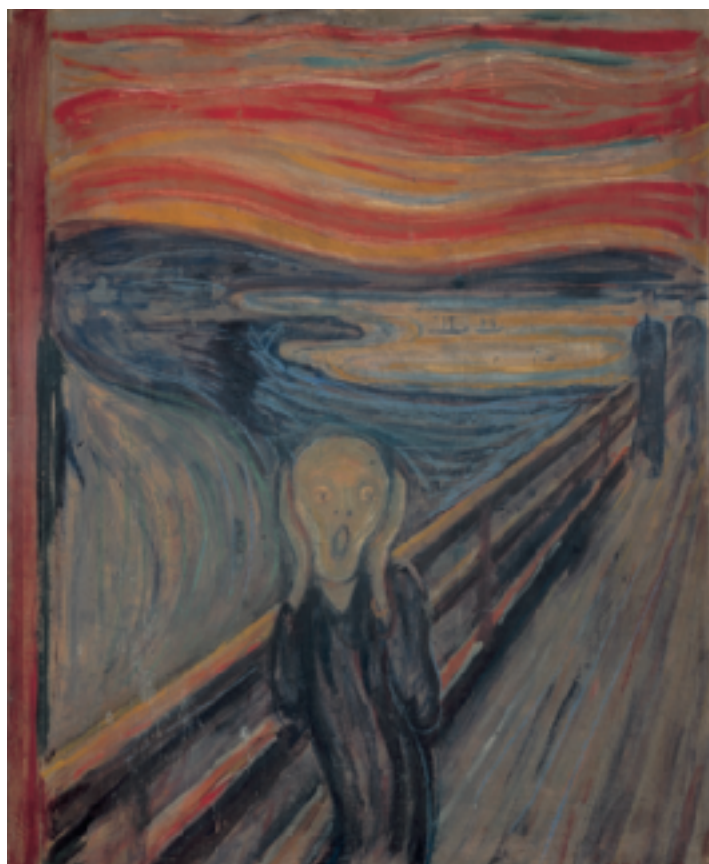
 A panic attack can be a one-time occurrence. People with panic disorder have recurrent attacks that sometimes cause them to be afraid to even leave their homes, a condition called agoraphobia.

In a **panic disorder**, however, a person experiences recurrent, sudden onsets of intense terror, often without warning and with no specific cause. Panic attacks can produce severe palpitations, extreme shortness of breath, chest pains, trembling, sweating, dizziness, and a feeling of helplessness (Oral & others, 2012). People with panic disorder may feel that they are having a heart attack or going to die.

panic disorder
Anxiety disorder in which the individual experiences recurrent, sudden onsets of intense terror, often without warning and with no specific cause.

During a panic attack, the brain registers fear as areas of the fear network of the limbic system, including the amygdala and hippocampus, are activated (Holzschneider & Mulert, 2011). Charles Darwin, the scientist who proposed the theory of evolution, suffered from intense panic disorder (Barloon & Noyes, 1997). Former NFL running back Earl Campbell has dealt with this disorder.

What is the etiology of panic disorder? Theories of the origins of panic attack take into account biological, psychological, and sociocultural factors (Pilecki, Arentoft, & McKay, 2011). In terms of biological factors, individuals may have a genetic predisposition to the disorder (Bayoglu & others, 2012). Of particular interest to researchers are genes that direct the action of neurotransmitters such as norepinephrine (Buttenschön & others, 2011) and GABA (Thoeringer & others, 2009). Another brain chemical, *lactate*, which plays a role in brain metabolism, has been found to be elevated in individuals with panic disorder (Maddock & others, 2009). Further, experimental research has shown that increasing lactate levels can produce panic attacks (Reiman & others 1989). Other research points to the involvement of a wider range of genes and bodily systems, implicating genes involved in hormone regulation (Wilson, Markie, & Fitches, 2012) and responses to stress (Esler & others, 2009).



Many experts interpret Edvard Munch's painting *The Scream* as an expression of the terror brought on by a panic attack.

With respect to psychological influences, learning processes, as described in Chapter 5, are one factor that has been considered in panic disorder. Classical conditioning research has shown that learned associations between bodily cues of respiration and fear can play a role in panic attacks (Acheson, Forsyth, & Moses, 2012). Interestingly, carbon dioxide (CO₂) has been found to be a very strong conditioned stimulus for fear, suggesting that humans may be *biologically prepared* to learn an association between high concentrations of CO₂ and fear (Acheson, Forsyth, & Moses, 2012; De Cort & others, 2012; Nardi & others, 2006; Schenberg, 2010). Thus, some learning researchers have suggested that at the heart of panic attacks are the learned associations between CO₂ and fear (De Cort & others, 2012).

In addition, the learning concept of *generalization* may apply to panic attack. Recall that in classical conditioning, generalization means showing a conditioned response (in this case, fear) to conditioned stimuli other than the particular one used in learning. Research shows that individuals who suffer from panic attacks are more likely to display overgeneralization of fear learning (Lissek & others, 2010). Why might those who suffer from panic attacks be more likely to show stronger and more generalized fear associations? One possibility is that the biological predispositions as well as early experiences with traumatic life events may play a role in setting the stage for such learning (Pilecki, Arentoft, & McKay, 2011).

In terms of sociocultural factors, in the United States, women are twice as likely as men to have panic attacks (Altemus, 2006). Possible reasons include biological differences in hormones and neurotransmitters (Altemus, 2006; Fodor & Epstein, 2002). Compared to men, women are more likely to complain of distressing respiratory experiences during panic attacks (Sheikh, Leskin, & Klein, 2002). Interestingly, a recent study showed that healthy women are more likely to experience panic-related emotions when exposed to air enriched with CO₂ (Nillni & others, 2012).

Research also suggests that women may cope with anxiety-provoking situations differently than men do, and these differences may explain the gender difference in panic disorder (Schmidt & Koselka, 2000; Viswanath & others, 2012). Panic attack has been observed in a variety of cultures, though there are some cultural differences in the experience of these attacks (Agorastos, Haasen, & Huber, 2012). For instance, in Korea, panic attacks are less likely to include a fear of dying than is the case in other societies (Weissman & others, 1995).

An earlier explanation of panic attack was called the suffocation false alarm theory. Can you see why it was initially proposed?

Whenever you encounter gender differences in this discussion, ask yourself whether men or women might be more likely to report having problems or to seek treatment. Research on psychological disorders is often based on individuals who have reported symptoms or sought help. If men are less likely to report symptoms or seek treatment, the data may underestimate the occurrence of psychological disorders in men.

Specific Phobia

Many people are afraid of spiders and snakes; indeed, thinking about letting a tarantula crawl over one's face is likely to give anyone the willies. It is not uncommon to be afraid of particular objects or specific environments such as extreme heights. For most of us, these fears do not interfere with daily life. A fear becomes a phobia when a situation is so dreaded that an individual goes to almost any length to avoid it. A snake phobia that keeps a city-dweller from leaving his apartment is clearly disproportionate to the actual chances of encountering a snake. **Specific phobia** is a psychological disorder in which an individual has an irrational, overwhelming, persistent fear of a particular object or situation. Specific phobias come in many forms, as shown in Figure 12.2.

Where do specific phobias come from? Approaches to answering this question typically first acknowledge that fear plays an important role in adaptive behavior. Fear tells us when we are in danger and need to take to action. The importance of this function

specific phobia

Psychological disorder in which an individual has an irrational, overwhelming, persistent fear of a particular object or situation.



"Stephen's fear of heights is particularly bad today."

Used by permission of CartoonStock, www.CartoonStock.com.



FIGURE 12.2 Specific Phobias This figure features examples of specific phobias—anxiety disorders characterized by irrational and overwhelming fear of a particular object or situation.

suggests that fears should be relatively quickly learned, because learning to fear things that will harm us keeps us out of harm’s way. Specific phobias, then, might be considered, an extreme and unfortunate variant on this adaptive process (Coelho & Purkis, 2009; Muris & Merckelbach, 2012).

Many explanations of specific phobias view these disorders as based on experiences, memories, and learned associations (Veale & others, 2013). For example, the individual with a fear of heights perhaps experienced a fall from a high place earlier in life and therefore associates heights with pain (a classical conditioning explanation). Alternatively, he or she may have heard about or watched others who demonstrated terror of high places (an observational learning explanation), as when a little girl develops a fear of heights after sitting next to her terrified mother and observing her clutch the handrails, white-knuckled, as the roller coaster creeps steeply uphill. Not all people who have a specific phobia can easily identify experiences that explain these, so other factors may also be at play (Coelho & Purkis, 2009). Each specific phobia may have its own neural correlates (Lueken, 2011), and some people may be especially prone to develop phobias (Burstein & others, 2012).

Social Anxiety Disorder

Imagine how you might feel just before you first meet the parents of the person you hope to marry. You might feel fearful of committing some awful gaff, ruining the impression you hope to make on them. Or imagine getting ready to give a big speech before a crowd and suddenly realizing you have forgotten your notes. **Social anxiety disorder** (also called *social phobia*) is an intense fear of being humiliated or embarrassed in social situations like these (Lampe & Sutherland, 2013; Morrison & Heimberg, 2013). Singers Carly Simon and Barbra Streisand have dealt with social phobia.

Social anxiety disorder (social phobia)

An intense fear of being humiliated or embarrassed in social situations.

Where does social anxiety disorder come from? Genes appear to play a role (Sakolsky, McCracken, & Nurmi, 2013), along with neural circuitry involving the thalamus, amygdala, and cerebral cortex (Damsa, Kosel, & Moussally, 2009). A number of neurotransmitters also may be involved, especially serotonin (Christensen & others, 2010). Social anxiety disorder may involve vulnerabilities, such as genetic characteristics or parenting styles that lay a foundation of risk, combined with learning experiences in a social context (Higa-McMillen & Besutani, 2011; Pejic & others, 2013).

In the *DSM-5*, generalized anxiety disorder, panic disorder, specific phobia, and social anxiety disorder are all classified as anxiety disorders (Andrews, 2014; Gallo & others, 2013). Our next two topics, obsessive-compulsive disorder and post-traumatic stress disorder, are not included under the umbrella of Anxiety Disorders. Instead, these disorders have their own separate categories. Nonetheless, anxiety is relevant to both of these disorders.



"I gotta go—we're discussing my compulsive communications disorder."

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Obsessive-Compulsive Disorder

Just before leaving on a long road trip, you find yourself checking to be sure you locked the front door. As you pull away in your car, you are stricken with the thought that you forgot to turn off the coffeemaker. Going to bed the night before an early flight, you check your alarm clock a few times to be sure you will wake up on time. These are examples of normal checking behavior.

obsessive-compulsive disorder (OCD)
Anxiety disorder in which the individual has anxiety-provoking thoughts that will not go away and/or urges to perform repetitive, ritualistic behaviors to prevent or produce some future situation.

In contrast, the disorder known as **obsessive-compulsive disorder (OCD)** features anxiety-provoking thoughts that will not go away and/or urges to perform repetitive, ritualistic behaviors to prevent or produce some future situation. *Obsessions* are recurrent thoughts, and *compulsions* are recurrent behaviors. Individuals with OCD dwell on their doubts and repeat their routines sometimes hundreds of times a day (Yap, Mogan, & Kyrios, 2012). The most common compulsions are excessive checking, cleansing, and counting. Game show host Howie Mandel has coped with OCD, as have soccer star David Beckham, singer-actor Justin Timberlake, and actress Jessica Alba. Obsessive-compulsive symptoms have been found in many cultures, and culture plays a role in the content of obsessive thoughts or compulsive behaviors (Matsunaga & Seedat, 2011).

An individual with OCD might believe that she has to touch the doorway with her left hand whenever she enters a room and count her steps as she walks. If she does not complete this ritual, she may be overcome with a sense of fear that something terrible will happen (Victor & Bernstein, 2009).

What is the etiology of obsessive-compulsive disorder? In terms of biological factors, there seems to be a genetic component (Alonso & others, 2012; Angoa-Perez & others, 2012). Also, brain-imaging studies have suggested neurological links for OCD (Hou & others, 2012; Stern & others, 2012). One neuroscientific analysis is that the frontal cortex or basal ganglia are so active in OCD that numerous impulses reach the thalamus, generating obsessive thoughts or compulsive actions (Rotge & others, 2009).

In one study, fMRI was used to examine the brain activity of individuals with OCD before and after treatment (Nakao & others, 2005). Following effective treatment, a number of areas in the frontal cortex showed decreased activation. Interestingly, the amygdala, which is associated with the experience of anxiety, may be smaller in individuals with OCD compared to those who do not have the disorder (Atmaca & others, 2008). Low levels of the neurotransmitters serotonin and dopamine likely are involved in the brain pathways linked with OCD (Goljecscek & Carvalho, 2011; Soomro, 2012).

In terms of psychological factors, OCD sometimes occurs during a period of life stress such as that surrounding the birth of a child or a change in occupational or marital status (Uguz & others, 2007). According to the cognitive perspective, what differentiates individuals with OCD from those who do not have it is the ability to turn off negative, intrusive thoughts by ignoring or effectively dismissing them (Leahy, Holland, & McGinn, 2012; C. Williams, 2012).

EXPERIENCE IT!
Obsessive-Compulsive Disorder



As long as the person performs the ritual, she never finds out that the terrible outcome doesn't happen. The easing of the anxiety exemplifies negative reinforcement (having something bad taken away after performing a behavior).

OCD-Related Disorders

DSM-5 expanded the disorders that are thought to be related to OCD (Abramowitz & Jacoby, 2014). All of these disorders involve repetitive behavior and often anxiety. Among the new additions are the following.

- *Hoarding disorder* involves compulsive collecting, poor organization skills, and difficulty discarding things, along with cognitive deficits in information processing speed, problems with decision making, and procrastination (Tolin, 2008). Individuals with hoarding disorder find it difficult to throw things away and are troubled by the feeling that they might need items like old newspapers at a later time (Dimauro & others, 2013).
- *Excoriation* (or skin picking) refers to the particular compulsion of picking at one's skin, sometimes to the point of injury. Skin picking is more common among women than men and is seen as a symptom of autism spectrum disorder.
- *Trichotillomania* (hair pulling) entails compulsively pulling at the hair from the scalp, eyebrows, and other body areas (Walther & others, 2013). Hair pulling from the scalp can lead to bald patches that the person can go to great lengths to disguise.
- *Body Dysmorphic Disorder* involves a distressing preoccupation with imagined or slight flaws in one's physical appearance (Kaplan & others, 2013). Individuals with this disorder cannot stop thinking about how they look and repeatedly compare their appearance to others, check themselves in the mirror, and so forth. Body dysmorphic disorder may include maladaptive behaviors such as compulsive exercise and body building and repeated cosmetic surgery and occurs about equally in men and women.

Post-Traumatic Stress Disorder

If you have ever been in even a minor car accident, you may have had a nightmare or two about it. You might have even found yourself reliving the experience for some time. This normal recovery process takes on a particularly devastating character in **post-traumatic stress disorder (PTSD)**, develops through exposure to a traumatic event that overwhelms the person's abilities to cope (Beidel, Bulik, & Stanley, 2012). The *DSM-5* has expanded the kinds of experiences that might foster PTSD, recognizing that the disorder can occur not only in individuals who directly experience a trauma but also in those who witness it and those who only *hear* about it (APA, 2013). The symptoms of PTSD vary but include:

- Flashbacks in which the individual relives the event. A flashback can make the person lose touch with reality and reenact the event for seconds, hours, or, very rarely, days. A person having a flashback—which can come in the form of images, sounds, smells, and/or feelings—usually believes that the traumatic event is happening all over again (Brewin, 2012).
- Avoiding emotional experiences and avoiding talking about emotions with others.
- Reduced ability to feel emotions, often reported as feeling numb.
- Excessive arousal, resulting in an exaggerated startle response or an inability to sleep.
- Difficulties with memory and concentration.
- Impulsive behavior.

PTSD symptoms can follow a trauma immediately or after months or even years (Solomon & others, 2012). Most individuals who are exposed to a traumatic event experience some of the symptoms in the days and weeks following exposure (National Center for PTSD, 2012). However, not every individual exposed to the same event develops PTSD (Brewin & others, 2012; Nemeroff & others, 2006).

post-traumatic stress disorder (PTSD)

Anxiety disorder that develops through exposure to a traumatic event, a severely oppressive situation, cruel abuse, or a natural or an unnatural disaster.



The Psychological Wounds of War

PTSD has been a concern for soldiers who have served in Iraq and Afghanistan (Klemanski & others, 2012; Yoder & others, 2012). In an effort to prevent PTSD, the U.S. military gives troops stress-management training before deployment (Ritchie & others, 2006). Branches of the armed forces station mental health professionals in combat zones around the world to help prevent PTSD and to lessen the effects of the disorder (Rabasca, 2000). These measures appear to be paying off: Researchers have found that PTSD sufferers from the Iraq and Afghanistan wars are generally less likely to be unemployed or incarcerated and more likely to maintain strong social bonds following their term of service than veterans of earlier wars (Fontana & Rosenheck, 2008).

Historically, the stigma associated with psychological disorders has been especially strong within the military ranks, where struggling with a psychological problem is commonly viewed as a sign of weakness or incompetence (Warner & others, 2011). Yet individuals engaged in combat are at considerable risk of developing PTSD, and the disorder can profoundly affect their lives. A survey of almost 3,000 soldiers who had just returned from the Iraq War revealed that 17 percent met the criteria for PTSD (Hoge & others, 2007). This figure is likely an underestimate given the stigma linked to psychological disorders in the military.

In 2008, military psychologist John Fortunato suggested that veterans with PTSD ought to be eligible for the Purple Heart, the prestigious military decoration awarded to those who have been physically wounded or killed in combat (Schogol, 2009). Awarding PTSD sufferers the Purple Heart, Fortunato argued, would not only acknowledge their sacrifice but also reduce the stigma attached to psychological disorders. That year, the military did consider whether PTSD sufferers in its ranks ought to be awarded the Purple Heart. However, the Pentagon decided against awarding the Purple Heart to military personnel with PTSD on the grounds that the disorder is not limited to victims of physical trauma from enemy fire but also can affect eyewitnesses (Schogol, 2009). Still, the fact that the top brass considered the possibility suggests that the military is becoming more aware of the serious problems facing those who are traumatized while serving their country in combat.



Researchers have examined PTSD associated with various experiences (Harder & others, 2012). These include combat and war-related traumas (Khamis, 2012), sexual abuse and assault (S. Y. Kim & others, 2012), natural disasters such as hurricanes and earthquakes (Sezgin & Punamaki, 2012), and unnatural disasters such as plane crashes and terrorist attacks (Luft & others, 2012).

Clearly, one cause of PTSD is the traumatic event itself (Risbrough & Stein, 2012). However, because not everyone who experiences the same traumatic life event develops PTSD, other factors, aside from the event, must influence a person's vulnerability to the disorder (Gabert-Quillen & others, 2012). These include a history of previous traumatic events and conditions, such as abuse and psychological disorders



Prior to deployment, U.S. troops receive stress-management training aimed at helping to prevent PTSD and other disorders that might be triggered by the high-stress conditions of war.

(Canton-Cortes, Canton, & Cortes, 2012), cultural background as in the case of traumatized refugees (Hinton & others, 2012), and genetic predisposition (Mehta & Binder, 2012; Skelton & others, 2012).

self-quiz

1. Sudden episodes of extreme anxiety or terror that involve symptoms such as heart palpitations, trembling, sweating, and fear of losing control are characteristic of
 - A. generalized anxiety disorder.
 - B. post-traumatic stress disorder.
 - C. obsessive-compulsive disorder.
 - D. panic disorder.
2. Which of the following is true of post-traumatic stress disorder?
 - A. It is caused by panic attacks.
 - B. It is the natural outgrowth of experiencing trauma.
 - C. It involves flashbacks.
 - D. The symptoms always occur immediately following a trauma.
3. An irrational, overwhelming, persistent fear of a particular object or situation is a defining characteristic of
 - A. post-traumatic stress disorder.
 - B. specific phobia.
 - C. panic disorder.
 - D. generalized anxiety disorder.

APPLY IT! 4. Lately Tina has noticed that her mother appears to be overwhelmed with worry about everything. Her mother

has told Tina that she is having trouble sleeping and experiencing racing thoughts of all the terrible things that might happen at any given moment. Tina's mother is showing signs of

- A. panic disorder.
- B. obsessive-compulsive disorder.
- C. generalized anxiety disorder.
- D. post-traumatic stress disorder.

3 Disorders Involving Emotion and Mood

Our emotions and moods tell us how we are doing in life. We feel good or bad depending on our progress on important goals, the quality of our relationships, and so on. For some individuals, however, the link between life experiences and emotions is off-kilter. They may feel sad for no reason or a sense of elation in the absence of any great accomplishment. Several psychological disorders involve this kind of dysregulation in a person's emotional life. In this section we examine the two such disorders—depressive disorders and bipolar disorders—and consider a tragic correlate of these disorders: suicide.

Depressive Disorders

Everyone feels blue sometimes. A romantic breakup, the death of a loved one, or a personal failure can cast a dark cloud over life. Sometimes, however, a person might feel unhappy and not know why. **Depressive disorders** are disorders in which the individual suffers from *depression*, an unrelenting lack of pleasure in life. Depressive disorders are common. A representative U.S. survey including individuals aged 13 and up found that approximately 30 percent reported a depressive episode or diagnosis in the last 12 months (Kessler & others, 2012).

A variety of cultures have recognized depression, and studies have shown that across cultures depression is characterized as involving an absence of joy, low energy, and high levels of sadness (Dritschel & others, 2011; Kahn, 2012). Moreover, culture may influence the ways individuals describe their experience. For instance, people from Eastern cultures may be less likely to talk about their emotional states, and more likely to describe depressive symptoms in terms of bodily feelings and symptoms, than those from Western cultures (Draguns & Tanaka-Matsumi, 2003). Many

depressive disorders

Mood disorders in which the individual suffers from depression—an unrelenting lack of pleasure in life.

successful individuals have been diagnosed with depression. They include musicians Sheryl Crow and Eric Clapton, actors Drew Barrymore, Halle Berry, and Jim Carrey, artist Pablo Picasso, astronaut Buzz Aldrin (the second moon walker), famed American architect Frank Lloyd Wright, and J. K. Rowling, the author of the *Harry Potter* series.

major depressive disorder (MDD)

Psychological disorder involving a major depressive episode and depressed characteristics, such as lethargy and hopelessness, for at least two weeks.

Major depressive disorder (MDD) involves a significant depressive episode and depressed characteristics, such as lethargy and hopelessness, for at least two weeks. MDD impairs daily functioning, and the National Institute of Mental Health (NIMH) has called it the leading cause of disability in the United States (NIMH, 2008). The symptoms of major depressive disorder may include:

- Depressed mood most of the day
- Reduced interest or pleasure in activities that were once enjoyable
- Significant weight loss or gain or significant decrease or interest in appetite
- Trouble sleeping or sleeping too much
- Fatigue or loss of energy
- Feeling worthless or guilty in an excessive or inappropriate manner
- Problems in thinking, concentrating, or making decisions
- Recurrent thoughts of death and suicide
- No history of manic episodes (periods of euphoric mood)

Individuals who experience less-extreme depressive mood for more than two months may be diagnosed with *persistent depressive disorder*. This disorder includes symptoms such as hopelessness, lack of energy, poor concentration, and sleep problems.

What are the causes of depressive disorders? A variety of biological, psychological, and sociocultural factors have been implicated in their development.

BIOLOGICAL FACTORS Genetic influences play a role in depression (Goenjian & others, 2012; Sabunciyani & others, 2012). In addition, specific brain structures are involved in depressive disorders. For example, depressed individuals show lower levels of brain activity in a section of the prefrontal cortex that is involved in generating actions (Duman & others, 2012) as well as in regions of the brain associated with the perception of rewards in the environment (Howland, 2012). A depressed person's brain may not recognize opportunities for pleasurable experiences.

Depression also likely involves problems in neurotransmitter regulation. Recall that neurotransmitters are chemicals that carry impulses from neuron to neuron. For smooth brain function, neurotransmitters must ebb and flow, often in harmony with one another. Individuals with major depressive disorder appear to have too few receptors for the neurotransmitters serotonin and norepinephrine (Houston & others, 2012; H. F. Li & others, 2012). Some research suggests that problems in regulating a neurotransmitter called *substance P* might be involved in depression (Munoz & Covenas, 2012). Substance P is thought to play an important role in the psychological experience of pain (Sacerdote & Levrini, 2012).

PSYCHOLOGICAL FACTORS Psychological explanations of depression have drawn on behavioral learning theories and cognitive theories. One behavioral view of depression focuses on *learned helplessness*, which, as we saw in Chapter 5, involves an individual's feelings of powerlessness after exposure to aversive circumstances over which the person has no control. Martin Seligman (1975) proposed that learned helplessness is a reason that some people become depressed. When individuals cannot control



This painting by Vincent Van Gogh, *Portrait of Dr. Gachet*, reflects the extreme melancholy that characterizes the depressive disorders.

their stress, they eventually feel helpless and stop trying to change their situations. This helplessness spirals into hopelessness (Becker-Weidman & others, 2009).

Cognitive explanations of depression focus on the thoughts and beliefs that contribute to this sense of hopelessness (Britton & others, 2012; Jarrett & others, 2012). Psychiatrist Aaron Beck (1967) proposed that negative thoughts reflect self-defeating beliefs that shape depressed individuals' experiences. These habitual negative thoughts magnify and expand depressed persons' negative experiences (Lam, 2012). For example, a depressed individual might overgeneralize about a minor occurrence—say, turning in a work assignment late—and think that he or she is

worthless. A depressed person might view a minor setback such as getting a *D* on a paper as the end of the world. The accumulation of such cognitive distortions can lead to depression (T. W. Lee & others, 2011).

The way people think can also influence the course of depression. Depressed individuals may ruminate on negative experiences and negative feelings, playing them over and over again in their minds (Nolen-Hoeksema, 2011). This tendency to ruminate is associated with the development of depression as well as other psychological problems such as binge eating and substance abuse (Cowdrey & Park, 2012; Kuhn & others, 2012).

Another cognitive view of depression focuses on people's attributions—their attempts to explain what caused something to happen (Seidel & others, 2012). Depression is thought to be related to a *pessimistic* attributional style. In this style, individuals regularly explain negative events as having internal causes (“It is my fault I failed the exam”), stable causes (“I’m going to fail again and again”), and global causes (“Failing this exam shows that I won’t do well in any of my courses”). Pessimistic attributional style means blaming oneself for negative events and expecting the negative events to recur (Abramson, Seligman, & Teasdale, 1978). This pessimistic style can be contrasted with an *optimistic* attributional style, which is essentially its opposite. Optimists make external attributions for bad things that happen (“I did badly on the test because it’s hard to know what a professor wants on the first exam”). They also recognize that these causes can change (“I’ll do better on the next one”) and that they are specific (“It was only one test”). Optimistic attributional style

PSYCHOLOGICAL INQUIRY

Lifetime Rate per 100 People

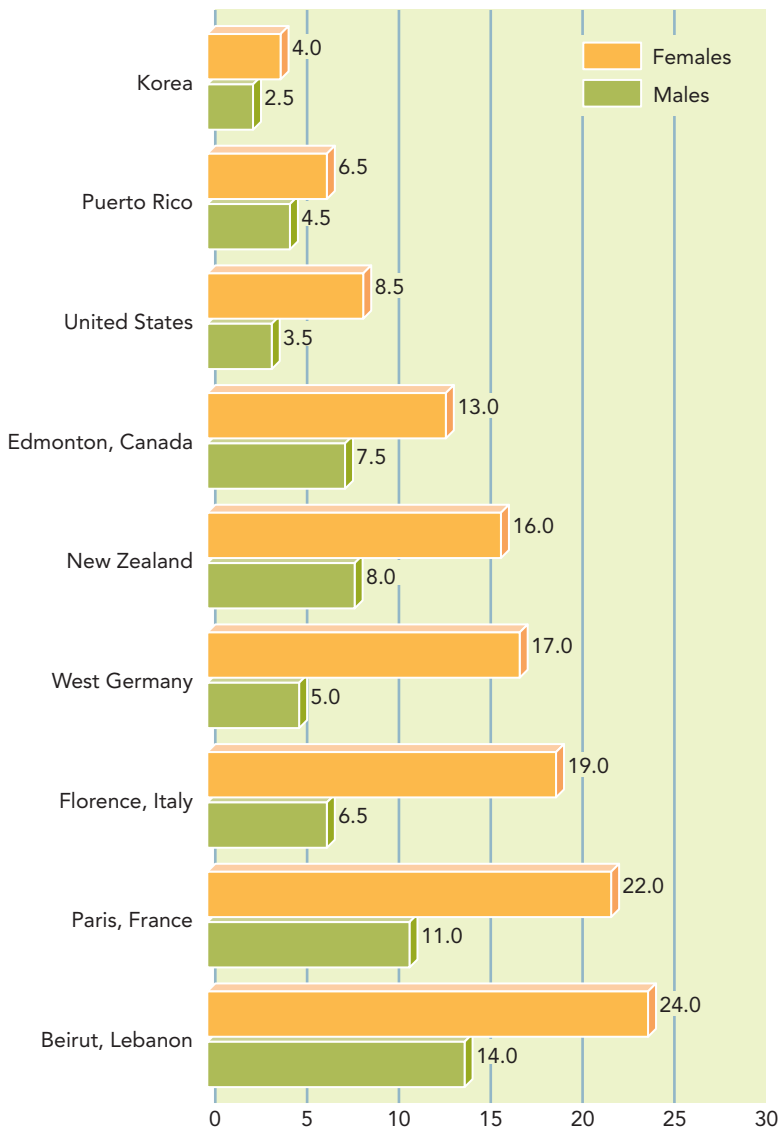


FIGURE 12.3 Gender Differences in Depression Across Cultures


This graph shows the rates of depression for men and women in nine cultures (Weissman & Olfson, 1995). > **Which cultures have the highest and lowest rates of depression? What might account for these differences?** > **Which cultures have the largest gender difference in depression? What might account for these differences?** > **In order to be diagnosed with depression, a person has to seek treatment for the disorder. How might gender and culture influence a person's willingness to get treatment?**

has been related to lowered depression and decreased suicide risk in a variety of samples (Rasmussen & Wingate, 2012; Tindle & others, 2012).

Having a spouse, roommate, or friend who suffers from depression can increase the risk that an individual will also become depressed (Coyne, 1976; Joiner, Alfano, & Metalsky, 1992; Ruscher & Gotlib, 1988). Such effects are sometimes called *contagion* because they suggest that depression can spread from one person to another (Kiuru & others, 2012). Of course, the term *contagion* here is metaphorical. In fact, research suggests that whether depression and anxiety are contagious depends on the quality of interactions between people. To read more about this topic and its potential role in children's psychological health, see the Intersection.

SOCIOCULTURAL FACTORS Individuals with a low socioeconomic status (SES), especially people living in poverty, are more likely to develop depression than their higher-SES counterparts (Boothroyd & others, 2006). A longitudinal study of adults revealed that depression increased as one's standard of living and employment circumstances worsened (Lorant & others, 2007). Studies have found very high rates of depression in Native American groups, among whom poverty, hopelessness, and alcoholism are widespread (Teesson & Vogl, 2006).

Women are nearly twice as likely as men to develop depression (Yuan & others, 2009). As Figure 12.3 shows, this gender difference occurs in many countries (Inaba & others, 2005). Incidence of depression is high, too, among single women who are the heads of households and among young married women who work at unsatisfying, dead-end jobs (Whiffen & Demidenko, 2006). Minority women also are a high-risk group for depression (Diefenbach & others, 2009).

 *Another gender difference to consider: Why might men show lower levels of depression than women?*

Bipolar Disorder

Just as we all have down times, there are times when things seem to be going phenomenally well. For individuals with bipolar disorder, the ups and downs of life take on an extreme and often harmful tone.

bipolar disorder
Mood disorder characterized by extreme mood swings that include one or more episodes of mania, an overexcited, unrealistically optimistic state.

Bipolar disorder is a disorder characterized by extreme mood swings that include one or more episodes of *mania*, an overexcited, unrealistically optimistic state. A manic episode is like the flipside of a depressive episode (Goldney, 2012). The person who experiences mania feels on top of the world. She has tremendous energy and might sleep very little. A manic state also features an impulsivity that can get the individual in trouble. For example, the sufferer might spend his life savings on a foolish business venture.

Most bipolar individuals experience multiple cycles of depression interspersed with mania, usually separated by six months to a year. Unlike depressive disorders, which are more likely to occur in women, bipolar disorder is equally common in women and men. Bipolar disorder does not prevent a person from being successful. Award-winning actor Catherine Zeta-Jones, famed dancer and choreographer Alvin Ailey, and actor-writer Carrie Fisher (Princess Leia) have been diagnosed with bipolar disorder.

What factors play a role in the development of bipolar disorder? Genetic influences are stronger predictors of bipolar disorder than of depressive disorders (Pirooznia & others, 2012). An individual with an identical twin who has bipolar disorder has a 70 percent probability of also having the disorder, and a fraternal twin has a more than 10 percent probability (Figure 12.4). Researchers are zeroing in on the specific genetic location of bipolar disorder (Crisafulli & others, 2012; Pedroso & others, 2012).

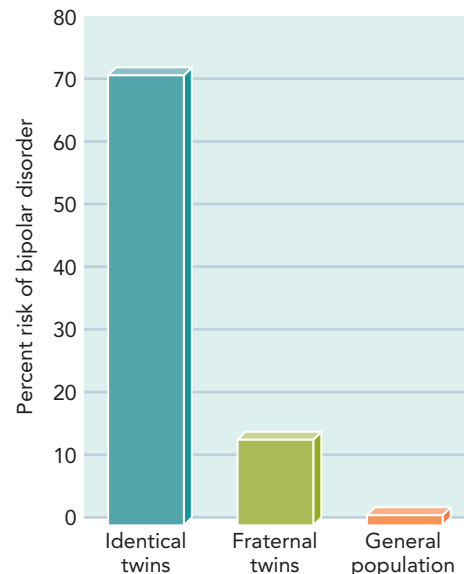


FIGURE 12.4 Risk of Bipolar Disorder in Identical and Fraternal Twins If One Twin Has the Disorder, and in the General Population Notice how much stronger the similarity of bipolar disorder is in identical twins as compared with fraternal twins and the general population. These statistics suggest a strong genetic role in the disorder.

INTERSECTION

Clinical and Developmental Psychology: Can Kids “Catch” Depression and Anxiety?

The role of friendships in children’s and adolescents’ lives is increasingly of interest to developmental psychologists.

Among youth, friends are important to self-esteem, well-being, and school adjustment (Mendel & others, 2012; Mora & Gil, 2012; Shany, Wiener, & Assido, 2012). Still, some friends may be better influences than others. A large body of evidence supports the conclusion that hanging around with friends who engage in problem behaviors such as delinquency and substance abuse increases the likelihood of youth involvement in such behavior (Giletta & others, 2012; Laursen & others, 2012). But what about associating closely with individuals who have psychological symptoms, like depression and anxiety, that are not as likely to be evident in behavior? Might such symptoms also “rub off” on friends?

Before addressing that question, let’s clarify some terms. In children, symptoms of psychological disorders are often categorized as either externalizing or internalizing symptoms. *Externalizing symptoms*, commonly referred to as “acting out,” include delinquency and aggression. *Internalizing symptoms* include feelings of depression and anxiety. While research supports the notion that externalizing symptoms are contagious (that is, they spread from one friend to another), only recently have researchers addressed the possibility that internalizing symptoms might be contagious as well. To put it concretely, can having a friend who is depressed or anxious increase the likelihood that a child or an adolescent will become depressed or anxious as well? Research suggests the answer is yes (Prinstein, 2007; Tompkins & others, 2011), and a recent study by Rebecca Schwartz-Mette and Amanda Rose (2012) provides an explanation for this effect.

These researchers proposed that depression and anxiety can pass from one friend to another through the conversations friends share. They examined a particular kind of social sharing called *co-rumination* (Rose, 2002; Rose & Smith, 2009). *Rumination* is a way of thinking that involves worrying about a topic without finding a resolution. When we ruminate, we might dwell on all the possible horrible consequences of some negative event or imagine



everything that might go wrong in the future. *Co-rumination* is like that too, but it involves engaging in a conversation with someone and making a negative event that the person is going through seem even worse. When friends co-ruminate, they focus on problems, rehashing them repeatedly, speculating on possible future problems, and emphasizing negative emotions (Rose, 2002). Ironically, though co-rumination can make both members of a friendship feel pretty miserable, this kind of social sharing is also related to friendship quality and closeness (Rose, Carlson, & Waller, 2007). Perhaps because of this

closeness, co-rumination is associated with strong feelings of *empathetic distress*, which occurs when one friend takes on the negative feelings of the other (Smith & Rose, 2011). If co-ruminating allows one to share deeply in the emotional life of another, it might well play a role in spreading depression or anxiety.

To explore this possibility, Schwartz-Mette and Rose (2012) examined whether symptoms of depression and anxiety in one youth predicted increases in these symptoms in that individual’s friends and whether this contagion might be explained by the tendency to co-ruminate. They surveyed several hundred children (third- and fifth-graders) and adolescents (seventh- and ninth-graders) and their best friends and found that having a friend who was feeling depressed or anxious indeed predicted increases in feelings of depression or anxiety six months later in all but the youngest boys. Further, co-rumination was associated with contagion of anxiety for all but the youngest boys in the study. For depression, co-rumination was associated with the contagion of depression but only for adolescents.

This work shows that peer relationships are a key factor to consider in psychological difficulties among youth.

Friends are a vital resource, and talking with friends is a primary channel by which we make sense of the world. Research is now showing that the quality of those conversations may be an important element in mental health.

\\ **How do these results match your experiences of childhood friendship?**

\\ **Do some of your present-day friends co-ruminate over negative events?**

Other biological processes are also a factor. Like depression, bipolar disorder is associated with differences in brain activity. Figure 12.5 shows the metabolic activity in the cerebral cortex of an individual cycling through depressive and manic phases. Notice the decrease in metabolic activity in the brain during depression and the increase in metabolic activity during mania (Baxter & others, 1995). In addition to high levels of norepinephrine and low levels of serotonin, studies link high levels of the neurotransmitter glutamate to bipolar disorder (Singh & others, 2010; Sourial-Bassillious & others, 2009).

Psychologists and psychiatrists have recently noted cases of children who appear to suffer from bipolar disorder (Cosgrove, Roybal, & Chang, 2013; Defilippis & Wagner, 2013). A key dilemma in such cases is that treating bipolar disorder in adults involves administering psychoactive drugs that have not been approved for children's use. The side effects of these drugs could put children's health and development at risk. To address this issue, *DSM-5* includes a new diagnosis, *disruptive mood dysregulation disorder*, which is considered a depressive disorder in children who show persistent irritability and recurrent episodes of out-of-control behavior (APA, 2013). This decision is not without controversy. As we saw with ADHD, some children who are perceived to be prone to wild mood swings may be simply behaving like children.

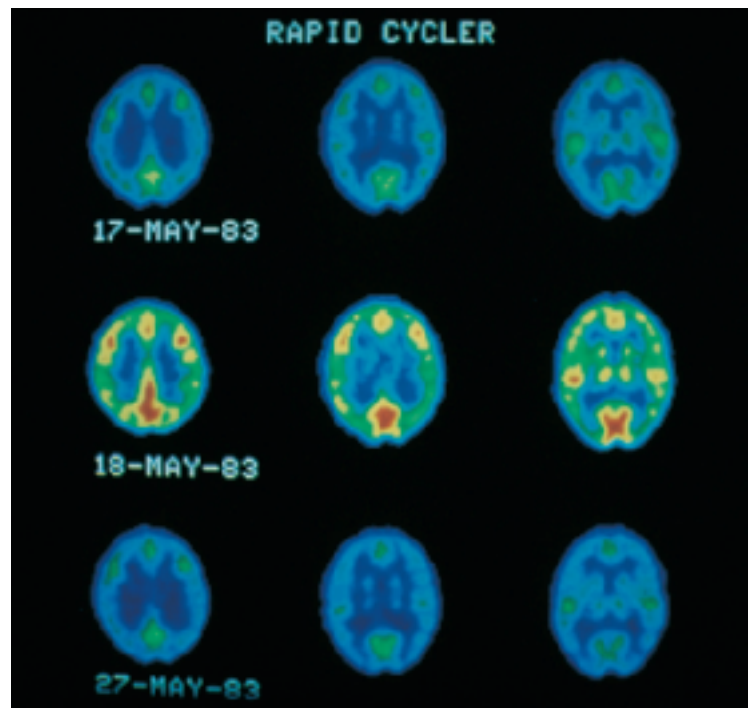


FIGURE 12.5 Brain Metabolism in Mania and Depression PET scans of an individual with bipolar disorder, who is described as a rapid-cycler because of how quickly severe mood changes occurred. (Top and bottom) The person's brain in a depressed state. (Middle) A manic state. The PET scans reveal how the brain's energy consumption falls in depression and rises in mania. The red areas in the middle row reflect rapid consumption of glucose.

Suicide

Thinking about suicide is not necessarily abnormal. However, attempting or completing the act of suicide is abnormal. Approximately 90 percent of individuals who commit suicide are estimated to have a diagnosable mental disorder (NIMH, 2008), and the most common disorders among individuals who commit suicide are depression and anxiety (Blanco & others, 2012; Nauta & others, 2012). Depressed individuals are also likely to attempt suicide more than once (da Silva Cais & others, 2009). Sadly, many individuals who, to the outside eye, seem to be leading successful and fulfilling lives have ended their lives through suicide. Examples include poet Sylvia Plath, novelist Ernest Hemingway, and grunge icon Kurt Cobain (who committed suicide after lifelong battles with ADHD and bipolar disorder).

According to the Centers for Disease Control and Prevention (CDC), in 2010, 37,793 people in the United States committed suicide, and suicide was the 10th-highest cause of death in the country (CDC, 2012). There are twice as many suicides as homicides in the United States, and the suicide rate increased 13 percent from 1999 to 2010 (Schmitz & others, 2012). Research indicates that for every completed suicide, 8 to 25 attempted suicides occur (NIMH, 2008). Suicide is the third-leading cause (after automobile accidents and homicides) of death today among U.S. adolescents 13 through 19 years of age (Murphy, Xu, & Kochanek, 2012). Even more shocking, in the United States suicide is the third-leading cause of death among children 10 to 14 years of age (CDC, 2007).

What to Do

1. Ask direct, straightforward questions in a calm manner. For example, “Are you thinking about hurting yourself?”
2. Be a good listener and be supportive. Emphasize that unbearable pain can be survived.
3. Take the suicide threat very seriously. Ask questions about the person’s feelings, relationships, and thoughts about the type of method to be used. If a gun, pills, rope, or other means is mentioned and a specific plan has been developed, the situation is dangerous. Stay with the person until help arrives.
4. Encourage the person to get professional help and assist him or her in getting help. If the person is willing, take the person to a mental health facility or hospital.

What Not to Do

1. Don’t ignore the warning signs.
2. Don’t refuse to talk about suicide if the person wants to talk about it.
3. Don’t react with horror, disapproval, or repulsion.
4. Don’t offer false reassurances (“Everything will be all right”) or make judgments (“You should be thankful for . . .”).
5. Don’t abandon the person after the crisis seems to have passed or after professional counseling has begun.



FIGURE 12.6 When Someone Is Threatening Suicide Do not ignore the warning signs if you think someone you know is considering suicide. Talk to a counselor if you are reluctant to say anything to the person yourself.

Note that people whose parents committed suicide may be more likely to consider suicide as an option. So, environment matters.

An immediate and highly stressful circumstance—such as the loss of a loved one or a job, flunking out of school, or an unwanted pregnancy—can lead people to threaten and/or to commit suicide (Videtic & others, 2009). In addition, substance abuse is linked with suicide more today than in the past (Conner & others, 2012).

In research focusing on suicide notes, Thomas Joiner and his colleagues have found that having a sense of belongingness or of being needed separates individuals who attempt suicide from those who complete it (Joiner, 2005; Joiner, Hollar, & Van Orden, 2006; Joiner & Ribeiro, 2011). Essentially, people who feel that someone will miss them or still need them are less likely than others to complete a suicide (A. R. Smith & others, 2012).

SOCIOCULTURAL FACTORS Chronic economic hardship can be a factor in suicide (Ferretti & Coluccia, 2009; Rojas & Stenberg, 2010). Cultural and ethnic contexts also are related to suicide attempts. In the United States, adolescents’ suicide attempts vary across ethnic groups. As Figure 12.7 illustrates, more than 20 percent of Native American/Alaska Native (NA/AN) female adolescents reported that they had attempted

Given these grim statistics, psychologists work with individuals to reduce the frequency and intensity of suicidal impulses. Figure 12.6 provides good advice on what to do and what not to do if you encounter someone who is threatening suicide.

What might prompt an individual to end his or her own life? Biological, psychological, and sociocultural circumstances can be contributing factors.

BIOLOGICAL FACTORS Genetic factors appear to play a role in suicide, which tends to run in families (Althoff & others, 2012). The Hemingways are one famous family that has been plagued by suicide. Five Hemingways, spread across generations, committed suicide, including the writer Ernest Hemingway and his granddaughter Margaux, a model and actor. Similarly, in 2009, Nicholas Hughes—a successful marine biologist and the son of Sylvia Plath, a poet who had killed herself—tragically hanged himself.

Studies have linked suicide with low levels of the neurotransmitter serotonin (Lyddon & others, 2012). Individuals who attempt suicide and who have low serotonin levels are 10 times more likely to attempt suicide again than are attempters who have high serotonin levels (Courtet & others, 2004). Poor physical health, especially when it is chronic, is another risk factor for suicide (Webb & others, 2012).

PSYCHOLOGICAL FACTORS Psychological factors that can contribute to suicide include mental disorders and traumas such as sexual abuse (Wanner & others, 2012). Struggling with the stress of a psychological disorder can leave a person feeling hopeless, and the disorder itself may tax the person’s ability to cope with life’s difficulties. Indeed, approximately 90 percent of individuals who commit suicide are estimated to have a diagnosable mental disorder (NIMH, 2008).

suicide in the previous year, and suicide accounts for almost 20 percent of NA/AN deaths in 15- to 19-year-olds (Goldston & others, 2008). As the figure also shows, African American and non-Latino White males reported the lowest incidence of suicide attempts. A major risk factor in the high rate of suicide attempts by NA/AN adolescents is their elevated rate of alcohol abuse.

Suicide rates vary worldwide; the lowest rates occur in countries with cultural and religious norms against ending one's own life. Among the nations with the highest suicide rates are several eastern European nations—including Belarus, Bulgaria, and Russia—along with Japan and South Korea. According to the World Health Organization (WHO), among the nations with the lowest rates are Haiti, Antigua and Barbuda, Egypt, and Iran (WHO, 2009). Of the 104 nations ranked by the WHO, the United States ranks 40th.

Research has also linked suicide to the culture of honor. Recall that in honor cultures, individuals are more likely to interpret insults as fighting words and to defend their personal honor with aggression. One set of studies examined suicide and depression in the United States, comparing geographic regions that are considered to have a culture of honor (that is, southern states) with other areas. Even accounting for a host of other factors, suicide rates were found to be higher in states with a culture of honor (Osterman & Brown, 2011). The researchers also examined how regions compared in terms of the use of prescription antidepressants and discovered that states with a culture of honor also had lower levels of use of these drugs. It may be that in a culture of honor, seeking treatment for depression is seen as a weakness or a mark of shame.

There are gender differences in suicide as well (Sarma & Kola, 2010). Women are three times more likely than men to attempt suicide. Men, however, are four times more likely than women to complete suicide (Kochanek & others, 2004). Men are also more likely than women to use a firearm in a suicide attempt (Maris, 1998). The highest suicide rate is among non-Latino White men ages 85 and older (NIMH, 2008).

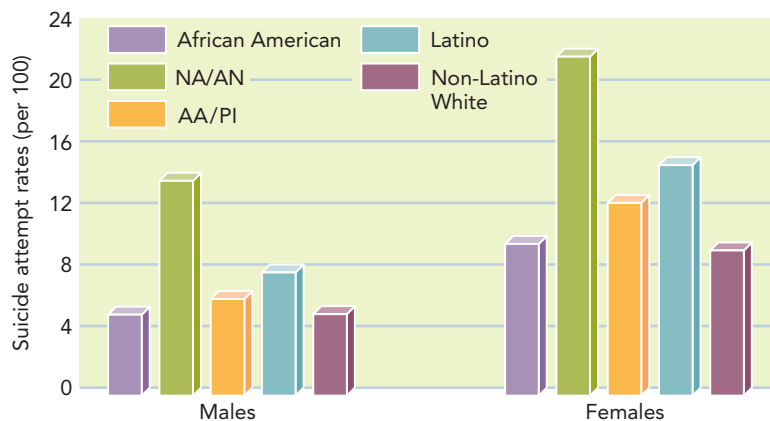


FIGURE 12.7 Suicide Attempts by U.S. Adolescents from Different Ethnic Groups Note that the data shown are for one-year rates of self-reported suicide attempts. NA/AN = Native Americans/Alaska Native; AA/PI = Asian American/Pacific Islander.

Men are less likely than women to report being depressed but are more likely to commit suicide. Clearly, depression in men might be underestimated.

self-quiz

- To be diagnosed with bipolar disorder, an individual must experience
 - a manic episode.
 - a depressive episode.
 - a manic episode and a depressive episode.
 - a suicidal episode.
- All of the following are a symptom of major depressive disorder except
 - fatigue.
 - weight change.
 - thoughts of death.
 - substance use.
- A true statement about suicide and gender is that
 - women are more likely to attempt suicide than men.
 - men are more likely to attempt suicide than women.
 - men and women are equally likely to attempt suicide.
 - men and women are equally likely to complete suicide.

APPLY IT! 4. During his first two college years, Barry has felt “down” most of the time. He has had trouble concentrating and difficulty making decisions. Sometimes he is so overwhelmed with deciding on his

major and struggling to focus that he feels hopeless. He has problems with loss of appetite and sleeps a great deal of the time, and in general his energy level is low. Barry has found that things he used to love, like watching sports and playing video games are just no fun anymore. Which of the following is most likely to be true of Barry?

- Barry is suffering from major depressive disorder.
- Barry is entering the depressive phase of bipolar disorder.
- Barry has an anxiety disorder.
- Barry is experiencing the everyday blues that everyone gets from time to time.

4 Eating Disorders



Disorders of eating can vary across cultures. In Fiji, a disorder known as macake involves poor appetite and refusing to eat. Very high levels of social concern meet this refusal, and individuals with macake are strongly motivated to start eating and enjoying food again.

anorexia nervosa

Eating disorder that involves the relentless pursuit of thinness through starvation.

For some people, concerns about weight and body image become a serious, debilitating disorder (Lock, 2012a; Wilson & Zandberg, 2012). For such individuals, the very act of eating is an arena where a variety of complex biological, psychological, and cultural issues are played out, often with tragic consequences.

A number of famous people have coped with eating disorders, including Princess Diana, Ashley Judd, Paula Abdul, Mary-Kate Olsen, and Kelly Clarkson. Eating disorders are characterized by extreme disturbances in eating behavior—from eating very, very little to eating a great deal. In this section we examine three eating disorders—anorexia nervosa, bulimia nervosa, and binge-eating disorder.

Anorexia Nervosa

Anorexia nervosa is an eating disorder that involves the relentless pursuit of thinness through starvation. Anorexia nervosa is much more common in girls and women than boys and men and affects between 0.5 and 3.7 percent of young women (NIMH, 2011). The American Psychiatric Association (2013) lists these main characteristics of anorexia nervosa:

- Weight less than 85 percent of what is considered normal for age and height, and refusal to maintain weight at a healthy level.
- An intense fear of gaining weight that does not decrease with weight loss.
- A distorted body image (Stewart & others, 2012). Even when individuals with anorexia nervosa are extremely thin, they never think they are thin enough.

Over time, anorexia nervosa can lead to physical changes, such as the growth of fine hair all over the body, thinning of bones and hair, severe constipation, and low blood pressure (NIMH, 2011). Dangerous and even life-threatening complications include damage to the heart and thyroid. Anorexia nervosa is said to have the highest mortality rate (about 5.6 percent of individuals with anorexia nervosa die within 10 years of diagnosis) of any psychological disorder (Hoek, 2006; NIMH, 2011).

Anorexia nervosa typically begins in the teenage years, often following an episode of dieting and some type of life stress (Fitzpatrick, 2012). Most individuals with anorexia nervosa are non-Latino White female adolescents or young adults from well-educated middle- and upper-income families (Darcy, 2012; Dodge, 2012). They are often high-achieving perfectionists (Forbush, Heatherton, & Keel, 2007). Obsessive thinking about weight and compulsive exercise are also related to anorexia nervosa (Hildebrandt & others, 2012).

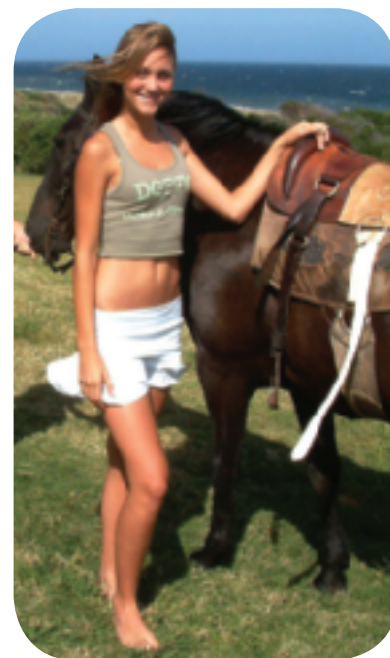


Individuals with anorexia nervosa lack personal distress over their symptoms. Recall that personal distress over one's behavior is just one aspect of the definition of abnormal.

bulimia nervosa

Eating disorder in which an individual (typically a girl or woman) consistently follows a binge-and-purge eating pattern.

Bulimia nervosa is an eating disorder in which an individual (typically female) consistently follows a binge-and-purge eating pattern. The individual goes on an eating binge and then purges by self-induced vomiting or the use of laxatives. Most people with bulimia




Uruguayan model Eliana Ramos posed for the camera in her native country. Tragically, the super-thin Ramos died at age 18 in February 2007, two years after this picture was taken, reportedly from health problems associated with anorexia nervosa.




nervosa are preoccupied with food, have a strong fear of becoming overweight, and are depressed or anxious (Birgegård, Norring, & Clinton, 2012). Because bulimia nervosa occurs within a normal weight range, the disorder is often difficult to detect. A person with bulimia nervosa usually keeps the disorder a secret and experiences a great deal of self-disgust and shame.

Bulimia nervosa can lead to complications such as a chronic sore throat, kidney problems, dehydration, and gastrointestinal disorders (NIMH, 2011). The disorder is also related to dental problems, as persistent exposure to the stomach acids in vomit can wear away tooth enamel.

Bulimia nervosa typically begins in late adolescence or early adulthood (Levine, 2002). The disorder affects between 1 and 4 percent of young women (NIMH, 2011). Like those with anorexia nervosa, many young women who develop bulimia nervosa are highly perfectionistic (Lampard & others, 2012). At the same time, they tend to have low levels of self-efficacy (Bardone-Cone & others, 2006). In other words, these are young women with very high standards but very low confidence that they can achieve their goals. Impulsivity, negative emotion, and obsessive-compulsive disorder are also related to bulimia (Roncero, Perpina, & Garcia-Soriano, 2011). Bulimia nervosa is associated, too, with a high incidence of sexual and physical abuse in childhood (Lo Sauro & others, 2008).

 *Dentists and dental hygienists are sometimes the first to recognize the signs of bulimia nervosa.*

 *Although much more common in women, bulimia can also affect men. Elton John has described his struggles with this eating disorder.*

Anorexia Nervosa and Bulimia Nervosa: Causes and Treatments

What is the etiology (cause) of anorexia nervosa and bulimia nervosa? For many years researchers thought that sociocultural factors, such as media images of very thin women and family pressures, were the central determinants of these disorders (Le Grange & others, 2010). Media images that glorify extreme thinness can indeed influence women's body image, and emphasis on the thin ideal is related to anorexia nervosa and bulimia nervosa (Carr & Peebles, 2012). However, as powerful as these media messages might be, countless females are exposed to media images of unrealistically thin women, but relatively few develop eating disorders. Many young women embark on diets, but comparatively few of them develop eating disorders.

Eating disorders occur in cultures that do not emphasize the ideal of thinness, although the disorders may differ from Western descriptions. For instance, in Eastern cultures, individuals can show the symptoms of anorexia nervosa, but they lack the fear of getting fat that is common in North Americans with the disorder (Pike, Yamamiya, & Konishi, 2011).

Since the 1980s, researchers have increasingly probed the potential biological underpinnings of these disorders, examining in particular the interplay of social and biological factors. Genes play a substantial role in both anorexia nervosa and bulimia nervosa (Lock, 2012b). In fact, genes influence many psychological characteristics (for example, perfectionism, impulsivity, obsessive-compulsive tendencies, and thinness drive) and behaviors (restrained eating, binge eating, self-induced vomiting) that are associated with anorexia nervosa and bulimia nervosa (Mikolajczyk, Grzywacz, & Samochowiec, 2010; Schur, Heckbert, & Goldberg, 2010). These genes are also factors in the regulation of serotonin, and problems in regulating serotonin are related to both anorexia nervosa and bulimia nervosa (Capasso, Putrella, & Milano, 2009).

Even as biological factors play a role in the emergence of eating disorders, eating disorders themselves affect the body, including the brain. Most psychologists believe that while social factors and experiences may play a role in triggering dieting, the physical effects of dieting, bingeing, and purging may change the neural networks that then sustain the disordered pattern, in a kind of vicious cycle (Lock, 2012b).

Although anorexia and bulimia nervosa are serious disorders, recovery is possible (Fitzpatrick, 2012; Treasure, Claudino, & Zucker, 2010). Anorexia nervosa may require hospitalization. The first target of intervention is promoting weight gain, in extreme cases through the use of a feeding tube. A common obstacle in the treatment of anorexia nervosa is that individuals with the disorder deny that anything is wrong. They maintain their belief that thinness and restrictive dieting are correct and not a sign of mental illness (Wilson, Grilo, & Vitousek, 2007). Still, drug therapies and psychotherapy have been shown to be effective in treating anorexia nervosa, as well as bulimia nervosa (Hagman & Frank, 2012; Wilson & Zandberg, 2012).

Binge-Eating Disorder

binge-eating disorder (BED)

Eating disorder characterized by recurrent episodes of eating large amounts of food during which the person feels a lack of control over eating.

Binge-eating disorder (BED) is characterized by recurrent episodes of consuming large amounts of food during which the person feels a lack of control over eating (APA, 2013). Unlike an individual with bulimia nervosa, someone with BED does not try to purge. Most individuals with BED are overweight or obese (Carrard, der Linden, & Golay, 2012).

Individuals with BED often eat quickly, eat a great deal when they are not hungry, and eat until they are uncomfortably full. They frequently eat alone because of embarrassment or guilt, and they feel ashamed and disgusted with themselves after overeating. BED is the most common of all eating disorders—affecting men, women, and ethnic groups within the United States more similarly than anorexia nervosa or bulimia nervosa (Azarbad & others, 2010). An estimated 2 to 5 percent of Americans will suffer from BED in their lifetime (NIMH, 2011).

BED is thought to characterize approximately 8 percent of individuals who are obese. Unlike obese individuals who do not suffer from BED, binge eaters are more likely to place great value on their physical appearance, weight, and body shape (Grilo, Masheb, & White, 2010). The complications of BED are those of obesity more generally, including diabetes, hypertension, and cardiovascular disease.



Unlike individuals with anorexia nervosa or bulimia nervosa, most people with binge eating disorder are overweight or obese.

Binge-Eating Disorder: Causes and Treatments

Researchers are examining the role of biological and psychological factors in BED. Genes play a role (Akkermann & others, 2012), as does dopamine, the neurotransmitter related to reward pathways in the brain (C. Davis & others, 2010). The fact that binge eating often occurs after stressful events suggests that binge eaters use food to regulate their emotions (Wilson, Grilo, & Vitousek, 2007). The areas of the brain and endocrine system that respond to stress are overactive in individuals with BED (Lo Sauro & others, 2008), and this overactivity leads to high levels of circulating cortisol, the hormone most associated with stress. Individuals with BED may be more likely to perceive events as stressful and then seek to manage that stress by binge eating.

Little research has examined the sociocultural factors in BED. One study examined whether exposure to U.S. culture might increase the risk of developing BED (Swanson & others, 2012). The results showed that Mexicans who immigrated to the United States and Mexican Americans were more likely to develop BED than were Mexicans who lived in Mexico, controlling for a variety of factors (Swanson & others, 2012).

self-quiz

Just as treatment for anorexia nervosa first focuses on weight gain, some believe that treatment for BED should first target weight loss (DeAngelis, 2002). Others argue that individuals with BED must be treated for disordered eating per se, and they insist that if the underlying psychological issues are not addressed, weight loss will not be successful or permanent (de Zwaan & others, 2005; Hay & others, 2009).

1. The main characteristics of anorexia nervosa include all of the following except
 - A. absence of menstrual periods after puberty.
 - B. distorted image of one's body.
 - C. strong fears of weight gain even as weight loss occurs.
 - D. intense and persistent tremors.
2. A person with bulimia nervosa typically
 - A. thinks a lot about food.
 - B. is considerably underweight.
 - C. is a male.
 - D. is not overly concerned about gaining weight.
3. The most common of all eating disorders is
 - A. bulimia nervosa.
 - B. anorexia nervosa.
 - C. binge eating disorder.
 - D. gastrointestinal disease.

APPLY IT! 4. Nancy is a first-year straight-A premed major. Nancy's roommate Luci notices that Nancy has lost a great deal of weight and is extremely thin. Luci observes that Nancy works out a lot, rarely finishes meals, and wears bulky sweaters all the time. Luci also notices that Nancy's arms have fine hairs growing on them, and Nancy has mentioned never getting her

period anymore. When Luci asks Nancy about her weight loss, Nancy replies that she is very concerned that she not gain the "freshman 15" and is feeling good about her ability to keep up with her work and keep off those extra pounds. Which of the following is the most likely explanation for what is going on with Nancy?

- A. Nancy likely has bulimia nervosa.
- B. Despite her lack of personal distress about her symptoms, Nancy likely has anorexia nervosa.
- C. Nancy has binge eating disorder.
- D. Given Nancy's overall success, it seems unlikely that she is suffering from a psychological disorder.

5 Dissociative Disorders

Have you ever been on a long car ride and completely lost track of time, so that you could not even remember a stretch of miles along the road? Have you been so caught up in a daydream that you were unaware of the passage of time? These are examples of normal dissociation. *Dissociation* refers to psychological states in which the person feels disconnected from immediate experience.

At the extreme of dissociation are individuals who persistently feel a sense of disconnection. **Dissociative disorders** are psychological disorders that involve a sudden loss of memory or change in identity. Under extreme stress or shock, the individual's conscious awareness becomes dissociated (separated or split) from previous memories and thoughts (Espirito-Santo & Pio-Abreu, 2009). Individuals who develop dissociative disorders may have problems putting together different aspects of consciousness, so that experiences at different levels of awareness might be felt as if they are happening to someone else (Dell & O'Neil, 2007).

Psychologists believe that dissociation is a way of dealing with extreme stress (Brand & others, 2012). Through dissociation the individual mentally protects his or her conscious self from the traumatic event. Dissociative disorders often occur in individuals who also show signs of PTSD (Lanius & others, 2012). Both psychological disorders are thought to be rooted, in part, in extremely traumatic life events (Foote & others, 2006). The notion that dissociative disorders are related to problems in pulling together emotional memories is supported by findings showing lower volume in the hippocampus and amygdala in individuals with dissociative disorders (Vermetten & others, 2006). The hippocampus is especially involved in consolidating memory and organizing life experience into a coherent whole (Spiegel, 2006).

Dissociative disorders are perhaps the most controversial of all diagnostic categories, with some psychologists believing that they are often mistakenly diagnosed (Freeland & others, 1993) and others arguing that they are underdiagnosed (Sar, Akyuz, & Dogan, 2007; Spiegel, 2006). Three kinds of dissociative disorders are dissociative amnesia, dissociative fugue, and dissociative identity disorder.

dissociative disorders

Psychological disorders that involve a sudden loss of memory or change in identity due to the dissociation (separation) of the individual's conscious awareness from previous memories and thoughts.

In dissociative disorders, consciousness (see Chapter 4) is split off from experience—the "stream of consciousness" is disrupted. Hypnosis is often used to treat dissociative disorders.

The study on dissociative disorders in Uganda from earlier in this chapter found agreement among respondents that dissociative states are brought on by trauma.

Dissociative Amnesia

dissociative amnesia

Dissociative disorder characterized by extreme memory loss that is caused by extensive psychological stress.

Recall from Chapter 6 that amnesia is the inability to recall important events (Markowitsch & Staniloiu, 2012). Amnesia can result from a blow to the head that produces trauma in the brain. **Dissociative amnesia** is a type of amnesia characterized by extreme memory loss that stems from extensive psychological stress. People experiencing dissociative amnesia remember everyday tasks like how to hail a cab and use a phone. They forget only aspects of their own identity and autobiographical experiences.

Sometimes individuals suffering from dissociative amnesia will also unexpectedly travel away from home, occasionally even assuming a new identity. For instance, on August 28, 2008, Hannah Upp, a 23-year-old middle school teacher in New York City, disappeared while out for a run (Marx & Didziulis, 2009). She had no wallet, no identification, no cell phone, and no money. Her family, friends, and roommates posted flyers around the city and messages on the Internet. As days went by, they became

At one point during her dissociative amnesia, Hannah was approached by someone who asked if she was the Hannah everyone was looking for, and she answered no.

increasingly concerned that something terrible had happened. Finally, Hannah was found floating face down in the New York harbor on September 16, sunburned and dehydrated but alive. She remembered nothing of her experiences. To her, it felt like she had gone out for a run and 10 minutes later was being pulled from the harbor. To this day, she does not know what event might have led to her dissociative amnesia, nor does she remember how she survived during her two-week disappearance.

Dissociative Identity Disorder

dissociative identity disorder (DID)

Formerly called multiple personality disorder, a dissociative disorder in which the individual has two or more distinct personalities or selves, each with its own memories, behaviors, and relationships.

Dissociative identity disorder (DID), formerly called *multiple personality disorder*, is the most dramatic, least common, and most controversial dissociative disorder. Individuals with this disorder have two or more distinct personalities or identities (Belli & others, 2012). Each identity has its own memories, behaviors, and relationships. One identity dominates at one time, another takes over at another time. Individuals sometimes report that a wall of amnesia separates their different identities (Dale & others, 2009); however, research suggests that memory does transfer across these identities, even if the person believes it does not (Kong, Allen, & Glisky, 2008).

The shift between identities usually occurs under distress (Sar & others, 2007) but sometimes can also be controlled by the person (Kong, Allen, & Glisky, 2008).

A famous real-life example of dissociative identity disorder is the “three faces of Eve” case, based on the life of a woman named Chris Sizemore (Thigpen & Cleckley, 1957) (Figure 12.8). Eve White was the original dominant personality. She had no knowledge of her second personality, Eve Black, although Eve Black had been alternating with Eve White for a number of years. Eve White was bland, quiet, and serious. By contrast, Eve Black was carefree, mischievous, and uninhibited. Eve Black would emerge at the most inappropriate times, leaving Eve White with hangovers, bills, and a reputation in local bars that she could not explain. During treatment, a




FIGURE 12.8 The Three Faces of Eve Chris Sizemore, the subject of the 1950s book and film *The Three Faces of Eve*, is shown here with a work she painted, titled *Three Faces in One*.

self-quiz

third personality emerged: Jane. More mature than the other two, Jane seems to have developed as a result of therapy. More recently, former Heisman Trophy winner and legendary NFL running back Herschel Walker (2008) revealed his experience with dissociative disorder in his book *Breaking Free: My Life with Dissociative Identity Disorder*.

Research on dissociative identity disorder links a high rate of extraordinarily severe sexual or physical abuse during early childhood to the condition (Ross & Ness, 2010). Some psychologists believe that a child can cope with intense trauma by dissociating from the experience and developing other alternate selves as protectors. Sexual abuse has occurred in as many as 70 percent or more of dissociative identity disorder cases (Foote & others, 2006); however, the majority of individuals who have been sexually abused do not develop dissociative identity disorder. The vast majority of individuals with dissociative identity disorder are women. A genetic predisposition might also exist, as the disorder tends to run in families (Dell & Eisenhower, 1990).

Until the 1980s, only about 300 cases of dissociative identity disorder had ever been reported (Suinn, 1984). In the past 30 years, hundreds more cases have been diagnosed. Social cognitive approaches point out that diagnoses have tended to increase whenever the popular media present a case, as in the miniseries *Sybil* and the Showtime drama *United States of Tara*. From this perspective, individuals develop multiple identities through social contagion. After exposure to these examples, people may be more likely to view multiple identities as a real condition. Some experts believe, in fact, that dissociative identity disorder is a *social construction*—that it represents a category some people adopt to make sense of their experiences (Spanos, 1996). Rather than being a single person with many conflicting feelings, wishes, and potentially awful experiences, the individual compartmentalizes different aspects of the self into independent identities. In some cases, therapists have been accused of creating alternate personalities. Encountering an individual who appears to have a fragmented sense of self, the therapist may begin to treat each fragment as its own “personality” (Spiegel, 2006).

 Therapists and patients are making attributions to understand abnormal behavior.

Cross-cultural comparisons can shed light on whether dissociative identity disorder is primarily a response to traumatic events or the result of a social cognitive factor like social contagion. If dissociation is a response to trauma, individuals with similar levels of traumatic experience should show similar degrees of dissociation, regardless of their exposure to cultural messages about dissociation. In China, the popular media *do not* commonly portray individuals with dissociative disorder, and professional knowledge of the disorder is rare. One study comparing individuals from China and Canada (where dissociative identity disorder is a widely publicized condition) found reports of traumatic experience to be similar across groups and to relate to dissociative experiences similarly as well (Ross & others, 2008), casting some doubt on the notion that dissociative experiences are entirely a product of social contagion.

1. Dissociative identity disorder is associated with unusually high rates of
 - A. anxiety.
 - B. abuse during early childhood.
 - C. depression.
 - D. divorce.
2. Someone who suffers memory loss after a psychological trauma is said to have
 - A. dissociative identity disorder.
 - B. dissociative recall disorder.
 - C. dissociative amnesia.
 - D. schizophrenia.
3. In cases of dissociative amnesia, the individual not only experiences amnesia but also
 - A. has frequent thoughts of suicide.
 - B. takes on multiple different identities.
 - C. refuses to leave his or her home.
 - D. travels away from home.

APPLY IT! 4. Eddie often loses track of time. He is sometimes late for appointments because he is so engrossed in whatever he is doing. While working on a term

paper in the library, he gets so caught up in what he is reading that he is shocked when he looks up and sees that the sun has set and it is night. Which of the following best describes Eddie?

- A. Eddie is showing signs of dissociative identity disorder.
- B. Eddie is showing signs of dissociative memory disorder.
- C. Eddie is showing normal dissociative states.
- D. Eddie is at risk for dissociative amnesia.

6 Schizophrenia

psychosis

A state in which a person's perceptions and thoughts are fundamentally removed from reality.

Have you had the experience of watching a movie and suddenly noticing that the film bears an uncanny resemblance to your life? Have you ever listened to a radio talk show and realized that the host was saying exactly what you were just thinking? Do these moments mean something special about you, or are they coincidences? For individuals with severe psychological disorders, such random experiences feel not random but filled with meaning. **Psychosis** refers to a state in which a person's perceptions and thoughts are fundamentally removed from reality. *DSM-5* recognizes a class of disorders called Schizophrenia Spectrum and Other Psychotic Disorders. Within this group is one of the most debilitating psychological disorders (and our focus in this section), schizophrenia.

Schizophrenia is a severe psychological disorder that is characterized by highly disordered thought processes. These disordered thoughts are referred to as *psychotic* because they are far removed from reality. The world of the person with schizophrenia is deeply frightening and chaotic.

Schizophrenia is usually diagnosed in early adulthood, around age 18 for men and 25 for women. Individuals with schizophrenia may see things that are not there, hear voices inside their heads, and live in a strange world of twisted logic. They may say odd things, show inappropriate emotion, and move their bodies in peculiar ways. Often, they are socially withdrawn and isolated.

Seeking treatment for schizophrenia takes courage. It requires that individuals accept that their perception of the world—their very sense of reality—is mistaken.

It is difficult to imagine the ordeal of people living with schizophrenia, who comprise about half of the patients in psychiatric hospitals. The suicide risk for individuals with schizophrenia is eight times that for the general population (Pompili & others, 2007). For many with the disorder, controlling it means using powerful medications to combat symptoms. The most common cause of relapse is that individuals stop taking their medication. They might do so because they feel better and believe they no longer need the drugs, they do not realize that their thoughts are disordered, or the side effects of the medications are too unpleasant.

schizophrenia

Severe psychological disorder characterized by highly disordered thought processes; individuals suffering from schizophrenia may be referred to as psychotic because they are so far removed from reality.

Symptoms of Schizophrenia

Psychologists generally classify the symptoms of schizophrenia as positive symptoms, negative symptoms, and cognitive deficits (NIMH, 2008).

POSITIVE SYMPTOMS The positive symptoms of schizophrenia are marked by a distortion or an excess of normal function. They are “positive” because they reflect something added above and beyond normal behavior. Positive symptoms of schizophrenia include hallucinations, delusions, thought disorders, and disorders of movement.

Hallucinations are sensory experiences that occur in the absence of real stimuli. Hallucinations are usually auditory—the person might complain of hearing voices—or visual, and much less commonly they can be experienced as smells or tastes (Bhatia & others, 2009). Culture affects the form hallucinations take, as well as their content and sensory modality—that is, whether the hallucinations are visual, auditory, or manifest as smells or tastes (Bauer & others, 2011). Visual hallucinations involve seeing things that are not there, as in the case of Moe Armstrong. At the age of 21, while serving in Vietnam as a Marine medical corpsman, Armstrong experienced a psychotic break. Dead Vietcong soldiers appeared to talk to him and beg him for help and did not seem to realize that they were dead. Armstrong, now a successful businessman and a sought-after public speaker who holds two master's degrees, relies on medication to keep such experiences at bay (Bonfatti, 2005).

hallucinations

Sensory experiences that occur in the absence of real stimuli.

Delusions are false, unusual, and sometimes magical beliefs that are not part of an individual's culture. A delusional person might think that he is Jesus Christ or Muhammad;

delusions

False, unusual, and sometimes magical beliefs that are not part of an individual's culture.

another might imagine that her thoughts are being broadcast over the radio. It is crucial to distinguish delusions from cultural ideas such as the religious belief that a person can have divine visions or communicate personally with a deity. Generally, psychology and psychiatry do not treat these ideas as delusional.

For individuals with schizophrenia, delusional beliefs that might seem completely illogical to the outsider are experienced as all too real. At one point in his life, Bill Garrett (from the chapter-opening vignette) was convinced that a blister on his hand was a sign of gangrene. So strong was his belief that he tried to cut off his hand with a knife, before being stopped by his family (M. Park, 2009).

Thought disorder refers to the unusual, sometimes bizarre thought processes that are characteristic positive symptoms of schizophrenia. The thoughts of persons with schizophrenia can be disorganized and confused. Often individuals with schizophrenia do not make sense when they talk or write. For example, someone with schizophrenia might say, “Well, Rocky, babe, happening, but where, when, up, top, side, over, you know, out of the way, that’s it. Sign off.” These incoherent, loose word associations, called *word salad*, have no meaning for the listener. The individual might also make up new words (Kerns & others, 1999). In addition, a person with schizophrenia can show **referential thinking**, which means giving personal meaning to completely random events. For instance, the individual might believe that a traffic light has turned red because he or she is in a hurry.

A final type of positive symptom is *disorders of movement*. A person with schizophrenia may show unusual mannerisms, body movements, and facial expressions. The individual may repeat certain motions over and over or, in extreme cases, may become catatonic.

Catatonia is a state of immobility and unresponsiveness that lasts for long periods of time (Figure 12.9).

NEGATIVE SYMPTOMS Whereas schizophrenia’s positive symptoms are characterized by a distortion or an excess of normal functions, schizophrenia’s negative symptoms reflect social withdrawal, behavioral deficits, and the loss or decrease of normal functions. One negative symptom is **flat affect**, which means the display of little or no emotion (LePage & others, 2011). Individuals with schizophrenia also may be lacking in the ability to read the emotions of others (Chambon, Baudouin, & Franck, 2006). They may experience a lack of positive emotional experience in daily life and show a deficient ability to plan, initiate, and engage in goal-directed behavior.

COGNITIVE SYMPTOMS Cognitive symptoms of schizophrenia include difficulty sustaining attention, problems holding information in memory, and inability to interpret information and make decisions (Sitnikova, Goff, & Kuperberg, 2009; Torniainen & others, 2012). These symptoms may be subtle and are often detected only through neuropsychological tests. Researchers now recognize that to understand schizophrenia’s cognitive symptoms fully, measures of these symptoms must be tailored to particular cultural contexts (Mehta & others, 2011).

Causes of Schizophrenia

A great deal of research has investigated schizophrenia’s causes, including biological, psychological, and sociocultural factors involved in the disorder.



FIGURE 12.9 Disorders of Movement in Schizophrenia Unusual motor behaviors are positive symptoms of schizophrenia. Individuals may cease to move altogether (a state called catatonia), sometimes holding bizarre postures.

catatonia

State of immobility and unresponsiveness lasting for long periods of time.

flat affect

The display of little or no emotion—a common negative symptom of schizophrenia.

referential thinking

Ascribing personal meaning to completely random events.

Because negative symptoms are not as obviously part of a psychiatric illness, people with schizophrenia may be perceived as lazy and unwilling to better their lives.

EXPERIENCE IT!
John Nash: A Beautiful Mind



BIOLOGICAL FACTORS Research provides strong support for biological explanations of schizophrenia. Especially compelling is the evidence for a genetic predisposition (Tao & others, 2012). However, structural abnormalities and neurotransmitters also are linked to this severe psychological disorder (Perez-Costas & others, 2012; Sugranyes & others, 2012).

Heredity Research supports the notion that schizophrenia is at least partially due to genetic factors (Vasco, Cardinale, & Polonia, 2012). As genetic similarity to a person with schizophrenia increases, so does a person’s risk of developing schizophrenia, as Figure 12.10 shows (Cardno & Gottesman, 2000). Such data strongly suggest that genetic factors play a role in schizophrenia. Researchers are seeking to pinpoint the chromosomal location of genes involved in susceptibility to schizophrenia (Crowley & others, 2012; van Beveren & others, 2012).

Structural Brain Abnormalities Studies have found structural brain abnormalities in people with schizophrenia. Imaging techniques such as MRI scans clearly show enlarged ventricles in the brain (Rais & others, 2012). Ventricles are fluid-filled spaces, and enlargement of the ventricles indicates the deterioration in other brain tissue. Individuals with schizophrenia also have a small frontal cortex (the area in which thinking, planning, and decision making take place) and show less activity in this area than individuals who do not have schizophrenia (Cotter & others, 2002).

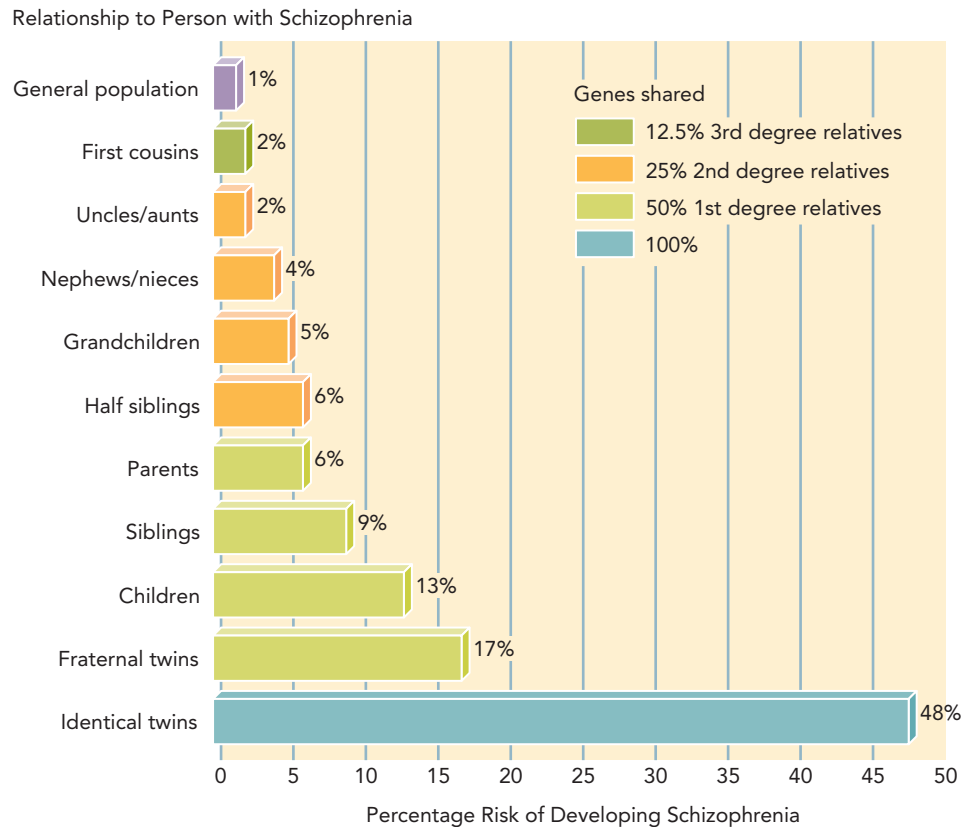
Still, the differences between the brains of healthy individuals and those with schizophrenia are small (NIMH, 2008). Microscopic studies of brain tissue after death reveal small changes in the distribution or characteristics of brain cells in persons with schizophrenia. It appears that many of these changes occurred prenatally, because they are not accompanied by glial cells, which are always present when a brain injury occurs after

PSYCHOLOGICAL INQUIRY

FIGURE 12.10 Lifetime Risk of Developing Schizophrenia According to Genetic Relatedness

As genetic relatedness to an individual with schizophrenia increases, so does the risk of developing schizophrenia.


> Which familial relationships have the lowest and highest level of genetic overlap? > What is the difference in genetic overlap between identical twins and non-twin siblings? > What is the difference in risk of schizophrenia between identical twins and non-twin siblings?



birth. It may be that problems in prenatal development such as infections (A. S. Brown, 2006) predispose a brain to developing schizophrenic symptoms during puberty and young adulthood (Fatemi & Folsom, 2009).

Problems in Neurotransmitter Regulation An early biological explanation for schizophrenia linked excess dopamine production to schizophrenia. The link between dopamine and psychotic symptoms was first noticed when the drug L-dopa (which increases dopamine levels) was given to individuals as a treatment for Parkinson disease. In addition to relieving their Parkinson symptoms, L-dopa caused some individuals to experience disturbed thoughts (Janowsky, Addario, & Risch, 1987). Furthermore, drugs that reduce psychotic symptoms often block dopamine (Kapur, 2003). Whether it is differences in the amount, the production, or the uptake of dopamine, there is good evidence that dopamine plays a role in schizophrenia (Brito-Melo & others, 2012; Howes & others, 2012).

As noted in the chapters about states of consciousness (Chapter 4) and learning (Chapter 5), dopamine is a “feel good” neurotransmitter that helps us recognize rewarding stimuli in the environment. As described in the chapter on personality (Chapter 10), dopamine is related to being outgoing and sociable. How can a neurotransmitter that is associated with good things play a crucial role in the most devastating psychological disorder?

 Excess dopamine basically tells the person that everything is important.

One way to think about this puzzle is to view dopamine as a neurochemical messenger that in effect shouts out, “Hey! This is important!” whenever we encounter opportunities for reward. Imagine what it might be like to be bombarded with such messages about even the smallest details of life (Kapur, 2003). The person’s own thoughts might take on such dramatic proportions that they sound like someone else’s voice talking inside the person’s head. Fleeting ideas such as “It’s raining today because I didn’t bring my umbrella to work” suddenly seem not silly but true. Shitij Kapur (2003) has suggested that hallucinations, delusions, and referential thinking may be expressions of the individual’s attempts to make sense of such extraordinary feelings.

A problem with the dopamine explanation of schizophrenia is that antipsychotic drugs reduce dopamine levels very quickly, but delusional beliefs take much longer to disappear. Even after dopamine levels are balanced, a person might still cling to the bizarre belief that members of a powerful conspiracy are watching his every move. If dopamine causes these symptoms, why do the symptoms persist even after the dopamine is under control? According to Kapur, delusions serve as explanatory schemes that have helped the person make sense of the random and chaotic experiences caused by out-of-control dopamine. Bizarre beliefs might disappear only after experience demonstrates that such schemes no longer carry their explanatory power (Kapur, 2003). That is, with time, experience, and therapy, the person might come to realize that there is, in fact, no conspiracy.



PSYCHOLOGICAL FACTORS Psychologists used to explain schizophrenia as rooted in an individual’s difficult childhood experiences with parents. Such explanations have mostly fallen by the wayside, but contemporary theorists do recognize that stress may contribute to the development of this disorder. The **diathesis-stress model** argues that a combination of biogenetic disposition and stress causes schizophrenia (Meehl, 1962). (*Diathesis* means “physical vulnerability or predisposition to a particular disorder.”) For instance, genetic characteristics might produce schizophrenia only when (and if) the individual experiences extreme stress.

 Recall that Moe Armstrong experienced his first symptoms during the extremely stressful experience of the Vietnam War.

diathesis-stress model

View of schizophrenia emphasizing that a combination of biogenetic disposition and stress causes the disorder.

SOCIOCULTURAL FACTORS A fascinating finding on sociocultural factors in schizophrenia is a consistent difference in the course of schizophrenia over time in developing versus developed nations. Specifically, individuals with schizophrenia in developing, nonindustrialized nations are more likely to show indications of recovery over time compared to those in developed, industrialized nations (Bhugra, 2006; Jablensky, 2000;

Myers, 2010). Whether measured in symptoms, disturbances in thought, or the ability to engage in productive work, individuals in less developed countries appear to do better than their counterparts in developed nations.

This difference is puzzling. Some experts argue that developing nations must be misdiagnosing more individuals or are better off than the label “developing” implies (Burns, 2009). Other commentators look to differences in cultural beliefs and practices to understand these effects. For instance, it might be that in more developed nations (such as the United States), there is not a very strong belief that individuals diagnosed with schizophrenia *can* recover (Luhmann, 2007). In addition, cultures vary in terms of their beliefs about and responses to symptoms. In Chandigarh, India, for example, where some of the developing-nation data were collected, visual hallucinations were not viewed as very different from commonplace religious experiences (Luhmann, 2007). Moreover, in developing nations, families remained involved in individuals’ lives after diagnosis, and many families lived in close-knit communities where care of their loved one was not so burdensome (Hopper & Wanderling, 2000). The fact that culture matters to schizophrenia highlights the role of cultural context in psychological disorders. Consider that even if individuals with schizophrenia were found to share some common brain characteristics, these similar brains would have different experiences and different outcomes as a result of culture.

In developed nations, schizophrenia is strongly associated with poverty, but it is not clear if poverty increases the likelihood of experiencing the disorder (Luhmann, 2007). Marriage, warm and supportive friends (Jablensky & others, 1992; Wiersma & others, 1998), and employment are related to better outcomes for people diagnosed with schizophrenia (Rosen & Garety, 2005). At the very least, this research suggests that some individuals with schizophrenia enjoy marriage, productive work, and friendships (Drake, Levine, & Laska, 2007; Fleischhaker & others, 2005; Marshall & Rathbone, 2006).



If you have never met anyone with schizophrenia, why not get to know Moe Armstrong online? Search for clips of one of Moe’s many speeches on YouTube.

self-quiz

1. A negative symptom of schizophrenia is
 - A. hallucinations.
 - B. flat affect.
 - C. delusions.
 - D. catatonia.
2. Joel believes that he has superhuman powers. He is likely suffering from
 - A. hallucinations.
 - B. delusions.
 - C. negative symptoms.
 - D. referential thinking.
3. The biological causes of schizophrenia include

- A. problems with the body’s regulation of dopamine.
- B. abnormalities in brain structure such as enlarged ventricles and a small frontal cortex.
- C. both A and B
- D. neither A nor B

APPLY IT! 4. During a psychiatric hospital internship, Tara approaches a young man sitting alone in a corner, and they have a short conversation. He asks her if she is with the government, and she tells him that she is not. She asks him a few

questions and walks away. She tells her advisor later that what disturbed her about the conversation was not so much what the young man said, but that she had this feeling that he just was not really there. Tara was noticing the _____ symptoms of schizophrenia.

- A. positive
- B. negative
- C. cognitive
- D. genetic

7 Personality Disorders

personality disorders

Chronic, maladaptive cognitive-behavioral patterns that are thoroughly integrated into an individual’s personality.

Imagine that your personality—the very thing about you that makes you *you*—is the core of your life difficulties. That is what happens with **personality disorders**, which are chronic, maladaptive cognitive-behavioral patterns that are thoroughly integrated into an individual’s personality. Personality disorders are relatively common. In one study of a representative U.S. sample, researchers found that 15 percent had a personality disorder (Grant & others, 2004).

With respect to *DSM-5*, the revisions for personality disorders were among the most highly anticipated. The biggest proposed change involved moving to an understanding of

personality disorders within the context of the five-factor model of personality traits (see Chapter 10). Using the five factors to explain personality disorders is called the *dimensional approach*. From this perspective, personality disorders can be understood not as categories but as variants or extreme cases of the kinds of traits we see in healthy people. Many scholars looked forward to the integration of a dimensional approach to personality disorders (Krueger & Eaton, 2010; Miller & others, 2012; Trull, Carpenter, & Widiger, 2013; Widiger, 2011; Widiger & Costa, 2013). Some research supported the idea that approaching personality disorders from a trait perspective would lead to better diagnoses (Yalch, Thomas, & Hopwood, 2012). Other research, however, suggested that the change was unnecessary (Zimmerman & others, 2011; Morgan & others, 2013) and would be less useful to clinicians (Rottman & others, 2011). In the end, the proposed changes were not adopted. *DSM-5* lists the same 10 personality disorders as previous editions (see Figure 12.11).

In this section we survey the two personality disorders that have been the object of most study: antisocial personality disorder and borderline personality disorder. Both are associated with dire consequences. Specifically, antisocial personality disorder is linked to criminal activity and violence; borderline personality disorder, to self-harm and suicide.

antisocial personality disorder (ASPD)

Psychological disorder characterized by guiltlessness, law-breaking, exploitation of others, irresponsibility, and deceit.

Antisocial Personality Disorder

Antisocial personality disorder (ASPD) is a psychological disorder characterized by guiltlessness, law-breaking, exploitation of others, irresponsibility, and deceit. Although

Personality Disorder	Description
Paranoid Personality Disorder	Paranoia, suspiciousness, and deep distrust of others. People with this disorder are always on the lookout for danger and the slightest social mistreatment. They may be socially isolated.
Schizoid Personality Disorder	Extreme lack of interest in interpersonal relationships. People with this disorder are emotionally cold and apathetic, and they are generally detached from interpersonal life.
Schizotypal Personality Disorder	Socially isolated and prone to odd thinking. People with this disorder often have elaborate and strange belief systems and attribute unusual meanings to life events and experiences.
Antisocial Personality Disorder	Manipulative, deceitful, and amoral. People with this disorder lack empathy for others, are egocentric, and are willing to use others for their own personal gain.
Borderline Personality Disorder	Emotionally volatile and unstable sense of self. These individuals are prone to mood swings, excessive self-criticism, extreme judgments of others, and are preoccupied with being abandoned.
Histrionic Personality Disorder	Attention-seeking, dramatic, lively, and flirtatious. These individuals are inappropriately seductive in their interactions with others.
Narcissistic Personality Disorder	Self-aggrandizing yet overly dependent on the evaluations of others. People with this disorder view themselves as entitled and better than others. They show deficits in empathy and in understanding the feelings of others.
Avoidant Personality Disorder	Socially inhibited and prone to feelings of inadequacy, anxiety, and shame. These individuals feel inadequate and hold back in social situations. They have unrealistic standards for their own behavior and avoid setting goals, taking personal risks, or pursuing new activities.
Dependent Personality Disorder	Dependent on others for emotional and physical needs. People with this disorder perceive others as powerful and competent and themselves as childlike and helpless.
Obsessive-Compulsive Personality Disorder	Conforming rigidly to rules. These individuals show an excessive attachment to moral codes and are excessively orderly in daily life.

FIGURE 12.11 The 10 Personality Disorders Included in DSM-5. Diagnoses of these disorders require that the person be over the age of 18, and all involve pervasive aspects of the person that color cognition, emotion, and behavior. Note that some of the labels are potentially confusing. Schizoid and schizotypal personality disorders are not the same thing as schizophrenia (though schizotypal personality disorder may proceed to schizophrenia). Further, obsessive-compulsive personality disorder is not the same thing as obsessive-compulsive disorder.

they may be superficially charming, individuals with ASPD do not play by the rules, and they often lead a life of crime and violence. ASPD is far more common in men than in women and is related to criminal behavior, vandalism, substance abuse, and alcoholism (Cale & Lilienfeld, 2002).

ASPD is characterized by:

- Failure to conform to social norms or obey the law
- Deceitfulness, lying, using aliases, or conning others for personal profit or pleasure
- Impulsivity
- Irritability and aggressiveness; getting into physical fights or perpetrating assaults
- Reckless disregard for the safety of self or others
- Consistent irresponsibility, inconsistent work behavior; not paying bills
- Lack of remorse, indifference to the pain of others, or rationalizing; hurting or mistreating another person

Generally, ASPD is not diagnosed unless a person has shown persistent antisocial behavior before the age of 15.

Although ASPD is associated with criminal behavior, not all individuals with ASPD engage in crime, and not all criminals suffer from ASPD. Some individuals with ASPD can have successful careers. There are antisocial physicians, clergy members, lawyers, and just about any other occupation. Still, such individuals tend to be exploitative of others, and they break the rules, even if they are never caught.

What is the etiology of ASPD? Biological factors include genetic, brain, and autonomic nervous system differences. We consider these in turn.


ASPD is genetically heritable (Nordstrom & others, 2012). Certain genetic characteristics associated with ASPD may interact with testosterone (the hormone most associated with aggressive behavior) to promote antisocial behavior (Sjoberg & others, 2008). Although the experience of childhood abuse may be implicated in ASPD, there is evidence that genetic differences may distinguish abused children who go on to commit violent acts themselves from those who do not (Caspi & others, 2002).

In terms of the brain, research has linked ASPD to low levels of activation in the prefrontal cortex and has related these brain differences to poor decision making and problems in learning (Raine & others, 2000). With regard to the autonomic nervous system, researchers have found that individuals with ASPD are less stressed than others by aversive circumstances, including punishment (Fung & others, 2005), and that they have the ability to keep their cool while engaging in deception (Verschuere & others, 2005). The underaroused autonomic nervous system may be a key difference between adolescents who become antisocial adults and those whose behavior improves during adulthood (Raine, Venables, & Williams, 1990).

The term *psychopath* is sometimes used to refer to a subgroup of individuals with ASPD (Pham, 2012). Psychopaths are remorseless predators who engage in violence to get what they want. Examples of psychopaths include serial killers John Wayne Gacy, who murdered 33 boys and young men, and Ted Bundy, who confessed to murdering at least 30 young women. Psychopaths tend to show less prefrontal activation than normal individuals and to have structural abnormalities in the amygdala, as well as the hippocampus, the brain structure most closely associated with



John Wayne Gacy (top) and Ted Bundy (bottom) exemplify the subgroup of people with ASPD who are also psychopathic.

 *Lack of autonomic nervous system activity suggests why individuals with ASPD might be able to fool a polygraph (lie detector).*

memory (Weber & others, 2008). Importantly, these brain differences are most pronounced in “unsuccessful psychopaths”—individuals who have been arrested for their behaviors (Yang & others, 2005). In contrast, “successful psychopaths”—individuals who have engaged in antisocial behavior but have not gotten caught—are more similar to healthy controls in terms of brain structure and function. However, in their behavior, successful psychopaths demonstrate a lack of empathy and a willingness to act immorally; they victimize others to enrich their own lives. Psychopaths show deficiencies in learning about fear and have difficulty processing information related to the distress of others, such as sad or fearful faces (Dolan & Fullam, 2006).

A key challenge in treating individuals with ASPD, including psychopaths, is their ability to con even sophisticated mental health professionals. Many never seek therapy, and others end up in prison, where treatment is rarely an option.

Their functioning frontal lobes might help successful psychopaths avoid getting caught.

Borderline Personality Disorder

Borderline personality disorder (BPD) is a pervasive pattern of instability in interpersonal relationships, self-image, and emotions, and of marked impulsivity beginning by early adulthood and present in various contexts. Individuals with BPD are insecure, impulsive, and emotional (Hooley, Cole, & Gironde, 2012). BPD is related to self-harming behaviors such as *cutting* (injuring oneself with a sharp object but without suicidal intent) and also to suicide (Soloff & others, 1994).

At the very core of BPD is profound instability in mood, in sense of self, and in relationships. BPD is characterized by four essential features (Trull & Brown, 2013):

- Unstable affect
- Unstable sense of self and identity, including self-destructive impulsive behavior and chronic feelings of emptiness
- Negative interpersonal relationships that are unstable, intense, and characterized by extreme shifts between idealization and devaluation
- Self-harm, including recurrent suicidal behavior, gestures, or threats or self-mutilating behavior.

Individuals with BPD are prone to wild mood swings and very sensitive to how others treat them. They often feel as if they are riding a nonstop emotional roller-coaster (Selby & others, 2009), and their loved ones may have to work hard to avoid upsetting them. Individuals with BPD tend to see the world in black-and-white terms, a thinking style called *splitting*. For example, they typically view other people as either hated enemies with no positive qualities or as beloved, idealized friends who can do no wrong.

Borderline personality disorder is far more common in women than men. Women make up 75 percent of those with the disorder (Korzekwa & others, 2008; Oltmanns & Powers, 2012).

The potential causes of BPD are likely complex and include biological factors as well as childhood experiences. The role of genes in BPD has been demonstrated in a variety of studies and across cultures (Mulder, 2012). The heritability of BPD is about 40 percent (Distel & others, 2008).

Many individuals with borderline personality disorder report experiences of childhood sexual abuse, as well as physical abuse and neglect (Al-Alem & Omar, 2008; De Fruyt & De Clercq, 2012). It is not clear, however, whether abuse is a primary cause of the disorder (Trull & Widiger, 2003). Childhood abuse experiences may combine with genetic factors in promoting BPD.

Cognitive factors associated with BPD include a tendency to hold a set of irrational beliefs (Leahy & McGinn, 2012). These include thinking that one

borderline personality disorder (BPD)

Psychological disorder characterized by a pervasive pattern of instability in interpersonal relationships, self-image, and emotions, and of marked impulsivity beginning by early adulthood and present in a variety of contexts.

EXPERIENCE IT! Borderline Personality Disorder



Movie depictions of BPD include Fatal Attraction, Single White Female, and Obsessed. Where these films get it wrong is that they show BPD as leading to more harm to others than to the self.

This would be a diathesis-stress model explanation for BPD.



To recognize the severe toll of BPD on those suffering from it (and on their families and friends), in 2008 the U.S. House of Representatives declared May to be National Borderline Personality Disorder Awareness Month.

is powerless and innately unacceptable and that other people are dangerous and hostile (Arntz, 2005). Individuals with BPD also display *hypervigilance*: the tendency to be constantly on the alert, looking for threatening information in the environment (Sieswerda & others, 2007).

Up until 20 years ago, experts thought that BPD was untreatable. More recent evidence, however, suggests that many individuals with BPD show improvement over time—as many as 50 percent within two years of starting treatment (Gunderson, 2008). One key aspect of successful treatment appears to be a reduction in social stress, such as that due to leaving an abusive romantic partner or establishing a sense of trust in a therapist (Gunderson & others, 2003).

self-quiz

- Individuals with ASPD
 - are incapable of having successful careers.
 - are typically women.
 - are typically men.
 - rarely engage in criminal behavior.
- People with BPD
 - pay little attention to how others treat them.
 - rarely have problems with anger or strong emotion.
 - tend to have suicidal thoughts or engage in self-harming actions.
 - tend to have a balanced viewpoint of people and things rather than to see them as all black or all white.
- All of the following are true of BPD except
 - BPD can be caused by a combination of nature and nurture—genetic inheritance and childhood experience.
 - Recent research has shown that people with BPD respond positively to treatment.
 - A common symptom of BPD is impulsive behavior such as binge eating and reckless driving.
 - BPD is far more common in men than women.

APPLY IT! 4. Your new friend Maureen tells you that she was diagnosed with borderline personality disorder at the age of 23. She feels hopeless when she considers

that her mood swings and unstable self-esteem are part of her very personality. Despairing, she asks, “How will I ever change?” Which of the following statements about Maureen’s condition is accurate?

- Maureen should seek therapy and strive to improve her relationships with others, as BPD is treatable.
- Maureen’s concerns are realistic, because a personality disorder like BPD is unlikely to change.
- Maureen should seek treatment for BPD because there is a high likelihood that she will end up committing a criminal act.
- Maureen is right to be concerned, because BPD is most often caused by genetic factors.

8 Combatting Stigma

Putting a label on a person with a psychological disorder can make the disorder seem like something that happens only to other people (Baumann, 2007). The truth is that psychological disorders are not just about other people; they are about people, period. Over 26 percent of Americans ages 18 and older suffer from a diagnosable psychological disorder in a given year—an estimated 57.7 million U.S. adults (Kessler & others, 2005; NIMH, 2008). Chances are that you or someone you know will experience a psychological disorder. Figure 12.12 shows how common many psychological disorders are in the United States.

A classic and controversial study illustrates that labels of psychological disorder can be “sticky”—hard to remove once they are applied to a person. David Rosenhan (1973) recruited eight adults (including a stay-at-home mother, a psychology graduate student, a pediatrician, and some psychiatrists), none with a psychological disorder, to see a psychiatrist at various hospitals. These “pseudo-patients” were instructed to act normally except to complain about hearing voices that said things like “empty” and “thud.” All eight expressed an interest in leaving the hospital and behaved cooperatively. Nevertheless, all eight were labeled with schizophrenia and kept in the hospital from 3 to 52 days. None of the mental health professionals they encountered ever questioned the diagnosis that was given to these individuals, and all were discharged with the label “schizophrenia in remission.” The label “schizophrenia” had stuck to the pseudo-patients and caused the professionals around them to interpret their quite normal behavior as abnormal. Clearly, once a person has been labeled with a psychological disorder, that label colors how others perceive everything else he or she does.

Labels of psychological disorder carry with them a wide array of implications for the individual. Is the person still able to be a good friend? A good parent? A competent worker? A significant concern for individuals with psychological disorders is the negative attitudes that others might have about people struggling with mental illness (Phelan & Basow, 2007). Stigma can be a barrier for individuals coping with a psychological disorder, as well as for their families and loved ones (Corrigan, 2007; Hinshaw, 2007). Negative attitudes about individuals with psychological disorders are common in many cultures, and cultural norms and values influence these attitudes (Abdullah & Brown, 2011). Fear of stigma can prevent individuals from seeking treatment and from talking about their problems with family and friends.

Consequences of Stigma

The stigma attached to psychological disorders can provoke prejudice and discrimination toward individuals who are struggling with these problems, thus complicating an already difficult situation. Having a disorder and experiencing the stigma associated with it can also negatively affect the physical health of such individuals.

PREJUDICE AND DISCRIMINATION Labels of psychological disorders can be damaging because they may lead to negative stereotypes, which play a role in prejudice. For example, the label “schizophrenic” often has negative connotations such as “frightening” and “dangerous.”

Vivid cases of extremely harmful behavior by individuals with psychological disorders can perpetuate the stereotype that people with such disorders are violent. For example, Cho Seung-Hui, a 23-year-old college student, murdered 32 students and faculty at Virginia Tech University in April 2007 before killing himself. The widely reported fact that Cho had struggled with psychological disorders throughout his life may have reinforced the notion that individuals with disorders are dangerous. In fact, however, people with psychological disorders (especially those in treatment) are no more likely to commit violent acts than the general population. Cho was no more representative of people with psychological disorders than he was representative of students at Virginia Tech.

Individuals with psychological disorders are often aware of the negative stigma attached to these conditions and may themselves have previously held such negative attitudes. Seeking the assistance they need may involve accepting a stigmatized identity (Thorncroft & others, 2009; Yen & others, 2009). Even mental health professionals can fall prey to prejudicial attitudes toward those who are coping with psychological disorders (Nordt, Rossler, & Lauber, 2006). Improved knowledge about the neurobiological and genetic processes involved in many psychological disorders appears to be a promising direction for interventions to reduce such prejudice. Research shows that information about the role of genes in these disorders reduces prejudicial attitudes (WonPat-Borja & others, 2012).

Among the most feared aspects of stigma is discrimination, or acting prejudicially toward a person who is a member of a stigmatized group. In the workplace, discrimination against a person with a psychological disorder violates the law. The Americans with

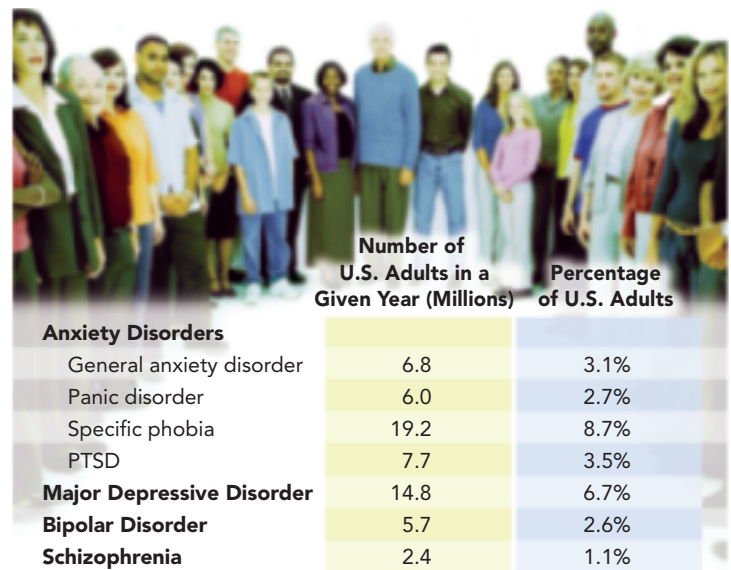


FIGURE 12.12 The 12-Month Prevalence of the Most Common Psychological Disorders If you add up the numbers in this figure, you will see that the totals are higher than the numbers given in the text. The explanation is that people are frequently diagnosed with more than one psychological disorder. An individual who has both a depressive and an anxiety disorder would be counted in both of those categories.

Disabilities Act (ADA) of 1990 made it illegal to refuse employment or a promotion to someone with a psychological disorder when the person's condition does not prevent performance of the job's essential functions (Cleveland, Barnes-Farrell, & Ratz, 1997). A person's appearance or behavior may be unusual or irritating, but as long as that individual is able to complete the duties required of a position, employment or promotion cannot be denied.

PHYSICAL HEALTH Individuals with psychological disorders are more likely to be physically ill and two times more likely to die than their psychologically healthy counterparts (Gittelman, 2008; Kumar, 2004). They are also more likely to be obese, to smoke, to drink excessively, and to lead sedentary lives (Kim & others, 2007; Lindwall & others, 2007; Mykletun & others, 2007; Osborn, Nazareth, & King, 2006).

You might be thinking that these physical health issues are the least of their worries. If people struggling with schizophrenia want to smoke, why not let them? This type of thinking sells short the capacity of psychological and psychiatric treatments to help those with psychological disorders. Research has shown that health-promotion programs can work well for individuals with a severe psychological disorder (Addington & others, 1998; Chafetz & others, 2008). When we disregard the potential of physical health interventions for people with psychological disorders to make positive life changes, we reveal our biases.

Overcoming Stigma

How can we combat the stigma of psychological disorders? One obstacle to changing people's attitudes toward individuals with psychological disorders is that mental illness is often "invisible." That is, sometimes a person we know can have a disorder without our being aware. We may be unaware of *many* good lives around us that are being lived under a cloud of psychological disorder, because worries about being stigmatized keep the affected individuals from "coming out." Thus, stigma leads to a catch-22: Positive examples of individuals coping with psychological disorders are often missing from our experience because those who are doing well shun public disclosure of their disorders (Jensen & Wadkins, 2007).

A critical step toward eliminating stigma is to resist thinking of people with disorders as limited by their condition. Instead, it is vital to recognize their strengths—both in confronting their disorder and in carrying on despite their problems—and their achievements. By creating a positive environment for people with disorders, we encourage more of them to become confidently "visible" and empower them to be positive role models.

When Milton Greek arrived at Ohio University in the 1980s as a young undergraduate, he had an ambitious goal: "to discover a psychological code that people should live by, to create world peace" (Carey, 2011a). He became known as a person with very strange ideas. By his senior year, Milt was in a failing marriage and was convinced that he had met God one day on the street and Jesus a few days later. Although he was a lifelong atheist, his delusions took on a distinctive religious character. He believed the Rapture would occur at any moment and that he himself was the anti-Christ. He heard voices no one else did and saw things that were not there. Eventually diagnosed with schizophrenia, Milt began taking medication and started to put his life back together. While in graduate school, he stopped taking his medications when things seemed to be going well, only to have a close friend give him a reality check. "When she used the word 'hallucination' I knew it was true," he said (Carey, 2011a).

Today Milt is a 49-year-old, happily married computer programmer. He takes medications to control his symptoms and seems again to have found a mission in life. This time it is about making a difference in the lives of others by sharing his story as a man with schizophrenia. Along with a small group of other people with serious psychiatric disorders, Milt has "come out" and related his experiences to combat stigma, providing hope

self-quiz

for others who are suffering with psychological disorders and helping psychologists who are interested in experiences like his.

After reading this chapter, you know that many admired individuals have dealt with psychological disorders. Their diagnoses do not detract from their accomplishments. To the contrary, their accomplishments are all the more remarkable in the context of the challenges they have faced.

1. The percentage of Americans 18 years of age and older who suffer from a diagnosable psychological disorder in a given year is closest to
 - A. 15 percent.
 - B. 26 percent.
 - C. 40 percent.
 - D. 46 percent.
2. The stigma attached to psychological disorders can have implications for
 - A. the physical health of an individual with such a disorder.
 - B. the psychological well-being of an individual with such a disorder.
 - C. other people's attitudes and behaviors toward the individual with such a disorder.
 - D. all of the above
3. Labeling psychological disorders can lead to damaging
 - A. stereotyping.
 - B. discrimination.
 - C. prejudice.
 - D. all of the above

APPLY IT! 4. Liliana has applied for a job after graduation doing data entry for a polling firm. During her second interview, Liliana asks the human resources manager whether the job's health benefits include

prescription drug coverage, as she is on anti-anxiety medication for generalized anxiety disorder. Which of the following statements is most applicable, legally and otherwise, in light of Liliana's request?

- A. The human resources manager should tell the hiring committee to avoid hiring Liliana because she has a psychological disorder.
- B. It is illegal for the firm to deny Liliana employment simply because she has a psychological disorder.
- C. Liliana should not have asked that question, because she will not be hired.
- D. Liliana must be given the job, or the firm could face a lawsuit.

SUMMARY

1 Defining and Explaining Abnormal Behavior

Abnormal behavior is deviant, maladaptive, or personally distressful. Theoretical perspectives on the causes of psychological disorders include biological, psychological, sociocultural, and biopsychosocial approaches.

Biological approaches to disorders describe psychological disorders as diseases with origins in structural, biochemical, and genetic factors. Psychological approaches include the behavioral, social cognitive, and trait perspectives. Sociocultural approaches place emphasis on the larger social context in which a person lives, including marriage, socioeconomic status, ethnicity, gender, and culture. Biopsychosocial approaches view the interactions among biological, psychological, and social factors as significant forces in producing both normal and abnormal behavior.

The classification of disorders provides a shorthand for communication, allows clinicians to make predictions about disorders, and helps them to decide on appropriate treatment. The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is the classification system clinicians use to diagnose psychological disorders. Some psychologists contend that the *DSM* perpetuates the medical model of psychological disorders, labels everyday problems as psychological disorders, and fails to address strengths.

2 Anxiety and Anxiety-Related Disorders

Anxiety disorders are characterized by unrealistic and debilitatingly high levels of anxiety. Generalized anxiety disorder involves a high

level of anxiety with no specific reason for the anxiety. Panic disorder involves attacks marked by the sudden onset of intense terror.

Specific phobias entail an irrational, overwhelming fear of a particular object, such as snakes, or a situation, such as flying. Social anxiety disorder refers to the intense fear that one will do something embarrassing or humiliating in public. Obsessive-compulsive disorder involves anxiety-provoking thoughts that will not go away (obsession) and/or urges to perform repetitive, ritualistic behaviors to prevent or produce some future situation (compulsion). Post-traumatic stress disorder (PTSD) is a disorder that develops through exposure to traumatic events. Symptoms include flashbacks, emotional avoidance, emotional numbing, and excessive arousal. A variety of experiential, psychological, and genetic factors have been shown to relate to these disorders.

3 Disorders Involving Emotion and Mood

In depressive disorders, the individual experiences a serious depressive episode and depressed characteristics such as lethargy and hopelessness. Biological explanations of depressive disorders focus on heredity, neurophysiological abnormalities, and neurotransmitter deregulation. Psychological explanations include behavioral and cognitive perspectives. Sociocultural explanations emphasize socioeconomic and ethnic factors, as well as gender.

Bipolar disorder is characterized by extreme mood swings that include one or more episodes of mania (an overexcited, unrealistic, optimistic state). Most individuals with bipolar disorder go through multiple cycles of depression interspersed with mania. Genetic

influences are stronger predictors of bipolar disorder than depressive disorder, and biological processes are also a factor in bipolar disorder.

Severe depression and other psychological disorders can cause individuals to want to end their lives. Theorists have proposed biological, psychological, and sociocultural explanations of suicide.

4 Eating Disorders

Anorexia nervosa is characterized by extreme underweight and starvation. The disorder is related to perfectionism and obsessive-compulsive tendencies. Bulimia nervosa involves a pattern of binge eating followed by purging through self-induced vomiting. In contrast, binge eating disorder involves binge eating without purging.

Anorexia nervosa and bulimia nervosa are much more common in women than men, but there is no gender difference in binge-eating disorder. Although sociocultural factors were once primary in explaining eating disorders, newer evidence points to the role of biological factors.

5 Dissociative Disorders

Dissociative amnesia involves memory loss caused by extensive psychological stress. In dissociative identity disorder, formerly called multiple personality disorder, two or more distinct personalities are present in the same individual; this disorder is rare.

6 Schizophrenia

Schizophrenia is a severe psychological disorder characterized by highly disordered thought processes. Positive symptoms of schizophrenia are behaviors and experiences that are present in individuals with schizophrenia but absent in healthy people; they include hallucinations, delusions, thought disorder, and disorders of movement. Negative symptoms of schizophrenia are behaviors and experiences that are part of healthy human life that are absent for those with this disorder; they include flat affect and an inability to plan or engage in goal-directed behavior.

Biological factors (heredity, structural brain abnormalities, and problems in neurotransmitter regulation, especially dopamine), psychological

factors (diathesis-stress model), and sociocultural factors may be involved in schizophrenia. Psychological and sociocultural factors are not viewed as stand-alone causes of schizophrenia, but they are related to the course of the disorder.

7 Personality Disorders

Personality disorders are chronic, maladaptive cognitive-behavioral patterns that are thoroughly integrated into an individual's personality. Two common types are antisocial personality disorder (ASPD) and borderline personality disorder (BPD).

Antisocial personality disorder is characterized by guiltlessness, law-breaking, exploitation of others, irresponsibility, and deceit. Individuals with this disorder often lead a life of crime and violence. Psychopaths—remorseless predators who engage in violence to get what they want—are a subgroup of individuals with ASPD.

Borderline personality disorder is a pervasive pattern of instability in interpersonal relationships, self-image, and emotions. This disorder is related to self-harming behaviors such as cutting and suicide.

Biological factors for ASPD include genetic, brain, and autonomic nervous system differences. The potential causes of BPD are complex and include biological and cognitive factors as well as childhood experiences.

8 Combatting Stigma

Stigma can create a significant barrier for people coping with a psychological disorder, as well as for their loved ones. Fear of being labeled can prevent individuals with a disorder from getting treatment and from talking about their problems with family and friends. In addition, the stigma attached to psychological disorders can lead to prejudice and discrimination toward individuals who are struggling with these problems. Having a disorder and experiencing the stigma associated with it can also negatively affect the physical health of such individuals. We can help to combat stigma by acknowledging the strengths and the achievements of individuals coping with psychological disorders.

KEY TERMS

abnormal behavior, p. 441

medical model, p. 443

DSM-5, p. 444

attention deficit hyperactivity disorder (ADHD), p. 445

anxiety disorders, p. 447

generalized anxiety disorder, p. 447

panic disorder, p. 448

specific phobia, p. 449

social anxiety disorder, p. 450

obsessive-compulsive disorder (OCD), p. 451

post-traumatic stress disorder (PTSD), p. 452

depressive disorders, p. 454

major depressive disorder (MDD), p. 455

bipolar disorder, p. 457

anorexia nervosa, p. 462

bulimia nervosa, p. 462

binge-eating disorder (BED), p. 464

dissociative disorders, p. 465

dissociative amnesia, p. 466

dissociative identity disorder (DID), p. 466

psychosis, p. 468

schizophrenia, p. 468

hallucinations, p. 468

delusions, p. 468

referential thinking, p. 469

catatonia, p. 469

flat affect, p. 469

diathesis-stress model, p. 471

personality disorders, p. 472

antisocial personality disorder (ASPD), p. 473

borderline personality disorder (BPD), p. 475

SELF-TEST

Multiple Choice

- The name for a mark of shame that may cause people to avoid, or act negatively toward, an individual is
 - disfigurement.
 - mortification.
 - stigma.
 - prejudice.
- Feeling an overwhelming sense of dread and worry without a specific cause is known as
 - obsessive-compulsive disorder.
 - generalized anxiety disorder.
 - social anxiety disorder.
 - panic disorder.
- A characteristic of post-traumatic stress disorder is
 - panic attacks.
 - an exaggerated startle response.
 - persistent nervousness about a variety of things.
 - extreme fear of an object or place.
- All of the following are disorders involving emotion or mood *except*
 - generalized anxiety disorder.
 - disruptive mood dysregulation disorder.
 - major depressive disorder.
 - bipolar disorder.
- The diagnostic criteria for major depressive disorder include the standard that a depressive episode must last at least
 - one week.
 - two weeks.
 - two months.
 - two years.
- Insistently focusing on being depressed is characteristic of
 - catastrophic thinking.
 - a ruminative coping style.
 - bipolar disorder.
 - learned helplessness.
- The eating disorder that involves binge eating followed by purging through self-induced vomiting is
 - binge eating disorder.
 - bulimia nervosa.
 - anorexia nervosa.
 - compulsive eating disorder.
- A dissociative disorder sometimes accompanied by unexpected sudden travel is
 - dissociate disorder.
 - dissociative personality disorder.
 - dissociative identity disorder.
 - dissociative amnesia.
- _____ symptoms of schizophrenia reflect a loss of normal functioning, while _____ symptoms reflect the addition of abnormal functioning.
 - Cognitive; behavioral
 - Behavioral; cognitive
 - Positive; negative
 - Negative; positive
- Antisocial personality disorder is characterized by _____, whereas borderline personality disorder is characterized by _____.
 - avoidance of impulsive behavior; avoidance of physical aggression
 - avoidance of physical aggression; avoidance of impulsive behavior
 - a tendency to harm oneself; violence toward others
 - violence toward others; a tendency to harm oneself

Apply It!

- What is the diathesis-stress model? In the text this model was applied to schizophrenia. Apply it to one eating disorder and one anxiety disorder.