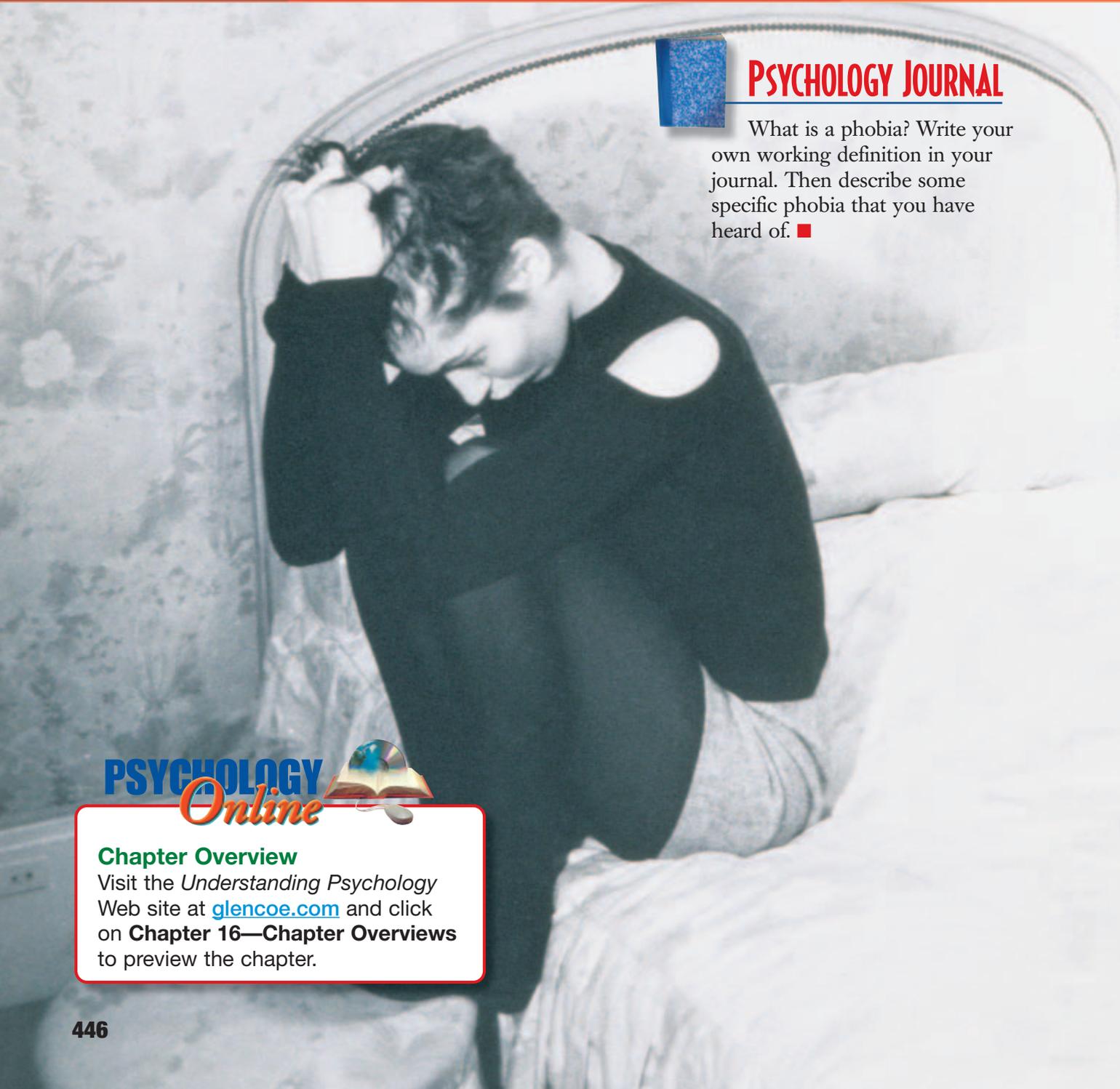


CHAPTER
16

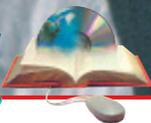
Psychological Disorders



PSYCHOLOGY JOURNAL

What is a phobia? Write your own working definition in your journal. Then describe some specific phobia that you have heard of. ■

PSYCHOLOGY
Online



Chapter Overview

Visit the *Understanding Psychology* Web site at glencoe.com and click on **Chapter 16—Chapter Overviews** to preview the chapter.

What Are Psychological Disorders?

Reader's Guide

■ Main Idea

Psychologists draw the line between normal and abnormal behavior in practice by looking at various attempts to define abnormal behavior, adjustments, and psychological health.

■ Vocabulary

- DSM-IV

■ Objectives

- Define psychological disorder.
- Distinguish between the concepts of normality and abnormality.

EXPLORING PSYCHOLOGY

Normal or Not?

A man living in the Ozark Mountains has a vision in which God speaks to him. He begins preaching to his relatives and neighbors, and soon he has the whole town in a state of religious fervor. People say he has a “calling.” His reputation as a prophet and healer spreads, and in time he is drawing large audiences everywhere he goes. However, when he ventures into St. Louis and attempts to hold a prayer meeting, blocking traffic on a main street at rush hour, he is arrested. He tells the policemen about his conversations with God, and they hurry him off to the nearest mental hospital.

—from *Understanding Psychology*, Richard A. Kasschau, 1995

Who is right? The prophet or the police officers? It is often difficult to draw a line between normal and abnormal behavior. Behavior that some people consider normal seems abnormal to others. Many believe that having visions and hearing voices are important parts of a religious experience. Other people believe these are symptoms of a psychological disorder. The man in the example above was interviewed by psychiatrists, diagnosed as paranoid schizophrenic, and hospitalized. Had he stayed home, people would have continued to see him as perfectly normal—even popular.

Figure 16.1

Defining Behavior

This person is obviously suffering, but is her behavior abnormal? The abnormality of her behavior would depend on whether other elements of a psychological disorder are present. **Why is adjustment an important way to distinguish normal behavior from abnormal behavior?**



DEFINING AND IDENTIFYING PSYCHOLOGICAL DISORDERS

In our example, the man was classified as mentally troubled because his behavior was so different from what others felt was normal under the circumstances. Yet the fact that a person is different does not necessarily mean that he or she is suffering from a mental illness. Indeed, going along with the crowd may at times be self-destructive. Most readers—and most psychologists—would agree that a teenager who uses cocaine because nearly everyone in his social circle does has problems.

How, then, do psychologists distinguish the normal from the abnormal?

There are a number of ways to define abnormality, none of which is entirely satisfactory. We will look at the most popular ways of drawing the line between normal and abnormal in terms of deviance, adjustment, and psychological health. Then we will look at the application of these principles in legal definitions of abnormality. Finally, we will consider the criticism that in all these models people are arbitrarily labeled mentally ill.

Did You Know?

Hysteria Sometimes a lack of knowledge leads to nonsensical explanations for psychological phenomena. For example, the term *hysteria* comes from the Greek word for “uterus.” The ancient Greeks diagnosed women with mental disorders by using a theory that the womb somehow moved around the body, occupying different positions. This “wandering of the uterus” theory led to characterizing any highly emotional behavior as hysteria. In the Middle Ages, the wandering uterus theory was used to explain demonic possession and led to persecutions of women for witchcraft.

Deviation From Normality

One approach to defining abnormality is to say that whatever most people do is normal. Abnormality, then, is any deviation from the average or from the majority. It is normal to bathe periodically, to express grief at the death of a loved one, and to wear warm clothes when going out in the cold, because most people do so. Because very few people take 10 showers a day, laugh when a loved one dies, or wear bathing suits in the snow, those who do so may be considered abnormal.

The deviance approach, however, as commonly used as it is, has serious limitations. If most people cheat on their income-tax returns, are honest taxpayers abnormal? If most people are noncreative, was Shakespeare abnormal? Different cultural norms must also be taken into consideration (see Figure 16.2). Because the majority is not always right or best, the deviance approach to defining abnormality is not by itself a useful standard.

Adjustment

Another way to distinguish normal from abnormal people is to say that normal people are able to get along in the world—physically, emotionally, and socially. They can feed and clothe themselves, work, find friends, and live by the rules of society. By this definition, abnormal people are the ones who fail to *adjust*. They may be so unhappy that they refuse to eat or so lethargic that they cannot hold a job. They may experience so much anxiety in relationships with others that they end up avoiding people, living in a lonely world of their own. However, not all people with psychological disorders are violent, destructive, or isolated. Sometimes, a person's behavior may only seem normal. Also, behavior that is socially acceptable in one society may not be acceptable in another. Again, the cultural context of a behavior must also be taken into consideration.

Psychological Health

The terms *mental illness* and *mental health* imply that psychological disturbance or abnormality is like a physical sickness—such as the flu or tuberculosis. Although many psychologists think that mental illness is different from physical illness, the idea remains that there is some ideal way for people to function psychologically, just as there is an ideal way for people to function physically. Some psychologists believe that the normal or healthy person would be one who is functioning ideally or who is at least striving toward ideal functioning. Personality theorists such as Carl Jung and Abraham Maslow (see Chapter 14) have tried to describe this striving process, which is often referred to as *self-actualization*. According to this line of thinking, to be normal or healthy involves full acceptance and expression of one's own individuality and humanness.

One problem with this approach to defining abnormality is that it is difficult to



Figure 16.2 Is This Normal?

What we consider normal and abnormal behavior depends on the context of the behavior. Here two men in Michoacán State, Mexico, display cultural dance masks. **Why must you consider the cultural context of a behavior when determining whether the behavior is abnormal?**

determine whether or not a person is doing a good job of actualizing himself or herself. How can you tell when a person is doing his or her best? What are the signs that he or she is losing the struggle? Answers to such questions often are arbitrary.

That definitions of abnormality are somewhat arbitrary has led some theorists to conclude that labeling a person as mentally ill simply because his or her behavior is odd is a mistake as well as cruel and irresponsible. The foremost spokesperson of this point of view is American psychiatrist Thomas Szasz (1984).

Szasz argued that most of the people whom we call mentally ill are not ill at all. They simply have “problems in living” that cause serious conflicts with the world around them. Yet instead of dealing with the patients’ conflicts as things that deserve attention and respect, psychiatrists simply label them as sick and shunt them off to hospitals. Society’s norms remain unchallenged, and psychiatrists remain in a comfortable position of authority. The ones who lose are the patients, who by being labeled abnormal are deprived both of responsibility for their behavior and of their dignity as human beings. As a result, Szasz claimed, the patients’ problems intensify. Szasz’s position, however, is a minority stand. Most psychologists and psychiatrists would agree that a person who claims to be God or Napoleon is truly abnormal and disturbed.

The fact that it is difficult to define abnormality does not mean that such a thing does not exist. What it does mean is that we should be very cautious about judging a person to be mentally ill just because he or she acts in a way that we cannot understand. It should also be kept in mind that mild psychological disorders are common. It is only when a psychological problem becomes severe enough to disrupt everyday life that it is thought of as an abnormality or illness.

THE PROBLEM OF CLASSIFICATION

For years psychiatrists have been trying to devise a logical and useful method for classifying emotional disorders. This task is difficult, because psychological problems do not lend themselves to the same sort of categorizing that physical illnesses do. The causes and symptoms of psychological disturbances and breakdowns and the cures for those breakdowns are rarely obvious or clear-cut.

All of the major classification schemes have accepted the medical model; they assume that abnormal behavior can be described in the same manner as

More About...

The Insanity Defense

When John Hinckley was tried for shooting President Ronald Reagan in 1981, he was found “not guilty by reason of insanity.” This raised public concerns about the legal definition of sanity.

In this case, not guilty did not mean that Hinckley did not commit the crime; it meant that he could not tell right from wrong or could not control his behavior because of a psychological disorder. Therefore, he could not be held criminally responsible for his behavior.

The terms *sane* and *insane* are legal terms. Psychological research has identified so many disorders of varying degrees that *insane* is too simplistic a term for a person with a psychological disorder. In fact, many people with psychological disorders are classified as sane under current legal standards.

People found not guilty by reason of insanity are not simply released; they are confined for treatment in special hospitals. Studies show that people found not guilty by reason of insanity are held for at least as long as people found guilty and sent to prison for similar crimes (American Psychiatric Association, 1993). After the Hinckley insanity defense, many states created review boards to oversee the treatment provided to those who have been found not guilty by reason of insanity.

any physical illness. The physician diagnoses a specific disease when a person has certain symptoms.

In 1952 the American Psychiatric Association agreed upon a system for classifying abnormal symptoms, which it published in the *Diagnostic and Statistical Manual of Mental Disorders*, or DSM. This book has been revised four times as the DSM-II (1968), DSM-III (1980), and DSM-III-Revised (1987). The most recent comprehensive revision, the **DSM-IV**, was published in 1994 and a minor text revision, DSM-IV-TR, in 2000.

A major change occurred in the shifts from DSM-II to DSM-III-R. Before 1980, the two most commonly used diagnostic distinctions were *neurosis* and *psychosis*. Although these terms have been replaced by more specific ones, they still are used by many psychologists. However, the conditions originally identified under neurosis and psychosis have been expanded into more detailed categories, including anxiety disorders, somatoform disorders, dissociative disorders, mood disorders, and schizophrenia.

DSM-IV: New Ways to Categorize Mental Illness

Within each diagnostic category of the DSM-IV, the following descriptions are included:

1. *essential features*—characteristics that define the disorder;
2. *associated features*—additional features that are usually present;
3. information on *differential diagnosis*—that is, how to distinguish this disorder from other disorders with which it might be confused; and



Profiles In Psychology

Abraham Maslow

1908–1970

“Human life will never be understood unless its highest aspirations are taken into account.”

One of the founders of humanistic psychology, Abraham Maslow spent his life developing theories that shaped counseling, education, social work, theology, marketing, and management. Early in his career, Maslow upset behaviorists by contradicting their theories of motivation and personality. If you recall, behaviorists propose that individuals learn new behaviors by responding to environmental stimuli that reward or punish their behaviors. Maslow emphasized that each individual has freedom in directing his or her own future. Maslow believed that individuals could achieve personal growth and self-fulfillment.

Maslow developed a theory of motivation that describes an individual’s hierarchy of needs (see Chapter 12). Individuals progress from filling basic, biological needs to the highest social needs of what Maslow called self-actualization—the fulfillment of one’s greatest human potential. Individuals organize their lives around these needs, trying to fulfill the needs at each level. If needs are not fulfilled at any level, conflict results. Attention to these needs, then, is a method to resolve psychological conflict.

DSM-IV: the fifth version of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*

4. *diagnostic criteria*—a list of symptoms, taken from the lists of essential and associated features, that must be present for the patient to be given a particular diagnostic label.

These more precise diagnostic criteria reduce the chances that the same patient will be classified as schizophrenic by one doctor and manic depressive by another. Because researchers often rely on diagnostic labels to study underlying factors that may cause disorders, it is especially important for their work that patients with similar symptoms be classified in the same diagnostic category.

The DSM-IV also recognizes the complexity of classifying people on the basis of mental disorders. Often a person may exhibit more than one disorder or may be experiencing other stresses that complicate the diagnosis. In early classification systems, it was difficult to give a patient more than one label. The DSM-III-R and now the DSM-IV have overcome this

Figure 16.3

DSM-IV—Major Psychological Disorders of Axis I

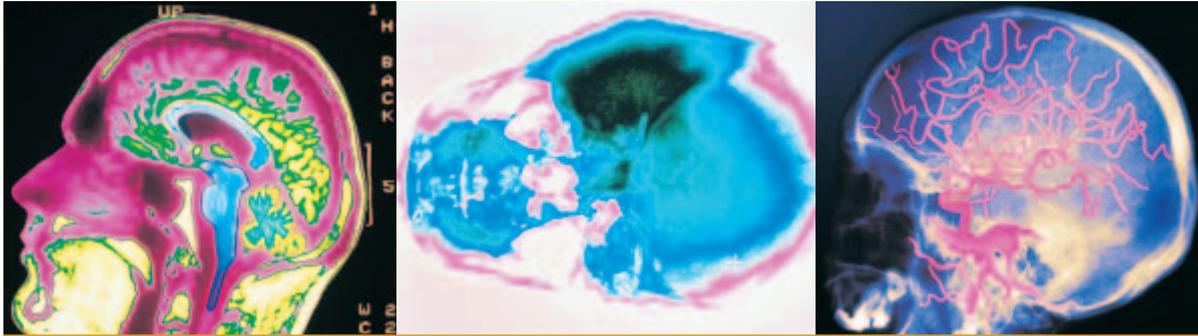
Individual cases of psychological disorders are diagnosed on the five axes of the DSM-IV. Axis I classifies symptoms into categories. *What are impulse control disorders?*

Disorders usually first diagnosed in infancy, childhood, or adolescence	Includes disorders typically arising before adolescence, including attention deficit disorders, mental retardation, and stuttering
Delirium, dementia, and other cognitive disorders	Includes disorders of perceptual, memory, and thought distortion that stem from damage to the brain, such as Alzheimer's disease
Substance-related disorders	Includes maladaptive use of alcohol and drugs
Schizophrenia and other psychotic disorders	Characterizes types of schizophrenia and psychotic disorders by symptoms
Mood disorders	Includes disorders characterized by emotional disturbance, such as depression and bipolar disorder
Anxiety disorders	Includes disorders characterized by signs of anxiety, such as panic disorders and phobias
Somatoform disorders	Includes disorders characterized by somatic symptoms that resemble physical illnesses, such as conversion disorder and hypochondriasis
Dissociative disorders	Includes disorders that are characterized by sudden and temporary changes in memory, consciousness, identity, and behavior, such as dissociative identity disorder
Sexual and gender-identity disorders	Includes preferences for unusual acts to achieve sexual arousal and sexual dysfunctions
Eating disorders	Includes disorders such as anorexia nervosa and bulimia nervosa
Sleep disorders	Includes disorders associated with sleep, such as insomnia and sleepwalking
Impulse control disorders	Includes disorders characterized by a tendency to act on impulses that others usually inhibit, such as to gamble excessively or steal

Source: DSM-IV, American Psychiatric Association, 1994.

Figure 16.4 PET Scans

The biological roots of abnormal behavior include genetic factors and occurrences that can lead to abnormal brain development. From left to right, these PET scans show a normal human brain, a brain tumor, and a brain aneurysm. **Which axis of the DSM-IV describes the medical conditions of psychological disorders?**



problem by using five major dimensions, or *axes*, to describe a person's mental functioning. Each axis reflects a different aspect of a patient's case.

Axis I is used to classify current symptoms into explicitly defined categories. These categories range from disorders that are usually first evident in infancy, childhood, or adolescence (such as conduct disorders) to substance-use disorders (such as alcoholism) to schizophrenia. **Figure 16.3** shows a listing of major Axis I categories.

Axis II is used to describe developmental disorders and long-standing personality disorders or maladaptive traits such as compulsiveness, over-dependency, or aggressiveness. Axis II is also used to describe specific developmental disorders for children, adolescents, and, in some cases, adults. Examples of developmental problems that would be classified under Axis II are language disorders, reading or writing difficulties, mental retardation, autism, and speech problems.

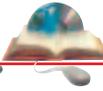
It is possible for an individual to have a disorder on both Axis I and Axis II. For example, an adult may have a major depression noted on Axis I and a compulsive personality disorder noted on Axis II. A child may have a conduct disorder noted on Axis I and a developmental language disorder on Axis II. In other cases, a person may be seeking treatment primarily for a condition noted on Axis I or Axis II only. The use of both Axes I and II permits multiple diagnoses and allows the clinician flexibility in making provisional diagnoses when there is not enough information available to make a firm diagnosis.

Axis III is used to describe physical disorders or general medical conditions that are potentially relevant to understanding or caring for the person. In some cases, a physical disorder such as brain damage or a chemical imbalance may be causing the syndrome diagnosed on either Axis I or II.

 **Reading Check**
How does the DSM-IV categorize psychological disorders?

Did You Know?

Neurosis In DSM-II, neurosis was used to describe a variety of anxiety-based disorders. Today, these disorders are identified individually in DSM-IV as mood disorders, anxiety disorders, somatoform disorders, and dissociative disorders. Although anxiety-based behaviors are still sometimes described as neurotic, the term *neurosis* is no longer used to identify any psychological disorder.



Student Web Activity

Visit the *Understanding Psychology* Web site at glencoe.com and click on **Chapter 16—Student Web Activities** for an activity on psychological disorders.

Axis IV is a measurement of the current stress level at which the person is functioning. The rating of stressors (such as death of a spouse or loss of a job) is based on what the person has experienced within the past year. The prognosis may be better for a disorder that develops following a severe stressor than for one that develops after no stressor or a minimal stressor.

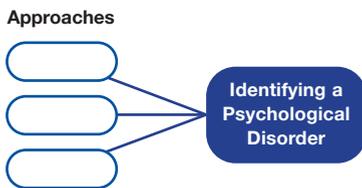
Axis V is used to describe the highest level of adaptive functioning present within the past year. Adaptive functioning refers to three major areas: social relations, occupational functioning, and the person’s use of leisure time. *Social relations* refer to the quality of a person’s relationships with family and friends. *Occupational functioning* involves functioning as a worker, student, or homemaker and the quality of the work accomplished. *Use of leisure time* includes recreational activities or hobbies and the degree of involvement and pleasure a person has in them.

This five-part diagnosis may be extremely helpful to researchers trying to discover connections among psychological disorders and other factors such as stress and physical illness. Although it is helpful, the DSM-IV labels a person, which may have negative influences on that person in the long run. When the label of a mental disorder is applied, it can reduce that person’s sense of responsibility for his/her own actions. It also affects how others, including mental health professionals, regard that person. Experiments have demonstrated that labels affect how others view someone. In one experiment, grade-school boys behaved in a more critical manner toward other boys if they had been led to believe that those other boys had a psychological disorder, such as attention deficit disorder (Harris et al., 1992). It is important to note that many people develop a disorder listed in the DSM-IV at some point in their life. Of course, many of these incidences are temporary. In effect, many people who qualify for a disorder as diagnosed according to the DSM-IV are not very different from anyone else.

SECTION 1

Assessment

- 1. **Review the Vocabulary** What is the DSM-IV? How do psychologists use it?
- 2. **Visualize the Main Idea** Using a diagram similar to the one below, identify and describe three approaches psychologists use to identify psychological disorders.



- 3. **Recall Information** What are the advantages and disadvantages of categorizing people by the DSM-IV?
- 4. **Think Critically** Many people suffer from mild psychological disorders. When do you think it is necessary for a person to seek help?

5. Application Activity Come up with your own definitions of normal and abnormal behavior. Explain how they differ from the descriptions in this section and why you defined them the way you did.

Reader's Guide

■ Main Idea

Anxiety disorders are marked by excessive fear, caution, and attempts to avoid anxiety.

■ Vocabulary

- anxiety
- phobia
- panic disorder
- post-traumatic stress disorder

■ Objectives

- Identify the behavioral patterns that psychologists label as anxiety disorders.
- Explain what causes anxiety disorders.

EXPLORING PSYCHOLOGY

Normal Anxiety or Not?

If you are walking down the street and a large dog runs at you barking, it's perfectly normal to be afraid. However, if you get anxious if a dog appears on the TV you're watching, that's a disorder. If a student gets up to give a speech in class and finds that his hands are trembling and his throat is dry, that's normal anxiety. If a student runs out of the room crying when called on to speak or faints while giving a speech, that isn't normal.

—from the files of Judith R. Levine, SUNY Farmingdale

Anxiety is a general state of dread or uneasiness that a person feels in response to a real or imagined danger. People suffering from anxiety disorders feel anxiety but not just normal anxiety. They suffer from anxiety that is out of proportion to the situation provoking it. This intense anxiety may interfere with normal functioning in everyday life. Anxiety disorders are the most common type of mental illness in the United States, affecting 40 million Americans annually (NIMH, 2006). These disorders share certain characteristics, including feelings of anxiety and personal inadequacy and an avoidance of dealing with problems. People with anxiety disorders often have unrealistic images of themselves. People who are deeply anxious seem unable to free themselves of recurring worries and fears. Their emotional problems may be expressed in constant worrying, sudden mood swings, or a variety of physical symptoms (for example, headaches, sweating, muscle tightness, weakness, and fatigue).

Anxious people often have difficulty forming stable and satisfying relationships. Even though their behavior may be self-defeating and ineffective in solving problems, those driven by anxiety often refuse to give up their behaviors in favor of more effective ways of dealing with anxiety. In

the DSM-IV, the anxiety disorders discussed include generalized anxiety disorder, phobic disorder, panic disorder, obsessive-compulsive disorder, and post-traumatic stress disorder.

GENERALIZED ANXIETY DISORDER

Once in a while, everyone feels nervous for reasons he or she cannot explain, but a severely anxious person almost always feels this way. **Anxiety** is a generalized apprehension—a vague feeling that one is in danger. This anxiety potentially could blossom into full-fledged panic attacks, which may include choking sensations, chest pain, dizziness, trembling, and hot flashes. Unlike fear, which is a reaction to real and identifiable threats, anxiety is a reaction to vague or imagined dangers.

Some people experience a continuous, generalized anxiety. Fearing unknown and unforeseen circumstances, they are unable to make decisions or enjoy life. They may become so preoccupied with their internal problems that they neglect their social relationships. People who experience generalized anxiety often have trouble dealing with their family and friends and fulfilling their responsibilities, and this adds to their anxiety. They are trapped in a vicious cycle. The more they worry, the more difficulty they have; the more difficulty they have, the more they worry.

Often the experience of generalized anxiety is accompanied by physical symptoms such as muscular tension, an inability to relax, a furrowed brow, and a strained face. Poor appetite, indigestion, diarrhea, and frequent urination are also common. Because anxious people are in a constant state of apprehension, they may have difficulty sleeping or, once asleep, may wake up suddenly in the night. As a result, they may feel tired when they wake up in the morning.

Why are some people so anxious? Some theorists stress the role of learning in producing anxiety. If a man feels very anxious on a date, for example, even the thought of another date may make him nervous, so he learns to avoid having dates and therefore never has a chance to unlearn the anxiety. His anxiety may then generalize to other situations and become a worse problem.

Other research suggests that anxiety disorders may be partly inherited. Environmental factors, such as unpredictable traumatic experiences in childhood, may also predispose someone to developing an anxiety disorder. Such a disorder usually occurs following a major life change, such as getting a job or having a baby. The uncertainties of modern life also may help explain the high incidence of generalized anxiety.

PHOBIC DISORDER

When severe anxiety is focused on a particular object, animal, activity, or situation that seems out of proportion to the real dangers involved, it is called a phobic disorder, or **phobia**. Phobias

anxiety: a vague, generalized apprehension or feeling that one is in danger

phobia: an intense and irrational fear of a particular object or situation

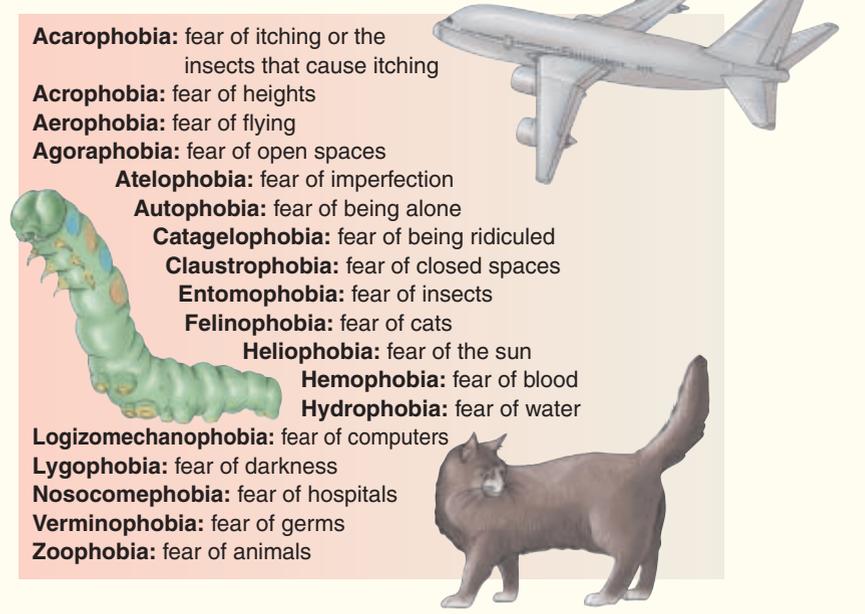
Figure 16.5 Normal Anxiety

Many situations may cause temporary anxiety or tension. Anxiety becomes a problem only when it interferes with your ability to cope with everyday life. **What are some characteristics of people who suffer from anxiety disorders?**



Figure 16.6**Phobias**

Some people's lives are consumed by inappropriate fears. These fears interfere with normal, everyday life. These people are suffering from a phobia. **What is the fear of flying called?**



may be classified as specific phobias, social phobias, and agoraphobia. A *specific phobia* can focus on almost anything, including high places (acrophobia), enclosed spaces (claustrophobia), and darkness (nyctophobia) (see Figure 16.6). Victims of *social phobias* fear that they will embarrass themselves in a public place or a social setting. Perhaps the most common specific fear is of speaking in public, but others include eating in public, using public restrooms, meeting strangers, and going on a first date.

Phobic individuals develop elaborate plans to avoid the situations they fear. For example, people suffering from an extreme fear of being in a public place (*agoraphobia*) may stop going to movies or shopping in large, busy stores. Some reach the point where they will not leave their houses at all because that is the only place they feel safe.

Phobias range in intensity from mild to extremely severe. Most people deal with phobias by avoiding the thing that frightens them. Thus the phobias are learned and maintained by the reinforcing effects of avoidance, which reduces anxiety but not the phobia. One form of treatment for phobias involves providing the phobic person with opportunities to experience the feared object under conditions in which he or she feels safe.

PANIC DISORDER

Another kind of anxiety disorder is **panic disorder**. (*Panic* is a feeling of sudden, helpless terror, such as the overwhelming fright one might experience when cornered by a predator.) During a panic attack, a victim

panic disorder: an extreme anxiety that manifests itself in the form of panic attacks



Quick Lab

What fears are most common among teenagers?

Although most people do not experience severe phobias, many do experience mild fears. Find out what fears your classmates experience or have experienced.

Procedure

1. Prepare a list identifying some objects, animals, activities, or situations that are feared.
2. Distribute the list among your friends, classmates, and the adults you know.
3. Direct them to check the items on the list that identify a fear that they have; encourage them to write a fear they have that does not appear on the list.
4. Tally the responses.

Analysis

1. Record the results in a chart or graph, differentiating responses of the teenagers from those of the adults.
2. Determine the most common fears. What reasons can you provide for the similarities or the differences between the two groups?



See the **Skills Handbook**, page 622, for an explanation of designing an experiment.



Reading Check
What is a panic attack?

experiences sudden and unexplainable attacks of intense anxiety, leading the individual to feel a sense of inevitable doom or even the fear that he or she is about to die. Although symptoms of panic disorder differ from individual to individual, they may include a sense of smothering, choking, or difficulty breathing; faintness or dizziness; nausea; and chest pains. Although panic attacks sometimes last for an hour or more, they usually last just a few minutes and occur without warning.

Panic disorder may be inherited, in part. However, the panic victim usually experiences the first attack shortly after a stressful event. The disorder may also be the result of interpreting physiological arousal, such as an increased heart rate, as disastrous.

OBSESSIVE-COMPULSIVE DISORDER

A person suffering from acute anxiety may think the same thoughts over and over. Such an uncontrollable pattern of thoughts is called *obsession*. A person also may repeatedly perform coping behaviors, called *compulsions*. A person with an anxiety-based disorder may experience both these agonies together—a condition called *obsessive-compulsive disorder*.

A compulsive person may feel compelled to wash his hands 20 or 30 times a day or to avoid stepping on cracks in the sidewalk when he goes out. An obsessive person may be unable to rid herself of unpleasant thoughts about death or of a recurring impulse to make obscene remarks in public. The obsessive-compulsive may wash her hands continually *and* torment herself with thoughts of obscene behavior.

Everyone has obsessions and compulsions. Love might be described as an obsession, as might a hobby that occupies most of a person's spare time. Striving to do something perfectly is often considered to be a compulsion. If the person who is deeply engrossed in a hobby or who aims for perfection enjoys this intense absorption and can still function effectively, he or she usually is not considered disabled by anxiety. Psychologists consider it a problem only when such thoughts and activities interfere with what a person wants and needs to do. Someone who spends so much time double-checking every detail of her work that she can never finish a job is considered more anxious than conscientious.

Why do people develop obsessions and compulsions? Perhaps it is because they serve as diversions from a person's real fears and their origins and thus may reduce anxiety somewhat. In addition, compulsions provide a disturbed person with the evidence that she is doing something

well, even if it is only avoiding the cracks on a sidewalk. Obsessive-compulsive disorder does run in families, so there may be a possible genetic basis. Although most people with obsessive-compulsive disorder realize that their thoughts and actions are irrational, they feel unable to stop them.

POST-TRAUMATIC STRESS DISORDER

Post-traumatic stress disorder is a condition in which a person who has experienced a traumatic event feels severe and long-lasting aftereffects. This disorder is common among veterans of military combat and survivors of acts of terrorism, natural disasters such as floods or tornadoes, other catastrophes such as plane crashes, and human aggression such as rape and assault. The event that triggers the disorder overwhelms a person's sense of reality and ability to cope. The disorder may begin immediately after the occurrence of the traumatic event or it may develop later. Typical symptoms include involuntary flashbacks or recurring nightmares during which the victim reexperiences the ordeal, often followed by insomnia and feelings of guilt. Post-traumatic stress disorder can be extremely long-lasting. Studies show that survivors of Nazi concentration camps and soldiers returning from war may display symptoms decades after the traumatic event. Not everyone who experiences a traumatic event, though, develops post-traumatic stress disorder. People who are exposed repeatedly or over a long period of time to distressing conditions are more likely to develop the disorder. Social support, as discussed in Chapter 15, may protect a victim of trauma from the psychological aftereffects.

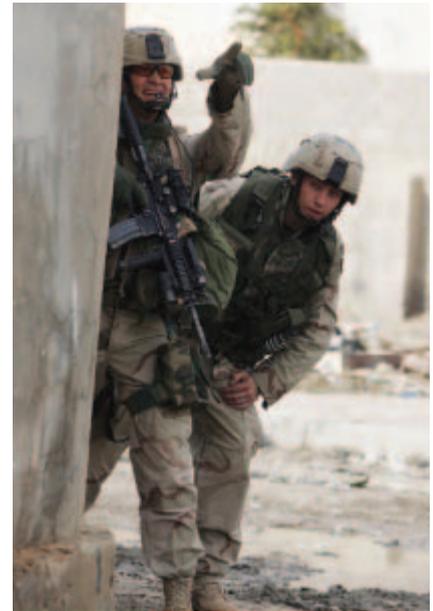


Figure 16.7 Trauma and Stress

Estimates suggest that about 18 percent of the American soldiers who fought in the Iraq War will develop post-traumatic stress disorder. *How might war cause someone to develop this disorder?*

post-traumatic stress disorder: disorder in which victims of traumatic events experience the original event in the form of dreams or flashbacks

SECTION 2 Assessment

- 1. Review the Vocabulary** Explain how excessive anxiety may lead to phobias or panic disorders.
- 2. Visualize the Main Idea** Using a diagram similar to the one below, list five symptoms of generalized anxiety disorder.
- 3. Recall Information** What is anxiety? When is it normal? Abnormal?
- 4. Think Critically** How would you differentiate between someone who is simply a perfectionist and someone who is suffering from obsessive-compulsive disorder?



- 5. Application Activity** Interview a doctor or nurse who deals with war veterans (such as at your local vets center). Ask the professional to list the symptoms of post-traumatic stress disorder. Summarize your findings.

Somatoform and Dissociative Disorders

Reader's Guide

■ Main Idea

The inability to deal with anxiety and stress can lead to somatoform and dissociative disorders.

■ Vocabulary

- somatoform disorder
- conversion disorder
- dissociative disorder
- dissociative amnesia
- dissociative fugue
- dissociative identity disorder

■ Objectives

- Identify the behavioral patterns that psychologists label as somatoform disorders.
- Describe the symptoms of dissociative disorders.

EXPLORING PSYCHOLOGY

Why Can't the Prince Walk?

There is an ancient Persian legend about a physician named Rhazes who was called into the palace for the purpose of diagnosing and treating a young prince. Apparently, the prince could not walk. After the usual examination of the day, Rhazes determined that there was nothing wrong with the prince's legs, at least not physically. With little more than a hunch, Rhazes set out to treat what may be the first recorded case of conversion. In doing so, he took a risk: Rhazes unexpectedly walked into the prince's bathroom brandishing a dagger and threatened to kill him. Upon seeing him, "the startled prince abruptly fled, leaving his clothes, his dignity, his symptom, and undoubtedly part of his self-esteem behind."

—from *The Neuroses* by H.P. Laughlin, 1967

The prince in the excerpt above suffered from a somatoform disorder. These disorders are characterized by physical symptoms brought about by psychological distress. Today psychologists treat somatoform disorders with less drastic techniques. Psychologists may challenge conversion patients, attempting to force them out of the symptoms. It is important to note that the prince did not consciously fake his symptoms to avoid pressure or work; it is likely that he honestly could not move his legs. Psychologists must take this into account when treating such disorders.

SOMATOFORM DISORDERS

Anxiety can create a wide variety of physical symptoms for which no physical cause is apparent. This phenomenon is known as a **somatoform disorder**, or hysteria. The term *hysteria* was more commonly used in Sigmund Freud's time to refer to unexplainable fainting, paralysis, or deafness. Today the term *somatoform disorder* is preferred. Two of the major types of somatoform disorders that psychologists identify are *conversion disorders* and *hypochondriasis*.

somatoform disorder: a condition in which there is no apparent physical cause

Conversion Disorders

A **conversion disorder** is the conversion of emotional difficulties into the loss of a specific physiological function. While the loss of functioning is real, no actual physical damage is present. Many people occasionally experience mild conversion disorders, such as when someone is so frightened he or she cannot move, but a conversion disorder is not simply a brief loss of functioning due to fright. It persists.

conversion disorder: changing emotional difficulties into a loss of a specific voluntary body function

A conversion disorder results in a real and prolonged handicap; the person literally cannot feel anything in his left hand, move his legs, or exercise some other normal physical function. For example, a man might wake up one morning and find himself paralyzed from the waist down. The normal reaction to this would be panic. However, he might accept the loss of function with relative calm, called *la belle indifférence*. This calmness is one sign that a person is suffering from a psychological rather than a physiological problem. Most psychologists believe that people suffering from conversion disorders unconsciously invent physical symptoms to gain freedom from unbearable conflict. For example, a woman who lives in terror of blurting out things that she does not want to say may lose the power of speech. This resolves the conflict about speaking. Conversion disorders are comparatively rare.

Hypochondriasis

Conversion disorders must be distinguished from *hypochondriasis*, in which a person who is in good health becomes preoccupied with imaginary ailments. The hypochondriac spends a lot of time looking for signs of serious illness and often misinterprets minor aches, pains, bruises, or bumps as early signs of a fatal illness. Despite negative results in medical tests and physical

Figure 16.8 Avoiding Happiness

Some people may accuse those suffering from hypochondriasis of faking their illness (and preventing their own happiness). These people, though, do not fake their symptoms; they unrealistically interpret normal aches and pains as symptoms of more serious illnesses. **How does hypochondriasis differ from a conversion disorder?**



Peanuts reprinted by permission of United Feature Syndicate, Inc.

evaluations, the hypochondriac typically continues to believe that a disease or malfunction exists. Hypochondriasis occurs mainly during young adulthood and is equally common in men and women. According to psychoanalytic theory, hypochondriasis, like conversion, occurs when an individual represses emotions and then expresses them symbolically in physical symptoms.

DISSOCIATIVE DISORDERS

dissociative disorder:

a disorder in which a person experiences alterations in memory, identity, or consciousness

dissociative amnesia:

the inability to recall important personal events or information; is usually associated with stressful events

dissociative fugue:

a dissociative disorder in which a person suddenly and unexpectedly travels away from home or work and is unable to recall the past

dissociative identity disorder:

a person exhibits two or more personality states, each with its own patterns of thinking and behaving

You have probably had the experience of being lost in a daydream and failing to notice your friend calling your name. This is a normal dissociative experience. A **dissociative disorder** involves a more significant breakdown in a person's normal conscious experience, such as a loss of memory or identity. These psychological phenomena fascinate many people, so we hear a good deal about amnesia and multiple personalities. Actually, they are very rare.

Memory loss that has no biological explanation, or **dissociative amnesia**, may be an attempt to escape from problems by blotting them out completely. Amnesiacs remember how to speak and usually retain a fund of general knowledge, but they may not know who they are, where they live and work, or who their family is. This amnesia should be distinguished from other losses of memory that result from physical brain damage, normal forgetting, or drug abuse. Dissociative amnesia most often results from a traumatic event, such as witnessing a terrible accident.

In **dissociative fugue**, another type of dissociative reaction, amnesia is coupled with active flight to a different environment. For example, a woman may suddenly disappear and wake up three days later in a restaurant 200 miles from home. If she is not treated, she may actually establish a new identity—assume a new name, marry, take a job, and so forth—in a new place. She may repress all knowledge of a previous life. A fugue state may last for days or for decades. However long it lasts, the individual, when she comes out of it, will have no memory of what happened in the interim. Fugue, then, is a sort of traveling amnesia, and it probably serves the same psychological function as dissociative amnesia, that is, escape from unbearable conflict or anxiety.

In **dissociative identity disorder** (previously known as multiple personality disorder), a third type of dissociative disorder, someone seems to have two or more distinct identities, each with its own way of thinking and behaving. These different personality states may take control at different times.

Eve White, a young woman who sought psychiatric treatment for severe headaches and blackouts, has become a famous example. Eve White was a conscientious, self-controlled, rather shy person. However, during one of her therapy sessions, her expression—and her personality—suddenly changed. Eve Black, as she now called herself, was childlike, fun-loving, and irresponsible—the opposite of the woman who originally walked into the psychiatrist's office. Eve Black was conscious of

Reading Check

How is dissociative amnesia different from dissociative fugue?

Eve White's existence but considered her a separate person. Eve White did not know about Eve Black, however, and neither was she conscious of Jane, a third personality that emerged during the course of therapy. (This case served as the basis for the film *The Three Faces of Eve*.) Some psychologists believe that this dividing up of the personality is the result of the individual's effort to escape from a part of the self that he or she fears. The secret self then emerges in the form of a separate personality. Dissociative identity disorder is extremely rare.

Eve's real name is Chris Costner Sizemore, and she published a book, *I'm Eve* (Sizemore & Pittillo, 1977), many years later, explaining that Eve ultimately had 22 separate personalities. Her case is often confused with Sybil, a woman whose 16 personalities were also described in a book and a film. While cases like Eve and Sybil are fascinating, they are extremely rare and very controversial.

People diagnosed with this disorder usually suffered severe physical, psychological, or sexual abuse during childhood. Individuals with dissociative disorders have learned to dissociate themselves from such stressful events by selectively forgetting them, thereby reducing the anxiety they feel.

Figure 16.9 The Personalities of Eve

Chris Sizemore (Eve) was able to overcome her disorder through therapy. She created this painting to symbolize the personalities present within her when she began therapy. **What causes dissociative identity disorder?**



SECTION 3 Assessment

- 1. Review the Vocabulary** Define and describe three dissociative disorders. Explain how these disorders differ from one another.
- 2. Visualize the Main Idea** Use a graphic organizer similar to the one below to list dissociative disorders.
- 3. Recall Information** What is the difference between a conversion disorder and hypochondriasis?
- 4. Think Critically** Besides anxiety, how might you realize that you are suffering from a somatoform or dissociative disorder?



- 5. Application Activity** As a class or in groups, arrange an appointment with a clinical psychologist, nurse, physician, or counseling psychologist. Question this person regarding the most common psychological problems young people face. Report your findings to the class.

Case Studies

Munchausen's Syndrome

Period of Study: 1994

Introduction: In 1994 a physician consulted psychiatrist Berney Goodman regarding the condition of a patient who seemingly had a rare bowel condition—the patient vomited every time she ate. Together they diagnosed the patient with bowel paralysis. Goodman himself wanted to examine the patient. From the start, the patient refused to cooperate with Goodman. Goodman discovered that the patient had low blood pressure. This, though, did not correspond with the diagnosis of bowel paralysis.



Hypothesis: Goodman suspected that the patient suffered from *Munchausen's Syndrome*. Those who suffer from the ailment have developed great sensitivity to emotional pain and will use any methods possible to avoid feeling it. These methods are quite extreme and often deadly. The sufferers often attempt to hospitalize themselves with self-defined or self-induced symptoms. Their ultimate goal is to have the physician take extraordinary measures to save their life.

Method: After further investigation, Goodman discovered that the patient was secretly taking diuretics to produce the symptoms associated with bowel paralysis. His suspicions had been correct. A Munchausen's patient might complain of a variety of symptoms. A physician, though, has trouble finding these symptoms when examining the patient. Patients have added sugar to samples of urine, suggesting the presence of diabetes. They have visited dermatologists with rashes, sores, and lesions with no medical explanation but used sandpaper, chemical irritants, or excessive heat to make these symptoms appear. Munchausen's patients have

swallowed corrosive substances, eroding the lining of their stomachs and throats to produce vomiting.

Munchausen's patients are not limited to displaying physical symptoms—they also imitate psychiatric disorders. Overdosing on psychoactive drugs to induce delusions and hallucinations is common for them. Patients may use techniques of persuasion to try to influence the physician to perform thorough medical investigations.

Although Munchausen's patients can puzzle and deceive physicians, they have a tendency to hide their methods poorly. Syringes are left lying around, they do not conceal pills neatly, and they allow themselves to be observed during their symptom-causing routines. These scenarios result in most diagnoses.

Results: Describing how Munchausen's Syndrome sufferers behave is much easier than explaining why. Some leads suggest that either all-caring or all-rejecting parental relationships are experienced and then re-created by the patient. They seem to invite their physicians into an all-nurturing relationship, and at other times they despise their physicians and create an all-rejecting relationship.

The difficulty in discovering and diagnosing Munchausen's Syndrome led to the absence of a clear-cut definition in the DSM-IV. Because of this, it is extremely difficult to treat those who are affected.

Analyzing the Case Study

1. What is Munchausen's Syndrome?
2. What are some possible causes of Munchausen's Syndrome?
3. **Critical Thinking** Why might a physician or psychologist suspect that someone is suffering from Munchausen's Syndrome? What is the danger in misdiagnosing this disorder?

Schizophrenia and Mood Disorders

Reader's Guide

■ Main Idea

Schizophrenia involves disordered thoughts. Mood disorders involve disturbances in the experience and expressions of depression.

■ Vocabulary

- schizophrenia
- delusions
- hallucinations
- major depressive disorder
- bipolar disorder

■ Objectives

- Describe the disorder of schizophrenia.
- Describe several theories that try to explain mood disorders.

EXPLORING PSYCHOLOGY

Word Salad

A woman was delighted to receive a letter from her son abroad, but distraught when she read it: “Dear mother . . . I am writing on paper. The pen I am using is from a factory called Perry and Co. The factory is in England. The city of London is in England. I know this from my school days. Then I always liked geography. My last teacher in that subject was Professor August A. He was a man with black eyes. There are also blue and grey eyes and other sorts too. I have heard it said that snakes have green eyes. All people have eyes. There are some, too, who are blind.”

—from *The Human Mind Explained*, edited by Susan A. Greenfield, 1996

The man who wrote this letter later was diagnosed with schizophrenia. Sufferers of schizophrenia often have difficulty using language to communicate. They seem to go from one phrase to another by random association. This confused language may result because schizophrenia affects the working memory, which is used to form sentences. A person with schizophrenia will not remember the beginning of a sentence and thus finishes it with an unrelated thought. Schizophrenia is often misunderstood.

We can understand depression, and most of us have experienced anxiety. In addition, we can appreciate how people with these problems strive to overcome them as best they can. An individual with schizophrenia, however, who withdraws from normal life and whose distorted perceptions and behavior reach an irrational, fantastic, fear-laden, unimaginable

schizophrenia: a group of disorders characterized by confused and disconnected thoughts, emotions, and perceptions

delusions: false beliefs that a person maintains in the face of contrary evidence

hallucinations: perceptions that have no direct external cause

level, does so in ways that are difficult to understand. Yet, psychologists are making progress in furthering our understanding of schizophrenia—the most complex and severe psychological problem we encounter.

WHAT IS SCHIZOPHRENIA?

While the disorders discussed thus far are primarily problems of emotion, schizophrenia is a problem of cognition, but it also involves emotion, perception, and motor functions. Schizophrenia affects about 1 percent of people worldwide, including 2.4 million Americans (National Institute of Mental Health, 2005), but the odds increase if schizophrenia is already in the family. What distinguishes this disorder from other types of psychological disturbance? **Schizophrenia** involves confused and disordered thoughts and perceptions. With schizophrenia, a person's thought processes are somewhat disturbed, and the person has lost contact with reality to a considerable extent. One expert has noted that someone with depression or severe anxiety problems dreams in an unreal way about life, while a person with schizophrenia lives life as an unreal dream. Schizophrenia is not a single problem; it has no single cause or cure. Rather, it is a collection of symptoms that indicates an individual has serious difficulty trying to meet the demands of life.

Suppose a psychiatrist is interviewing a patient who has just been admitted to a hospital. The individual demonstrates a wide assortment of symptoms. He is intensely excited, expresses extreme hostility toward members of his family, and at the same time claims that he loves them, showing conflicting feelings. One minute he is extremely aggressive, questioning the psychiatrist's motives and even threatening her. The next minute he withdraws and acts as if he does not hear anything she says. Then he begins talking again. "Naturally," he says, "I am growing my father's hair." Although all of the person's other behavior indicates psychological problems, this last statement would be the diagnostic bell ringer. It reveals that the man is living in a private, disordered reality.

Many individuals with schizophrenia experience **delusions**—false beliefs maintained in the face of contrary evidence—and **hallucinations**—perceptions in the absence of corresponding sensation. For example, a person with schizophrenia may perceive a voice when, in fact, there is no sound present. A person with schizophrenia may show a number of other symptoms as well. One is *incoherence*, or a marked decline in thought processes. The language of someone with schizophrenia may be sped up; sometimes, it is described as "word salad"—lots of words thrown together. Another symptom is

More About...

Autism

Schizophrenia and autism involve neurons in specialized areas of the brain. In autism, errors in the final stages of brain development affect the amygdala, limbic system, and possibly the cerebellum. These regions are related to language, information processing, and the emotional coloration of those processes (Ciaranello, 2001).

Obvious to the parents in haunting ways soon after birth, *infantile autism* causes children to differ from normal children in three ways. First, children with autism do not respond to other people. If you pick up an autistic child, he or she is stiff or limp; the child will not cling to you as normal children will. Second, an autistic child is very slow in developing language and communication skills. By age 5 or 6, they may simply repeat what has been said, a condition called *echolalia*. Third, autistic children are very limited in their interests and behavior. They may abuse themselves or repeat a simple hand motion for hours without ceasing.

Explaining autism's cause has been difficult. Learning-based and psychoanalytic attempts have failed. It is clear that genetics play a role (see Chapter 6; Ciaranello, 2001); an inborn defect may interact with later environmental or biological events (Carson & Butcher, 1992) to produce autism.

disturbances of affect, or emotions that are inappropriate for the circumstances. In addition, an individual with schizophrenia may display severe *deterioration in normal movement*, which may occur as slowed movement, nonmovement, or as highly agitated behavior. Another symptom is a marked *decline in previous levels of functioning*; for example, a sharp dropoff in productivity at work. Yet another symptom is *diverted attention*, perhaps brought about by cognitive flooding, as if the person is unable to focus his or her attention.

TYPES OF SCHIZOPHRENIA

Psychologists classify schizophrenia into several subtypes. One, the *paranoid type*, involves hallucinations and delusions, including *grandeur*: “I am the savior of my people;” or *persecution*: “Someone is always watching me” (see Figure 16.10). People with the *catatonic type* may remain motionless for long periods, exhibiting a waxy flexibility in which limbs in unusual positions may take a long time to return to a resting, relaxed position—exactly as if melting a wax statue (see Figure 16.11). Symptoms of the *disorganized type* include incoherent language, inappropriate emotions, giggling for no apparent reason, generally disorganized motor behavior, and hallucinations and delusions. Another form of schizophrenia is the *remission type*. This diagnostic label is applied to anyone whose symptoms are completely gone or still exist but are not severe enough to have earned a diagnosis of schizophrenia in the first place. The expectation is that symptoms will return, so the schizophrenia is simply viewed as in remission. It is sometimes difficult to differentiate between types of schizophrenia because some symptoms are shared by all types. The *undifferentiated type* encompasses the basic symptoms of schizophrenia, such as deterioration of daily functioning, hallucinations, delusions, inappropriate emotions, and thought disorders.

Schizophrenia is a very complex condition, and treatment is long-term and usually requires hospitalization. Long-term institutionalization sometimes leads to a patient who is *burned out*—one who is unlikely to function normally in society. Schizophrenia may go into remission, in which the symptoms disappear and the person seems quite normal, but according to the DSM-IV, adjustment tends to deteriorate between successive episodes of

Figure 16.10 Paranoia

A male patient diagnosed with schizophrenia with paranoid tendencies created this painting. It displays the symbolism of watchful eyes, grasping hands, and the self as subject matter. **How is the paranoid type of schizophrenia characterized?**



Did You Know?

Split Personality The term *schizophrenia* comes from Greek for “split personality.” Schizophrenia does not refer to split personalities such as dissociative identity disorder, though. Schizophrenia involves a split between the intellectual and emotional parts of a single personality.

the reappearance of symptoms. Although recovery from schizophrenia is possible, no real cure for schizophrenia exists, and once an individual is diagnosed with schizophrenia, he or she may never escape from it.

CAUSES OF SCHIZOPHRENIA

What is the actual cause of schizophrenia? There are many theories, and just as certainly, there is disagreement among practitioners. In all likelihood, the ultimate cause is an interaction of environmental, genetic, and biochemical factors.

Biological Influences

Genetics is almost certainly involved in causing schizophrenia. One psychologist (Gottesman, 1991) summarized the results of more than 35 studies conducted in Western Europe from 1920 to 1987. As confirmed by others, he found that there is a 1 percent likelihood that anyone in the general population will develop schizophrenia. These odds, however, increase to 10 percent if schizophrenia is already in the family. Yet, even among identical twins, if one twin develops schizophrenia, only 48 percent of the twin’s siblings will develop it. Schizophrenia is likely caused by a combination of genetic, epigenetic (factors that affect a cell but not its DNA), and environmental factors (Hanson & Gottesman, 2005) (see Figure 16.12).

Figure 16.11 Catatonic Type

A person suffering from the catatonic type of schizophrenia can hold an unusual position for long periods of time. *Is schizophrenia curable?*



Researchers have studied children born into families where either parent or a parent’s sibling was diagnosed with schizophrenia. Across several studies, if one or more siblings are diagnosed with schizophrenia, other children in the family will later be diagnosed with the condition less than 2 percent of the time. That probability rises to 5.5 percent if a parent or sibling is diagnosed (Mortensen, et al., 1999). Even where both parents were later diagnosed as having schizophrenia, about 50 percent of the children show no signs of schizophrenia. In summary, these studies show that psychologists cannot specify the exact contribution hereditary factors make to schizophrenia (Carson & Sanislow, 1992).

Biochemistry and Physiology

The proper working of the brain depends on the presence of right amounts of many chemicals, from oxygen to proteins. Some psychologists believe that psychosis is due largely to chemical imbalances in the brain. According to some theorists, occasionally people are born with a nervous system that gets aroused very easily and takes a long time to return to normal. Such people might be particularly likely to get upset when they are stressed.

Figure 16.12 The Genain Quadruplets

In 1930 four identical girls were born. By high school, people had labeled the girls as somehow different. By the time they were young adults, all four were diagnosed with schizophrenia. **From this case, what can psychologists infer about the causes of schizophrenia?**



Chemical problems may also be involved in the occurrence of schizophrenia. A number of researchers believe that the basic problem in schizophrenia is that too much or too little of certain chemicals has upset the brain's mechanisms for processing information, perhaps interfering with normal synaptic transmission.

The *dopamine hypothesis* suggests that an excess of dopamine at selected synapses is related to a diagnosis of schizophrenia. One psychologist (Carlsson, 1988) notes that correlational studies are not enough to demonstrate a direct role for dopamine in schizophrenia. It seems likely that chemicals play a role, but it is hard to tell whether these chemicals are the cause of schizophrenia or the result of it. Symptoms of schizophrenia may even be caused by the fact that people with schizophrenia tend to live in hospitals, where they get little exercise, eat institutional food, and are usually given daily doses of tranquilizers. Living under such conditions, anyone might develop chemical imbalances and abnormal behavior.

The use of CT and fMRI scans (see Chapter 6) has led to the discovery that the brains of people with schizophrenia often show signs of deteriorated brain tissue (Pearlson et al., 1989). One consistent result is that women who at some time develop schizophrenia are likely to have difficult pregnancies and difficulties giving birth. Obesity prior to pregnancy, infection during the second trimester (Wyatt & Susser, 2000), and oxygen deprivation to the fetus (Cannon et al., 2000) are correlated with children developing schizophrenia. The exact role of the environment in fostering schizophrenia is unclear, but it is involved.

Family and Interactions

From Freud onward, it has been tempting to blame the family situation in childhood for problems that develop during adulthood. Paul Meehl (1962, 1989) suggested that bad experiences during childhood are not enough, in and of themselves, to lead to schizophrenia; being part of a *pathogenic*, or unhealthy, family may contribute to problems in the adult years.

Studies show that families of individuals who later develop schizophrenia are often on the verge of falling apart. Another frequent finding is that family members organize themselves around—or in spite of—the very unusual, demanding, or maladaptive behavior of one member of the family. Communication, too, often seems disorganized in the early family life of people who later develop schizophrenia.

In Summary Which of these theories is correct? At this point, psychologists do not know. It may be that each is partially true. Perhaps people who inherit a tendency toward psychological disorders react more strongly to stressful situations than others would. The *diathesis-stress hypothesis* states that an individual may have inherited a predisposition toward schizophrenia. For schizophrenia to develop, however, that person must be exposed to an environment with certain stressors, such as bad family experiences, before the schizophrenia will develop. Explaining the causes of schizophrenia is perhaps the most complex research problem psychologists face.

MOOD DISORDERS

We all experience mood swings. Sometimes we are happy or elated, while at other times we feel dejected, miserable, or depressed. Yet even when we are discouraged, most of us still feel we can control our emotions and that these feelings will pass.

Occasional depression is a common experience. In some people, however, these moods are more intense and tend to last for longer periods. These individuals often get the sense that their depression will go on forever and that there is nothing they can do to change it. As a result, their emotions hamper their ability to function effectively or to seek help for their disorder. In extreme cases, a mood may cause individuals to lose touch with reality or seriously threaten their health or lives.

Major Depressive Disorder

Individuals suffering from **major depressive disorder** spend at least two weeks feeling depressed, sad, anxious, fatigued, and agitated, experiencing a reduced ability to function and interact with others. The depression ranges from mild feelings of uneasiness, sadness, and apathy to intense suicidal despair. To be diagnosed as depression, these feelings cannot be attributed to bereavement (the loss of a loved one). This disorder is marked by at least four of the following symptoms: problems with eating, sleeping, thinking, concentrating, or decision making; lacking energy; thinking about suicide; and feeling worthless or guilty (American Psychiatric Association, 1994).

major depressive disorder: severe form of lowered mood in which a person experiences feelings of worthlessness and diminished pleasure or interest in many activities

Bipolar Disorder

One type of mood disorder is **bipolar disorder**, in which individuals are excessively and inappropriately happy or unhappy. These reactions may take the form of high elation, hopeless depression, or an alternation between the two.

In the *manic phase*, a person experiences elation, extreme confusion, distractibility, and racing thoughts. Often the person has an exaggerated sense of self-esteem and engages in irresponsible behavior, such as shopping sprees or insulting remarks. As an example, consider the following behavior:

On admission she slapped the nurse, addressed the house physician as God, made the sign of the cross, and laughed loudly when she was asked to don the hospital garb. This she promptly tore to shreds. . . . She sang at the top of her voice, screamed through the window, and leered at the patients promenading in the recreation yard. (Karnash, 1945)

Often, this state is not as easy to detect as some others because the person seems to be in touch with reality and blessed with an unending sense of optimism. During a manic episode, a person may behave as if he or she needs less sleep, and the activity level typically increases, as does the loudness and the frequency with which he or she speaks.

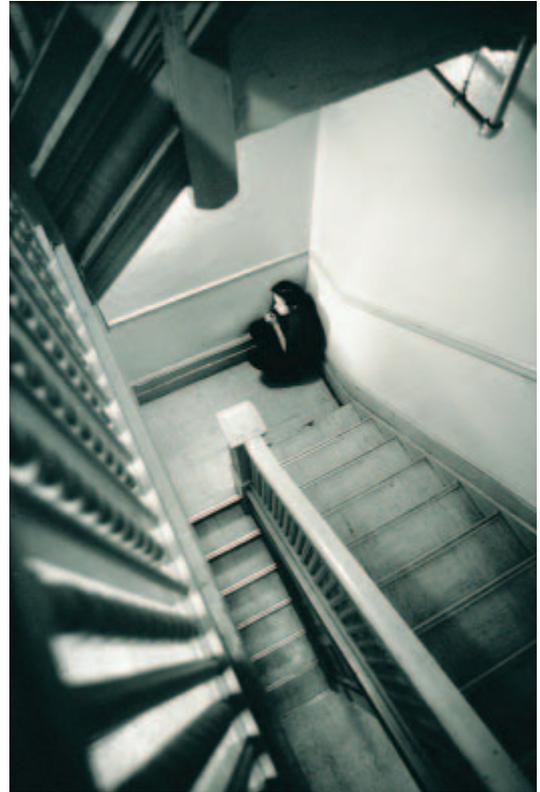
In the *depressive phase*, the individual is overcome by feelings of failure, sinfulness, worthlessness, and despair. In contrast to the optimism and high activity of a manic-type reaction, a depressive-type reaction is marked by lethargy, despair, and unresponsiveness. The behavior of someone who is depressed in a bipolar disorder is essentially the same as someone with a major depressive disorder (Perris, 1982), as in the following case:

The patient lay in bed, immobile, with a dull, depressed expression on his face. His eyes were sunken and downcast. Even when spoken to, he would not raise his eyes to look at the speaker. Usually he did not respond at all to questions, but sometimes, after apparently great effort, he would mumble something about the “Scourge of God.” (Morris & Maisto, 2005)

In some cases, a patient will alternate between frantic action and motionless despair. Some people experience occasional episodes of a manic-type or depressive-type reaction, separated by long intervals of relatively normal behavior. Others exhibit almost no normal behavior, cycling instead from periods of manic-type reactions to equally intense depressive-type reactions. Some theorists have speculated that the manic periods serve as an attempt to ward off the underlying hopelessness of the depressive periods. Others believe that mania can be traced to the same biochemical disorder responsible for depression.

Figure 16.13 Down in the Dumps

This scene expresses the emptiness and bleakness that a depressed person feels. **When does depression become a psychological disorder?**

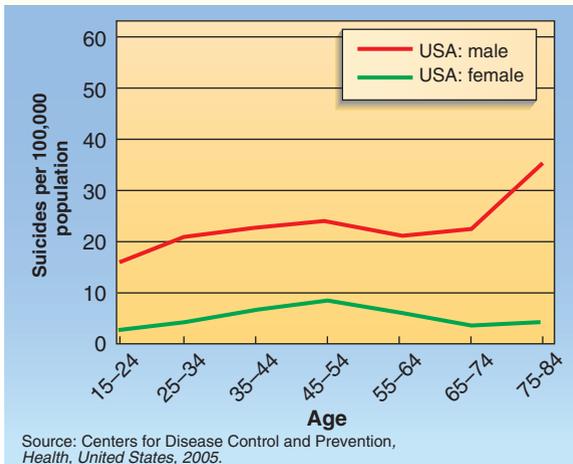


bipolar disorder: disorder in which an individual alternates between feelings of mania (euphoria) and depression

 **Reading Check**
What is the difference between a major depressive disorder and a bipolar disorder?

Figure 16.14 Suicide Rates

Suicide rates vary according to age and gender. **Which age group has the highest suicide rate? Which gender has the highest suicide rate?**



Seasonal Affective Disorder

Many of us may feel a tinge of sadness when looking at a mid-February landscape of dull grays and browns. However, there are people who develop a deep depression in the midst of winter. These people are victims of *seasonal affective disorder*, or *SAD*. Throughout the winter they struggle with depression; their spirits lift only with the coming of spring. (People may also suffer annual depressions during the summer.) People suffering from SAD tend to sleep and eat excessively during their depressed periods.

Researchers have proposed that the hormone melatonin may play a role. The less light available (in winter), the more melatonin is secreted by the brain's pineal gland. A higher level of melatonin in their blood levels may cause some people to suffer from SAD. Researchers do not know why higher levels of melatonin lead to SAD in some people and not in others. Many SAD sufferers can be treated by sitting under bright fluorescent lights during the evening or early morning hours.

Explaining Mood Disorders

Psychological factors underlying mood disorders include certain personality traits (such as self-esteem, amount of social support, and the ability to deal with stressful situations). The cognitive theories of Aaron Beck and Martin Seligman have often served as the basis for research on depression. Beck (1983) believes that depressed people draw illogical conclusions about themselves; they blame themselves for normal problems and consider every minor failure a catastrophe. As described in Chapter 9, Martin Seligman (1975) believes that depression is caused by a feeling of learned helplessness. The depressed person learns to believe that he has no control over events in his life and that it is useless even to try.

Psychologists developed theories to provide a physiological or biological explanation of depression. Researchers are currently searching for the neurotransmitters (such as serotonin and noradrenaline) that cause mood disorders. They are also looking at genetic factors and faulty brain structure and function as possible causes. Many causes of depression may result from an interaction of biological and psychological factors.

Suicide and Depression

Not all people who commit suicide are depressed, and not all depressed people attempt suicide. Many depressives, though, do think about suicide, and

More About...

Depression and Gender

After adolescence, women are about twice as likely as men to experience major depression. Why? One possibility is that hormonal changes occurring as a result of pregnancy lead to depression. In fact, some women go through postpartum depression shortly after giving birth. Some psychologists believe that the numbers are high for female depression simply because more women report their depression and seek help. Other psychologists believe that men may simply distract themselves when experiencing depression. For example, a man might go play basketball and not think about his feelings.

some of them translate these thoughts into action.

People may take their lives for any number of reasons. It may be to escape from physical or emotional pain—perhaps a terminal illness or the loneliness of old age. It might be an effort to end the torment of unacceptable feelings, to punish themselves for wrongs they think they have committed, or to punish others who have not perceived their needs (Mintz, 1968). In many cases we simply do not know why the suicide occurred.

Statistics show, however, that every year more than 30,000 Americans end their lives—about 1 every 20 minutes. More women than men attempt suicide, but more men than women succeed (see Figure 16.14). Suicide is common among the elderly but also ranks as the fourth most common cause of death among adults between the ages of 18 and 65. Contrary to popular belief, people who threaten suicide or make an unsuccessful attempt usually *are* serious. Studies show that about 70 percent of people who kill themselves had threatened to do so within the three months preceding the suicide, and an unsuccessful attempt is often a trial run (American Foundation for Suicide Prevention, 2006).



What Should You Do?

If you suspect someone you know is thinking about suicide, what should you do? Treat him (or her) like a normal human being. (Meanwhile, contact a professional psychologist or trusted teacher on how to guide your own behavior.) Do not assume that you will upset him—just talk to him. Do not be afraid to ask him about his thoughts (even suicidal ones). Listen to him—he might be relieved to have someone just listen. Urge him to get professional help. Most cities have suicide prevention hot lines.

SECTION 4

Assessment

- 1. Review the Vocabulary** Define schizophrenia and list five symptoms of the disorder.
- 2. Visualize the Main Idea** Use a graphic organizer similar to the one below to identify types of schizophrenia.



- 3. Recall Information** What is the diathesis-stress hypothesis? How does it explain the development of schizophrenia?

- 4. Think Critically** Recall the last time you failed or did not do well at something. What kind of explanation did you offer for your failure? Was this explanation pessimistic or optimistic? Explain. How did your explanation affect your mood or feelings?

5. Application Activity

Schizophrenia often is misunderstood. Research facts about schizophrenia or the life of someone who has been diagnosed with schizophrenia and share this information with the class. As a class discuss and correct the false impressions about schizophrenia that you hold.

Personality Disorders and Drug Addiction

Reader's Guide

■ Main Idea

Personality disorders and drug addiction prohibit normal relationships and normal functioning.

■ Vocabulary

- personality disorders
- antisocial personality
- psychological dependence
- addiction
- tolerance
- withdrawal

■ Objectives

- Describe how personality disorders differ from other psychological disorders.
- Explain how drug abuse is a psychological problem.

EXPLORING PSYCHOLOGY

Aimless Crime

On October 7, 1976, Gary Gilmore was sentenced to death by a Utah court after a seemingly purposeless crime spree, and on January 16, 1977, he became the first person to be executed in the United States since 1966. . . . Gilmore had been released from prison only six months earlier, after serving time for armed robbery. . . . Gilmore himself described the next events: “I pulled up near a gas station. I told the service station guy to give me all of his money. I then took him to the bathroom and told him to kneel down and then I shot him in the head twice. The guy didn’t give me any trouble but I just felt like I had to do it.”

The very next morning, Gilmore left his car at another service station. . . . “I went in and told the guy to give me the money. . . . [T]hen I shot him. . . .”

—from *Abnormal Psychology*, 4th edition, by Martin E.P. Seligman, Elaine F. Walker, and David L. Rosenhan, 2001

Gary Gilmore’s crimes are an example of crime without understandable motives. During a psychiatric interview, Gilmore observed, “I don’t remember any real emotional event in all my life. . . . When you’re in the joint, you stay pretty even all the time. . . . I’m not really excitable you know. I don’t get emotional” (Rosenhan & Seligman, 1984). For Gilmore, emotions and social rules did not constrain his behavior. This lack of constraint is a sign of a personality disorder, specifically an antisocial personality disorder.

PERSONALITY DISORDERS

Personality disorders are different from the problems we have been discussing. People with personality disorders generally do not suffer from acute anxiety nor do they behave in bizarre, incomprehensible ways. Psychologists consider these people to have a disorder because they seem unable to establish meaningful relationships with other people, to assume social responsibilities, or to adapt to their social environment. This diagnostic category includes a wide range of self-defeating personality patterns, from painfully shy, lonely types to vain, pushy show-offs (see Figure 16.15). In this section we focus on people with **antisocial personalities**, who in the past were referred to as sociopaths or psychopaths.

personality disorders: maladaptive or inflexible ways of dealing with others and one's environment

Antisocial Personality

Individuals with antisocial personalities exhibit a persistent disregard for and violation of others' rights. They treat people as objects—as things to be used for gratification and to be cast aside coldly when no longer wanted. Intolerant of everyday frustrations and unable to save or plan or wait, they live for the moment. Seeking thrills is their major occupation. If they should injure other people along the way or break social rules, they do not seem to feel any shame or guilt. Getting caught does not seem to rattle them, either. No matter how many times they are reprimanded, punished, or jailed, they never learn how to stay out of trouble. They simply do not profit from experience.

Many individuals with antisocial personalities can get away with destructive behavior because they are intelligent, entertaining, and able to feign emotions they do not feel. They win affection and confidence from

antisocial personality: a personality disorder characterized by irresponsibility, shallow emotions, and lack of conscience

Figure 16.15 Types of Personality Disorders

An individual with a personality disorder displays an inflexible, long-standing, and maladaptive way of dealing with the environment and other people. **What are the characteristics of an individual with a paranoid personality disorder?**

Disorder	Characteristics
Antisocial	displays pattern of disregarding and violating the rights of others without feeling remorse
Dependent	displays pattern of submissiveness and excessive need to be taken care of
Histrionic	displays excessive emotions; excessively seeks attention
Obsessive-Compulsive	has an intense interest in being orderly, having control, and achieving perfection
Paranoid	distrusts others; perceives others as having evil motives
Schizotypal	feels intense discomfort in close relationships; has distorted thinking and eccentric behavior



Reading Check

How are personality disorders different from anxiety disorders?

others of whom they then take advantage. If caught, these individuals will either spin a fantastic lie or simply insist, with wide-eyed sincerity, that their intentions were utterly pure. Guilt and anxiety have no place in the antisocial personality.

For example, Hugh Johnson was caught after defrauding people out of thousands of dollars in 64 separate swindles. Researchers reported the following when they asked Johnson why he had victimized so many people: “He replied with some heat that he never took more from a person than the person could afford to lose, and further, that he was only reducing the likelihood that other more dangerous criminals would use force to achieve the same ends” (Nathan & Harris, 1975).

How do psychologists explain such a lack of ordinary human decency? According to one theory, individuals with antisocial personalities have simply imitated their own antisocial parents. Other theories point to lack of discipline or inconsistent discipline or other problems during childhood. Finally, some researchers believe that these individuals have a dysfunction of the nervous system. Psychologists are still investigating the relationship between genes and antisocial behavior. While most of us get very nervous when we do something that we have been punished for in the past, those with antisocial personalities never seem to learn to anticipate punishment and remain calm while committing antisocial acts.

DRUG ADDICTION

In American society, drug abuse has become a major psychological problem. Millions of Americans depend so heavily on drugs that they hurt themselves physically, socially, and psychologically. For these reasons, drug addiction and alcoholism are covered in the DSM-IV.

Abuse of drugs invariably involves **psychological dependence**. Users come to depend so much on the feeling of well-being they obtain from the drug that they feel compelled to continue using it. People can become psychologically dependent on a wide variety of drugs, including alcohol, caffeine, nicotine (in cigarettes), cocaine, marijuana, and amphetamines. When deprived of the drug, a psychologically dependent person becomes restless, irritable, and uneasy.

In addition to psychological dependence, drugs can lead to physiological **addiction**. A person is addicted when his system has become so used to the drug that the drugged state becomes the body’s normal state. If the drug is not in the body, the person experiences extreme physical discomfort as he would if he were deprived of oxygen or water.

Just as dependence causes a psychological need for the drug, addiction causes a physical need. Furthermore, once a person is addicted to a drug, he develops **tolerance**; that is, his body becomes so accustomed to the drug that he has to keep increasing his dosage to obtain the high achieved with smaller doses. With certain sleeping pills, for example, a person can rapidly develop a tolerance for up to 16 times the original dose. Further, an addict must have his drug to

psychological dependence: use of a drug to such an extent that a person feels nervous and anxious without it

addiction: a pattern of drug abuse characterized by an overwhelming and compulsive desire to obtain and use the drug

tolerance: physical adaptation to a drug so that a person needs an increased amount in order to produce the original effect

retain what little physical and psychological balance he has left. If he does not get it, he is likely to go through the dreaded experience of withdrawal.

Withdrawal is a state of physical and psychological upset during which the body and the mind revolt against and finally get used to the absence of the drug. Withdrawal symptoms vary from person to person and from drug to drug. They range from a mild case of nausea and the shakes to hallucinations, convulsions, coma, and death.

withdrawal: the symptoms that occur after a person discontinues the use of a drug to which he or she has become addicted

Alcoholism

This country's most serious drug problem is alcoholism. In American society, consumption of alcohol often begins at an early age. Researchers estimate that nearly 77 percent of all high school seniors have consumed alcohol at some point in their lifetimes and that 48 percent of seniors have consumed it within the past month—down from 54 percent in 1991. Approximately 44 percent of all students entering high school have tried alcohol. An estimated 29 percent report having consumed five or more drinks in a row within the past two weeks, and nearly 3 percent of graduating seniors are drinking alcohol daily (Monitoring the Future, 2005). About 24 percent of the drivers' deaths in automobile and motorcycle accidents each year can be traced to alcohol. Excessive alcohol use is the third leading lifestyle-related cause of death in the United States. The cost in human suffering to the alcoholic, as well as to his or her family, is impossible to measure.

In small doses, alcohol is often called a social drug. The first psychological function that it slows down is our inhibitions. Two drinks can make a person relaxed, talkative, playful, even giggly. It is for this reason that many people consider alcohol a stimulant, when it is really a depressant.

As the number of drinks increases, problems multiply. One by one, the person's psychological and physiological functions begin to shut down. Perceptions and sensations become distorted, and behavior may become obnoxious. The person begins to stumble and weave, speech becomes slurred, and reactions, to a stop sign, for example, become sluggish or disappear. If enough alcohol accumulates in the body, it leads to unconsciousness and, in some cases, coma and death. It all depends on how much and how rapidly alcohol enters the bloodstream, which, in turn, depend on a person's weight, body chemistry, how much he or she drinks and how quickly, and his or her past experience with drinking.

Alcohol can produce psychological dependence, tolerance, and physiological dependence. One researcher (Jellinek, 1960) outlined four stages of a Disease Model of Alcoholism. In Stage I, the individual drinks and relaxation encourages more drinking. In Stage II, secret drinking occurs, with blackouts and no memory of drinking. Stage III features rationalization to justify the drinking, and Stage IV shows impaired thinking and compulsive drinking. The disease model is no longer favored. Other

Figure 16.16 Alcohol Abuse

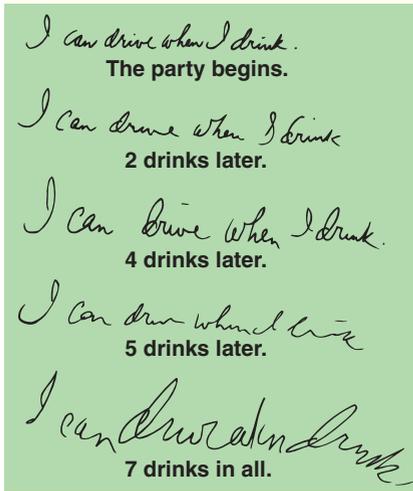
Alcohol abuse is responsible for the deaths of approximately 75,000 Americans each year.

When does alcohol use become a problem?



Figure 16.17**Effects of Alcohol Use**

As a person consumes more and more alcohol, psychological and physiological functions begin to shut down, as shown in these handwriting samples. **How do you treat alcoholism?**



researchers have noted that if alcoholism is a disease, how many among those who never decide to drink would “catch” the “disease”? Those supporting an Adaptive Model suggest that choosing to drink is a voluntary process influenced by alcoholism as a response to individual psychological and environmental factors. Those with a former substance abuse problem have no problem because they choose not to (Alexander, 1990).

Alcoholism may develop from both environmental and genetic factors. A person’s risk of becoming an alcoholic is three to four times higher if a member of the family is an alcoholic. Children of alcoholic parents may also be raised in an atmosphere of distrust, overdependence, and stress, which contributes to the possible development of alcoholism.

The first step in treating the alcoholic is to help her through the violent withdrawal, called *delirium tremens*, typical of alcohol addiction and then to try to make her healthier. She may be given a variety of treatments, from drugs to psychotherapy. Alcoholics Anonymous (AA), an organization for alcoholics run by people who have had a drinking problem in the past, has been more successful than most organizations. Some alcoholics must turn to medical treatment. Some doctors prescribe *Antabuse* to alcoholics. Antabuse, or disulfiram, is a chemical that blocks the conversion of acetaldehyde to acetic acid (O’Farrell et al., 1995). (Ordinarily, the liver converts alcohol into acetaldehyde, a toxic substance, and then converts acetaldehyde into acetic acid, a harmless substance.) When alcoholics take a daily Antabuse pill, they become violently sick if they have a drink of alcohol. The threat of the violent sickness may become an effective prevention. There is, however, no certain cure for alcoholism. One problem is that our society tends to encourage social drinking and to tolerate the first stage of alcoholism.

SECTION 5**Assessment**

- 1. Review the Vocabulary** How are addiction, tolerance, and withdrawal related to drug abuse?
- 2. Visualize the Main Idea** Use an outline similar to the one below to list characteristics of an antisocial personality.
- 3. Recall Information** What are the four stages of alcoholism? How does the Adaptive Model explain drinking?
- 4. Think Critically** How do personality disorders differ from other psychological disorders?

- I. Characteristics of an Antisocial Personality
- A. _____
- B. _____

- 5. Application Activity** Create a questionnaire for teens to help them determine when drinking alcohol becomes a problem.

When people's psychological processes break down, they can no longer function on a daily basis.

Section 1 What Are Psychological Disorders?

Main Idea:

Psychologists draw the line between normal and abnormal behavior by looking at deviance, adjustment, and psychological health.

- One approach to defining abnormality is to say that whatever most people do is normal and any deviation from the majority is abnormal.
- Abnormality can be viewed as an inability to adjust to getting along in the world—physically, emotionally, and socially.
- No single, accepted definition of abnormal behavior exists.
- Psychiatrists use the DSM-IV to help them classify psychological disorders.

Section 2 Anxiety Disorders

Main Idea: Anxiety disorders are marked by excessive fear, caution, and avoidance.

- Generalized anxiety is often accompanied by physical symptoms.
- Other anxiety disorders include phobic, obsessive-compulsive, post-traumatic stress, and panic disorders.

Section 3 Somatoform and Dissociative Disorders

Main Idea: Failing to deal with anxiety can lead to somatoform and dissociative disorders.

- Somatoform disorders are psychological problems in which symptoms are focused on the body.
- Dissociative disorders involve a breakdown in a person's normal conscious experience.

Section 4 Schizophrenia and Mood Disorders

Main Idea:

Schizophrenia involves disordered thoughts. Mood disorders involve disturbances in the experience and expressions of depression.

- Schizophrenia is a collection of symptoms relating to impairments in cognition, emotion, perception, and motor movement.
- Psychologists have classified several types of schizophrenia.
- Types of mood disorders are major depressive disorder, bipolar disorder, and seasonal affective disorder.

Section 5 Personality Disorders and Drug Addiction

Main Idea:

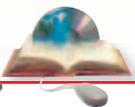
Personality disorders and drug addiction prohibit normal relationships and normal functioning.

- People with personality disorders seem unable to establish meaningful relationships with other people or to adapt to their social environment.
- Abuse of drugs often involves psychological dependence, addiction, tolerance, and sometimes withdrawal.

Chapter Vocabulary

DSM-IV (p. 451)
 anxiety (p. 456)
 phobia (p. 456)
 panic disorder (p. 457)
 post-traumatic stress disorder (p. 459)
 somatoform disorder (p. 461)
 conversion disorder (p. 461)
 dissociative disorder (p. 462)
 dissociative amnesia (p. 462)
 dissociative fugue (p. 462)
 dissociative identity disorder (p. 462)
 schizophrenia (p. 466)
 delusions (p. 466)
 hallucinations (p. 466)
 major depressive disorder (p. 470)
 bipolar disorder (p. 471)
 personality disorders (p. 475)
 antisocial personality (p. 475)
 psychological dependence (p. 476)
 addiction (p. 476)
 tolerance (p. 476)
 withdrawal (p. 477)

PSYCHOLOGY
Online



Self-Check Quiz

Visit the *Understanding Psychology* Web site at glencoe.com and click on **Chapter 16—Self-Check Quizzes** to prepare for the Chapter Test.

Reviewing Vocabulary

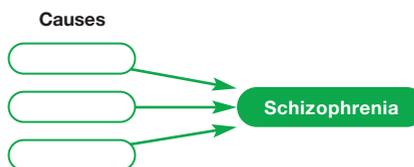
Choose the letter of the correct term or concept below to complete the sentence.

- | | |
|-----------------------------------|------------------------------------|
| a. DSM-IV | f. bipolar disorder |
| b. phobia | g. delusions |
| c. anxiety | h. hallucinations |
| d. post-traumatic stress disorder | i. antisocial personality disorder |
| e. somatoform disorder | j. withdrawal |

- An extreme fear of crowds is an example of a(n) _____.
- A mood disorder in which individuals are excessively and inappropriately happy or unhappy is called a(n) _____.
- A person who experiences severe and long-lasting aftereffects of a traumatic event is suffering from _____.
- The _____ is a standard system for classifying abnormal behavior.
- During _____, an addicted person's body and mind revolt against and finally get used to the absence of a drug.
- _____ are perceptions in the absence of corresponding sensations.
- A psychological disorder in which there is no apparent physical cause for certain physical symptoms is known as a(n) _____.
- People suffering from schizophrenia sometimes experience _____, or false beliefs maintained in the face of contrary evidence.
- A person who is experiencing a generalized apprehension is suffering from _____.
- People with a(n) _____ are generally irresponsible and immature.

Recalling Facts

- In what way does the system psychologists currently use to classify abnormal behavior differ from the one that preceded it?
- Describe the symptoms associated with anxiety. Give two explanations for the occurrence of anxiety.
- What is a dissociative fugue? What psychological function might it serve? How does it differ from dissociative amnesia?
- Use a diagram similar to the one below to list and explain three possible causes of schizophrenia.



- How would you describe someone who is classified as having an antisocial personality disorder?

Critical Thinking

- Synthesizing Information** Develop your own definition of *psychological disorder*. Is your definition free of social values, or are values a necessary part of such a definition? Explain.
- Analyzing Information** Consider times you have experienced a general apprehension and try to list the particular settings or situations in which you are most likely to feel this way. How do you cope with your anxiety?
- Applying Concepts** Why do you think it can be difficult for people suffering from major depressive disorder to take action to overcome the disorder?
- Making Inferences** Why might using drugs to treat schizophrenia be more effective than psychotherapy?
- Synthesizing Information** Why do you think people who have been treated for alcohol or drug abuse run the risk of a relapse?

Psychology Projects

- 1. What Are Psychological Disorders?** Find out how psychological disorders were viewed in the past. You might focus on the views of ancient Greeks and of Europeans during the Middle Ages. Find out what were thought to be the causes of certain psychological disorders and how people with these disorders were treated. Summarize your findings in a brief report.
- 2. Anxiety Disorders** Research magazine articles about programs available to help people combat certain phobias. For example, you might find out about classes that airlines provide to help people overcome their fear of flying. Summarize your findings in an informational pamphlet. Use standard grammar, spelling, sentence structure, and punctuation.
- 3. Mood Disorders** The artist Vincent van Gogh suffered from a mood disorder. Find out how his disorder affected his work. You might provide examples of paintings that were created when he was psychologically healthy and those that were created when he was suffering from the disorder. Create a biography of 1–5 pages that details your findings.

4. Personality Disorders and Drug Addiction

Contact a drug rehabilitation center for information about drug treatment programs in your community. If possible, have a qualified person from the center address the class about the kinds of treatment programs available. You might prepare a list of questions in advance to ask the speaker.



Technology Activity

Locate Web sites on the Internet about some of the psychological disorders discussed in this chapter, such as anxiety disorders or mood disorders. Find out about the latest methods of diagnosing and treating these disorders. Present your findings in a written report.



Psychology Journal

Read the working definition that you wrote in your journal at the start of Chapter 16. Revise the definition based on your study of the chapter, and write a paragraph describing a specific phobia.

Building Skills

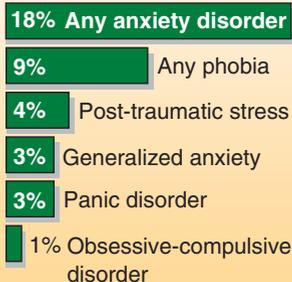
Interpreting a Graph Review the graph at right, then answer the questions that follow.

1. According to the graph, what is the most common anxiety disorder reported in the United States?
2. What percentage of the United States population reports any anxiety disorder?
3. Do you think that suffering from an anxiety disorder is a common occurrence? Explain.



See the **Skills Handbook**, page 628, for an explanation of interpreting graphs.

Reported Anxiety Disorders in the United States



Source: National Institute of Mental Health, 2006.



Practice and assess key social studies skills with **Glencoe Skillbuilder Interactive Workbook CD-ROM, Level 2**.

TIME REPORTS

Attack on the Spirit

Shock waves from the terrorist blasts shook the nation's psyche. How do we recover?

By **JEFFREY KLUGER**

MOLLY GALO HAD GROWN accustomed to getting up at 3 a.m. to nurse her infant son. The tender moments in the quiet house were good for both mother and baby. But she won't do it anymore—at least not alone. Molly's husband Matt works on the 75th floor of Chicago's Sears Tower, "an obvious target" for terrorists, she says. Now when she gets up in the middle of the night, she gets Matt up with her. "I need company," says Galo. "I don't want to be alone with my thoughts." She now also insists that her husband always keep his cell phone on.

There can be an odd, exponential geometry to trauma. Lose a single person in an accident, and the lives of five or six more people are rocked. If the original death toll is higher, the shock waves may extend across an entire state. And when the number of fatalities reaches the thousands, the very mental health of the nation can be shaken.

As rescue workers began weighing the destruction from the terrorist attacks of September 11, psychologists were similarly beginning to estimate just what the emotional cost might be. Around the country, normally well-adjusted people have found themselves jumping at shadows, avoiding crowds, giving in to little rituals (take the subway to work but the bus home in the evening) that provide not a jot of real

protection but somehow offer them an irrational reassurance that if another plane comes screaming out of the sky, maybe it won't be coming for them or their loved ones.

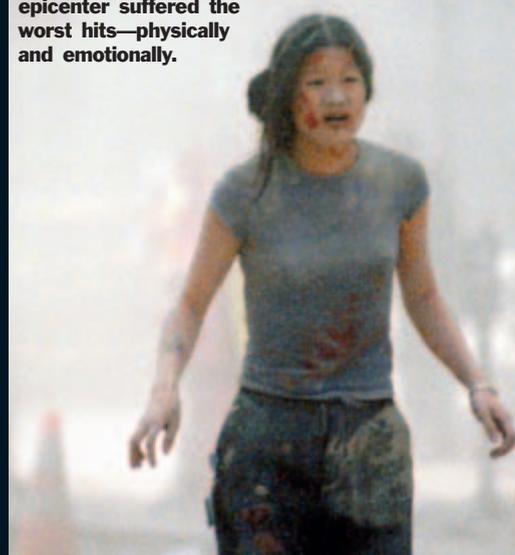
Some people will easily shake the jumpiness, but others may not—and therein could lie a quiet national crisis. Unlike cockpit recorders and buried bodies, damaged psyches often require a long time to reveal themselves. The longer they take to appear, the longer they will take to heal. "We need a systematic approach to triage not only physical problems but also emotional ones," says Dr. Robert Pynoos, director of the trauma and psychiatry program at UCLA.

Of the three places that were hit by the hijacked planes, New York City suffered by far the greatest emotional damage. As soon as the scope of the disaster became clear, grief counselors went on duty in hospitals and emergency centers around the city. The most severely shaken people were those who had been in or around the World Trade Center and survived the explosions.

Just as hard to soothe, though for different reasons, were the people one step away from the disaster—the tens of thousands of relatives of people missing or killed. At Manhattan's 69th Regiment Armory, family members waited in lines for hours to scan lists of victims treated at emergency rooms or identified as dead, looking for a familiar name. When they found nothing—as

GROUND ZERO

Victims closest to the epicenter suffered the worst hits—physically and emotionally.



ROBERT STOLARIK—GAMMA PRESSE FOR TIME

AFTERSHOCKS

The mental fallout may spread, but there are ways to control the damage

WHAT TO EXPECT

- Fear and anxiety
- Difficulty sleeping or nightmares
- Inability to concentrate
- Irritability
- Nervousness at sudden noises
- Inability to shake disturbing images of the tragedy

most did—they filled out a seven-page form describing the missing person with details that included hair color, length of fingernails and even earrings and shoes. Some brought strands of hair plucked from loved ones' brushes, hoping that if survival was out of the question, DNA identification would at least make death a tolerable certainty.

It's this kind of clutching at strands of hope that helps define the early stages of grief and shock. In most cases the grieving move on, following familiar steps that include anger, depression and, finally, acceptance. The September 11 blasts, however, may have ripped out that recovery route. "A woman kisses her husband goodbye, and the next thing she sees, the whole building falls down," says psychiatrist Marvin Lipkowitz of



ONE STEP AWAY

As they fled, people who witnessed the buildings' collapse were stunned by the sight.



DISTANT RIPPLES

Those farther away who only read about the events or saw them on TV felt the anguish too.

PATRICK WITTY

STEVE LISK FOR TIME

period of grieving to recover. But others could move on fairly quickly. The acute anxiety that follows a trauma typically lasts one to three weeks before the feeling fades. It's only after three months elapse and the symptoms persist that true post-traumatic stress disorder [PTSD] sets in.

PTSD has been around as long as human traumas have, but it's only recently that experts have truly understood it. People with PTSD suffer repeated nightmares and flashbacks. They may sometimes feel emotionally flattened and at other times be given to outbursts. Left alone, PTSD can become completely disabling. But treatment with a trained therapist can be marvelously straightforward. Reliving the experiences in a controlled way—by talking about them, calling them up and laying them bare—strips them of their power to harm. Gradual exposure to the things that trigger anxiety—elevators, skyscrapers, airplanes—can also help. In some cases, so may antidepressants.

There's no way of knowing who will develop full-blown PTSD in the wake of the recent violence, and early indicators provide conflicting clues. A TIME/CNN poll taken two days after the attacks showed that 34% of Americans will change some aspect of their lives in response to the tragedies. While that also means that more than 60% won't, some people wonder how honest the respondents were being. The public has made a great show of declaring that no terrorist is going to make Americans alter the way they live. And while such swagger has served us well in the past, this time it may simply be discouraging us from admitting how downright scared we are. Doing so could be a vital step toward recovery. ■

—For the complete text of this article and related articles from TIME, please visit www.time.com/teach

HOW TO COPE

- Talk with friends and family members about your feelings of fear, grief, anger and irritability
- Volunteer to assist victims and their families
- Avoid making important decisions, but gradually return to as many routine activities as possible

WHEN TO SEEK HELP

All the symptoms at left are normal responses to extraordinary events like the Sept. 11 terrorist attack. Ordinarily, they dissipate over one to two weeks. If the number and intensity of the symptoms continue, they may signal post-traumatic stress disorder and require professional help. When begun early, treatment is extremely effective.

Maimonides Medical Center in Brooklyn. "There's a limit to what the mind can take."

If people who were touched by the devastation may be reaching that limit, it's possible that people living in other parts of the country may be moving close enough to glimpse it. The repeated slow-motion images of the towers swooning and buckling, the shots of victims tarred and feathered with blood and dust, the very ordinariness of the workday exploding into a doomsday may exact a psychological toll as people wonder whether the same fate will be visited on them too.

The physical symptoms that cascade from the brain when it is infected by fear are familiar—sweaty palms, jumpiness, accelerated

heartbeat, sleeplessness. Long after the immediate danger has passed, anything that calls the trauma to mind—a picture of the New York skyline shorn of its two largest shapes; the sight of an airplane gliding by overhead—can give rise to the same symptoms. All too often, the most obvious coping mechanism, if only in the short run, is simple avoidance.

Happily, most experts don't expect the edginess to last. People who lost a loved one will naturally need a long

ANALYZING THE ARTICLE

1. "Damaged psyches often require a long time to reveal themselves," writes TIME's Jeffrey Kluger. What does this mean?
2. **CRITICAL THINKING** Do you think it's better to maintain or to change one's routine in response to tragedy? Explain.