

Psychological Disorders

Chapter 12 Brief Overview

Psychological Disorders

We have come a long way in developing an understanding of behavior. Many students find abnormal forms of behavior to be quite fascinating. Perhaps they see some symptoms in themselves and wonder what causes such abnormal behaviors. Our discussion of basic processes such as how neurotransmitters operate will help us understand some unusual forms of behavior. We will also see that learning plays a role in the development of some forms of abnormal behavior. However, the types of abnormal behavior we will describe often have no simple explanations; they are the result of an interaction of factors within and outside of the person.

Criteria of Abnormality

Psychologists have identified several criteria for distinguishing between normal and abnormal behaviors. Sometimes just one criterion will do; at other times, we may rely on more than one. The most commonly used criteria for distinguishing between normal and abnormal behaviors are statistical rarity, interference with normal functioning, personal distress, and deviance from social norms.

Statistical Rarity. A common way to define abnormal behavior is to determine how often the behavior occurs in the population. Abnormal literally means “away from the norm.” Thus a behavior that is abnormal does not occur very often. By itself, statistical rarity is clearly not a reliable indicator of what we should label abnormal.

Interference with Normal Functioning. Behavior is said to be dysfunctional when it interferes with a person’s ability to function on a daily basis. All of us probably experience some degree of anxiety every day, but imagine a level of anxiety that renders you unable to speak or eat in the presence of other people. That degree of anxiety would be dysfunctional because it would interfere with your day-to-day activities and might affect others who depend on you. Behavior that is dysfunctional is generally considered abnormal.

Personal Distress. People may be diagnosed as suffering from a psychological disorder if their behavior is upsetting, distracting, or confusing to themselves. The criterion of personal distress is useful in cases in which the psychological disorder is accompanied by discomfort. Imagine the distress felt by someone who believes that other people are “out to get” him or her or by a hopelessly depressed person who sees suicide as the only solution. Personal distress does not always accompany abnormal behavior, however.

Deviance from Social Norms. All social groups, ranging from your neighborhood to an entire society, decide which behaviors are acceptable for members of the group. The resulting guidelines, called social norms, are used to distinguish acceptable behaviors from unacceptable or deviant ones. Norms may be recorded as laws, like those that prohibit writing bad checks or running a red light. However, remember that norms differ from group to group and also change over time. For example, some groups might view body piercing as self-mutilation; other groups might see it as a valued expression of group solidarity or rebellion against conformity imposed from outside the group.

A Working Definition

Each of the criteria of abnormality that we have discussed has advantages and disadvantages. As mentioned, we often use several criteria simultaneously in making judgments about particular behaviors. In general, therefore, we can define behaviors as abnormal when they are statistically unusual, are not socially approved, and cause distress to the person or interfere with his or her ability to function.

However, it is important to keep several points in mind when making such judgments. Moreover, these judgments vary with social or cultural standards, which change over time.

The Concept of Insanity

On March 30, 1981, radio and television stations flashed a news bulletin: John Hinckley Jr. had shot and wounded President Ronald Reagan and three other people. At the time when Hinckley came to trial, federal law required prosecutors to prove that a defendant was sane. Hinckley's lawyers argued that their client had tried to kill the president to attract the attention of an actress. Experts testified that Hinckley suffered from a psychological disorder, but they disagreed about its severity. After deliberating the conflicting testimony, the jury returned a verdict of not guilty by reason of insanity.

How did the concept of an insanity plea develop? In 1843, an Englishman, Daniel M'Naughton, attempted to assassinate the prime minister of Great Britain, killing the minister's secretary. Convincing testimony at the trial supported the defense's contention that M'Naughton believed that the prime minister and others were conspiring against him. When the prosecution could not refute that testimony, the judge directed the jury to find M'Naughton not guilty by reason of insanity.

In most states, the current basis for determining insanity is the M'Naughton or "right-wrong" rule (Steadman et al., 1993): An accused individual is not held legally responsible if he or she was unable to tell the difference between right and wrong at the time of the crime. M'Naughton fired the gun in the belief that he was defending himself against individuals who were plotting to kill him. The determination of insanity is a legal decision (decided by a judge or a jury), not a psychological or psychiatric one, although psychologists and psychiatrists often offer testimony to the court in insanity cases.

Models of Abnormal Behavior

In their efforts to identify and explain abnormal behaviors, psychologists often adopt models, or general views of what causes those behaviors. Models help by pointing out which symptoms are most important, directing attention to their likely causes, and suggesting possible treatments. We can organize the models under two general headings: the medical model and psychological models.

The Medical Model. Physicians began to document their patients' symptoms and to note which ones occurred together. The occurrence of groups of symptoms, called syndromes, helped physicians identify underlying diseases and develop effective treatments. Approaching abnormal behaviors just as one would approach medical illnesses is known as the medical model.

Psychiatrist Thomas Szasz (1993) argues for limiting the medical model to conditions that result from actual brain dysfunctions. In his opinion, this model has been expanded to cover a range of behaviors that are perhaps annoying or inappropriate but are not diseases of the brain. For example, the list of proposed or recognized diseases includes shoplifting, pathological gambling, and nicotine dependence. According to Szasz, applying the medical model to such behaviors does nothing to advance our understanding of the causes of the problems and allows individuals to avoid taking responsibility for their problems by attributing them to a disease process.

The Psychological Models. In contrast to the medical model, various psychological models emphasize the importance of mental functioning, social experiences, and learning histories in trying to explain the causes of abnormal behaviors. Sigmund Freud's psychodynamic model focuses on unconscious conflicts involving the id, ego, and superego or fixations at an early stage of psychosexual development. For example, anxiety is seen as a warning that the ego is about to be overwhelmed by conflict. **The behavioral model** focuses on environmental factors that mold human and animal behaviors. Behavioral theorists such as John B. Watson and B. F. Skinner believed that we learn both normal and abnormal behaviors via the principles of classical conditioning, operant conditioning, and modeling discussed in Chapter 6. In contrast to the behavioral model, the cognitive model focuses on understanding the content

and processes of human thought. **Cognitive psychologists** claim that to understand human behavior, we must look beyond actual events to understand how people interpret those events.

The sociocultural model emphasizes the role of social and cultural influences on the frequency, diagnosis, and conception of psychological disorders. Among those influences are poverty and discrimination; these factors may promote a climate that increases the likelihood that psychological disorders will develop. Poverty is related to the prevalence of psychological disorders, and rates of psychological disorders are influenced by socioeconomic status (Bruce, Takeuchi, & Leaf, 1991; Dohrenwend et al., 1992).

The influence of culture is also seen in the fact that anorexia nervosa (see Chapter 9) occurs primarily in the United States and several other Western countries where thinness is considered a sign of female beauty. The lower rates of several psychological disorders in Taiwan compared to the United States may be due to cultural factors (Compton et al., 1991).

Classifying and Counting Psychological Disorders

DSM-IV

You walk into a mental hospital and report that you heard a voice say “empty,” “hollow,” and “thud.” You have no history of any psychological disorder, and except for giving the false report about hearing voices, you answer all questions truthfully. Will you be recognized as a fraud, or will you be diagnosed with a psychological disorder and treated for hearing voices in your head?

Can we tell the difference between normal and disturbed people?

Suppose that someone tells you that your cousin has suffered a nervous breakdown. You know that something is wrong, but you also have a number of unanswered questions. What are the symptoms? How serious are they? Are treatments available? When you ask these questions, you are asking whether there is a diagnosis. Diagnosis is the process of recognizing the presence of a disorder and naming it by using an existing classification system.

DSM-IV

The most frequently used system for classifying psychological disorders is the American Psychiatric Association’s **Diagnostic and Statistical Manual of Mental Disorders**, known as the DSM. More than 200 psychological disorders are listed in the fourth edition of the DSM, called DSM-IV (1994). The major DSM-IV categories and examples of each are listed in **Table 12-1**.

One reason for revising the DSM is that diagnoses based on the categories listed in earlier editions were not sufficiently reliable. At times, different mental health professionals who interviewed the same patient failed to agree on the diagnosis. To remedy this problem, the developers of the DSM added rules for making diagnoses. The DSM spells out the number, severity, and duration of symptoms that define a diagnostic category. These detailed rules have had the desired effect: The reliability of diagnoses has improved.

The Labeling Issue

Recall the vignette at the beginning of this section, in which we put you in the position of someone who walked into a mental hospital and reported hearing a voice say “empty,” “hollow,” and “thud.” Do you believe that the hospital staff could tell the difference between a normal and a disturbed person?

The pseudopatients could not escape the label, even when they were released from the hospital; they were given the diagnosis of “schizophrenia in remission.” These results suggest that the use of diagnostic labels can be a double-edged sword. Diagnosis can help advance our knowledge about the causes of disorders and aid in making treatment decisions, but diagnostic labels may also create a stigma that can be difficult

to overcome when looking for housing or a job or simply interacting with other people. Labels inevitably affect how we perceive and respond to others; our responses to those labeled as having a psychological disorder are often different from our responses to other people.

The Prevalence of Psychological Disorders

Epidemiologists study the distribution and factors associated with accidents, diseases, and psychological disorders. The data they collect are our best estimates of the numbers of people who suffer from various ailments and disorders. The information is also used to identify population subgroups (such as adolescents) that are susceptible to particular disorders, to plan and evaluate treatments, and to determine the need for additional health care services.

Epidemiologists are interested in the **prevalence of disorders**—the percentage of a population experiencing a given disorder during some specified period. For example, if 500 people in a population of 10,000 had the flu during the past 6 months, the 6-month prevalence for flu would be 5 percent (500/10,000). Questions like “Did you have the flu at any time during your life?” yield lifetime prevalence figures.

The incidence of a disorder is the rate (or number) of new cases reported during a given period. If there were 100 newly diagnosed cases this year, the incidence of flu in our population of 10,000 would be 1 percent.

Anxiety, Somatoform, and Dissociative Disorders

One day while driving home, Deborah realized that her heart suddenly began racing; she was also dizzy, short of breath, and sweating profusely. Afraid that she might pass out, she rolled down the car window to let cold air rush across her face. Over the next several months, the attacks occurred more frequently—at the bank, the laundromat, the grocery store, almost everywhere. She opted to drive the side streets to and from work out of fear that she might be caught in traffic during an attack. Deborah began to think she was going crazy or was about to die. As she read the obituaries in the morning newspaper, she thought the deceased were lucky because “they didn’t have to go on anymore.” Eventually she was unable to leave home; she was even afraid to walk across the backyard to her neighbor’s house.

Anxiety Disorders

Giving a speech in class, waiting to take an exam, interviewing for a job—what do these experiences have in common? You may feel a bit apprehensive and uncomfortable in each of these situations. Does the word anxious come to mind? At moderate levels, anxiety is normal and expected; indeed, it often provides the motivation needed to give an outstanding speech, do well on an exam, or get a good job. However, high levels of anxiety are distressing and interfere with effective functioning.

Phobias. As we saw in Chapter 5, a phobia is an intense, excessive fear of an activity, object, or situation. The fear in a phobia is out of proportion to the real danger, and it is difficult to overcome. If your concern about facing fear-arousing stimuli leads to efforts to avoid those stimuli, you may have a **phobia**.

The DSM-IV organizes phobias into three categories: agoraphobia, social phobia, and specific phobia.

Agoraphobia (literally “fear of the marketplace”) is the most common phobia treated in mental health clinics. Most people with agoraphobia are women who avoid public places or situations from which it would be difficult to escape if they developed embarrassing or incapacitating symptoms such as dizziness or vomiting. They prefer the safety of a private place, quite often their home.

Different phobias tend to develop at different ages. Agoraphobia usually begins in one's twenties; **social phobias**, such as fear of speaking in front of a group, usually begin between ages 10 and 19. **Specific phobias**—fears of particular objects or situations—often begin between ages 5 and 9 (Ost, 1987). Examples of specific phobias are the fear of blood (hemophobia), fire (pyrophobia), and heights (acrophobia) (see Table 12-2).

How do phobias develop? On the basis of their study of Little Albert (see Chapter 6), John B. Watson and Rosalie Rayner (1920) proposed that phobias are learned through classical conditioning. A phobia may result when a formerly neutral stimulus (such as a white rat) becomes associated with a fear-producing stimulus (such as a loud noise). Through this association, the neutral stimulus becomes a feared stimulus; that is, it is now the conditioned stimulus (CS) or phobic stimulus.

Panic Disorder. At the beginning of the section we met Deborah, who experienced symptoms such as a racing heart and difficulty breathing while driving home. Do these symptoms suggest that she is suffering from a psychological disorder?

Panic attacks, which are intense physiological reactions that occur even in the absence of an emergency. Within seconds, the heart rate can accelerate by 50 or more beats per minute (see Figure 12-4). Such attacks can last from a few minutes to more than an hour. About half the people who suffer from panic attacks also experience agoraphobia.

What causes such attacks? The symptoms can be induced by administering an injection of sodium lactate (a chemical whose level in the body increases after vigorous exercise) to individuals with a history of panic attacks. Two other findings also support a biological cause: (1) Panic disorder occurs at a higher rate among family members of victims than in the general population (Clum, 1990), and (2) victims respond well to antidepressant drugs such as imipramine (Tofranil) or fluoxetine (Prozac) (Yudofsky, Hales, & Ferguson, 1991). (3) Suffocation Response the person responds to respiratory cues inappropriately they may think they are going to suffocate However, the cognitive model offers a different explanation for this disorder.

Cognitive psychologists suggest that panic attacks occur when the bodily sensations of anxiety are misinterpreted as signs of impending disaster. Rather than attributing the symptoms to stressors in their lives, victims of panic disorder view them as indicators of a serious physical problem such as a heart attack (McNally, Hornig, & Donnell, 1995). This interpretation increases their arousal during and after an attack and makes them more vigilant about physical signs in the future.

Generalized Anxiety Disorder. Imagine walking around each day feeling on edge. Every muscle is tense, your mouth is dry, and you worry constantly about topics such as school, career, and relationships. This condition, termed generalized anxiety disorder, typically begins in one's twenties or thirties. The anxiety characterizing this disorder is called "free-floating" because it is not brought on by one specific stimulus. The distress resulting from chronic worry often leads to additional symptoms of depression.

Generalized anxiety disorder, along with some other anxiety disorders, may result from low levels of the inhibitory neurotransmitter gamma-aminobutyric acid (GABA; see Chapter 2). Anxiety often occurs when there is a high level of nerve impulses in brain circuits related to fear and vigilance. Elevated levels of GABA can block this neurological activity; low levels allow it to occur, and the result can be what we term anxiety.

Obsessive-Compulsive Disorder. "Did I turn off the stove?" "Are the windows closed?" Do thoughts like these run through your mind occasionally? If so, you are like most people. But some people are dominated by thoughts of this kind or worse. Intrusive, recurrent, persistent thoughts, impulses, or images (singly or in combinations) that are inappropriate and appear "out of the blue" are obsessions. They can cause such unbearable anxiety that some individuals feel they must do something to get rid of or reduce their occurrence. These people may check the stove or windows over and over each day. The repeated, irresistible behaviors (e.g., hand washing) or mental acts (e.g., counting) that often follow obsessions are called compulsions. Obsessions and compulsions may occur separately, but most people with obsessive-

compulsive disorder (OCD) have both of them (Foa & Kozak, 1995; Nymberg & Van Noppen, 1994). Table 12-3 lists some common obsessions and compulsions.

Behavioral psychologists view compulsions as learned habits that reduce anxiety. That is, the compulsive behavior has been associated with anxiety reduction through operant conditioning.

Somatoform Disorders

Somatoform disorders involve complaints of bodily symptoms (soma means “body”) that do not have a medical cause; instead, psychological factors are involved. Do not confuse somatoform disorders with the psychophysiological disorders. Psychophysiological disorders have a medical basis; in the case of ulcers, for example, digestive juices erode the stomach lining. These disorders generally occur in parts of the body that are controlled by the autonomic nervous system, such as the digestive tract; in contrast, somatoform disorders usually affect parts that are controlled by the central nervous system, such as the sensory organs or the limbs. Among the somatoform disorders listed in the DSM-IV are hypochondriasis, somatization disorder, and conversion disorder.

Hypochondriasis. Hypochondriasis is a preoccupation with physical symptoms that are believed to indicate a serious illness; it occurs equally in men and women. People with hypochondriasis detect aches, pains, or bodily changes that many of us would ignore; they interpret these signs as proof that they are suffering from some dire, though undiagnosed, disorder. This belief is genuine; they do not voluntarily produce their symptoms. Despite repeated assurances of good health, they are never convinced and continually consult one physician after another.

Somatization Disorder. Individuals with somatization disorder present vague but complicated and dramatic medical histories, usually beginning in their teenage years. In contrast to hypochondriasis, which centers on some specific disease, somatization disorder involves a large number of gastrointestinal, pain, sexual, and neurological symptoms. The symptoms cause significant suffering that leads victims to consult physicians who inevitably fail to find a medical basis for physical complaints that do not correspond to recognized diseases (Margo & Margo, 1994). The disorder occurs more frequently in women than in men, although physicians may be less likely to recognize it in men (Golding, Smith, & Kashner, 1991).

Conversion Disorder. A loss or impairment of motor or sensory function that does not coincide with the organization of the nervous system is a conversion disorder. For example, a patient who reports paralysis of the wrist may still be able to move the fingers (see Figure 14-5), even though the fingers and wrist are on the same nerve pathway. Sensory symptoms include blindness, deafness, and inability to feel sensations in some parts of the body, even though the sensory system is not damaged. Such symptoms are real to these individuals, who do not feel that they produce them voluntarily. Nevertheless, there is no obvious medical explanation for the symptoms and the disability they produce.

The stress that can lead to a conversion disorder does not have to be life-threatening. For example, in April 1989, hundreds of middle and high school performers gathered to present a concert for 2,000 spectators in Santa Monica, California. Just after the performance began, several students complained of dizziness, headaches, and nausea. The rapid development of these symptoms halted the concert and sent some students to the hospital. The symptoms lasted for a brief time and occurred only among the performers, not among the spectators who had shared the environment (Small et al., 1991). The development of physical symptoms without a medical cause in a number of people is called mass psychogenic illness or mass hysteria.

Dissociative Disorders

Dissociative disorders involve a disruption in a particular function of the mind, such as memory or self-awareness, usually in response to extreme stress. These rare disorders are dramatic and have been the

basis of plots for movies, books, and television shows. Dissociative disorders include dissociative amnesia, dissociative fugue, and dissociative identity disorder (multiple personality).

Dissociative Amnesia and Dissociative Fugue.

An individual with **dissociative amnesia** is unable to recall important personal information. The memory impairment is too extensive to be due to normal forgetting; it may involve a specific traumatic event, most of the person's life, or a stretch of time ending in the present. Dissociative amnesia occurs suddenly, does not affect storage of new information, and frequently ends as abruptly as it began.

When amnesia is accompanied by travel, the person is suffering from **dissociative fugue**. People with this disorder may leave a stressful environment and take up residence in a distant city, with a new identity and no memory of their past life. Recovery is often sudden, and the victim's recall of the episode is no better than a dream. Cases of dissociative fugue are fascinating but rare; more typical cases, although still infrequent, involve wandering away from a natural disaster.

Dissociative Identity Disorder. The presence of more than one personality in a single individual, dissociative identity disorder (multiple personality), is the most dramatic dissociative disorder. Although it was once thought to be extremely rare, mental health professionals are reporting significant numbers of cases of dissociative identity disorder, which suggests that perhaps the disorder is not rare but underdiagnosed. Most cases of dissociative identity disorder are associated with an early childhood history of sexual or physical abuse (Coons, Bowman, & Milstein, 1988; Lowenstein, 1994). Children are ill-equipped to cope with the trauma of abuse and may split off new personalities in an attempt to deal with it, in much the same way that some children invent imaginary playmates. There are usually three or four personalities, although more than 100 have been reported in a single individual.

Mood Disorders

Depression

Clinical forms of depression are more severe than what we might term "the blues." How do we recognize depression, and how common is it?

Symptoms. The most obvious symptoms of depression are sadness, a lack of interest in previously pleasurable activities, and reduced energy. Depressed people often describe themselves in the most unflattering terms: undesirable, inferior, unattractive. They do not see themselves as capable of completing intellectually demanding tasks; reports of difficulty in concentrating and complaints of memory problems are common. This negative self-evaluation extends to their views of the world and the future. They torture themselves with guilt over what they see as past failures and inadequacies, and the future holds no promise of improvement. Moreover, they may blame themselves for a host of negative events, including ones that have no connection to them, yet they rarely credit themselves for any achievements. This sense of worthlessness and utter hopelessness makes them very vulnerable to thoughts of suicide. Other symptoms of depression can occur in different and even opposite ways. Two forms of insomnia are frequently associated with depression: difficulty falling asleep (sleep-onset insomnia) and awakenings early in the morning with an inability to return to sleep (see Chapter 5). Conversely, about 10 to 20 percent of depressed individuals greatly extend their sleep, perhaps to provide temporary refuge (Kupfer & Reynolds, 1992). Depression seems to occur in all cultures; the similarities in depression across cultures are more apparent than the differences. However, one difference does stand out: the tendency for depressed people in Western countries to exhibit guilt and self-reproach more often than people in non-Western countries (Marsella et al., 1985).

Prevalence and Course. Depression strikes rich and poor, young and old, men and women, the famous (the words in the quote on p. xxx are those of Abraham Lincoln) and the unknown. Approximately 6 percent of adults have experienced at least one episode of major depression (Weissman et al., 1991). Milder forms of depression (dysthymia) are so common that it is known as the “common cold of psychological disorders.”

Given the traditional gender roles in most societies, women are more likely to assume a passive role, whereas men are more likely to overcome the depression. Sexual and physical abuse is another factor that puts women at risk for depression. Although marriage may create a protective buffer against depression, the advantage is greater for men than it is for women. Mothers of young children are especially vulnerable to depression. Finally, poverty is a “pathway to depression,” and the rate of poverty is especially high among women and children (McGrath et al., 1990).

What accounts for this “epidemic of depression”? Close family and community ties are important in preventing depression. For example, the Amish people have maintained their customs in rural farming communities for generations. Their strong and supportive families and community provide comfort and aid in times of need. When an Amish family loses a barn to a fire or other disaster, neighbors join together to rebuild it. Depression occurs among the Amish at about one-fifth to one-tenth the rate as it does among people in, say, the city of Baltimore (Seligman, 1989). It is very probable that their close-knit families and strong sense of community provide the Amish with a buffer against depression.

The symptoms of depression are somewhat more likely to occur at certain times during the year. Although the majority of people notice mood changes related to the seasons, some are so susceptible to these changes that they develop a form of depression called seasonal affective disorder (SAD) (Rosenthal, 1989). The reduced levels of light during winter are associated with greater sleep length, social withdrawal, increased appetite (especially for carbohydrates), weight gain, and fatigue. The symptoms of SAD may be related to levels of the hormone melatonin, which is secreted by the pineal gland.

In the United States, someone commits suicide every 17 minutes (approximately 30,000 deaths and 200,000 attempts a year); in 1992, 1.4 percent of all deaths were suicides. Compared to other countries, the suicide rate in the United States is moderate. Hungary has the highest rate of suicide; other countries with high suicide rates are Denmark, Finland, and Sweden. Italy, Spain, and Greece have low rates of suicide.

Suicide is the ninth most frequent cause of death overall but the third most frequent cause of death for individuals aged 15 to 24. Between 1980 and 1992 there were significant increases in the suicide rates for two age groups: a 28 percent increase for ages 15 to 19 and a 120 percent increase for ages 10 to 14.

Suicide is about three times more frequent among men than among women. Married people have the lowest suicide rates; divorced people have the highest rates.

About 50 percent of college students have thought about suicide, and 5 to 6 percent have made suicide attempts

Bipolar Disorder

Will experienced an episode of extreme euphoria known as mania. Manic symptoms can result from cocaine or amphetamine use or hyperthyroidism; therefore, these possibilities must be considered when making a diagnosis and planning treatment (Werder, 1995). The knowledge that mood disorders run in families is helpful:

Will’s mother had been treated for depression, and an uncle had numerous hospitalizations for mania and depression. Will’s episode of mania was a mood disorder; it was followed by depression, and the diagnosis was bipolar disorder.

The depression and mania in bipolar disorder may occur simultaneously, but they usually alternate, often separated by periods of relative normalcy. During a manic episode, boundless energy replaces the fatigue of depression; sadness and despair give way to euphoria and elevated self-esteem. Depression often reduces the desire for sex; mania often brings uncharacteristic promiscuity. Manic individuals become highly sociable, although irritability lurks beneath the surface should anyone question their plans. They ignore painful or harmful consequences of their behavior and may incur huge debts, break the law, or make unwise business and personal decisions. Fortunately, bipolar disorder responds quite effectively to treatment with lithium (see Chapter 15), which was the treatment prescribed for Will.

Bipolar disorder is less prevalent than depression; it affects about 1 percent of the population with equal rates in men and women. Most often, the symptoms begin in a person's twenties (Werder, 1995), as they did for Will. Like many other disorders, bipolar disorder often occurs with other disorders, especially substance abuse or dependence (Tohen, 1994).

Causes of Mood Disorders

Biological Explanations. For several reasons, biological factors are thought to play a role in the development of mood disorders. First, as noted earlier, the symptoms of depression tend to be rather similar across cultures, suggesting a common underlying biological cause. Second, certain drugs such as Elavil and Prozac reduce depression, and mania responds to treatment with lithium. Third, mood disorders tend to run in families, which suggests genetic transmission. Nevertheless, researchers agree that rising rates of depression in this century are unlikely to result from genetic factors; psychological and social factors must also be considered. Explaining mood disorders as the result of abnormal levels of certain neurotransmitters seems to be simple and straightforward. However, this theory cannot account for an interesting finding: Antidepressant drugs alter neurotransmitter levels almost immediately, yet depression may take as long as 2 weeks to lift after the start of drug treatment. Moreover, the activity of neurotransmitters may respond to environmental factors. Thus, although individuals with mood disorders may inherit a tendency to develop these disorders, other factors need to be understood to complete the picture.

The Psychodynamic Explanation. The psychodynamic model emphasizes early childhood experiences as the foundation of adult behavior and emotional reactions. An infant depends on its caregiver, usually its mother. As its needs are met, the infant feels supported and loved, and attachment develops (see Chapter 10). However, the mother must leave at times, temporarily or perhaps permanently. When this happens, the child may experience rage at being abandoned, yet is ambivalent (feeling both love and rage) because the mother was also a source of comfort and love. The rage is turned against a more convenient and acceptable target—the child itself.

Cognitive and Behavioral Explanations. Suppose that you have been looking for a job for over a year, to no avail. Some job seekers might decide that they simply cannot get a job. They give up because they believe that no amount of searching will succeed. In short, if nothing they do makes a difference, why do anything at all? Under such circumstances, according to Martin Seligman (1975/1992), a psychological state known as learned helplessness may develop. Learned helplessness occurs when we believe that we have no control over the reinforcements in our lives, such as finding a job or getting a good grade on an exam.

Explanatory style consists of three significant dimensions: permanent versus temporary, universal versus specific, and internal versus external. When bad events happen, we may view them as permanent or temporary. If you think about bad things in terms of “always” and “never,” you have a permanent pessimistic style. Explanations may also be specific to the situation or universal, applying to all situations. People who rely on universal explanations for their failures often give up on everything when a failure strikes in one area. Finally, our explanations may be either internal (we blame ourselves) or external (we believe outside forces are at work); people who use internal explanations find that their self-esteem is lowered significantly.

Schizophrenia

What are the symptoms of schizophrenia?

The Swiss psychiatrist Eugen Bleuler (1857-1939) coined the word schizophrenia, which literally means “splitting of the mind.” Schizophrenia is one of the psychotic disorders. Psychosis is a general term for disorders in which severely disturbed individuals lose contact with reality and may require hospitalization.

The symptoms of schizophrenia usually appear around age 20, although deficiencies in attention and emotional responses are frequently noted during childhood. Approximately 1.5 percent of the adult population has had the disorder (Carpenter & Buchanan, 1994). Although the rate of schizophrenia is about equal in men and women, it strikes men earlier (Beratis, Gabriel, & Hoidas, 1994). The symptoms frequently lead to significant social and occupational impairment (Breier et al., 1991). The overall death rate among victims of schizophrenia is twice the expected rate, in part because the suicide rate is ten times higher than it is among the general population (Allebeck, 1989).

Schizophrenia is often confused with dissociative identity disorder. However, the “split” in schizophrenia is not among different personalities; it is a split from reality as well as a split between thoughts and emotions. As we discuss this disorder in detail, keep these two points in mind: Schizophrenia is not dissociative identity disorder, and it is far more prevalent.

Symptoms of Schizophrenia

Schizophrenia involves an extraordinary range of symptoms, none of which is present in all cases. There may be disturbances in perception, language, thinking, and emotional expression. How can we make sense of this array of symptoms? A new approach to classifying symptoms seems to hold promise; it is based on two types of symptoms: positive and negative.

Positive Symptoms. The positive symptoms of schizophrenia are distortions or excesses of normal functions, such as fluent but disorganized speech, delusions, and hallucinations. While listening to the speech of a patient with schizophrenia, you may struggle to follow his or her train of thought. The ideas expressed can be like a train that has slipped off the track onto another, unrelated track; this pattern of speech is called loose associations. Some patients use neologisms, common words used in uncommon ways (“I wrote the letter with my writing toy”) or newly created words (“I wrote the letter with my zemps”). Words may be strung together in ways that seem to follow grammatical rules, yet the words form an incoherent collection called a word salad. A simple question like “What brought you here?” can give rise to an odd response like “The, my, not, rode, for, new, cold, it, what, may, so”

Among the most frequently observed positive symptoms are delusions, or false beliefs that cannot be corrected in spite of evidence. **Delusions** can appear in numerous forms. Individuals with persecutory delusions (the most common) believe that others are tormenting, following, or ridiculing them. Some delusions are bizarre, as is evident in the case of a patient who said she was “persecuted by a secret insect from the District Office” (Spitzer et al., 1994). A delusion of grandeur is the belief that a person has special powers or abilities; a delusion of control is the belief that one’s thoughts, feelings, and actions are controlled by some other person or outside force.

Schizophrenia often alters perceptions of the world. Objects take on unusual dimensions, and sensations seem to materialize from thin air. A frequent perceptual symptom is the hallucination (from a Latin word meaning “to wander mentally”). **Hallucinations** are perceptions that are not caused by stimulation of the relevant sensory organ. They can occur in any of the senses, although auditory hallucinations are the most common. The person may hear voices that give orders, criticize, or offer ongoing commentary. Visual hallucinations, such as George’s seeing a stove turn into a devil, are less common.

Negative Symptoms. Negative symptoms are reductions or losses of function. These behavior deficits or defects include poverty of speech as well as disturbances in affect and volition (McGlashan & Fenton, 1992). These symptoms are associated with poorer outcomes and more cognitive impairment than positive symptoms (Andreasen et al., 1990; Fenton & McGlashan, 1991).

The speech of people with schizophrenia may be adequate in amount yet convey little information: Language that is vague, too abstract, too concrete, or repetitive is termed poverty of content. Poverty of speech is a restriction in the amount of spontaneous speech and is evident in brief and unelaborated replies to questions. Interviewers frequently find it necessary to prompt the individual for additional information (Andreasen & Black, 1995).

Subtypes of Schizophrenia

The DSM-IV describes five subtypes of schizophrenia: catatonic, disorganized, paranoid, residual, and undifferentiated (see Table 12-7). Although the prevalence of schizophrenia is similar around the world, rates of diagnosis of the subtypes differ. For example, disorganized schizophrenia accounts for about 50 percent of diagnoses of schizophrenia in Japan but only about 10 percent in other countries (Nakane, Ohta, & Radford, 1992). Such differences may be due to diagnostic, social, or cultural factors.

Each subtype of schizophrenia is characterized by a different set of symptoms, although distinctions among the types are not always clear-cut. Indeed, one subtype—undifferentiated—is really a catchall category for cases that do not fit into other subtypes. A patient may exhibit the symptoms of different subtypes of schizophrenia at different times during the course of the disorder.

Causes of Schizophrenia

The search for what causes schizophrenia is difficult because there are no physical tests for the disorder and no animal models exist. Moreover, researchers are not sure if schizophrenia results from a single process or several processes. There have been many false leads and potential breakthroughs. Currently considered to be among the possible causes are genetic factors, brain abnormalities, altered neurotransmitter levels, and environmental factors.

Genetic factors. We noted earlier that approximately 1.5 percent of the population develops schizophrenia, so the answer to the first question is about 1.5 percent. Because schizophrenia runs in families, the odds that it will occur in a person selected from a family with a member who has the diagnosis are greater than 1.5 percent. How much greater depends on the person's relationship to the family member with schizophrenia. Figure 14-8 lists the risk (odds) of developing schizophrenia for various family members. The risk increases as the degree of genetic relatedness increases (Gottesman, 1991). Thus having a brother or sister with schizophrenia raises the risk to 9 percent; the risk spirals to 46 percent for children of two schizophrenic parents. Beth's baby has about a 5 percent chance of developing schizophrenia because the grandfather (Beth's father) was schizophrenic; the risk for the grandchild of an individual with schizophrenia is 5 percent. Moreover, the concordance rates across several reports are 48 percent for identical twins and 17 percent for fraternal twins (Gottesman, 1991). In sum, this research has produced evidence suggesting that schizophrenia may be transmitted genetically.

Brain Abnormalities. A promising area of research on the causes of schizophrenia is the study of brain abnormalities. A number of studies using different methods have demonstrated that patients with schizophrenia have significantly larger cerebral ventricles—fluid-filled chambers in the brain—than nonschizophrenic individuals and therefore have smaller brain areas (Lickey & Gordon, 1991; Suddath et al., 1990). For example, limbic-area brain structures such as the hippocampus are smaller in persons with schizophrenia (Cannon & Marco, 1994). The limbic system plays a role in emotional response, memory, and other functions (see Chapter 2). These differences—larger ventricles and smaller limbic structures—are apparently sensitive indicators of the presence of schizophrenia.

Neurotransmitters. Available evidence suggests that the neurotransmitter dopamine (see Chapter 2) plays a role in producing schizophrenia. Certain drugs, such as amphetamines and cocaine, can induce some of the symptoms of schizophrenia, and these drugs are known to raise dopamine levels in the brain. The brains of schizophrenic persons may have more dopamine receptors, or their dopamine receptors may be more sensitive. Moreover, levels of dopamine activity may differ in different parts of the brain, and this could account for some of the variations in the symptoms of schizophrenia.

Environmental Causes. Genetic and various biological factors are not the only possible causes of schizophrenia. Consider the following: Schizophrenia runs in families, and identical twins are concordant for schizophrenia more often than fraternal twins. Yet 89 percent of all schizophrenic individuals do not have a schizophrenic parent, and 81 percent do not have a schizophrenic parent, sister, or brother (Gottesman, 1991). A series of studies have demonstrated a relationship between home environment and the risk of relapse for patients with schizophrenia who live with family members. These studies have focused on expressed emotion (EE), the degree to which family members are critical, hostile, or overinvolved with the patient.

In sum, it appears that no one inherits the specific symptoms of schizophrenia, although genetic factors play a role in a person's chances of developing the disorder. What is inherited? Irving Gottesman (1991) suggests that "what is inherited is a predisposition toward developing the disorder—a loading of nature's dice that increases the risk of developing schizophrenia" (p. 91). The child of a schizophrenic parent is at higher risk for developing the disorder than the cousin of an individual with schizophrenia. Whether a child actually develops schizophrenia is determined by a number of environmental factors, none of which has been clearly identified to date.

Personality Disorders

Personality Disorders

Personality disorders are long-standing patterns of maladaptive behavior that are usually evident during the adolescent years and are resistant to treatment, which is seldom sought. Approximately 10 percent of the adult population may have one or more personality disorders. The high rate of comorbidity of personality disorders with other psychological disorders as well as with medical conditions complicates both diagnosis and treatment (Oldham, 1994). Moreover, many individuals with personality disorders are convinced that if a problem exists, it lies not in them but in other people's reactions to their behaviors. The DSM-IV describes a number, **(10) currently**, of personality disorders, but a great deal of attention has focused on one of them: the antisocial personality disorder. About 5 to 6 percent of adult men and 1 percent of adult women would meet the criteria for this diagnosis (Kessler et al., 1994; Robins, Tipp, & Przybeck, 1991). Consider Chuck, whom we described at the beginning of the section. Is his long-standing pattern of deviant behavior characteristic of a psychological disorder?

Sexual Disorders

The DSM-IV divides sexual disorders into several categories: gender identity disorder (transsexualism), the paraphilias, and sexual dysfunctions. In this section we will discuss the first two categories.

Gender Identity Disorder. Are you a male or a female? Although this seems like a silly question, for people with a gender identity disorder it is a serious matter. Beginning in childhood, some people believe that their anatomical sex does not match their gender identity. Many cases of gender identity disorder in childhood cease by the time the individual reaches adolescence, but some cases progress into what is known as transsexualism.

Transsexualism is a disorder in which a person is uncomfortable with his or her anatomical sex, views it as inappropriate, and wants to be a member of the other sex. This rare disorder occurs in 1 in 30,000 biological males and 1 in 100,000 biological females (American Psychiatric Association, 1994). The only

effective treatment is sex-reassignment surgery, in which surgeons create external sex organs that are characteristic of the other biological sex. Mental health professionals screen the candidates for sex reassignment surgery to ensure that disorders like schizophrenia are not present.

Paraphilias. Paraphilia literally means “love beyond the usual” (Money, 1984). People with paraphilias are sexually aroused by objects or situations that are considered unusual or bizarre by most people, ranging from animals to dressing in the clothes of the other sex. Most of these individuals are males; their unusual activity is typically harmless or involves consenting others. However, some can be dangerous and may come into contact with legal authorities. This is especially true of pedophiles, who are sexually aroused by children.

Table 12-9 lists some of the more common paraphilias.