Psychological Disorders

Overview

Perspectives on Psychological Disorders
Historical Views of Psychological Disorders
Theories of the Nature, Causes, and Treatment of Psychological Disorders
Classifying Psychological Disorders
The Prevalence of Psychological Disorders
Mental Illness and the Law

Mood Disorders
Depression
Mania and Bipolar Disorder
Causes of Mood Disorders
Suicide

Anxiety Disorders
Specific Phobias
Panic Disorder
Other Anxiety Disorders
Causes of Anxiety Disorders

Psychosomatic and Somatoform Disorders
Psychosomatic Disorders
Somatoform Disorders
Causes of Somatoform Disorders

Dissociative Disorders
Dissociative Amnesia
Dissociative Identity Disorder
Depersonalization Disorder
Causes of Dissociative Disorders

Sexual Disorders
Sexual Dysfunction
Paraphilias

Gender-Identity Disorders

Personality Disorders
Types of Personality Disorders
Causes of Antisocial Personality Disorder

Schizophrenic Disorders
Types of Schizophrenic Disorders
Causes of Schizophrenia

Childhood Disorders
Attention-Deficit/Hyperactivity Disorder (AD/HD)
Autistic Disorder

Gender and Cultural Differences in Psychological Disorders
Gender Differences
Cultural Differences

Chapter 13

Psychological Disorders
When does behavior become abnormal? The answer to this question is more complicated than it may seem. There is no doubt that the man on the street corner claiming to be Jesus Christ or the woman insisting that aliens from outer space are trying to kill her is behaving abnormally. But what about the following people:

- A male college student is popular with women and enjoys partying. His grades have always been fairly good, but recently he is having difficulty concentrating on anything but having a good time.
- A 10-year-old child has a mild developmental delay in fine-motor coordination that makes his handwriting immature compared to his classmates. Although his reading, calculating, and reasoning abilities are all normal or advanced, his handwriting makes him feel so self-conscious that he stops trying to get good grades and withdraws socially from other children.
- A highly successful female lawyer is unmarried and, although she has many relationships with men, is unwilling to make a commitment. She feels driven to become a partner in her firm before the age of 28 (she is 27 now). Recently, she has occasionally found herself drinking to excess.

Unlike physical diseases, the presence or absence of mental illness cannot be determined objectively. Diagnosing an emotional disorder is a judgment call, and judgments can differ. Which, if any, of these three people do you think is experiencing a psychological disorder? What criteria did you use in reaching your decision?

Perspectives on Psychological Disorders

What causes psychological disorders?

Society, the individual, and the mental health professional use different standards to judge normal and abnormal behavior. Society’s main standard is whether behavior conforms to the existing social order; the individual’s primary criterion is his or her own sense of well-being; and the mental health professional looks chiefly at personality characteristics as well as personal discomfort (the person’s experience of inner distress) and life functioning (the person’s success in meeting societal expectations for performance in work or school and in social relationships). Table 13–1 presents the three distinct views of mental health.

Look again at the three cases at the start of the chapter. The popular college student apparently feels happy, and the female lawyer is unlikely to think of herself as having a psychological problem. Although their actions appear to be abnormal from the perspective of society, from their own perspectives, neither suffers from the sort of personal discomfort that can define abnormal behavior. The opposite is true of the child with handwriting problems. Perhaps society would judge his behavior as odd or unusual, but society is not likely to view him as “abnormal.” His behavior does not violate any essential social rules, and he is functioning adequately. Yet he is experiencing much personal discomfort. From his own perspective, something is wrong.

Although individual and societal perspectives are in conflict in these cases, a mental health professional would have little difficulty deciding that all three people are displaying abnormal behavior. Mental health professionals define abnormal behavior as either maladaptive life functioning or serious personal discomfort or
both. But now imagine that the cases were slightly different. What if the college student’s grades were not suffering? What if the child was not embarrassed but simply preferred being a “loner”? What if the lawyer did not have a drinking problem? In the absence of maladaptive life functioning or serious personal discomfort, a mental health professional would conclude that none of the three people is displaying abnormal behavior.

Historical Views of Psychological Disorders

No one knows for sure what was considered abnormal behavior thousands of years ago. However, we can hazard a general description: Mysterious actions were attributed to supernatural powers, and madness was a sign that spirits had possessed a person. Sometimes people who were “possessed” were seen as sacred and their visions considered messages from the gods. At other times, their behavior indicated the presence of evil spirits and their affliction was considered dangerous to the community. It is likely that this supernatural view of abnormal behavior dominated all early societies.

The roots of a more naturalistic view of abnormal behavior can be traced to ancient Greece. The Greek physician Hippocrates (c. 460–c. 377 B.C.), for example, maintained that madness was like any other sickness—a natural event arising from natural causes. Hippocrates’s naturalistic approach had a lasting positive influence: It encouraged a systematic search to uncover the causes of mental illness, and it implied that disturbed people should be treated with the care and sympathy offered to people suffering from physical ailments.
During the Middle Ages, Europeans reverted to the supernatural view of abnormal behavior (although more naturalistic accounts were kept alive in Arab cultures). Psychological disorders were often viewed as the work of demons; the emotionally disturbed person was thought to be a witch or possessed by the devil. Exorcisms, ranging from the mild to the hair-raising, were performed, and many people endured horrifying tortures. Some unfortunates were burned at the stake.

By the late Middle Ages, public and private asylums where emotionally disturbed people could be confined were being established. The move away from viewing the mentally ill as witches and demon-possessed was a significant advance. But although these institutions were founded with good intentions, most were little more than prisons. In the worst cases, inmates were chained down and deprived of food, light, or air to “cure” them.

The year 1793 was a turning point in the history of the treatment of the mentally ill. In that year, Philippe Pinel (1745–1826) became director of the Bicêtre Hospital in Paris. Under his direction, the hospital was drastically reorganized: Patients were released from their chains and allowed to move about the hospital grounds, rooms were made more comfortable and sanitary, and dubious and violent medical treatments were abandoned (Harris, 2003). Pinel’s reforms were soon followed by similar efforts in England and, somewhat later, in America.

The most notable American reformer in this area was Dorothea Dix (1802–1887), a schoolteacher from Boston who led a nationwide campaign for humane treatment of mentally ill people. Under her influence, the few existing asylums in the United States were gradually turned into hospitals, and many new institutions were built. Sadly, these hospitals often failed to offer the humane treatment Dix had campaigned for, and deinstitutionalization—the movement of mental patients out of large hospitals—became a major goal of mental health care in the last half of the twentieth century.

Theories of the Nature, Causes, and Treatment of Psychological Disorders

The basic reason for the failed, and sometimes abusive, treatment of mentally disturbed people throughout history has been the lack of understanding of the nature, causes, and treatment of psychological disorders. Although our knowledge is still inadequate, important advances in understanding these disorders can be traced to the late nineteenth and early twentieth centuries. Three influential but conflicting models emerged during this time: the biological model, the psychoanalytic model, and the cognitive-behavioral model.

The Biological Model  The biological model holds that psychological disorders are caused by physiological malfunctions—of the nervous systems or the endocrine glands, for example—and that heredity often plays a significant role. As we shall see, there is growing evidence in support of the biological model of mental illness. Moreover, advances in the new interdisciplinary field of neuroscience leave little doubt that our understanding of the role of biological factors in mental illness will continue to expand. (See On the Cutting Edge: The Neuroscience Revolution to learn more.)
Chapter 13 • Psychological Disorders

The Psychoanalytic Model
Freud and his followers developed the psychoanalytic model at the end of the nineteenth and the beginning of the twentieth century (see Chapter 11, Personality). According to this model, behavior disorders are symbolic expressions of unconscious internal conflicts, which generally can be traced to the early years of life. The psychoanalytic model argues that people must become aware that the source of their problems lies in their childhood and infancy before they can resolve those problems effectively.

The Cognitive-Behavioral Model
A third model of psychological disorders grew out of psychological research on learning and cognition during the twentieth century. The cognitive-behavioral model suggests that psychological disorders, like all behavior, are the result of learning. The cognitive-behavioral model stresses both internal and external learning processes in the development and treatment of psychological disorders. For example, a bright student who considers himself academically inferior to his classmates and who believes that he doesn’t have the ability to perform well on a test does not study with much care or confidence. Naturally, he performs poorly, and his poor test score both punishes his minimal efforts and confirms his belief that he is academically inferior.

The Diathesis-Stress Model and Systems Theory
The three major competing theories have each shed some light on certain types of abnormality, and each may...
continue to do so. However, the most exciting recent developments in abnormal psychology integrate the various theoretical models to discover specific causes and specific treatments for different mental disorders.

The **diathesis-stress model** is one promising approach to integration (Fowles, 1992; Rende & Plomin, 1992; Walker & Diforio, 1997). This model suggests that a biological predisposition, or **diathesis**, must combine with some kind of stressful circumstance before the predisposition to a mental disorder shows up as behavior (Rosenthal, 1970). According to this model, some people are biologically prone to developing a particular disorder under stress, whereas others are not.

The **systems approach** is an even more promising method of integrating evidence on such behavior (Oltmanns & Emery, 2001). This approach examines how biological, psychological, and social risk factors combine to produce psychological disorders; for this reason, it is also known as the **biopsychosocial model**. According to this model, emotional problems are “lifestyle diseases” that, much like heart disease and many other physical illnesses, are caused by a combination of biological risks, psychological stresses, and societal pressures and expectations. In this chapter, we will follow the systems approach in examining the causes of and treatments for psychological disorders.

**Diathesis-stress model** View that people biologically predisposed to a mental disorder (those with a certain diathesis) will tend to exhibit that disorder when particularly affected by stress.

**Diathesis** Biological predisposition.

**Systems approach** View that biological, psychological, and social risk factors combine to produce psychological disorders. Also known as the biopsychosocial model of psychological disorders.

### Causes of Mental Disorders

Throughout this chapter, as we discuss what is known about the causes of psychological disorders, you will see that biological and psychological factors are intimately connected. For example, you will see that there is strong evidence for a genetic component in some personality disorders as well as in schizophrenia. However, not everyone who inherits these factors develops a personality disorder or becomes schizophrenic. Our current state of knowledge allows us to pinpoint certain causative factors for certain conditions, but it does not allow us to completely differentiate biological and psychological factors.

### Classifying Psychological Disorders

For nearly 40 years, the American Psychiatric Association (APA) has issued a manual describing and classifying the various kinds of psychological disorders. This publication, the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, has been revised four times. The fourth edition, text revision *DSM-IV-RT* (American Psychiatric Association, 2000), was coordinated with the tenth edition of the World Health Organization’s *International Classification of Diseases*.

The *DSM-IV-RT* is intended to provide a complete list of mental disorders, with each category painstakingly defined in terms of significant behavior patterns so that diagnoses based on it will be reliable (see Table 13–2). As we saw in Chapter 8, Intelligence and Mental Abilities, reliability means repeatability, and for the *DSM* the most important test of reliability is whether different mental health professionals arrive at the same diagnosis for the same individual. Although the manual provides careful descriptions of symptoms of different disorders to bolster consistent diagnosis, it is generally silent on cause and treatment. The *DSM* has gained increasing acceptance because its detailed criteria for diagnosing mental disorders have made diagnosis much more reliable (Nathan & Langenbucher, 1999). Today it is the most widely used classification of psychological disorders.
### DIAGNOSTIC CATEGORIES OF DSM-IV-RT

<table>
<thead>
<tr>
<th>Category</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence</strong></td>
<td>Mental retardation, learning disorders, autistic disorder, attention-deficit/hyperactivity disorder.</td>
</tr>
<tr>
<td><strong>Delirium, Dementia, and Amnestic and Other Cognitive Disorders</strong></td>
<td>Delirium, dementia of the Alzheimer's type, amnestic disorder.</td>
</tr>
<tr>
<td><strong>Mental Disorders Due to a General Medical Condition</strong></td>
<td>Psychotic disorder due to epilepsy.</td>
</tr>
<tr>
<td><strong>Substance-Related Disorders</strong></td>
<td>Alcohol dependence, cocaine dependence, nicotine dependence.</td>
</tr>
<tr>
<td><strong>Schizophrenia and Other Psychotic Disorders</strong></td>
<td>Schizophrenia, schizoaffective disorder, delusional disorder.</td>
</tr>
<tr>
<td><strong>Mood Disorders</strong></td>
<td>Major depressive disorder, dysthymic disorder, bipolar disorder.</td>
</tr>
<tr>
<td><strong>Anxiety Disorders</strong></td>
<td>Panic disorder with agoraphobia, social phobia, obsessive-compulsive disorder, post-traumatic stress disorder, generalized anxiety disorder.</td>
</tr>
<tr>
<td><strong>Somatoform Disorders</strong></td>
<td>Somatization disorder, conversion disorder, hypochondriasis.</td>
</tr>
<tr>
<td><strong>Factitious Disorders</strong></td>
<td>Factitious disorder with predominantly physical signs and symptoms.</td>
</tr>
<tr>
<td><strong>Dissociative Disorders</strong></td>
<td>Dissociative amnesia, dissociative fugue, dissociative identity disorder, depersonalization disorder.</td>
</tr>
<tr>
<td><strong>Sexual and Gender-Identity Disorders</strong></td>
<td>Hypoactive sexual desire disorder, male erectile disorder, female orgasmic disorder, vaginismus.</td>
</tr>
<tr>
<td><strong>Eating Disorders</strong></td>
<td>Anorexia nervosa, bulimia nervosa.</td>
</tr>
<tr>
<td><strong>Sleep Disorders</strong></td>
<td>Primary insomnia, narcolepsy, sleep terror disorder.</td>
</tr>
<tr>
<td><strong>Impulse-Control Disorders</strong></td>
<td>Kleptomania, pyromania, pathological gambling.</td>
</tr>
<tr>
<td><strong>Adjustment Disorders</strong></td>
<td>Adjustment disorder with depressed mood, adjustment disorder with conduct disturbance.</td>
</tr>
<tr>
<td><strong>Personality Disorders</strong></td>
<td>Antisocial personality disorder, borderline personality disorder, narcissistic personality disorder, dependent personality disorder.</td>
</tr>
</tbody>
</table>

Still, the DSM has its critics. Some charge that the manual is too medically oriented and that it includes too many behaviors that have nothing to do with mental illness (Sarbin, 1997). For instance, premenstrual dysphoric disorder, described as an increase in sadness, tension, and irritability that occurs in the week before a woman begins to menstruate, has been denounced as a sexist attempt to label as “illness” what may actually be a normal psychological reaction to significant biological changes (Adler, 1990).

Some of the controversies surrounding the DSM reflect political concerns, whereas others reflect legitimate scientific disagreements about the nature of psychological disorders. These controversies aside, our understanding of the nature, causes, and treatment of some forms of psychological disorders continues to grow.

Throughout this chapter, we will look at a variety of psychological disorders from the integrative systems perspective. As you read, you may occasionally feel an uncomfortable twinge of recognition. This is only natural and nothing to worry about. Much abnormal behavior is simply normal behavior greatly exaggerated or displayed in inappropriate situations.

### The Prevalence of Psychological Disorders

How common are psychological disorders in the United States? Are they increasing or decreasing over time? Are some population groups more prone to these disorders
than others? These questions are of interest to psychologists and public-health experts, who are concerned with both the prevalence and the incidence of mental health problems. Prevalence refers to the frequency with which a given disorder occurs at a given time. If there were 100 cases of depression in a population of 1,000, the prevalence of depression would be 10 percent. The incidence of a disorder refers to the number of new cases that arise in a given period. In a population of 1,000, if there were 10 new cases of depression in a year, the incidence rate would be 1 percent per year.

The American Psychiatric Association funded an ambitious and wide-ranging study of the prevalence of psychological disorders, which involved interviewing more than 20,000 people around the country. The results were surprising: 14.9 percent of the population was found to be experiencing a clinically significant mental disorder, and 6 percent a significant substance abuse disorder (Narrow, Rae, Robins, & Regier, 2001). The most common mental disorders were anxiety disorders, followed by phobias and mood disorders. Schizophrenia, a severe mental disorder that often involves hospitalization, was found to afflict 1 percent of the population, or over 2 million people. Substance abuse problems were found in 6 percent of the population, with abuse of alcohol being three times more prevalent than abuse of all other drugs combined. Perhaps in future years epidemiologists—scientists who study the distribution of health problems—will determine whether our 15 percent prevalence figure for mental disorders is typical of the rest of the world.

**Mental Illness and the Law**

Particularly horrifying crimes—assassinations of public figures, mass murders, and serial murders, for instance—have often been attributed to mental disturbance, because it seems to many people that anyone who could commit such crimes must be “crazy.” But to the legal system, this presents a problem: If a person is truly “crazy,” are we justified in holding him or her responsible for criminal acts? The legal answer to this question is a qualified yes. A mentally ill person is responsible for his or her crimes unless he or she is determined to be insane. What’s the difference between being “mentally ill” and being “insane”? Insanity is a legal term, not a psychological one. It is typically applied to defendants who, when they committed the offense with which they are charged, were so mentally disturbed that they either lacked substantial capacity to appreciate the criminality of their actions (know right from wrong) or to conform to the requirements of the law (control their behavior).

When a defendant is suspected of being mentally disturbed or legally insane, another important question must be answered before that person is brought to trial: Is the person able to understand the charges against him or her and to participate in a defense in court? This issue is known as competency to stand trial. The person is examined by a court-appointed expert and, if found to be incompetent, is sent to a mental institution, often for an indefinite period. If judged to be competent, the person is required to stand trial.

At this point the defendant may decide to plead not guilty by reason of insanity. When a defendant enters an insanity plea, the court system relies heavily on the testimony of forensic psychologists and psychiatrists to determine the mental state of the defendant at the time of the crime. Because most such trials feature well-credentialed experts testifying both for the defense and for the prosecution, the jury is often perplexed about which side to believe. Furthermore, there is much cynicism about “hired-gun” professionals, who receive large fees to appear in court and argue that a defendant is or is not sane. The public, skeptical about professional jargon, often feels that psychological testimony allows dangerous criminals to “get off.” Actually, those who successfully plead insanity often are confined longer in mental hospitals than they would have been in prison if
convicted of their crimes. Therefore, the insanity plea is not an easy way out of responsibility for a crime.

**CHECK YOUR UNDERSTANDING**

1. Match the following model of abnormal behavior with the appropriate description.
   - ___ biological model  
     a. Abnormal behaviors result from unconscious internal conflicts.
   - ___ psychoanalytic model  
     b. Abnormal behavior is the product of biological, psychological, and social-risk factors.
   - ___ biopsychosocial model  
     c. Abnormal behavior is the result of learning and can be unlearned.
   - ___ cognitive-behavior model  
     d. Abnormal behaviors have a biochemical, physical or a physiological basis.

2. The DSM-IV-RT is a classification system for mental disorders developed by the ___ a. American Psychiatric Association
   ___ b. American Psychological Association
   ___ c. National Institutes for Mental Health

3. At any given time, what percentage of Americans suffers from mental disorders?
   ___ a. 5 percent  
   ___ b. 10 percent  
   ___ c. 15 percent

**Answers:**

- biological model—d
- psychoanalytic model—a
- biopsychosocial model—b
- cognitive-behavior model—c
- 2.a
- 3.c

**Mood Disorders**

*What are some early signs of the development of depression?*

As their name suggests, **mood disorders** are characterized by disturbances in mood or prolonged emotional state, sometimes referred to as affect. Most people have a wide emotional range—that is, they are capable of being happy or sad, animated or quiet, cheerful or discouraged, overjoyed or miserable, depending on the circumstances. In some people with mood disorders, this range is greatly restricted. They seem stuck at one or the other end of the emotional spectrum—either consistently excited and euphoric or consistently sad—whatever the circumstances of their lives. Other people with a mood disorder alternate between the extremes of euphoria and sadness.

**Depression**

The most common mood disorder is **depression**, a state in which a person feels overwhelmed with sadness, loses interest in activities, and displays other symptoms such as excessive guilt or feelings of worthlessness. People suffering from depression are unable to experience pleasure from activities they once enjoyed. They are tired and apathetic, sometimes to the point of being unable to make the simplest everyday decisions. They may feel as if they have failed utterly in life, and they tend to blame themselves for their problems. Seriously depressed people often have insomnia and lose interest in food and sex. They may have trouble thinking or concentrating—even to the extent of finding it difficult to read a newspaper. In fact, some research indicates that difficulty concentrating and subtle changes in...
Most people feel unhappy and low now and then, but depression goes much deeper than mere unhappiness. Clinically depressed people lose interest in the things that usually give them pleasure. Typically, they feel overwhelmed by sadness, loss, and guilt. Short-term memory are sometimes the first signs of the onset of depression (Williams et al., 2000). In very serious cases, depressed people may be plagued by suicidal thoughts or may even attempt suicide (Cicchetti & Toth, 1998).

It is important to distinguish between clinical depression and the “normal” kind of depression that all people experience from time to time. It is entirely normal to become sad when a loved one has died, when you’ve come to the end of a romantic relationship, when you have problems on the job or at school—even when the weather's bad or you don’t have a date for Saturday night. Most psychologically healthy people also get “the blues” occasionally for no apparent reason. It has even been suggested that depression may in some cases be an adaptive response, one that helped our ancestors survive periods of hardship (Nesse, 2000). But in all of these instances, the mood disturbance is either a normal reaction to a “real-world” problem (for example, grief) or passes quickly. Only when depression is serious, lasting, and well beyond the typical reaction to a stressful life event is it classified as a mood disorder (APA, 2000). (See Applying Psychology: Recognizing Depression.)

The DSM-IV-RT distinguishes between two forms of depression. Major depressive disorder is an episode of intense sadness that may last for several months; in contrast, dysthymia involves less intense sadness (and related symptoms) but persists with little relief for a period of 2 years or more. Some depressions can become so intense that people become psychotic—that is, they lose touch with reality. For example, consider the case of a 50-year-old depressed widow who was transferred to a medical center from a community mental health center. This woman believed that her neighbors were against her, that they had poisoned her coffee, and that they had bewitched her to punish her for her wickedness (Spitzer, Skodal, Gibbon, & Williams, 1981).

Children and adolescents can also suffer from depression. In very young children, depression is sometimes difficult to diagnose because the symptoms are usually different than those seen in adults. For instance, in infants or toddlers, depression may be manifest as a “failure to thrive” or gain weight, or as a delay in speech or motor development. In school-age children, depression may be manifested as antisocial behavior, excessive worrying, sleep disturbances, or unwarranted fatigue.

A disorder that is often mistaken for depression sometimes occurs following a head injury, as may result from an automobile accident or a sudden jolt. The symptoms, which may include fatigue, headache, loss of sex drive, apathy, and feelings of helplessness, generally last for only a few days, although they can persist for a couple of months. When such symptoms arise following a sudden trauma to the brain, they are more likely to be diagnosed as mild traumatic brain injury (MTBI) than depression (Rabasca, 1999b Rapoport, McCullagh, Streiner, & Feinstein, 2003).

**Mania and Bipolar Disorder**

Another mood disorder, less common than depression, is mania, a state in which the person becomes euphoric or “high,” extremely active, excessively talkative, and easily distracted. People suffering from mania may become grandiose—that is, their self-esteem is greatly inflated. They typically have unlimited hopes and schemes but little interest in actually carrying them out. People in a manic state sometimes become aggressive and hostile toward others as their self-confidence grows. At the extreme, people going through a manic episode may become wild, incomprehensible, or violent until they collapse from exhaustion.

Manic episodes rarely appear by themselves; rather, they usually alternate with depression. Such a mood disorder, in which both mania and depression are present, is known as bipolar disorder. In bipolar disorder, periods of mania and depression alternate (each lasting from a few days to a few months), sometimes with periods of

**Psychotic** Marked by defective or lost contact with reality.

**Mania** A mood disorder characterized by euphoric states, extreme physical activity, excessive talkativeness, distractness, and sometimes grandiosity.

**Bipolar disorder** A mood disorder in which periods of mania and depression alternate, sometimes with periods of normal mood intervening.
almost everyone from time to time feels depressed. Failing a major exam, breaking up with a boyfriend or girlfriend, even leaving home and friends to attend college can all produce a temporary state of “the blues.” More significant life events can have an even greater impact: the loss of one’s job or of a loved one can produce a sense of hopelessness about the future that feels very much like a slide into depression.

The preceding instances would typically be considered “normal” reactions to negative life events. But at what point do these normal responses cross the line into clinical depression? How do clinicians determine whether the hopelessness and despair being expressed by a person constitute a major depressive episode or just a period of sadness that will eventually pass?

The DSM-VI-RT provides the framework for making this distinction. First, clinical depression is characterized by depressed mood, by the loss of interest and pleasure in usual activities, or both. Clinicians also look for some significant impairment or distress in social, occupational, or other important areas of functioning. People suffering from depression not only feel sad or empty but also have significant problems in carrying on a normal lifestyle.

Doctors look, too, for other explanations of the symptoms: Could they be due to substance abuse or the side effects of medication that the person is taking? Could they be the result of a medical condition, such as hypothyroidism (the inability of the thyroid gland to produce an adequate amount of its hormones)? Could the symptoms be better interpreted as an intense grief reaction?

If the symptoms do not seem to be explained by the preceding causes, how do clinicians make a diagnosis of depression? The DSM-IV-RT notes that at least five of the following symptoms, including at least one of the first two, must be present:

1. **Depressed mood:** Does the person feel sad or empty for most of the day, almost every day, or do others observe these symptoms?
2. **Loss of interest in pleasure:** Has the person lost interest in performing normal activities, such as working or going to social events? Does the person seem to be “just going through the motions” of daily life without deriving any pleasure from them?
3. **Significant weight loss or gain:** Has the person gained or lost more than 5 percent of body weight in a month? Has the person lost interest in eating or complain that food has lost its taste?
4. **Sleep disturbances:** Is the person having trouble sleeping? Or, conversely, is the person sleeping too much?
5. **Disturbances in motor activities:** Do others notice a change in the person’s activity level? Does the person just “sit around,” or does the behavior reflect agitation or unusual restlessness?
6. **Fatigue:** Does the person complain of being constantly tired and having no energy?
7. **Feelings of worthlessness or excessive guilt:** Does the person express feelings such as “you’d be better off without me around” or “I’m evil and I ruin everything for everybody I love”?
8. **Inability to concentrate:** Does the person complain of memory problems (“I just can’t remember anything anymore”) or the inability to focus attention on simple tasks, such as reading a newspaper?
9. **Recurrent thoughts of death:** Does the person talk about committing suicide or express the wish that he or she were dead?

When these symptoms are present and are not due to other medical conditions, a diagnosis of major depression is typically the result, and appropriate treatment can be prescribed. As you will learn in Chapter 14: Therapies, appropriate diagnosis is the first step in the effective treatment of psychological disorders.

normal mood intervening. Occasionally, bipolar disorder is seen in a mild form: The person has alternating moods of unrealistically high spirits followed by moderate depression. Research suggests that bipolar disorder differs in several ways from unipolar depression. Bipolar disorder is much less common and, unlike depression, it is equally prevalent in men and women. Bipolar disorder also seems to have a stronger biological component than depression: It is more strongly linked to heredity and is most often treated by drugs (Gershon, 1990; Maj, 2003).

**Causes of Mood Disorders**

Some people insist that mood disorders are caused solely by nature or by nurture. You may have heard, for example, that depression results from “a chemical imbalance in the brain” or “unresolved grief.” However, consistent with the biopsychosocial model, most psychologists now believe that mood disorders result from a combination of risk factors. Although we can identify many of the causative factors, we still do not yet know exactly how they interact to cause a mood disorder.

**Biological Factors** There is consistent evidence that genetic factors play an important role in the development of depression (Mineka, Watson, & Clark, 1998), particularly, as we have noted, in bipolar disorder (Badner, 2003; Katz & McGuffin, 1993). The strongest evidence comes from studies of twins. If one identical twin is clinically depressed, the other twin (who is genetically identical) is more likely to be clinically depressed also. Among fraternal twins (who share only about half their genes), if one twin is clinically depressed, the likelihood is much less that the second twin will also be clinically depressed (McGuffin, Katz, Watkins, & Rutherford, 1996).

But just what is it that some people seem to inherit that predisposes them to a mood disorder? Some promising research has linked mood disorders to certain chemical imbalances within the brain—principally to high and low levels of certain neurotransmitters, the chemicals involved in the transmission of nerve impulses from one cell to another (Kato, 2001).

Biological research on mood disorders is promising. In fact, as we shall see in the next chapter, several medications have been found to be effective in treating mood disorders. Still, there is no firm evidence linking high or low levels of neurotransmitters to an increased genetic risk for mood disorders. In fact, the so-called chemical imbalance in the brain associated with depression could be caused by stressful life events. Biology affects psychological experience, but psychological experience also alters biological functioning.

**Psychological Factors** Although a number of psychological factors are thought to play a role in causing severe depression, in recent years research has focused on the contribution of maladaptive cognitive distortions. According to Aaron Beck (1967, 1976, 1984, 2002), during childhood and adolescence some people undergo such wrenching experiences as the loss of a parent, severe difficulties in gaining parental or social approval, or humiliating criticism from teachers and other adults. One response to such experience is to develop a negative self-concept—a feeling of incompetence or unworthiness that has little to do with reality but that is maintained by a distorted and illogical interpretation of real events. When a new situation arises that resembles the situation under which the self-concept was learned, these same feelings of worthlessness and incompetence may be activated, resulting in depression.

Considerable research supports Beck’s view of depression (Alloy, Abramson, Whitehouse, Hogan, Tashman, Steinberg, Rose, & Donovan, 1999; Alloy, Abramson, & Francis, 1999). For instance, Lauren Alloy and her colleagues have

---

**Cognitive distortions** An illogical and maladaptive response to early negative life events that leads to feelings of incompetence and unworthiness that are reactivated whenever a new situation arises that resembles the original events.
found that college students with negative cognitive styles are at considerably higher risk of developing depression than are students with more positive cognitive styles. When compared to people who are not depressed, depressed people also seem to perceive and recall information in more negative terms (Roth & Rehm, 1980; Watkins, Vache, Verney, Mathews, & Muller, 1996). Critics of Beck’s theories have pointed out that such negative responses may be the result of depression instead of the cause (Hammen, 1985). However, prospective studies, which analyze people’s cognitive styles when they are not depressed and then monitor the same group of people over time, suggest that cognitive style has predictive value (Alloy, Abramson, & Francis, 1999; Kwon & Oei, 2003). As we shall see in the next chapter, therapy based on Beck’s theories has proved quite successful in the treatment of depression.

**Social Factors**

Many social factors have been linked with mood disorders, particularly difficulties in interpersonal relationships. Freud viewed depression as resulting from excessive and irrational grief over a real or “symbolic” loss. Freud’s view of how “unresolved grief” is transformed into depression is complex and not supported by current evidence (Crook & Eliot, 1980). However, the analogy he drew between grief and depression has been fruitfully noted by other theorists, and there is considerable research linking depression with troubled close relationships (Monroe & Simons, 1991). In fact, some theorists have suggested that the link between depression and troubled relationships explains the fact that depression is two to three times more prevalent in women than in men (Culbertson, 1997; Weissman & Olfson, 1995), since women tend to be more relationship-oriented than men are in our society (Gilligan, 1982). Yet not every person who experiences a troubled relationship becomes depressed. As the systems approach would predict, it appears that a genetic predisposition or cognitive distortion is necessary before a distressing close relationship or other significant life stressor will result in a mood disorder.

**The Chicken or the Egg?**

It is sometimes difficult to tease apart the relative contribution of the person’s biological or cognitive tendencies and the social situation. People with certain depression-prone genetic or cognitive tendencies may be more likely than others to encounter stressful life events by virtue of their personality and behavior. For example, studies show that depressed people tend to evoke anxiety and even hostility in others, partly because they require more emotional support than people feel comfortable giving. As a result, people tend to avoid those who are depressed, and this shunning can intensify the depression. In short, depression-prone and depressed people may become trapped in a vicious circle that is at least partly of their own creation (Coyne & Whiffen, 1995).

**Suicide**

More than 29,000 people in the United States commit suicide each year making it the 11th leading cause of death. Indeed, suicides outnumber homicides by 5 to 3 in the United States, and more than twice as many people die of suicide than of HIV/AIDS (NIMH, 2000). More women than men attempt suicide, but more men actually succeed at it, partly because men more often choose violent and lethal means, such as guns.

Although the largest number of suicides occurs among older white males, since the 1960s the rates of suicide attempts have been rising among adolescents and
young adults (see Figure 13–1). In fact, adolescents account for 12 percent of all suicide attempts in this country, and suicide is the third leading cause of death in that age group (Centers for Disease Control and Prevention, 1999; Hoyert, Kochanek, & Murphy, 1999). As yet, no convincing explanation has been offered for the increase, though the stresses of leaving home, meeting the demands of college or career, and surviving loneliness or broken romantic attachments seem to be particularly great at this time. External problems such as unemployment, the financial costs of attending college, and the dread that one’s future is threatened by economic decline may also add to people’s personal problems. Still, suicidal behavior is more common among adolescents who have psychological problems.

There are several dangerous myths concerning suicide.

**Myth:** Someone who talks about committing suicide will never do it.

**Fact:** Most people who kill themselves have talked about it. Such comments should always be taken seriously.

**Myth:** Someone who has tried suicide and failed is not serious about it.

**Fact:** Any suicide attempt means that the person is deeply troubled and needs help immediately. A suicidal person will try again, picking a more deadly method the second or third time around.

**Myth:** Only people who are life’s losers—those who have failed in their careers and in their personal lives—commit suicide.

**Fact:** Many people who kill themselves have prestigious jobs, conventional families, and a good income. Physicians, for example, have a suicide rate several times higher than that for the general population; in this case the tendency to commit suicide may be related to their work stresses.

People considering suicide are overwhelmed with hopelessness. They feel that things cannot get better and see no way out of their difficulties. This is depression in the extreme, and it is not a state of mind that someone can easily be talked out of. It does little good to tell a suicidal person that things aren’t really so bad; the person will only take this as further evidence that no one understands his or her suffering. But most suicidal people do want help, however much they may despair of
Anxiety disorders
Disorders in which anxiety is a characteristic feature or the avoidance of anxiety seems to motivate abnormal behavior.

Specific phobia
Anxiety disorder characterized by intense, paralyzing fear of something.

Anxiety Disorders

When does a normal fear become a phobia?

Although all of us are afraid from time to time, we usually know why we are fearful: Our fear is caused by something appropriate and identifiable, and it passes with time. But in the case of anxiety disorders, either the person does not know why he or she is afraid, or the anxiety is inappropriate to the circumstances. In either case, the person's fear and anxiety don't seem to make sense. The main types of anxiety disorders that we will consider are specific phobias, panic disorder, generalized anxiety disorder, and obsessive-compulsive disorder.

Specific Phobias

A national survey has found that anxiety disorders are more common than any other form of mental disorder (Kessler et al., 1994). Anxiety disorders can be subdivided into more specific diagnostic categories. One familiar subtype of anxiety disorder is specific phobia. A specific phobia is an intense, paralyzing fear of something that perhaps should be feared, but the fear is excessive and unreasonable. In fact, the fear in a specific phobia is so great that it leads the person to avoid routine or adaptive activities, and thus interferes with life functioning. For example, it is not inappropriate to be a bit fearful as an airplane takes off or lands, but it is inappropriate to be so afraid of flying that you refuse to get on or even go near an airplane—particularly...
if your career demands frequent travel. Other common phobias focus on animals, heights, closed places, blood, needles, or injury. Some fear of all these objects or situations is normal and common, but excessive, intense, paralyzing fear is a sign of specific phobia. Estimates indicate that about 1 in 10 people in the United States suffer from at least one specific phobia.

Another important subtype of phobia is social phobia, which refers to excessive, inappropriate fears connected with social situations or performances in front of other people. Intense fear of public speaking is a common form of social phobia. In other cases, simply talking with people or eating in public causes such severe anxiety that the phobic person will go to great lengths to avoid these situations. As with specific phobias, it is normal to experience some mild fear or uncertainty in many social situations. These fears are only considered to be social phobias when they are excessive enough to interfere significantly with life functioning.

Agoraphobia is a much more debilitating type of anxiety disorder than social phobias. Agoraphobia is a term formed from Greek and Latin words that literally means “fear of the marketplace,” but the disorder typically involves multiple, intense fears, such as the fear of being in public places from which escape might be difficult, of being in crowds, of being alone, of traveling in an automobile, or of going through tunnels or over bridges. The common element in all these situations seems to be a great dread of being separated from sources of security.

**Panic Disorder**

Another type of anxiety disorder is panic disorder, a problem characterized by recurrent panic attacks. A panic attack is a sudden, unpredictable, and overwhelming experience of intense fear or terror without any reasonable cause. During a panic attack, a person may have feelings of impending doom, chest pain, dizziness or fainting, sweating, difficulty breathing, and a fear of losing control or dying. A panic attack usually lasts only a few minutes, but such attacks may recur for no apparent reason.

Panic attacks not only cause tremendous fear while they are happening but also leave the sufferer with a dread of having another panic attack that can persist for days or even weeks. This dread can be so overwhelming that it leads to the development of agoraphobia: In their efforts to prevent a recurrence, some people avoid any circumstance that might cause anxiety and cling to people or situations that help keep them calm. In other words, their agoraphobia develops out of their attempt to avoid further panic attacks.

**Other Anxiety Disorders**

The various phobias and panic attacks have a specific source of anxiety, such as fear of heights, fear of social situations, or fear of being in crowds. In contrast, generalized anxiety disorder is defined by prolonged vague but intense fears that are not attached to any particular object or circumstance. Generalized anxiety disorder perhaps comes closest to the everyday meaning attached to the term neurotic. Its symptoms include inability to relax, constantly feeling restless or keyed up, muscle tension, rapid heart beat or pounding heart, apprehensiveness about the future, hypervigilance (constant alertness to potential threats), and sleeping difficulties.
Considerable research indicates that generalized anxiety disorder and major depressive disorder may share a common genetic basis, although the specific genetic factors that account for this relationship remain unclear (Mineka, Watson, & Clark, 1998).

A very different form of anxiety disorder is obsessive-compulsive disorder, or OCD. Obsessions are involuntary thoughts or ideas that keep recurring despite the person’s attempts to stop them, and compulsions are repetitive, ritualistic behaviors that a person feels compelled to perform. Obsessive thoughts are often of a horrible and frightening nature. One person, for example, reported that “when she thought of her boyfriend she wished he were dead; when her mother went down the stairs, she ‘wished she’d fall and break her neck’; when her sister spoke of going to the beach with her infant daughter [she] ‘hoped that they would both drown’” (Carson & Butcher, 1992, p. 190). Truly compulsive behaviors may be equally dismayng to the person who feels driven to perform them. They often take the form of washing or cleaning, as if the compulsive behavior were the person’s attempt to “wash away” the contaminating thoughts. Another common type of compulsion is checking: repeatedly performing some kind of behavior to make sure that something was or was not done in a certain way. For example, a person might feel compelled to check dozens of times whether the doors are locked before going to bed.

Anyone can experience mild obsessions or compulsions at times. Most of us have occasionally been unable to get a particular song lyric out of our head or have felt that we had to walk so as to avoid stepping on cracks in the sidewalk. But in OCD, the obsessive thoughts and compulsive behavior are of a more serious nature. For example, a man who checks his watch every 5 minutes when his wife is late coming home is merely being normally anxious. But a man who feels that he must go through his house every hour checking every clock for accuracy, even though he knows there is no reason to do so, is showing signs of an obsessive-compulsive disorder.

Because people who experience obsessions and compulsions often do not seem particularly anxious, you may wonder why this disorder is considered an anxiety disorder. The answer is that if such people try to stop their irrational behavior, or if someone else tries to stop them, they experience severe anxiety. In other words, the obsessive-compulsive behavior seems to keep anxiety at bay.

Finally, two types of anxiety disorders are clearly caused by some specific highly stressful event. Some people who have lived through a fire, flood, tornado, or airplane crash experience repeated episodes of fear and terror after the event itself is over. If the anxious reaction occurs soon after the event, the diagnosis is acute stress disorder. If it takes place long after the event is over, the diagnosis is likely to be post-traumatic stress disorder, which we discussed in the previous chapter (Oltmanns & Emery, 2001).

Causes of Anxiety Disorders

A starting point in considering the cause of anxiety disorders is to recall our discussion of phobias in Chapter 5, Learning. We noted that phobias are often learned after only one fearful event and are extremely difficult to shed. We also saw that there is a relatively limited and predictable range of phobic objects: Even though people are more likely to be injured in an automobile accident than by a snake or spider bite, snake and spider phobias are far more common than car phobias. Some theorists, therefore, believe phobias are prepared responses—that is, responses that evolution has made us biologically predisposed to acquire through learning so that we seem to be “hardwired” to associate certain stimuli with intense fears (Marks & Nesse, 1994; Nesse, 2000; Öhman, 1996).

From a cognitive perspective, people who feel they are not in control of stressful events in their lives are more likely to experience anxiety than those who believe...
they have control over such events. As one real-life example of this, African Americans who live in high-crime areas have a higher incidence of anxiety disorders than other Americans (Neal & Turner, 1991). In the same situation, though, some people develop unrealistic fears and others do not. Why?

Psychologists working from the biological perspective point to heredity, arguing that a predisposition to anxiety disorders may be inherited (Eysenck, 1970; Sarason & Sarason, 1987). In fact, some evidence suggests that anxiety disorders tend to run in families (Kendler, Neale, Kessler, Heath, & Eaves, 1992; Torgersen, 1983; Weissman, 1993), and have a higher concordance rate among identical twins compared to fraternal twins (Skre, Onstad, Torgersen, & Lygren, 1993).

Finally, any comprehensive model of anxiety must account for what would seem to be the vital role of internal psychological conflicts. From the Freudian perspective, unacceptable impulses or thoughts (usually sexual or aggressive in nature) can threaten to overwhelm the ego and break through into full consciousness. The Freudian defense mechanisms protect the conscious mind against such threats, but at a cost in anxiety.

CHECK YOUR UNDERSTANDING

1. Match the following terms with the appropriate description.
   ___ specific phobia a. great dread of being separated from sources of security
   ___ social phobia b. an unreasonable, paralyzing fear of something
   ___ agoraphobia c. a sudden, unpredictable, and overwhelming experience of intense fear or terror without any reasonable cause
   ___ panic attack d. feeling driven to think disturbing thoughts or to perform meaningless rituals
   ___ generalized anxiety disorder e. excessive, inappropriate fears connected with social situations or performances in front of other people
   ___ obsessive-compulsive disorder f. prolonged vague but intense fears not attached to any particular object or circumstance

2. Phobias are often learned after only one fearful event and are ____ to shed.
   ___ a. easy
   ___ b. hard
   ___ c. impossible

Answers: 1. specific phobia—b; social phobia—e; agoraphobia—a; panic attack—c; generalized anxiety disorder—f; obsessive-compulsive disorder—d

Psychosomatic and Somatoform Disorders

Can psychological factors cause real physical illnesses?

To many people, the term *psychosomatic* implies that a condition is not “real,” that it exists “only in your head.” In fact, *psychosomatic disorders* are real physical illnesses that appear to have a psychological cause. The term *psychosomatic* perfectly captures the interplay of psyche (mind) and soma (body) that characterizes these disorders. In contrast, *somatoform disorders* are characterized by physical
Somatization disorder  A somatoform disorder characterized by recurrent vague somatic complaints without any identifiable physical cause. Despite reassurances to the contrary from physicians, people suffering from somatoform disorders believe they are physically ill and describe symptoms that correspond to physical illnesses, yet there is no evidence of physical illness. Their problem is somatic (physical) in appearance only, as indicated by the term somatoform (somatic in form or appearance).

Conversion disorders  Somatoform disorders in which a dramatic specific disability has no physical cause but instead seems related to psychological problems. Symptoms without any identifiable physical cause. Despite reassurances to the contrary from physicians, people suffering from somatoform disorders believe they are physically ill and describe symptoms that correspond to physical illnesses, yet there is no evidence of physical illness. Their problem is somatic (physical) in appearance only, as indicated by the term somatoform (somatic in form or appearance).

Psychosomatic Disorders

Tension headaches are an example of a psychosomatic disorder. They are caused by muscle contractions brought on by stress. The headache is real, but it is called “psychosomatic” because psychological factors (such as stress and anxiety) appear to play an important role in causing the symptoms. People suffering from tension headaches are often taught relaxation techniques that relieve stress and reduce muscle tension.

Scientists used to believe that psychological factors contributed to the development of some physical illnesses, principally headaches, allergies, asthma, and high blood pressure, but not others, such as infectious diseases. Today modern medicine leans toward the idea that all physical ailments are to some extent “psychosomatic”—in the sense that stress, anxiety, and various states of emotional arousal alter body chemistry, the functioning of bodily organs, and the body’s immune system (which is vital in fighting infections). As we saw in the previous chapter, we now recognize that stress and psychological strains can also alter health behavior, which includes positive actions such as eating a balanced diet and exercising as well as such negative activities as cigarette smoking and excessive alcohol consumption. As we noted earlier in the chapter, both physical and mental illnesses are now conceptualized as “lifestyle diseases” that are caused by a combination of biological, psychological, and social factors.

Somatoform Disorders

People who suffer from somatoform disorders do not consciously seek to mislead others about their physical condition. The symptoms are real to them; they are not faked or under voluntary control (APA, 2000). For example, in one kind of somatoform disorder, somatization disorder, the person experiences vague, recurring physical symptoms for which medical attention has been sought repeatedly but no organic cause found. Common complaints are back pains, dizziness, partial paralysis, abdominal pains, and sometimes anxiety and depression. The following case is typical:

An elderly woman complained of headaches and periods of weakness that lasted for over six months. Her condition had been evaluated by doctors numerous times; she was taking several prescription medications, and she had actually undergone 30 operations for a variety of complaints. She was thin, but examination showed her to be within normal limits in terms of physical health (except for numerous surgical scars). Her medical history spanned half a century, and there can be little doubt that she suffered from somatization disorder. (Quill, 1985)

Another form of somatoform disorder involves complaints of far more bizarre symptoms, such as paralysis, blindness, deafness, seizures, loss of feeling, or false pregnancy. Sufferers from such conversion disorders have intact, healthy muscles and nerves, yet their symptoms are very real. For example, a person with such a “paralyzed” limb has no feeling in it, even if stuck with a pin. Sometimes it is easy to determine that there is no organic cause for the symptoms of a conversion disorder because the symptoms are anatomically impossible. Take glove anesthesia, which is a lack of feeling in the hand from the wrist down. There is no way that damage to the nerves running into the hand could cause such a localized pattern of anesthesia.
Psychologists also look for evidence that the “illness” resolves a difficult conflict or relieves the patient of the need to confront a difficult situation. For example, a housewife reported serious attacks of dizziness, nausea, and visual disturbances that came on in the late afternoon and cleared up at about 8:00 P.M. After ruling out any physical cause for her problems, a therapist discovered that she was married to an extremely tyrannical man who, shortly after coming home from work in the evening, habitually abused her verbally, criticizing her housekeeping, the meal she had prepared, and so on. Her psychological distress was unconsciously converted to physical symptoms that served to remove her from this painful situation (Spitzer et al., 1981).

Yet another somatoform disorder is hypochondriasis. Here, the person interprets some small symptom—perhaps a cough, bruise, or perspiration—as a sign of a serious disease. Although the symptom may actually exist, there is no evidence that the serious illness does. Nevertheless, repeated assurances of this sort have little effect, and the person is likely to visit one doctor after another in search of a medical authority who will share his or her conviction.

Body dysmorphic disorder, or imagined ugliness, is a recently diagnosed and poorly understood type of somatoform disorder. Cases of body dysmorphic disorder can be very striking. One man, for example, felt that people stared at his “pointed ears” and “large nostrils” so much that he eventually could not face going to work—so he quit his job. Clearly people who become that preoccupied with their appearance cannot lead a normal life. Ironically, most people who suffer body dysmorphic disorder are not ugly. They may be average looking or even attractive, but they are unable to evaluate their looks realistically. When they look in the mirror, all they seem to see is their “defect”—greatly magnified.

Causes of Somatoform Disorders

Somatoform disorders (especially conversion disorders) present a challenge for psychological theorists. They seem to involve some kind of unconscious processes. Freud concluded that the physical symptoms were often related to traumatic experiences buried in a patient’s past: A woman who years earlier saw her mother physically abused by her father suddenly loses her sight; a man who was punished for masturbating later loses the use of his hand. By unconsciously developing a handicap, Freud theorized, people accomplish two things. First, they prevent themselves from acting out forbidden desires or repeating forbidden behavior; Freud called this the primary gain of the symptom. Second, the symptoms often allow the person to avoid an unpleasant activity, person, or situation; Freud called this secondary gain.

Cognitive behavioral theories of somatoform disorders focus on Freud’s idea of secondary gain—that is, they look for ways in which the symptomatic behavior is being rewarded. For example, a person may have learned in the past that aches, pains, and so on can be used to avoid unpleasant situations. (Timely headaches and stomachaches have “solved” a lot of problems over the years.) Later in life, this person may use somatic symptoms to avoid facing unpleasant or stressful situations. Moreover, people who are ill often enjoy a good deal of attention, support, and care, which is indirectly rewarding.

Now we turn to the biological perspective. Research has shown that at least some diagnosed somatoform disorders actually were real physical illnesses that were overlooked or misdiagnosed. For example, one set of follow-up studies indicated that some cases of “conversion disorder” eventually proved to be undiagnosed neurological problems such as epilepsy or multiple sclerosis (Shalev & Munitz, 1986). Still, most cases of conversion disorder cannot be explained by current medical science. These cases pose as much of a theoretical challenge today as they did when conversion disorders captured Freud’s attention over a century ago.
Dissociative Disorders

Disorders in which some aspect of the personality seems separated from the rest.

A dissociative disorder characterized by loss of memory for past events without organic cause.

A dissociative disorder that involves flight from home and the assumption of a new identity, with amnesia for past identity and events.

**CHECK YOUR UNDERSTANDING**

1. Match the following terms with the appropriate description.

   ___ somatoform disorder  a. the person’s interpretation of some small symptom as a sign of a serious disease
   ___ body dysmorphic disorder  b. recurring physical symptoms for which no organic cause is found
   ___ conversion disorders  c. imagined ugliness
   ___ hypochondriasis  d. condition in which sufferers have healthy muscles and nerves, yet their symptoms of paralysis, blindness, deafness, seizures, loss of feeling, or pregnancy are real

2. Freud called developing symptoms that allow a person to avoid an unpleasant activity

   ___ a. a primary gain
   ___ b. a secondary gain
   ___ c. neither a primary nor secondary gain

Answers: 1. somatoform disorder—b; body dysmorphic disorder—c; conversion disorders—d; hypochondriasis—a, 2.b

**Dissociative Disorders**

Most patients with multiple personalities experienced childhood abuse. True or false?

Disassociative disorders are among the most puzzling forms of mental disorders, both to the observer and to the sufferer. Dissociation means that part of an individual’s personality is separated, or dissociated, from the rest, and for some reason the person cannot reassemble the pieces. It usually involves memory loss and a complete—though generally temporary—change in identity. Rarely, several distinct personalities may be present in one person.

**Dissociative Amnesia**

Loss of memory without an organic cause may be a reaction to intolerable experiences. People often block out an event or a period of their lives that has been extremely stressful. During World War II, some hospitalized soldiers could not recall their names, where they lived, where they were born, or how they came to be in battle. But war and its horrors are not the only causes of dissociative amnesia. The man who betrays a friend to complete a business deal or the woman who has been raped may also forget—selectively—what has happened. Sometimes an amnesia victim leaves home and assumes an entirely new identity, although this phenomenon, known as dissociative fugue, is highly unusual.

Total amnesia, in which people forget everything, is quite rare, despite its popularity in novels and films. In one unusual case of fugue, the police picked up a 42-year-old man after he became involved in a fight with a customer at the diner where he worked. The man reported that he had no memory of his life before drifting into that town a few weeks earlier. Eventually, the authorities discovered that he matched the description of a missing person who had wandered from his home 200 miles away. Just before he disappeared, he had been passed over for promotion at work and had a violent argument with his teenage son (Spitzer et al., 1981).
**Dissociative Identity Disorder**

Even more bizarre than amnesia is **dissociative identity disorder**—commonly known as *multiple personality*—in which a person has several distinct personalities that emerge at different times. This dramatic disorder, which has been the subject of popular fiction and films, is thought by most psychologists to be extremely rare—although in recent years the number of cases appears to be increasing (Eich, Macaulay, Loewenstein, & Dihle, 1997). In the true multiple personality, the various personalities are distinct people, with their own names, identities, memories, mannerisms, speaking voices, and even IQs. Sometimes the personalities are so separate that they don’t know they inhabit a body with other “people”; at other times, the personalities do know of the existence of other “people” and will even make disparaging remarks about them. Consider the case of Maud and Sara K., two personalities that coexisted in one woman:

In general demeanor, Maud was quite different from Sara. She walked with a swinging, bouncing gait contrasted to Sara’s sedate one. While Sara was depressed, Maud was ebullient and happy. . . . Insofar as she could Maud dressed differently from Sara. . . . Sara used no make-up. Maud used a lot of rouge and lipstick, [and] painted her fingernails and toenails deep red. . . . Sara was a mature, intelligent individual. Her mental age was 19.2 years, IQ, 128. A psychometric done on Maud showed a mental age of 6.6, IQ, 43. (Carson, Butcher, & Coleman, 1988, p. 206)

This case is typical in that the personalities contrasted sharply with each other. It is as if the two (and sometimes more) personalities represent different aspects of a single person—one the more socially acceptable, “nice” side of the person, the other the darker, more uninhibited or “evil” side.

The origins of dissociative identity disorder have long puzzled researchers and clinicians. One common suggestion is that it develops as a response to childhood abuse. The child learns to cope with abuse by a process of dissociation—by assigning the abuse, in effect, to “someone else,” that is, to a personality who is not conscious most of the time (Putnam, Guroff, Silberman, Barban, & Post, 1986). The fact that one or more of the multiple personalities in almost every case is a child (even when the patient is an adult) seems to support this idea, and clinicians report a history of child abuse in over three-quarters of their cases of dissociative identity disorder (Ross, Norton, & Wozney, 1989).

Other clinicians suggest that dissociative identity disorder is not a real disorder at all but an elaborate kind of role playing—feigned in the beginning, and then perhaps genuinely believed in by the patient (Lilienfeld & Lynn, 2003; Mersky, 1992; Rieber, 1998). However, some intriguing biological data show that in at least some patients with dissociative identity disorder, the various personalities have different blood pressure readings, different responses to medication, different allergies, different vision problems (necessitating several pairs of glasses, one for each personality), and different handedness—all of which would be difficult to feign. Each personality may also exhibit distinctly different brain-wave patterns (Putnam, 1984).

**Depersonalization Disorder**

A far less dramatic (and much more common) dissociative disorder is **depersonalization disorder**. Its essential feature is that the person suddenly feels changed or different in a strange way. Some people feel they have left their bodies, others that their actions have suddenly become mechanical or dreamlike. A sense of losing control over one’s own behavior is common, and it is not unusual to imagine changes in one’s environment. This kind of feeling is especially common during adolescence and young adulthood, when our sense of ourselves and our interactions with others changes rapidly. Only when the sense of depersonalization becomes a

---

**Dissociative identity disorder** A dissociative disorder in which a person has several distinct personalities that emerge at different times.

**Depersonalization disorder** A dissociative disorder whose essential feature is that the person suddenly feels changed or different in a strange way.
long-term or chronic problem or when the alienation impairs normal social functioning can this be classified as a dissociative disorder (APA, 2000).

**Causes of Dissociative Disorders**

Dissociative disorders, like conversion disorders, seem to involve some kind of unconscious processes. The loss of memory is real in amnesia, fugue, and in many cases of multiple personality disorder as well. The patient often lacks awareness of the memory loss, and memory impairments usually cannot be overcome despite the patient's desire and effort to do so. Biological factors may also play a role in some cases. We know that dissociation and amnesia result from some physical processes: Memory impairments are commonly associated with aging and disorders such as Alzheimer's disease, and dissociative experiences are a common consequence of the ingestion of some drugs such as LSD. Trauma is a psychological factor that is of obvious importance in the onset of amnesia and fugue; it also appears to play a role in the development of dissociative identity disorder (Oltmanns & Emery, 2001). Nonetheless, we must admit that all these observations are only early leads in the fascinating mystery of what causes dissociative disorders.

**ENDURING ISSUES**

**diversity universality**

**What's Normal?**

Ideas about what is normal and abnormal in sexual behavior vary with the times, the individual, and, sometimes, the culture. Alfred Kinsey and his associates showed years ago (1948, 1953) that many Americans enjoy a variety of sexual activi-
ties, some of which were, and still are, forbidden by law. We know that there are a number of sexual universals that all people share, regardless of culture (D. E. Brown, 1991). These include great interest in sex, sexual attractiveness based on signs of health, avoidance of incest, and sexual relations carried out in private. So in spite of the wide variation in courtship and marriage customs and other sexual practices, some things remain universally human—and some are universally shunned. Throughout the late twentieth century, as psychologists became more aware of the diversity of “normal” sexual behaviors, they increasingly narrowed their definition of abnormal sexual behavior. Today the DSM-IV-RT recognizes only three main types of sexual disorders: sexual dysfunction, paraphilias, and gender-identity disorders. We will discuss each of these in turn.

Sexual Dysfunction

Sexual dysfunction is the loss or impairment of the ordinary physical responses of sexual function (see Figure 13–2). In men, this may take the form of erectile disorder or erectile dysfunction (ED), the inability to achieve or maintain an erection. In women, it often takes the form of female sexual arousal disorder, the inability to become sexually excited or to reach orgasm. (These conditions were once called “impotence” and “frigidity,” respectively, but professionals in the field have rejected these terms as negative and judgmental.) Occasional problems with achieving or maintaining an erection in men or with lubrication or reaching orgasm in women are common. Only when the problem is frequent or constant, and when enjoyment of sexual relationships becomes impaired, should it be considered serious.

Studies have shown that the incidence of ED is quite high, even among otherwise healthy men. One survey found, for example, that nearly 10 percent of 40- to 70-year-old men had complete ED, 25 percent moderate ED, and 17 percent minimal ED. Less than half the men in this age group reported having no ED (Lamberg, 1998). Fortunately, the medication sildenafil citrate, known popularly as Viagra, has been shown to be extremely effective in treating many men who have ED, regardless of whether the disorder has an organic or a psychological origin (Dinsmore et al., 1999; Goldstein et al., 1998; Marks, Duda, Dorey, Macairan, & Santos, 1999; also see Meston & Frohlich, 2000). Research has even demonstrated the effectiveness of Viagra in helping men with spinal cord injury regain a normal sex life (Derry et al., 1998).

Although Viagra appears to help most male patients overcome ED, it is of little value unless a man is first sexually aroused. Unfortunately, some men and women find it difficult or impossible to experience any desire for sexual activity to begin with. Sexual desire disorders involve a lack of interest in sex or perhaps an active distaste for it. Low sexual desire is more common among women than among men and plays a role in perhaps 40 percent of all sexual dysfunctions (Southern & Gayle, 1982). The extent and causes of this disorder in men or women is difficult to analyze, because some people simply have a low motivation for sexual activity; scant interest in sex is normal for them and does not necessarily reflect any sexual disorder (Beck, 1995). Others report no anxiety about or aversion to sex but exhibit physiological indicators of inhibited desire (Wincze, Hoon, & Hoon, 1978). This fact has led some researchers to conclude that the disorder is sometimes caused by a physical abnormality. In those people who report feeling neutral about sex or having an aversion to it, investigators suggest that the problem may have originated in earlier traumatic experiences or unfulfilling relationships.

Other people are able to experience sexual desire and maintain arousal but are unable to reach orgasm, the peaking of sexual pleasure and the release of sexual tension. These people are said to experience orgasmic disorders. Male orgasmic disorder—the inability to ejaculate even when fully aroused—is rare but seems to be becoming increasingly common as more men find it desirable to practice the delay

Sexual dysfunction Loss or impairment of the ordinary physical responses of sexual function.

Erectile disorder or erectile dysfunction (ED) The inability of a man to achieve or maintain an erection.

Female sexual arousal disorder The inability of a woman to become sexually aroused or to reach orgasm.

Sexual desire disorders Disorders in which the person lacks sexual interest or has an active distaste for sex.

Orgasm Peaking of sexual pleasure and release of sexual tension.

Orgasmic disorders Inability to reach orgasm in a person able to experience sexual desire and maintain arousal.
of orgasm (Rosen & Rosen, 1981). Masters and Johnson (1970) attributed male orgasmic disorder primarily to such psychological factors as traumatic experiences. The problem also seems to be a side effect of some medications, such as certain antidepressants. This difficulty is considerably more common among women than among men (see Figure 13–2).

Among the other problems that can occur during the sexual response cycle are premature ejaculation, a fairly common disorder that the DSM-IV-RT defines as the male’s inability to inhibit orgasm as long as desired, and vaginismus, involuntary muscle spasms in the outer part of a woman’s vagina during sexual excitement that make intercourse impossible. Again, the occasional experience of such problems is common; the DSM-IV-RT considers them dysfunctions only if they are “persistent and recurrent.”

**Paraphilias**

A second group of sexual disorders, known as paraphilias, involves the use of unconventional sex objects or situations to obtain sexual arousal. Most people have unconventional sexual fantasies at some time, and this kind of fantasizing can be a healthy stimulant of normal sexual enjoyment. However, the repeated use of a nonhuman object—a shoe, for instance, or underwear—as the preferred or exclusive
method of achieving sexual excitement is considered a sexual disorder known as **fetishism**. Fetishes are typically articles of women’s clothing, or items made out of rubber or leather (Junginger, 1997; Mason, 1997). People with fetishes are almost always male, and the fetish frequently begins during adolescence. At least one theorist has suggested that fetishes derive from unusual learning experiences: As their sexual drive develops during adolescence, some boys learn to associate arousal with inanimate objects, perhaps as a result of early sexual exploration while masturbating or because of difficulties in social relationships (Bertolini, 2001; Wilson, 1987).

Other unconventional patterns of sexual behavior are **voyeurism**, watching other people have sex or spying on people who are nude; achieving arousal by **exhibitionism**, the exposure of one’s genitals in inappropriate situations, such as to strangers; **frotteurism**, achieving sexual arousal by touching or rubbing against a nonconsenting person in situations like a crowded subway car; and **transvestic fetishism**, wearing clothes of the opposite sex for sexual excitement and gratification. **Sexual sadism** ties sexual pleasure to aggression. To attain sexual gratification, sadists humiliate or physically harm sex partners. **Sexual masochism** is the inability to enjoy sex without accompanying emotional or physical pain. Sexual sadists and masochists sometimes engage in mutually consenting sex, but at times sadistic acts are inflicted on unconsenting partners.

One of the most serious paraphilias is **pedophilia**, which is technically defined as “recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child” (APA, 1994, p. 528). Child sexual abuse has been found to be shockingly common in the United States. Moreover, evidence indicates that in most cases the person who commits the abuse is someone close to the child, not a stranger. According to one survey, 5 percent of adult women living in the San Francisco area reported that they had been forced into oral, anal, or genital intercourse by their father, stepfather, or brother during their childhood years (Russell, 1986). Other studies suggest that the frequency of sexual abuse of both male and female children is much higher than this (Finkelhor, Hotaling, Lewis, & Smith, 1990).

Pedophiles are almost invariably men under the age of 40 (Barbaree & Seto, 1997). Although there is no single cause of pedophilia, some of the most common explanations are: Pedophiles cannot adjust to the sexual role of an adult male and have been interested exclusively in children as sex objects since adolescence; they turn to children as sexual objects in response to stress in adult relationships in which they feel inadequate; they have records of unstable social adjustment and generally commit sexual offenses against children in response to a temporary aggressive mood. Studies also indicate that the majority of pedophiles have histories of sexual frustration and failure, tend to perceive themselves as immature, and are dependent, unassertive, lonely, and insecure (Cohen & Galynker, 2002).

---

**Gender-Identity Disorders**

Gender-identity disorders involve the desire to become—or the insistence that one really is—a member of the other biological sex. Some little boys, for example, want to be girls instead. They may reject boys’ clothing, desire to wear their sisters’ clothes, and play only with girls and with toys that are considered “girls’ toys.” In these cases, the diagnosis is **gender-identity disorder in children**. The same is true for girls who wear boys’ clothing and play only with boys and “boys’ toys.” In all these cases, the children are uncomfortable with being a male or a female and are unwilling to accept themselves as such.

Most gender-identity disorders begin in childhood, and although many children with the disorder eventually develop normal gender identities, others carry the disorder into adult life. **Sexual reassignment surgery** (Hage, 1995) is one possible (and
Personality disorders

Disorders in which inflexible and maladaptive ways of thinking and behaving learned early in life cause distress to the person and/or conflicts with others.

controversial) option for adults with gender-identity disorder: Surgical procedures, accompanied by hormonal treatments, are used to remove sex organs and create reasonable facsimiles of the organs of the opposite sex. Generally, people who have undergone sexual reassignment surgery are satisfied with the outcome. In addition, evidence from psychological tests indicate they experience reduced levels of anxiety and depression following the surgery (Bodlund & Kullgren, 1996).

The causes of gender-identity disorders are not known. Both animal research and the fact that these disorders are often apparent from early childhood suggest that biological factors are major contributors. In fact, some biologists believe that human gender identity exists along a continuum and that two sexes are not adequate to encompass human sexuality. As evidence, they cite the many babies born each year with ambiguous genitalia or whose genitalia do not match their chromosomal sex (Fausto-Sterling, 1993, 2000a, 2000b). However, family dynamics and learning experiences may also be contributing factors.

CHECK YOUR UNDERSTANDING

1. A paraphilia is
   ___a. a form of sexual dysfunction.
   ___b. a sexual attraction to unconventional objects.
   ___c. a type of sex reassignment surgery.

2. Erectile disorders in men and sexual arousal disorders in women are examples of
   ___a. sexual dysfunctions.
   ___b. paraphilias.
   ___c. gender identity disorders.

3. Biologists point to babies born with ambiguous genitalia as evidence
   ___a. that two sexes are not adequate to encompass human sexuality.
   ___b. of pedophilia.
   ___c. of sexual dysfunction.

Answers: 1a, 2a, 3a

Personality Disorders

How do “personality disorders” differ from other psychological disorders?

In Chapter 11, Personality, we saw that personality is the individual’s unique and enduring pattern of thoughts, feelings, and behavior. We also saw that, despite having certain characteristic views of the world and ways of doing things, people normally can adjust their behavior to fit the needs of different situations. But some people, starting at some point early in life, develop inflexible and maladaptive ways of thinking and behaving that are so exaggerated and rigid that they cause serious distress to themselves or problems to others. People with such personality disorders range from harmless eccentrics to cold-blooded killers. A personality disorder may also coexist with one of the other problems already discussed in this chapter; that is, someone with a personality disorder may also become depressed, develop sexual problems, and so on.
Types of Personality Disorders

One group of personality disorders is characterized by odd or eccentric behavior. For example, people who exhibit schizoid personality disorder lack the ability or desire to form social relationships and have no warm or tender feelings for others. Such loners cannot express their feelings and are perceived by others as cold, distant, and unfeeling. Moreover, they often appear vague, absentminded, indecisive, or “in a fog.” Because their withdrawal is so complete, persons with schizoid personality disorder seldom marry and may have trouble holding jobs that require them to work with or relate to others (APA, 2000).

People with paranoid personality disorder also exhibit odd behavior. They are suspicious and mistrustful even when there is no reason to be, and they are hypersensitive to any possible threat or trick. They refuse to accept blame or criticism even when it is deserved. They are guarded, secretive, devious, scheming, and argumentative, although they often see themselves as rational and objective.

Another cluster of personality disorders is characterized by anxious or fearful behavior. Among these are dependent personality disorder and avoidant personality disorder. People with dependent personality disorder are unable to make decisions on their own or to do things independently. They rely on parents, a spouse, friends, or others to make the major choices in their lives and usually are extremely unhappy being alone. Their underlying fear seems to be that they will be rejected or abandoned by important people in their lives. In avoidant personality disorder, the person is timid, anxious, and fearful of rejection. Not surprisingly, this social anxiety leads to isolation, but unlike the schizoid type, the person with avoidant personality disorder wants to have close relationships with other people.

Another cluster of personality disorders is characterized by dramatic, emotional, or erratic behavior. For example, people with narcissistic personality disorder display a grandiose sense of self-importance and a preoccupation with fantasies of unlimited success. (The word narcissism comes from a character in Greek mythology named Narcissus who fell in love with his own reflection in a pool and pined away because he could not reach the beautiful face he saw before him.) Such people believe they are extraordinary, need constant attention and admiration, display a sense of entitlement, and tend to exploit others. They are given to envy and arrogance and lack the ability to really care for anyone else (APA, 2000).

Psychologists know relatively little about the causes of most personality disorders, but some are better understood than others. One such is borderline personality disorder, which is characterized by marked instability—in self-image, mood, and interpersonal relationships. People with this personality disorder tend to act impulsively and often in self-destructive ways. They feel uncomfortable being alone, and they often manipulate their self-destructive impulses in an effort to control or solidify their personal relationships. Such self-destructive behavior includes promiscuity, drug and alcohol abuse, and threats of suicide (Gunderson, 1984, 1994).

Borderline personality disorder is both common and serious. The available evidence indicates that although it runs in families, genetics do not seem to play an important role in its development (Oltmanns & Emery, 2001). Instead, studies of people with borderline personality disorder point to the influence of dysfunctional relationships with their parents, including a pervasive lack of supervision, frequent exposure to domestic violence, and physical and sexual abuse (Guzder, Paris, Zelkowitz, & Marchessault, 1996). Moreover, it is often accompanied by mild forms of brain dysfunction (such as attention-deficit disorder), schizophrenic-like conditions, and mood disorders, which has led some psychologists to question whether borderline personality disorder should be considered a separate and distinguishable category of personality disorder (Akiskal, 1994; Tyrer, 1994). On the other hand,
family studies show that relatives of people diagnosed as borderline individuals are much more likely to be treated for borderline disorder than for other types of personality disorders. This finding supports the position that borderline disorder is a legitimate category of personality disorder.

One of the most widely studied personality disorders is antisocial personality disorder. People who exhibit this disorder lie, steal, cheat, and show little or no sense of responsibility, although they often seem intelligent and charming on first acquaintance. The “con man” exemplifies many of the features of the antisocial personality, as does the person who compulsively cheats business partners because he or she knows their weak points. Antisocial personalities rarely show the slightest trace of anxiety or guilt about their behavior. Indeed, they are likely to blame society or their victims for the antisocial actions that they themselves commit.

Approximately 3 percent of American men and less than 1 percent of American women suffer from antisocial personality disorder. Not surprisingly, the prevalence of the disorder is high among prison inmates. One study categorized 50 percent of the populations of two prisons as having antisocial personalities (Hare, 1983). Not all people with antisocial personality disorder are convicted criminals, however. Many skillfully and successfully manipulate others for their own gain while steering clear of the criminal justice system.

Causes of Antisocial Personality Disorder

Because of the consequences for society, the causes of antisocial personality disorders have been studied much more extensively than the causes of other personality disorders. Antisocial personality disorder seems to result from a combination of biological predisposition, adverse psychological experiences, and an unhealthy social environment (Moffitt, 1993). Some findings suggest that heredity is a risk factor for the later development of antisocial behavior (Fu et al., 2002; Lyons et al., 1995). Impulsive violence and aggression have also been linked with abnormal levels of certain neurotransmitters (Virkkunen, 1983). Evidence suggests that in some people with antisocial personalities the autonomic nervous system is less responsive to stress (Patrick, 1994). Thus, they are more likely to engage in thrill-seeking behaviors, which can be harmful to themselves or others. In addition, because they respond less emotionally to stressful situations, punishment is less effective for them than for other people (Hare, 1993).

Another intriguing explanation for the cause of antisocial personality disorder is that it arises as a consequence of damage to the prefrontal region of the brain during infancy. One case study reported that two infants who had experienced damage to the prefrontal cortex prior to 16 months of age had defective social and moral reasoning and displayed no empathy as adults. Although these patients’ cognitive abilities were not impaired, both appeared insensitive to the future consequences of their decisions. As adults, both patients were also compulsive liars and thieves and never expressed guilt or remorse for their actions (Anderson, Bechara, Damasio, Tranel, & Damasio, 1999).

Some psychologists feel that emotional deprivation in early childhood predisposes people to antisocial personality disorder. The child for whom no one cares, say

**Antisocial personality disorder**

Personality disorder that involves a pattern of violent, criminal, or unethical and exploitative behavior and an inability to feel affection for others.
psychologists, cares for no one. The child whose problems no one identifies with can identify with no one else’s problems. Respect for others is the basis of our social code, but if you cannot see things from the other person’s perspective, rules about what you can and cannot do will seem nothing more than an assertion of adult power to be defied as soon as possible.

Family influences may also prevent the normal learning of rules of conduct in the preschool and school years. Theorists reason that a child who has been rejected by one or both parents is not likely to develop appropriate social behavior. They also point out the high incidence of antisocial behavior in people with an antisocial parent and suggest that antisocial behavior may be partly learned and partly inherited from parents. Once serious misbehavior begins in childhood, there is an almost predictable progression: The child’s conduct will result in rejection by peers and failure in school, followed by affiliation with other children who have behavior problems. By late childhood or adolescence, the deviant patterns that will later show up as a full-blown antisocial personality disorder are well established (Hill, 2003; Patterson, DeBaryshe, & Ramsey, 1989).

Cognitive theorists emphasize that in addition to the failure to learn rules and develop self-control, moral development may be arrested among children who are emotionally rejected and inadequately disciplined (Soygut & Tuerkcapar, 2001). For example, between the ages of about 7 and 11, all children are apt to respond to unjust treatment by behaving unjustly toward someone else who is vulnerable. At about age 13, when they are better able to reason in abstract terms, most children begin to think more in terms of fairness than vindictiveness. This seems to be especially true if new cognitive skills and moral concepts are reinforced by parents and peers (Berkowitz & Gibbs, 1983).

CHECK YOUR UNDERSTANDING

1. Lifelong patterns of relatively “normal” but rigid and maladaptive behaviors are called
   ___a. schizophrenia
   ___b. personality disorders
   ___c. anxiety disorders

2. Match the following personality disorders with the appropriate description.

   ___schizoid personality disorder  a. shows instability in self-image, mood, and relationships
   ___paranoid personality disorder  b. is fearful and timid
   ___dependent personality disorder  c. is mistrustful even when there is no reason
   ___avoidant personality disorder  d. shows little sense of responsibility
   ___narcissistic personality disorder  e. exhibits extreme dramatic behavior and self-centeredness
   ___borderline personality disorder  f. lacks the ability to form social relationships
   ___antisocial personality disorder  g. is unable to make own decisions

   \begin{tabular}{ll}
   \hline
   schizoid personality disorder & a. shows instability in self-image, mood, and relationships \\
   paranoid personality disorder & b. is fearful and timid \\
   dependent personality disorder & c. is mistrustful even when there is no reason \\
   avoidant personality disorder & d. shows little sense of responsibility \\
   narcissistic personality disorder & e. exhibits extreme dramatic behavior and self-centeredness \\
   borderline personality disorder & f. lacks the ability to form social relationships \\
   antisocial personality disorder & g. is unable to make own decisions \\
   \hline
   \end{tabular}

   Answers: 1. b, 2. a. schizoid personality disorder—f; paranoid personality disorder—c; dependent personality disorder—g; avoidant personality disorder—b; narcissistic personality disorder—e; antisocial personality disorder—d.
Schizophrenic disorders are severe conditions marked by disordered thoughts and communications, inappropriate emotions, and bizarre behavior that lasts for months, even years. People with schizophrenia are out of touch with reality, which is to say they are psychotic. Many also suffer from hallucinations, false sensory perceptions that usually take the form of hearing voices that are not really there. (Visual, tactile, or olfactory hallucinations are more likely to result from substance abuse or organic brain damage than from schizophrenia.) They also frequently have delusions—false beliefs about reality with no factual basis—that distort their relationships with their surroundings and with other people. Typically, these delusions are paranoid: People with schizophrenia believe that someone is out to harm them. They may think that a doctor wishes to kill them or that they are receiving radio messages from aliens invading from outer space. They often regard their own bodies—as well as the outside world—as hostile and alien. These distorted thoughts sometimes lead to self-destructive behaviors, increasing the risk of suicide (McGuire, 2000).

Because their world is utterly different from the one most people live in, people with schizophrenia usually cannot live anything like a normal life unless they are successfully treated with medication (see Chapter 14, Therapies). Often, they are unable to communicate with others, for when they speak, their words are incoherent. The following case illustrates some of the characteristic features of schizophrenia:

For many years [a 35-year-old widow] has heard voices, which insult her and cast suspicion on her chastity. . . . The voices are very distinct, and in her opinion, they must be carried by a telescope or a machine from her home. Her thoughts are dictated to her; she is obliged to think them, and hears them repeated after her. She . . . has all kinds of uncomfortable sensations in her body, to which something
is “done.” In particular, her “mother parts” are turned inside out, and people send a pain through her back, lay ice-water on her heart, squeeze her neck, injure her spine, and violate her. There are also hallucinations of sight—black figures and the altered appearance of people—but these are far less frequent. . . . (Spitzer et al., 1981, pp. 308–309)

There are actually several kinds of schizophrenic disorders, which have different characteristic symptoms.

**Types of Schizophrenic Disorders**

**Disorganized schizophrenia** includes some of the more bizarre symptoms of schizophrenia, such as giggling, grimacing, and frantic gesturing. People suffering from disorganized schizophrenia show a childish disregard for social conventions and may urinate or defecate at inappropriate times. They are active but aimless, and they are often given to incoherent conversations.

The primary feature of **catatonic schizophrenia** is a severe disturbance of motor activity. People with this disorder alternate between a catatonic state, in which they remain immobile, mute, and impassive, and an extremely active state, in which they become excessively excited, talking and shouting continuously. They may behave in a robotlike fashion when ordered to move, and some have even let doctors mold their arms and legs into strange and uncomfortable positions that they then manage to maintain for hours.

**Paranoid schizophrenia** is marked by extreme suspiciousness and complex delusions. People with paranoid schizophrenia may believe themselves to be Napoleon or the Virgin Mary, or they may insist that Russian spies with laser guns are constantly on their trail because they have learned some great secret. Because they are less likely to be incoherent or to look or act “crazy,” these people can appear more “normal” than people with other schizophrenic disorders if their delusions are compatible with everyday life. However, they may become hostile or aggressive toward anyone who questions their thinking or tries to contradict their delusions. Note that this disorder is far more severe than paranoid personality disorder, which does not involve bizarre delusions or loss of touch with reality.

Finally, **undifferentiated schizophrenia** is the classification developed for people who have several of the characteristic symptoms of schizophrenia, such as delusions, hallucinations, or incoherence, yet who do not show the typical symptoms of any other subtype of the disorder.

**Causes of Schizophrenia**

Schizophrenia is a very serious disorder, and considerable research has been directed at trying to discover its causes. As we saw in Chapter 2, The Biological Basis of Behavior, a wide range of studies clearly show that schizophrenia has a genetic component (Gottesman, 1991). People with schizophrenia are more likely than other people to have children with schizophrenia, even when those children have lived with adoptive parents since early in life. And if one identical twin suffers from schizophrenia, the chances are about 50 percent that the other twin will also develop schizophrenia; but if a fraternal twin has schizophrenia, the chances are only about 15 percent that the other twin will also develop schizophrenia (see Figure 2–19). These studies indicate that a biological predisposition to schizophrenia may be inherited. Recent research suggests that part of the problem may involve the faulty regulation of dopamine in the central nervous system, resulting in excessive accumulations of this neurotransmitter in critical regions of the brain (Koh et al., 2003). Drugs that alleviate schizophrenic symptoms also decrease the amount of dopamine in the brain and block dopamine receptors. On the other hand, amphetamines raise the amount of
PET scan of the brain of a patient with schizophrenia and the brain of a normal volunteer. Neuroimaging techniques often reveal important differences between the brains of patients with schizophrenia and normal volunteers. Still, neuroimaging does not provide a decisive diagnostic test for schizophrenia.

dopamine in the brain, aggravate schizophrenic symptoms, and, if taken in excess, lead to what is called amphetamine psychosis, which is very similar to schizophrenia.

Other research suggests that pathology in various structures of the brain plays a role in the onset of schizophrenia (van Elst & Trimble, 2003; Weinberger, 1997). For example, patients with schizophrenia have been shown to have enlarged ventricles, which are chambers in the brain that are filled with cerebrospinal fluid (Torrey, Bowler, Taylor, & Gottesman, 1994; Yotsutsuji et al., 2003). Because the largest ventricles are commonly seen in chronic or long-term cases of schizophrenia, researchers theorize that the ventricles may enlarge over the course of the illness as the neurons around these cavities degenerate (Zipursky, Lambe, Kapur, & Mikulis, 1998).

Other studies have focused on what appears to be an abnormal pattern of connections between cortical cells in patients with schizophrenia. Because these cortical connections are largely established during the prenatal period, this finding suggests that the onset of schizophrenia, which generally takes place in adulthood, may be traceable to some form of early prenatal disturbance (Wolf & Weinberger, 1996). Still, scientists have found only average differences in brain structure and chemistry between people with schizophrenia and healthy people (Noga, Bartley, Jones, Torrey, & Weinberger, 1996). In fact, studies of identical twins in which only one twin suffers from schizophrenia have sometimes found more evidence of brain abnormalities in the well twin than in the sick twin.

This finding brings us back to the research on genetics and schizophrenia. Although this point is often overlooked, studies of identical twins can also be used to identify the importance of environment in causing schizophrenia. How? Remember, half of the identical twins of people with schizophrenia do not develop schizophrenia themselves. Because identical twins are genetically identical, this means that this severe and puzzling disorder cannot be caused by genetic factors alone. Environmental factors—ranging from disturbed family relations to taking drugs to biological

THINKING CRITICALLY

Genius and Mental Disorders

Jean-Jacques Rousseau allegedly was paranoid. Mozart composed his Requiem while under the delusion that he was being poisoned. Van Gogh cut off his ear and sent it to a prostitute. Schopenhauer, Chopin, and John Stuart Mill were depressed. Robert Burns and Lord Byron apparently were alcoholics. Virginia Woolf suffered from bipolar disorder through her entire adult life.

- Do you think that creative people in general are more likely than others to suffer from psychological problems? What leads you to believe as you do?
- What evidence would you need to have in order to answer this question in a scientific way?
damage at any age, even before birth—must also figure in determining whether a person will develop schizophrenia.

Some psychologists regard family relationships as an important factor in the development of schizophrenia. The evidence regarding this position is mixed. Recent research has discovered that patients with schizophrenia whose families display high levels of negative expressed emotion are rehospitalized at twice the average rate for people with this disorder (Kavanagh, 1992). Moreover, treatments designed to reduce negative expressed emotion in the families of people with schizophrenia have reduced the rates of rehospitalization. Though it is still not clear how—or if—family variables such as expressed emotion combine with biological predispositions to cause some people to develop schizophrenia, research in this area continues (Subotnik, Goldstein, Nuechterlein, Woo, & Mintz, 2002).

A number of studies have demonstrated a relationship between social class and schizophrenia (Neale & Oltmanns, 1980). The prevalence of schizophrenia is decidedly higher in the lower social classes. One theory holds that lower-class socioeconomic environments—which offer little education, opportunity, or reward and put considerable stress on individuals—are a cause of schizophrenia. Another theory speculates that the symptoms of schizophrenia cause people to drift downward into the lower socioeconomic classes. There appears to be some truth to both theories.

Although they obviously differ greatly in emphasis, the various explanations for schizophrenic disorders are not mutually exclusive. Although genetic factors are universally acknowledged, many theorists believe that it takes a combination of biological, psychological, and social factors to produce schizophrenia (Gottesman, 1991). According to the systems model, genetic factors predispose some people to schizophrenia, and family interaction and life stress activate the predisposition.

**CHECK YOUR UNDERSTANDING**

1. Match the following terms with the appropriate description.
   - ___ disorganized schizophrenia a. is marked by extreme suspiciousness and complex delusions
   - ___ catatonic schizophrenia b. has bizarre symptoms that may include giggling, grimacing, frantic gesturing, and a childish disregard for social conventions
   - ___ paranoid schizophrenia c. is marked by a severe disturbance of motor activity
   - ___ undifferentiated schizophrenia d. is found in people who have several characteristic symptoms of schizophrenia but do not show the typical symptoms of any other subtype

2. If one identical twin suffers from schizophrenia, the chances are about ____ that the other twin will develop schizophrenia.
   - ___ a. 15 percent
   - ___ b. 50 percent
   - ___ c. 100 percent

3. If one fraternal twin has schizophrenia, the chances are about ____ that the other twin will develop it.
   - ___ a. 15 percent
   - ___ b. 50 percent
   - ___ c. 100 percent

Answers: 1. disorganized schizophrenia—b; catatonic schizophrenia—c; paranoid schizophrenia—a; undifferentiated schizophrenia—d; 2. b; 3. a.
Awareness of childhood disorders has increased. DSM-IV-TR lists mental disorders first manifest in early life. AD/HD and autistic disorder are common. AD/HD, previously hyperactivity, affects one in five school children. It is more prevalent in boys. 

Attention Deficit/Hyperactivity Disorder (AD/HD)

AD/HD is associated with decreased ability to focus attention. Many children diagnosed with AD/HD are hyperactive, impulsive, and easily distracted. The condition begins before school age, and challenges school setting. 

AD/HD is caused by biological factors like central nervous system anomalies and heredity. It affects 5% of school-aged children, with boys more affected. 

Psychostimulant drugs are used. They improve focus and reduce hyperactivity. However, they yield short-term benefits only. 

AD/HD's rise may be due to environmental or biological changes. More research is needed. 

Thinking Critically

- In the United States, AD/HD prevalence is high. How does this compare to Britain? Research evidence needed. 
- Play and activity are basic needs of young mammals. Could AD/HD be a normal variation of this need? 

AD/HD presence may differ due to environmental or biological factors. Further research is needed.
Autistic Disorder

A very different, and profoundly serious, disorder that is first evident in childhood is **autistic disorder**. Autism is present in about one in 500 children (Filipek et al., 2000) and affects three to four times as many boys as girls (Rodier, 2000). Autistic children are usually identified as such in the first few years of life. They fail to form normal attachments to parents, remaining distant and seemingly withdrawn into their own separate worlds. As infants, they may even show distress at being picked up or held. As they grow older, they often do not develop speech, or they develop a peculiar speech pattern called *echolalia*, in which they repeat the words said to them. Autistic children typically show strange motor behavior, such as repeating body movements endlessly or walking constantly on tiptoe. Their play is not like that of normal children. They are not at all social and may use toys in odd ways, such as constantly spinning the wheels on a toy truck or tearing paper into strips. Autistic children often appear to have mental retardation, but it is hard to test their mental ability because they are frequently non-verbal. This disorder lasts into adulthood in the great majority of cases.

The precise cause of autism is unknown, although most theorists believe that it results almost entirely from biological conditions. Some causes of mental retardation, such as fragile X syndrome (see Chapter 8, Intelligence and Mental Abilities), also seem to increase the risk of autistic disorder. Recent evidence suggests that autism may result from faulty development of brain stem structures during the early prenatal period (Rodier, 2000). Considerable evidence indicates that genetics also plays a strong role in causing this disorder (Bailey et al., 1995; Cook et al., 1998; Lamb, Moore, Bailey, & Monaco, 2000; Rodier, 2000).

### CHECK YOUR UNDERSTANDING

1. Failure to form normal attachments to parents, lack of social instincts, and strange motor behavior are characteristic of
   ___a. disorganized schizophrenia
   ___b. AD/HD
   ___c. autistic disorder
   ___d. borderline personality disorder

2. Easily distracted, often fidgety and impulsive, and almost constantly in motion describe children who have
   ___a. disorganized schizophrenia
   ___b. AD/HD
   ___c. autistic disorder
   ___d. borderline personality disorder

Answers: 1.c, 2.b
Gender and Cultural Differences in Psychological Disorders

What are the differences between men and women in psychological disorders?

Gender Differences

For the most part, men and women are similar with respect to mental disorders, but differences do exist. Many studies have concluded that women have a higher rate of psychological disorders than men do, but this is an oversimplification (see Culbertson, 1997; Lerman, 1996; Hartung & Widiger, 1998). We do know that more women than men are treated for mental disorders. Indeed, as one expert observed, “Women have always been the main consumers of psychotherapy from Freud’s era onward” (Williams, 1987, p. 465). But this cannot be taken to mean that more women than men have mental disorders, for in our society, it is much more acceptable for women to discuss their emotional difficulties and to seek professional help openly. It may be that mental disorders are equally common among men—or even more common—but that men do not so readily show up in therapists’ offices and therefore are not counted in the studies (for further discussion see Lerman, 1996).

Moreover, those mental disorders for which there seems to be a strong biological component, such as bipolar disorder and schizophrenia, are distributed fairly equally between the sexes. Differences tend to be found for those disorders without a strong biological component—that is, disorders in which learning and experience play a more important role. For example, men are more likely than women to suffer from substance abuse and antisocial personality disorder. Women, on the other hand, are more likely to suffer from depression, agoraphobia, simple phobia, obsessive-compulsive disorder, and somatization disorder (Basow, 1986; Douglas, Moffitt, Dar, McGee, & Silva, 1995; Russo, 1990). These tendencies, coupled with the fact that gender differences observed in the United States are not always seen in other cultures (Culbertson, 1997), suggest that socialization plays a part in developing a disorder: When men display abnormal behavior, it is more likely to take the forms of drinking too much and acting aggressively; when women display abnormal behavior, they are more likely to become fearful, passive, hopeless, and “sick” (Basow, 1986).

One commonly reported difference between the sexes concerns marital status. Men who are separated or divorced or who have never married have a higher incidence of mental disorders than do either women of the same marital status or married men. But married women have higher rates than married men. What accounts for the apparent fact that marriage is psychologically less beneficial for women than for men?

Here, too, socialization appears to play a role. For women, marriage, family relationships, and child rearing are likely to be more stressful than they are for men (Basow, 1986). For men, marriage and family provide a haven; for women, they are a demanding job. In addition, women are more likely than men to be the victims of incest, rape, and marital battering. As one researcher has commented, “for women, the U.S. family is a violent institution” (Koss, 1990).

For some married women, employment outside the home seems to provide the kind of psychological benefits that marriage apparently provides for many men. However, these benefits are likely to be realized only if the woman freely chooses to work, has a satisfying job, receives support from family and friends, and is able to set up stable child-care arrangements (Basow, 1986; Hoffman, 1989). For women who
enter the workforce because they have to rather than because they want to, whose work is routine or demeaning, or who are responsible for all domestic duties as well as their outside jobs, economic pressures and the stress of performing two demanding roles can be additional risk factors for psychological disorder.

We saw in Chapter 12 that the effects of stress are greater to the extent that a person feels alienated, powerless, and helpless. Alienation, powerlessness, and helplessness are more prevalent in women than in men. They are especially common factors among minority women, so it is not surprising that the prevalence of psychological disorders is greater among these women than among other women (Russo & Sobel, 1981). And alienation, powerlessness, and helplessness play an especially important role in anxiety disorders and depression—precisely those disorders experienced most often by women (Kessler et al., 1994). A 1990 report by a task force of the American Psychological Association noted that the rate of depression among women is twice that of men and ascribed that difference to the more negative and stressful aspects of women’s lives, including lower incomes and the experiences of bias and physical and sexual abuse (APA, 1990).

In summary, women do seem to have higher rates of anxiety disorders and depression than men do, and they are more likely than men to seek professional help for their problems. However, greater stress, due in part to socialization and lower status rather than psychological weakness, apparently accounts for this statistic. Marriage and family life, associated with lower rates of mental disorders among men, introduce additional stress into the lives of women, particularly young women (25 to 45), and in some instances this added stress translates into a psychological disorder.

---

**ENDURING ISSUES**

**diversity universality**

**Are We All Alike?**

The frequency and nature of some psychological disorders vary significantly among the world’s different cultures (López & Guarnaccia, 2000). This suggests that many disorders have a strong cultural component, or that diagnosis is somehow related to culture. On the other hand, disorders that are known to have a strong genetic component generally display a more uniform distribution across different cultures.

**Cultural Differences**

As the U.S. population becomes more diverse, it is increasingly important for mental health professionals to be aware of cultural differences if they are to understand and diagnose disorders among people of various cultural groups. Many disorders occur only in particular cultural groups. For example, *ataque de nervios*—literally translated as “attack of nerves”—is a culturally specific phenomenon that is seen predominately among Latinos. The symptoms of *ataque de nervios* generally include the feeling of being out of control, which may be accompanied by fainting spells, trembling, uncontrollable screaming and crying, and, in some cases, verbal or physical aggressiveness. Afterwards, many patients display amnesia of the attack, and quickly return to normal functioning. Another example, called *taijin kyofusbo* (roughly translated as “fear of people”), involves a morbid fear that one’s body or actions may be offensive to others. *Taijin kyofusbo* is rarely seen outside of Japan. Other cross-cultural investigations have found differences in the course of schizophrenia and in the way childhood psychological disorders are manifest between different cultures (López & Guarnaccia, 2000; Weisz, McCarty, Eastman, Chaiyasit, & Suwanlert, 1997).
For some psychological disorders, the prevalence among males and females also differs markedly among countries. For instance, in the United States and most developed nations, females generally display a markedly higher incidence of depression than males. But in many underdeveloped countries of the world, such as Iran, Uganda, or Nigeria, very little or no gender difference in the incidence of depression is found (Culbertson, 1997).

Prevalence of childhood disorders also differs markedly by culture. Of course, it is adults—parents, teachers, counselors—who decide whether a child is suffering from a psychological disorder, and those decisions are likely to be influenced by cultural expectations. For example, in a series of cross-cultural studies, Thai children were more likely to be referred to mental health clinics for internalizing problems, such as anxiety and depression, compared to U.S. children, who were more likely to be referred for externalizing problems, such as aggressive behavior (Weisz, McCarty, Eastman, Chaiyasit, & Suwanlert, 1997).

CHECK YOUR UNDERSTANDING

1. Of the two genders, which one undergoes more treatment for mental disorders?
   ___ a. men
   ___ b. women
   ___ c. neither; both spend equal amounts of time in therapy

2. Married women have ____ incidences of mental disorder than married men.
   ___ a. higher
   ___ b. lower
   ___ c. the same

ANSWERS: 1. b, 2. a

Perspectives on Psychological Disorders

Whether an individual suffers from an emotional disorder is, at least in part, a subjective judgment. Mental health professionals define abnormal behavior as either maladaptive life functioning or serious personal discomfort or both.

Historical Views of Psychological Disorders In early societies mysterious actions were often attributed to supernatural powers. The roots of a more naturalistic view of psychological disorders can be traced to Hippocrates, who maintained that madness was like any other sickness—a natural event arising from natural causes. This approach to mental illness fell into disfavor in the Middle Ages, and it was not until the nineteenth century that it again received systematic scientific attention.

Theories of the Nature, Causes, and Treatment of Psychological Disorders Three influential, conflicting models of psychological disorders emerged during the late 1800s and early 1900s: the biological, psychoanalytic, and cognitive-behavioral models. The biological model states that psychological disorders have a physiological basis. The psychoanalytic model developed by Freud, states that psychological disorders are a symbolic expression of unconscious mental conflicts that generally can be traced to early childhood or infancy. The cognitive-behavioral model states that psychological disorders are the result of learning maladaptive ways of behaving and proposes that what has been learned can be unlearned. Cognitive-behavioral therapists therefore strive to modify both dysfunctional behavior and inaccurate cognitive processes in their patients. The model has been criticized for its extreme emphasis on environmental causes and treatments.

The most promising recent development in abnormal psychology is the integration of the major approaches. The diathesis-stress model, for example, states that psychological disorders develop when a diathesis (biological predisposition to the disorder) is set off by a stressful circumstance. The systems approach (also known as the biopsychosocial approach to psychological disorders) states
that biological, psychological, and social risk factors combine to produce psychological disorders. According to this model, emotional problems are “lifestyle diseases” that are caused by a combination of biological risks, psychological stresses, and societal pressures and expectations.

Classifying Psychological Disorders For nearly 40 years, the American Psychiatric Association has published an official manual describing and classifying the various kinds of psychological disorders. This publication, the Diagnostic and Statistical Manual of Mental Disorders (DSM), has gone through four editions. The current version, known as the DSM-IV-TR, provides careful descriptions of symptoms of different disorders, but includes little on causes and treatments.

The Prevalence of Psychological Disorders The prevalence of a disorder refers to the frequency of the disorder at a given time. The incidence of a disorder refers to the number of new cases that arise in a given period of time. Approximately 15 percent of Americans suffer from mental disorders at any given time.

Mental Illness and the Law A mentally ill person is responsible for his or her crimes unless he or she is determined to be insane. Insanity is a legal term referring to an individual who is not considered responsible for their criminal actions as a result of a mental illness.

Mood Disorders

Mood disorders are characterized by disturbances in mood or prolonged emotional state.

Depression The most common mood disorder is depression, a state in which a person feels overwhelmed with sadness, loses interest in activities, and displays other symptoms such as excessive guilt or feelings of worthlessness. The DSM-IV-TR distinguishes between two forms of depression. Major depressive disorder is an episode of intense sadness that may last for several months; in contrast, dysthymia involves less intense sadness but persists with little relief for a period of two years or more. Some depressions become so intense that people become psychotic—that is, lose contact with reality.

Mania and Bipolar Disorder Another, less common mood disorder is mania. People suffering from mania become euphoric (“high”), extremely active, excessively talkative, and easily distractible. Manic episodes rarely appear by themselves; rather, they usually alternate with depression. Such a mood disorder, in which both mania and depression are alternately present, sometimes interrupted by periods of normal mood, is known as bipolar disorder.

Causes of Mood Disorders Most psychologists believe that mood disorders result from a combination of biological, psychological, and social factors. Biological factors seem to play an important role in the development of depression and, especially, bipolar disorder. But just as biology affects psychological experience, so does psychological experience alter biological functioning. Cognitive distortions, illogical and maladaptive responses to early negative life events, can lead to feelings of incompetence that are reactivated whenever a new situation arises that resembles the original events. This psychological factor has been found to operate in many depressed people, though it is uncertain whether the cognitive distortions cause the depression or are caused by it. Finally, social factors such as troubled relationships have been linked with mood disorders.

Suicide Suicide is the 11th leading cause of death in the United States. Although the largest number of suicides occurs among older white males, adolescents account for 12 percent of all suicide attempts. People considering suicide are overwhelmed with hopelessness. Suicide is depression in the extreme, and getting professional help is urgent.

Anxiety Disorders

In anxiety disorders, a person’s anxiety is inappropriate to the circumstances.

Specific Phobias Anxiety disorders have been subdivided into many specific diagnostic categories. One familiar subtype is specific phobia, an intense, paralyzing fear of something that it is unreasonable to fear so excessively. Another subtype is social phobia—excessive, inappropriate fears connected with social situations or performances in front of other people. Agoraphobia is a less common and much more debilitating type of anxiety disorder that involves multiple, intense fears such as the fear of being alone or of being in public places or other situations that require separation from a source of security.

Panic Disorder Panic disorder is characterized by recurrent panic attacks, which are sudden, unpredictable, and overwhelming experiences of intense fear or terror without any reasonable cause.

Other Anxiety Disorders Generalized anxiety disorder is defined by prolonged vague but intense fears that are not attached to any particular object or circumstance. Obsessive-compulsive disorder involves either involuntary thoughts that keep recurring despite the person’s attempt to stop them or compulsive rituals that a person feels compelled to perform. Two other types of anxiety disorder are caused by highly stressful events. If the anxious reaction occurs soon after the event, the diagnosis is acute stress disorder; if it occurs long after the event is over, the diagnosis is post-traumatic stress disorder.

Causes of Anxiety Disorders Some theorists believe phobias are prepared responses that evolution has made us biologically predisposed to acquire. Cognitive psychologists have suggested that people who believe they have no control over stressful events in their lives are more likely to suffer from anxiety. Psychologists with a biological perspective propose that a predisposition to anxiety disorders may be inherited because these types of disorders tend to run in families. Psychoanalytic theorists have focused on external psychological conflicts as the source of anxiety disorders.

Psychosomatic and Somatoform Disorders

Psychosomatic Disorders Psychosomatic disorders are illnesses that have a valid physical basis but are largely caused by
psychological factors such as stress and anxiety. In fact, many physicians now recognize that nearly every physical disease can be linked to psychological stress in the sense that such stress can negatively affect body chemistry, organ functioning, and the immune system.

Somatoform Disorders Somatoform disorders are characterized by physical symptoms without any identifiable physical cause. Somatization disorder is defined by vague, recurring, physical symptoms (such as back pains, dizziness, and abdominal pains) for which medical attention has been sought repeatedly but no organic cause found. Sufferers from conversion disorders have a dramatic specific disability for which there is no physical cause. In hypochondriasis, the person interprets some small symptom as a sign of a serious disease. Body dysmorphic disorder, or imagined ugliness, is a type of somatoform disorder characterized by extreme dissatisfaction with some part of one’s appearance.

Causes of Somatoform Disorders Freud concluded that somatoform disorders were related to traumatic experiences in a patient’s past. Cognitive behavioral therapists look for ways in which the symptomatic behavior is being rewarded. In some cases, diagnosed somatoform disorders were real physical illnesses that were overlooked or misdiagnosed.

Dissociative Disorders

In dissociative disorders, some part of an individual’s personality or memory is separated from the rest.

Dissociative Amnesia Dissociative amnesia involves the loss of at least some significant aspects of memory. When an amnesia victim leaves home and assumes an entirely new identity, the disorder is known as dissociative fugue.

Dissociative Identity Disorder In dissociative identity disorder—commonly known as multiple personality—a person has several distinct personalities that emerge at different times.

Depersonalization Disorder In depersonalization disorder, the person suddenly feels changed or different in a strange way.

Causes of Dissociative Disorders Dissociative disorders seem to involve unconscious processes, and biological factors may also play a role in some cases.

Sexual Disorders

The DSM-IV-TR recognizes three main types of sexual disorders: sexual dysfunction, paraphilias, and gender-identity disorders.

Sexual Dysfunction Sexual dysfunction is the loss or impairment of the ability to function effectively during sex. In men, this may take the form of erectile disorder, the inability to achieve or keep an erection; in women, it often takes the form of female sexual arousal disorder, the inability to become sexually excited or to reach orgasm. Sexual desire disorders are those in which the person either lacks sexual interest or has an active aversion to sex. People with orgasmic disorders experience both desire and arousal but are unable to reach orgasm. Other problems that can occur include premature ejaculation—the male’s inability to inhibit orgasm as long as desired—and vaginismus—involuntary muscle spasms in the outer part of a woman’s vagina during sexual excitement that make intercourse impossible.

Paraphilias Paraphilias involve the use of unconventional sex objects or situations. These disorders include fetishism, voyeurism, exhibitionism, frotteurism, transvestic fetishism, sexual sadism, and sexual masochism. One of the most serious paraphilias is pedophilia, the desire to have sexual relations with children.

Gender-Identity Disorders Gender-identity disorders involve the desire to become, or the insistence that one really is, a member of the other sex. Gender-identity disorder in children is characterized by rejection of one’s biological gender as well as the clothing and behavior society considers appropriate to that gender during childhood.

Personality Disorders

Personality disorders are enduring, inflexible, and maladaptive ways of thinking and behaving that are so exaggerated and rigid that they cause serious inner distress and/or conflicts with others.

Types of Personality Disorders One group of personality disorders is characterized by odd or eccentric behavior. For example, people who exhibit schizoid personality disorder lack the ability or desire to form social relationships and have no warm feelings for other people; those with paranoid personality disorder are inappropriately suspicious of others. Another cluster of personality disorders is characterized by anxious or fearful behavior. Examples are dependent personality disorder (inability to make decisions or do things independently) and avoidant personality disorder (social anxiety leading to isolation). A third cluster of personality disorders is characterized by dramatic, emotional, or erratic behavior. For example, people with narcissistic personality disorder display a grandiose sense of self-importance. Borderline personality disorder is characterized by marked instability in self-image, mood, and interpersonal relationships. People with antisocial personality disorder lie, steal, cheat, and show little or no sense of responsibility.

Causes of Antisocial Personality Disorder Antisocial personality disorder seems to result from a combination of biological predisposition, adverse psychological experiences, and an unhealthy social environment.

Schizophrenic Disorders

Schizophrenic disorders are severe conditions marked by disordered thoughts and communications, inappropriate emotions, and bizarre behavior that lasts for years. People with schizophrenia are out of touch with reality and usually cannot live anything like a normal life unless they are successfully treated with medication. They often suffer from hallucinations (false sensory perceptions) and delusions (false beliefs about reality).

Types of Schizophrenic Disorders There are several kinds of schizophrenic disorders, including disorganized schizophrenia, catatonic schizophrenia, paranoid schizophrenia, and undifferentiated schizophrenia.
Causes of Schizophrenia Research indicates that a biological predisposition to schizophrenia may be inherited. Part of the problem may lie in excessive amounts of dopamine in the central nervous system; pathology in various structures of the brain may also play a role. The development of schizophrenia may be influenced by environmental factors such as family relationships and social class. According to the systems model, genetic factors predispose some people to schizophrenia, and family interaction and life stress activate the predisposition.

Childhood Disorders

The DSM-IV-RT contains a long list of disorders usually first diagnosed in infancy, childhood, or adolescence.

Attention-Deficit/Hyperactivity Disorder Children diagnosed with attention-deficit/hyperactivity disorder (AD/HD) are easily distracted, often fidgety and impulsive, and almost constantly in motion. The most frequent treatment for children with AD/HD is the use of psychostimulants, drugs that increase the children’s ability to focus their attention.

Autistic Disorder Autistic disorder, a profoundly serious problem identified in the first few years of life, is characterized by a failure to form normal attachments to parents, lack of social instincts, and strange motor behavior.

Gender and Cultural Differences in Psychological Disorders

Gender Differences Studies have concluded that women have a higher rate of psychological disorders than men do, especially for the mood and anxiety disorders. There is controversy about what accounts for these differences, but it seems both socialization and biology play important roles.

Cultural Differences Many disorders occur only in particular cultural groups. The prevalence of some disorders among males and females and in children also differs markedly by culture.