

Key Questions/ Chapter Outline

Core Concepts

Psychology Matters

12.1 What Is Psychological Disorder?

Changing Concepts of Psychological Disorder
Indicators of Abnormality
A Caution to Readers

- The medical model takes a “disease” view, while psychology sees psychological disorder as an interaction of biological, mental, social, and behavioral factors.

The Plea of Insanity

It’s not a psychological or psychiatric term, and, contrary to popular opinion, it is a defense that is seldom used.

12.2 How Are Psychological Disorders Classified in the DSM-IV?

Overview of the *DSM-IV* Classification System
Mood Disorders
Anxiety Disorders
Somatoform Disorders
Dissociative Disorders
Schizophrenia
Developmental Disorders
Adjustment Disorders and Other Conditions
Gender Differences in Mental Disorders

- The *DSM-IV*, the most widely used system, classifies disorders by their mental and behavioral symptoms.

Shyness

If you have it, it doesn’t have to be permanent. (And, by the way, it’s not a mental disorder.)

12.3 What Are the Consequences of Labeling People?

Diagnostic Labels, Labeling, and Depersonalization
The Cultural Context of Psychological Disorder

- Ideally, accurate diagnoses lead to proper treatments, but diagnoses may also become labels that depersonalize individuals and ignore the social and cultural contexts in which their problems arise.

Using Psychology to Learn Psychology

It will be tempting, but your authors caution against using your new knowledge of mental disorders to diagnose your friends and family.

Critical Thinking Applied

Insane Places Revisited—Another Look at the Rosenhan Study

chapter 12

psychological disorders



The volunteers knew they were on their own. If they managed to get into the hospital, the five men and three women knew that they would be treated as mental patients, not observers. None had ever been diagnosed with a mental illness, but perhaps they were not so “normal” after all: Would a normal person lie to get into such a place? In fact, all were collaborators in an experiment designed to find out whether normality would be recognized in a mental hospital.

The experimenter, David Rosenhan—himself one of the pseudopatients—suspected that terms such as *sanity*, *insanity*, *schizophrenia*, *mental illness*, and *abnormal* might have fuzzier boundaries than the psychiatric community thought. He also suspected that some strange behaviors seen in mental patients might originate in the abnormal atmosphere of the mental hospital rather than in the patients themselves. To test these ideas, Rosenhan and his collaborators decided to see how mental hospital personnel would deal with patients who were, in fact, not mentally ill.

Individually, they applied for admission at different hospitals, complaining that they had recently heard voices that seemed to say “empty,” “hollow,” and “thud.” Aside from this, they claimed no other symptoms. All used false names, and the four who were mental health professionals gave false occupations—but, apart from these fibs, the subjects answered all questions truthfully. They tried to act normally, although the prospect of entering the alien hospital environment made them feel anxious; they also worried about not being admitted and—worse yet—being exposed as frauds. Their concerns about fraud vanished quickly, for all readily gained admittance at 12 different hospitals (some did it twice). All but one were diagnosed with “schizophrenia,” a major psychological disorder often accompanied by hearing imaginary voices.

After admission, the pseudopatients made no further claims of hearing voices or any other abnormal symptoms. Indeed, all wanted to be on their best behavior to gain release. Their only apparent “deviance” involved taking notes on the experience—at first privately and later publicly, when they found that the staff paid little attention. The nursing records indicated that, when the staff did notice, they interpreted the note taking as part of the patient’s illness. (One comment: “Patient engages in writing behavior.”) But for the most part, the patients found themselves ignored by the staff—even when they asked for help or advice. When the staff did interact with the patients it was as though the patients were simply “patients,” not persons. Consequently, it took an average of 19 days for the pseudopatients to convince the hospital staff that they were ready for discharge, despite the absence of abnormal symptoms. One unfortunate volunteer wasn’t released for almost two months.

Two main findings from this classic study jarred the psychiatric community to its core. First, *no professional staff member at any of the hospitals ever realized that any of Rosenhan’s pseudopatients was a fraud.* Of course, the staff may have assumed that the patients had been ill at the time of admission and had improved during their hospitalization. But that possibility did not let the professionals off Rosenhan’s hook: Despite apparently normal behavior, not one pseudopatient was ever labeled as “normal” or “well” while in the hospital. And, on discharge, they were still seen as having schizophrenia—but “in remission.”

The mistaken diagnosis does not suggest that the hospital staff members were unskilled or unfeeling. The fact that they did not detect the pseudopatients’ normal behavior is probably because, busy with other duties, they spent little time observing and interacting with the patients. Most of the time they kept to themselves in a glassed-in central office that patients called “the cage.” As Rosenhan (1973a) said:

It could be a mistake, and a very unfortunate one, to consider that what happened to us derived from malice or stupidity on the part of the staff. Quite the contrary, our overwhelming impression of them was of people who really cared, who were committed and who were uncommonly intelligent. Where they failed, as they sometimes did painfully, it would be more accurate to attribute those failures to the environment in which they, too, found themselves than to personal callousness. Their perceptions and behavior were controlled by the situation. (p. 257)

CONNECTION • CHAPTER 11

Social psychology has also emphasized the power of the situation on behavior.

The mental hospital, then, may become another example of a “sick” system that we discussed in the last chapter.

A second finding tells us volumes about the patients and the nature of psychological disorder itself: *To everyone’s surprise, the hospital patients readily detected the ruse, even though the professional staff did not.* The pseudopatients reported that the

other patients regularly voiced their suspicions: “You’re not crazy. You’re a journalist or a professor. . . . You’re checking up on the hospital.” In his report of this experience, entitled “On Being Sane in Insane Places,” Rosenhan (1973a) noted dryly: “The fact that the patients often recognized normality when staff did not raises important questions” (p. 252). You will hear the echo of these “important questions” as we critically examine the medical view of mental disorder in this chapter.

Here’s the problem that the Rosenhan study raises for us:

PROBLEM: Can we reliably distinguish mental disorder from merely unusual behavior?

This is the issue around which this chapter is organized. Please note that Rosenhan did not deny the existence of psychological disorders. Rather, he called into question the *reliability* of psychiatric diagnoses. People *do* suffer the anguish of **psychopathology** (also called *mental disorder* or *mental illness*). According to the National Institute of Mental Health (NIMH), over 26% of the U.S. population—more than one in four Americans—suffer from diagnosable mental health problems in a given year (2008d). For one in 17 it will be a mental illness of serious proportions, such as major depression, schizophrenia, or another debilitating disorder. Over the lifespan, an estimated 46% of Americans will suffer from some psychological disorder (Butcher et al., 2008). Again, Rosenhan was not suggesting that these conditions do not exist or do not exact a horrendous toll in human suffering—just that it can be difficult to distinguish normality from abnormality.

Rosenhan’s pseudopatient study caused a tremendous flap, and many psychiatrists and clinical psychologists cried foul. Several ensuing responses in *Science*, the journal in which the study had been published, accused Rosenhan of slipshod research and of damaging the reputation of the mental health professions. Did they have a point? Was Rosenhan’s study flawed? Or was it simply the cries of those who perceived Rosenhan’s study as a personal attack? We will take a close look at these issues in the Critical Thinking section at the end of the chapter. In the meantime, let’s explore the problem of determining what mental disorder is and how it might be diagnosed.



12.1 KEY QUESTION WHAT IS PSYCHOLOGICAL DISORDER?

On the world stage, the picture of mental disorder is arresting. According to the World Health Organization, some 450 million people around the world suffer from mental disorders, with a large proportion living in poor countries that have no mental health care system (Miller, 2006d). Depression, for example, caused more disability among people aged 15 to 44 than any other cause except HIV/AIDS.

Yet, as Rosenhan’s study suggests, distinguishing “normal” from “abnormal” is not always a simple task. Consider, for example, how you would classify such eccentric personalities as Michael Jackson or Britney Spears. And what about a soldier who risks his or her life in combat: Is that “normal”? Or consider a grief-stricken woman who is unable to return to her normal routine three months after her husband died: Does she have a psychological disorder?

Psychopathology Any pattern of emotions, behaviors, or thoughts inappropriate to the situation and leading to personal distress or the inability to achieve important goals. Other terms having essentially the same meaning include *mental illness*, *mental disorder*, and *psychological disorder*.



Advertisements like the one shown here have gone a long way toward correcting our views of mental illness and creating sympathy for its sufferers.

core concept

The medical model takes a “disease” view, while psychology sees psychological disorder as an interaction of biological, mental, social, and behavioral factors.

No matter how we conceptualize psychopathology, nearly everyone agrees that psychological disorder is common. It touches the daily lives of millions. It can be insidious, working its way into thoughts and feelings, diminishing its victims’ emotional and physical well-being, along with their personal and family relationships. And it can create an enormous financial burden through lost productivity, lost wages, and the high costs of prolonged treatment. Yet the way people think of psychopathology does have a consequence: As we will see, it determines how they attempt to treat it—whether with drugs, charms, rituals, talk, torture, brain surgery, hospitalization, or commitment to an “insane asylum.”

In this section of the chapter, we will find that the two main ways of looking at psychopathology, the medical model and the psychological view, are often at odds. Some of this conflict is territorial, resulting from professional infighting. But some of the conflict has historical roots, as we shall see next.

Changing Concepts of Psychological Disorder

Before December 10, 1973, homosexuality was considered an illness. But on that day the Board of Directors of the American Psychiatric Association voted to drop homosexuality from its list of officially recognized disorders. After a year of rancorous debate, the membership voted to remove homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. The decision—that homosexuality is not associated with any evidence of mental disorder, with the understandable exception of problems related to the stress of discrimination—has since been repeatedly verified (Cochran et al., 2003; Meyer, 2003). This change in the perception of homosexuality, however, was only one of the

Hallucination A false sensory experience that may suggest mental disorder. Hallucinations can have other causes, such as drugs or sensory isolation.

Delusion An extreme disorder of thinking, involving persistent false beliefs. Delusions are the hallmark of paranoid disorders.

Affect Emotion or mood.

TABLE 12.1 The Spectrum of Mental Disorder

Mental disorder occurs on a spectrum that ranges from the absence of signs of pathology to severe disturbances, such as are found in major depression or schizophrenia. The important point is that there is no sharp distinction that divides those with mental disorders from those who are “normal.”

No disorder	Mild disorder	Moderate disorder	Severe disorder
Absence of signs of psychological disorder	Few signs of distress or other indicators of psychological disorder	Indicators of disorder are more pronounced and occur more frequently	Clear signs of psychological disorder, which dominate the person's life
Absence of behavior problems	Few behavior problems; responses usually appropriate to the situation	More distinct behavior problems; behavior is often inappropriate to the situation	Severe and frequent behavior problems; behavior is usually inappropriate to the situation
No problems with interpersonal relationships	Few difficulties with relationships	More frequent difficulties with relationships	Many poor relationships or lack of relationships with others

most recent in a continuously evolving concept of mental disturbance that stretches back thousands of years.

Historical Roots In the ancient world, people assumed that supernatural powers were everywhere, accounting for good fortune, disease, and disaster. In this context, psychopathology was believed to be caused by demons and spirits that had taken possession of the person's mind and body (Sprock & Blashfield, 1991). If you had been living in the ancient world, your daily routine would have included rituals aimed at outwitting or placating these supernatural beings.

In about 400 B.C., the Greek physician Hippocrates took humanity's first step toward a scientific view of mental disorder when he declared that abnormal behavior has physical causes. As we saw in the Personality chapter, Hippocrates taught his disciples to interpret the symptoms of psychopathology as an imbalance among four body fluids called “humors”: blood, phlegm (mucus), black bile, and yellow bile. Those with an excess of black bile, for example, were inclined to melancholy or depression, while those who had an abundance of blood were sanguine, or warmhearted. With this simple but revolutionary idea, Hippocrates incorporated mental disorder into medicine, and his view—that mental problem had natural, not supernatural, causes—influenced educated people in the Western world until the end of the Roman Empire.

Then, in the Middle Ages, superstition eclipsed the Hippocratic model of mental disorder. Under the influence of the medieval Church, physicians and clergy reverted to the old ways of explaining abnormality in terms of demons and witchcraft. In these harsh times, the Inquisition was driven by the belief that unusual behavior was the work of Satan. The “cure” involved attempts to drive out the demons that possessed the unfortunate victim's soul. As a result, thousands of mentally disturbed people were tortured and executed all across the European continent. Even in 1692, the same view of mental disorder led the young American colony in Salem, Massachusetts, to convict and execute a group of its residents for witchcraft (Karlsen, 1998). A group of young girls had frightened the community with a rash of convulsions and reports of sensory disturbances that were interpreted as signs of demonic possession. A modern analysis of the Salem witch trials has concluded that the girls were probably suffering from poisoning by a fungus growing on rye grain—the same fungus that produces the hallucinogenic drug LSD (Caporeal, 1976; Matossian, 1982, 1989).

The Medical Model In the latter part of the 18th century, the “disease” view that originated with Hippocrates reemerged with the rise of science. The resulting **medical model** held that mental disorders are *diseases* of the mind that, like ordi-

CONNECTION • CHAPTER 10

Hippocrates' humor theory was a theory of temperaments.

Medical model The view that mental disorders are diseases that, like ordinary physical diseases, have objective physical causes and require specific treatments.



A painting of the witchcraft trials held in Salem, Massachusetts, in 1692. Twenty people were executed before the hysteria subsided.

nary physical diseases, have objective causes and require specific treatments. People began to perceive individuals with psychological problems as sick (suffering from illness), rather than as demon possessed or immoral. And what a difference a new theory made! Treating mental disorders by torture and abuse no longer made sense. The new view of mental illness brought sweeping reforms that were implemented in “asylums” for the “insane.” In this supportive atmosphere, many patients actually improved—even thrived—on rest, contemplation, and simple but useful work (Maher & Maher, 1985). Unfortunately, political pressures eventually turned the initially therapeutic asylums into overcrowded warehouses of neglect.

Despite such problems, however, the revived medical model was unquestionably an improvement over the old demon model. Yet modern psycholo-

gists think that we are ready for another revolutionary change in perspective. The medical model has its own weaknesses, they say, pointing out that the assumption of “disease” leads to a doctor-knows-best approach in which the therapist takes all the responsibility for diagnosing the illness and prescribing treatment. Under this “disease” assumption, the patient may become a passive recipient of medication and advice, rather than an active participant in treatment—as we see in so many mental patients today who are treated simply by the dispensing of pills. Psychologists believe that this attitude wrongly encourages dependency on the doctor, encourages unnecessary drug therapy, and does little to help the patient develop good coping skills.

Not incidentally, a doctor-knows-best approach also takes responsibility away from psychologists and gives it to psychiatrists. Psychologists bristle at the medical model’s implication that their treatment of mental “diseases” should be done under the supervision of a physician. In effect, the medical model assigns psychologists to second-class professional status. As you can see, ownership of the whole territory of psychological disorder is hotly contested.

CONNECTION • CHAPTER 1

Psychiatrists, but not psychologists, are trained in medicine.

Psychological Models What does psychology have to offer in place of the medical model? Most clinical psychologists have now turned to a combination of psychological perspectives that derive from *behaviorism*, *cognitive psychology*, *social learning*, and *biological psychology*. We will look at these more closely.

The Social-Cognitive-Behavioral Approach Modern psychologists often combine ideas from perspectives that were once considered incompatible: cognitive psychology and behaviorism. In brief, cognitive psychology looks inward, emphasizing mental processes, while behaviorism looks outward, emphasizing the influence of the environment. As we saw in the chapter on learning, bridges between these perspectives were built by social-learning theorists and others. As a result, a major shift in psychological thinking in recent years now views these traditions as complementary, rather than competitive. Moreover, both sides now acknowledge that cognition and behavior usually occur in a social context, requiring a *social perspective*.

In addition, the *behavioral perspective* tells us that abnormal behaviors can be acquired in the same fashion as healthy behaviors—through behavioral learning. This view focuses on our behavior and the environmental conditions, such as rewards, punishments, and social pressures, that maintain it. For example, the behavioral perspective would suggest that a fear of public speaking could result from a humiliating public speaking experience and subsequent avoidance of any opportunity to develop public speaking skills.

Finally, the *cognitive perspective* suggests that we must also consider how people *perceive* or *think about* themselves and their relations with other people.

Among the important cognitive variables are these: whether people believe they have control over events in their lives (an *internal* or *external locus of control*), how they cope with threat and stress, and whether they attribute behavior to situational or personal factors (Bandura, 1986).

The **social-cognitive-behavioral approach**, then, is a psychological alternative to the medical model, combining three of psychology's major perspectives. Typical of this approach is Albert Bandura's theory of *reciprocal determinism*, which proposes that behavior, cognition, and social/environmental factors all influence each other. From this viewpoint, if you have a fear of public speaking, for example, it can be understood as a product of social learning, behavioral learning, and cognitive learning. Thus, your fear of public speaking could have its origins in *social learning*: hearing people talk about "stage fright" and their anxiety about public speaking. Against that backdrop, then, you may have had an unpleasant *behavioral conditioning* experience in which people laughed at you while you were making a speech. That experience, in turn, could easily make you view yourself as "a poor public speaker"—as a result of *cognitive learning*. The result of this chain of social learning, behavioral learning, and cognitive learning—in which each step *reciprocally* reinforces the others—is the idea that public speaking is fear-producing experience.

CONNECTION • CHAPTER 10

Reciprocal determinism is a part of Bandura's social learning theory.

The Biopsychology of Mental Disorder Although most psychologists have reservations about the medical model, they do not deny the influence of biology on thought and behavior. Modern biopsychology assumes that some mental disturbances involve the brain or nervous system in some way, and this view is taking an increasingly prominent position. An explosion of recent research in neuroscience confirms the role of the brain as a complex organ whose mental functions depend on a delicate balance of chemicals and ever-changing circuits. Subtle alterations in the brain's tissue or in its chemical messengers—the neurotransmitters—can profoundly alter thoughts and behaviors. Genetic influences, brain injury, infection, and learning are a few factors that can tip the balance toward psychopathology.

On the heredity front, the Human Genome Project has specified the complete human genetic package. Many psychologists see this accomplishment as a ripe opportunity for specialists in behavioral genetics who are searching for genes associated with specific psychological disorders (National Institute of Mental Health, 2003b). It won't be easy, however. So far, suspicious genetic abnormalities have been linked to schizophrenia, bipolar disorder, anxiety disorders, and autism, although their exact roles in these conditions remain unclear. Most experts believe that such disorders are likely to result from multiple genes interacting with forces in the environment (See National Institute of Mental Health, 2008c). Watch the news for further developments.

Indicators of Abnormality

While clinicians sometimes disagree about the *etiology* (causes) of psychological disorders, they usually agree broadly on the indicators of abnormality (Rosenhan & Seligman, 1995). What are these indicators? Earlier we noted that hallucinations, delusions, and extreme affective changes are signs of severe mental disorder. But many psychological problems don't reveal themselves in such stark ways. Accordingly, clinicians also look for the following more subtle signs that may also indicate psychological disturbances, ranging from mild to severe (see Table 12.1):

- **Distress.** Does the individual show unusual or prolonged levels of unease or anxiety? Almost anyone will get nervous before an important test, but feeling so overwhelmed with unpleasant emotions that concentration becomes impossible for long periods is a sign of abnormality.
- **Maladaptiveness.** Does the person act in ways that make others fearful or interfere with his or her well-being? We can see this in someone who drinks so

Social-cognitive-behavioral approach A psychological alternative to the medical model that views psychological disorder through a combination of the social, cognitive, and behavioral perspectives.



Behaviors that make other people feel uncomfortable or threatened may be a sign of abnormality.

heavily that she or he cannot hold down a job or drive a car without endangering others.

- **Irrationality.** Does the person act or talk in ways that are irrational or incomprehensible to others? A woman who converses with her long-dead sister, whose voice she hears in her head, is behaving irrationally. Likewise, behavior or emotional responses that are inappropriate to the situation, such as laughing at the scene of a tragedy, show irrational loss of contact with one's social environment.
- **Unpredictability.** Does the individual behave erratically and inconsistently at different times or from one situation to another, as if experiencing a loss of control? For example, a child who suddenly smashes a fragile toy with his fist for no apparent reason is behaving unpredictably. Similarly, a manager who treats employees compassionately one day and abusively the next is acting unpredictably.
- **Unconventionality and undesirable behavior.** Does the person behave in ways that are statistically rare and violate social norms of what is legally or morally acceptable or desirable? Being merely "unusual" is not a sign of abnormality—so feel free to dye your hair red and green at Christmastime. But if you decide to act beyond the bounds of social acceptability by strolling naked in the mall, that would be considered abnormal.

Is the presence of just one indicator enough to demonstrate abnormality? It's a judgment call. Clinicians are more confident in labeling behavior as "abnormal" when two or more of the indicators are present. (You will remember that the pseudopatients in Rosenhan's study presented only one symptom: hearing voices.) And the more extreme and prevalent the indicators are, the more confident psychologists can be about identifying an abnormal condition. Moreover, none of these criteria is a condition shared by all forms of disorder that we will describe later in this chapter. Different diagnoses, we shall see, include different combinations from the above list.

While these indicators may suggest a disorder, the clinician still must decide which disorder it is. This can be difficult, because psychopathology takes many forms. Some diagnoses may have a familiar ring: *depression*, *phobias*, and *panic disorder*. You may be less well acquainted with others, such as *conversion disorder* or *catatonic schizophrenia*. In all, 300-plus specific varieties of psychopathology are described in the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition), known by clinicians and researchers as the *DSM-IV* ("DSM-four") and used by mental health professionals of all backgrounds to describe and diagnose psychopathology. So influential is this system that we will devote the entire middle section of this chapter to an explanation of it.

A Caution to Readers

As you read about the symptoms of psychological disorder, you are likely to wonder about your own mental health. All students studying abnormal psychology face this hazard. To see what we mean, you might answer the following questions, which are based on the indicators of abnormality discussed earlier:

1. Have you had periods of time when you felt "blue" for no apparent reason? (distress)
2. Have you ever gone to a party on a night when you knew you should be studying? (maladaptiveness)
3. Have you had an experience in which you thought you heard or saw something that wasn't really there? (irrationality)
4. Have you had a flash of temper in which you said something that you later regretted? (unpredictability)
5. Have you had unusual thoughts that you told no one about? (unconventionality)

DO IT YOURSELF!**The Insanity Plea: How Big Is the Problem?**

How often is the plea of insanity used? Before you read about the insanity defense in the next part of the chapter, try to guess the approximate percentage of accused crimi-

nals in the United States who use a plea of insanity in court: ____%. You will find the correct answer in the “Psychology Matters” section below. (An answer within 10% indicates that

you have an exceptionally clear grasp of reality!)

Hint: Research shows that the public has an exaggerated impression of the problem.

6. Have you made someone fearful or distressed because of something you said or did? (maladaptiveness)

The fact is that almost everyone will answer “yes” to at least one—and perhaps all—of these questions. This does not necessarily mean abnormality. Whether you, or anyone else, is normal or abnormal is a matter of degree and frequency—and clinical judgment.

So, as we take a close look at specific psychological disorders in the next section of the chapter, you will most likely find some symptoms that you have experienced. So will your classmates. Even though they may not say so, most other students will find themselves in one or more of the disorders that we will be studying. (A similar problem is common among medical students, who begin to notice that they, too, have symptoms of the physical diseases they learn about.) You should realize that *this is normal*. Another reason, of course, that you may see yourself in this chapter arises from the fact that no sharp line separates psychopathology from normalcy. All psychological disorders involve exaggerations of normal tendencies. Moreover, people who are basically healthy may occasionally become depressed, for example—although they do not *stay* depressed or develop the depths of despair that persons with clinical depression do. We are not suggesting that concerns about psychological disorder should be taken lightly, however. If, after reading this chapter, you suspect that you may have a problem, you should discuss it with a professional.



(Source: That's Life © 2003 Mike Twohy. All rights reserved. Used with permission of Mike Twohy and the Cartoonist Group.)

PSYCHOLOGY MATTERS

The Plea of Insanity

Now let's look at a closely related issue: the *plea of insanity*. What is your opinion: Does the insanity plea really excuse criminal behavior and put thousands of dangerous people back on the streets? Let's take a critical look at the facts.

In 1843, Daniel M'Naughten, a deranged woodcutter from Glasgow, thought he had received “instructions from God” to kill the British Prime Minister, Robert Peel. Fortunately for Peel, this would-be assassin struck down his secretary by mistake. Apprehended and tried, M'Naughten was found “not guilty by reason of insanity.” The court reasoned that M'Naughten's mental condition prevented him from knowing right from wrong. The public responded with outrage. Fast-forwarding 138 years, a similarly outraged public decried the modern-day insanity ruling involving John Hinckley, the young man who shot and wounded then-President Ronald Reagan.

Such infamous cases have molded a low public opinion of the insanity defense. The citizenry blames psychologists and psychiatrists for clogging the courts with insanity pleas, allowing homicidal maniacs back on the streets, and letting criminals go to hospitals for “treatment” instead of prisons for punishment. But this public image of insanity stems from several erroneous assumptions.

For one thing, “insanity” appears nowhere among the *DSM-IV* listing of disorders recognized by psychologists and psychiatrists. Technically, **insanity** is

Insanity A legal term, not a psychological or psychiatric one, referring to a person who is unable, because of a mental disorder or defect, to conform his or her behavior to the law.



The plea of insanity is rare—and it is usually unsuccessful.

neither a psychological nor psychiatric term. Rather, it is a *legal* term, which only a court—not psychologists or psychiatrists—can officially apply. By law, insanity can include not only psychosis, but jealous rage, mental retardation, and a wide variety of other conditions in which a person might not be able to control his or her behavior or distinguish right from wrong (Thio, 1995).

So, why can we not simply abolish the laws that allow this technicality? The answer to that question turns on the definition of a crime. Legally, a crime requires two elements: (a) an *illegal act* (just wanting to commit a crime is not enough) and (b) the *intent* to commit the act. Merely wishing your boss dead is no crime (because you committed no illegal act). Neither is flattening the boss who accidentally steps in front of your moving car in the parking lot (assuming you had not planned the deed). But, if you plot and plan and then lie in wait to willfully run over the dastardly dude, you have committed an intentional and illegal act—and the courts can convict you of murder. From this example, you can see why no one wants to give up the legal requirement of intent. But you can also

- see why this safeguard leaves the door open for the controversial plea of insanity.
- With these things in mind, take a moment to recall your estimate of the percentage of accused criminals who use the insanity plea. (See the “Do It Yourself!” box above.) In reality, accused criminals use the insanity defense far less often than the public realizes. In actuality, it occurs in less than 1% of criminal cases, and of this tiny number, only a fraction are successful (Chiaccia, 2007), although we would note that it has been tried *unsuccessfully* in several famous murder cases, including those of David Birkowitz, Ted Bundy, Charles Manson, John Wayne Gacey, and Jeffrey Dahmer. Still, public concern about abuses of the insanity plea has led several states to experiment with alternatives. Some now require separate verdicts on the act and the intent, allowing a jury to reach a verdict of “guilty but mentally ill” (Savitsky & Lindblom, 1986).

Check Your Understanding

1. **RECALL:** How did Rosenhan go about studying the way psychiatrists diagnose mental disorders?
2. **RECALL:** What are the three classic symptoms of severe mental disorder?
3. **ANALYSIS:** Consider the symptoms presented by the pseudopatients in Rosenhan’s study. To what would their hallucinations have probably been attributed by (a) Hippocrates, (b) a physician or priest in the Middle Ages, and (c) a physician in the 1800s?
4. **RECALL:** Approximately how often do psychologists diagnose criminals as being insane? How often is the plea of insanity used in criminal cases in the United States?
5. **UNDERSTANDING THE CORE CONCEPT:** Give an example of what a psychologist might look for in attempting to understand a person’s mental disorder (but that a psychiatrist using the “medical model” would probably *not* explore).

Answers 1. He arranged for mentally healthy volunteers to request admission to mental hospitals, based on the assertion that they had been hearing voices. Rosenhan interpreted their success (all were admitted) as an indicator that psychiatric diagnoses are not reliable. 2. Hallucinations, delusions, and severe affective disturbances are the classic symptoms of severe mental disorder. 3. a. Hippocrates would have said that the hallucinations stemmed from a physical cause, most likely an imbalance in the four humors. b. A medieval physician or priest would probably have attributed hallucinations to demonic possession. c. A physician in the 1800s would have attributed the symptoms to a disease—much as Hippocrates would have done. 4. Psychologists do not diagnose people as sane or insane. Those are legal terms. In U.S. courts, the plea of insanity is used in less than 1% of criminal cases—most often unsuccessfully. 5. A psychologist might look for many social, cognitive, and behavioral factors, such as the family environment (social), attention for disturbing behavior (behavioral), or locus of control (cognitive).

12.2 KEY QUESTION

HOW ARE PSYCHOLOGICAL DISORDERS CLASSIFIED IN THE DSM-IV?

Imagine that you have entered a music store looking for a particular CD. Anything you could possibly want is there, but the employees do not bother group-

ing albums by musical category: They just dump everything randomly into the bins. With so many selections, but no organization, shopping there would be impossible—which is why music stores never operate this way. Instead, they organize selections into categories, such as rock, blues, classical, rap, country, and jazz. In much the same way, the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) brings order to the more than 300 recognized mental disorders. Usually called simply the *DSM-IV*, this manual represents the most widely used system for classifying such disorders. We will use it as the scheme for organizing the disorders we have selected for discussion in this chapter.

What is the organizing pattern employed by the *DSM-IV*? It groups nearly all recognized forms of psychopathology into categories, *according to mental and behavioral symptoms*, such as anxiety, depression, sexual problems, and substance abuse. Our Core Concept states:

The *DSM-IV*, the most widely used system, classifies disorders by their mental and behavioral symptoms.

core
concept

With over 300 disorders described in the *DSM-IV*, it would be impossible to cover all of them in this chapter. Therefore we must focus on those that you are most likely to encounter either in daily life or in the study of psychopathology in more advanced courses.

Overview of the *DSM-IV* Classification System

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, the *DSM-IV*, was published in 1994 by the American Psychiatric Association. Then, in 2000, that volume was given a mid-edition update, called the *DSM-IV-TR*¹ (*TR* means *Text Revision*). It offers practitioners a common and concise language for the description of psychopathology. It also contains criteria for diagnosing each of the disorders it covers. Even though the manual was developed primarily by psychiatrists, its terminology has been adopted by clinicians of all stripes, including psychiatrists, psychologists, and social workers. In addition, most health insurance companies use *DSM-IV-TR* standards in determining what treatments they will pay for—a fact that gives this manual enormous economic clout.

The fourth edition of the *DSM* brought with it some big changes. For example, it banished the term *neurosis* from the official language of psychiatry (although you will frequently hear the term used in more casual conversation). Originally, a **neurosis** or *neurotic disorder* was conceived of as a relatively common pattern of subjective distress or self-defeating behavior that did not show signs of brain abnormalities or grossly irrational thinking. In short, a “neurotic” was someone who might be unhappy or dissatisfied but not considered dangerously ill or out of touch with reality. In the *DSM-IV*, the term *neurosis* has been dropped or replaced by the term *disorder* (Carson et al., 2000; Holmes, 2001). So, for example, “obsessive–compulsive neurosis” is now simply *obsessive–compulsive disorder*.

Similarly, a **psychosis** was thought to differ from neurosis in both the quality and severity of symptoms. A condition was frequently designated as *psychotic* if it involved profound disturbances in perception, rational thinking, or affect (emotion)—the three classic signs we discussed earlier. As a result, a clinician using previous editions of the *DSM* would have been more likely to diagnose severe depression, for example, as “psychotic.” In the *DSM-IV*, the term *psychotic* is restricted mainly to a loss of contact with reality, as is found in the *schizophrenic disorders*, which we shall discuss later.

DSM-IV The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association; the most widely accepted psychiatric classification system in the United States.

Neurosis Before the *DSM-IV*, this term was used as a label for subjective distress or self-defeating behavior that did not show signs of brain abnormalities or grossly irrational thinking.

Psychosis A disorder involving profound disturbances in perception, rational thinking, or affect.

¹For our purposes, both versions of the *DSM*'s fourth edition are essentially the same, so we will refer to them here simply as the *DSM-IV*.

As you may have surmised from its origins in psychiatry, the *DSM-IV* has close ties to the medical model of mental illness. Its language is the language of medicine—symptoms, syndromes, diagnoses, and diseases—and its final form is a curious mixture of science and tradition. (Note: It contains no diagnosis of “normal.”) Yet, in contrast with early versions of the manual, which had a distinctly Freudian flavor, the *DSM-IV* manages, for the most part, to avoid endorsing theories of cause or treatment. It also differs from early versions of the *DSM* by giving extensive and specific descriptions of the symptoms of each disorder. So, while the *DSM-IV* has its critics, the need for a common language of psychological disorder has brought it wide acceptance.

Let us turn now to a sampling of disorders described in the *DSM-IV*. A look at the chart in the margin will give you an overview of the scheme the manual uses to classify these disorders. We begin with those that involve sustained extremes of emotion: the *mood disorders*, also known as *affective disorders*.

Mood Disorders: Extremes of mood, from mania to depression

- Major depression
- Bipolar disorder



Dutch artist Vincent Van Gogh showed signs of bipolar disorder. This problem seems to have a high incidence among very creative people.

Mood disorder Abnormal disturbance in emotion or mood, including bipolar disorder and unipolar disorder. Mood disorders are also called affective disorders.

Major depression A form of depression that does not alternate with mania.

Mood Disorders

Everyone, of course, experiences occasional strong or unpleasant emotional reactions. Emotionality, including the everyday highs and lows, is a normal part of our ability to interpret and adapt to our world. However, when moods careen out of control, soaring to extreme elation or plunging to deep depression, the diagnosis will probably be one of the **mood disorders**. The clinician will also suspect an affective disorder when an individual’s moods are consistently inappropriate to the situation. Here we will discuss the two best-known of these affective disturbances, *major depression* and *bipolar disorder*.

Major Depression If you fail an important examination, lose a job, or lose a love, it is normal to feel depressed for a while. If a close friend dies, it is also normal to feel depressed. But if you remain depressed for weeks or months, long after the depressing event has passed, then you may have the clinically significant condition called **major depression** or *major depressive disorder*, among the commonest of all major mental disturbances.

Novelist William Styron (1990) writes movingly about his own experience with severe depression. The pain he endured convinced him that clinical depression is much more than a bad mood: He characterized it as “a daily presence, blowing over me in cold gusts” and “a veritable howling tempest in the brain” that can begin with a “gray drizzle of horror.” Major depression lingers; it does not give way to manic periods.

Incidence Psychologist Martin Seligman (1973, 1975) has called depression the “common cold” of psychological problems. Nearly everyone has, at some time, suffered either major depression or a milder form that clinicians call *dysthymia*. In the United States, depression accounts for the majority of all mental hospital admissions, but clinicians still believe it to be underdiagnosed and undertreated (Kessler et al., 2003; Robins et al., 1991). The National Institute of Mental Health (2006) estimates that depression costs Americans about \$83 billion each year, including the costs of hospitalization, therapy, and lost productivity. But the human cost cannot be measured in dollars. Countless people in the throes of depression may feel worthless, lack appetite, withdraw from friends and family, have difficulty sleeping, lose their jobs, and become agitated or lethargic. In severe cases, they may also have psychotic distortions of reality. You can give yourself a quick evaluation for signs of depression in the box, “Do It Yourself! A Depression Check.”

Most worrisome of all, suicide claims one in 50 depression sufferers (Bostwick & Pankratz, 2000). Significantly, a person with depression faces a greater risk of suicide on the way down in a depressive episode or on the mend than during the deepest phase of the depressive cycle. Why? Because, in the depths of

DO IT YOURSELF!**A Depression Check**

Most people think that depression is marked by outward signs of sadness, such as weeping. But depression affects other aspects of thought and behavior, as well. For a quick check on your own tendencies to depression, please answer “yes” or “no” to each of the following questions, all adapted from the signs of depression listed in the *DSM-IV*:

1. Do you feel deeply depressed, sad, or hopeless most of the day?
2. Do you feel you have lost interest in most or all activities?
3. Have you experienced any major change in appetite or body weight, though not from dieting?
4. Have you experienced a significant change in your sleeping patterns?
5. Do you feel more restless than usual—or more sluggish than usual?
6. Do you feel more fatigued than you ought to?
7. Do you feel persistently hopeless or inappropriately guilty?
8. Have you been finding it increasingly difficult to think or concentrate?
9. Do you have recurrent thoughts of death or suicide?

Your answers to these items do not constitute any proof that you are, or are not, depressed. While there is no “magic number” of items to which you must answer “yes” to qualify as depressed, if you answered “yes” to some of them and if you are concerned, you might want to seek a

professional opinion. Remember that a diagnosis of depression is a clinical judgment call, based on the signs listed in the *DSM-IV*: Essentially, it is the pattern and the quality of your life, your feelings, and your behavior that determine whether or not you are depressed. Remember also that self-report is always subject to some bias. If you are concerned after considering the signs of depression in your life, we recommend an examination by a competent mental health professional, who will take into account not only your self-descriptions but also your behavior, your social context, and the rewards and aversive circumstances in your life.

depressive despair, a person may have no energy or will to do *anything*, much less carry out a plan for suicide.

Incidentally, your authors advise that a suicide threat always be taken seriously, even though you may think it is just a bid for attention—and even if you see no other signs of depression. Other factors may be at work. Abuse of alcohol or other drugs, for example, multiplies the likelihood of suicide, as do chronic physical diseases or brain abnormalities (Ezzell, 2003). You should direct any person who suggests he or she is thinking about suicide to a competent professional for help.

Cross-cultural studies indicate that depression is the single most prevalent form of disability around the globe (Holden, 2000a), although the incidence of major depression varies widely throughout the world, as Table 12.2 shows. While some of the variation may be the result of differences in reporting and in readiness or reluctance to seek help for depression, other factors seem to be at work, too. In Taiwan and Korea, for example, these factors may include relatively low rates of marital separation and divorce—factors known to be associated with high risk of depression in virtually all cultures. In contrast, the stresses of war have undoubtedly inflated the rate of depression in the Middle East (e.g., Thabet, 2004).

Causes of Depression We have many pieces for the puzzle of depression, but no one has managed to put them all together into a coherent picture yet. Some cases almost certainly have a genetic predisposition: Severe bouts with depression often run in families (Plomin et al., 1994). Further indication of a biological basis for depression comes from the favorable response that many patients with depression have to drugs that affect the brain’s neurotransmitters norepinephrine, serotonin, and dopamine (Ezzell, 2003). These drugs also stimulate growth of new neurons in the hippocampus—although no one has yet figured out whether this is a key to depression or just a by-product (Insel, 2007).

Evidence also connects depression with lower brain wave activity in the left frontal lobe (Davidson, 1992a,b, 2000; Robbins, 2000). And, in a few cases, depression may be caused by viral infection (Bower, 1995b; Neimark, 2005). Such evidence leads some observers to view depression as a collection

TABLE 12.2 Lifetime Risk of a Depressive Episode Lasting a Year or More

Taiwan	1.5%
Korea	2.9%
Puerto Rico	4.3%
United States	5.2%
Germany	9.2%
Canada	9.6%
New Zealand	11.6%
France	16.4%
Lebanon	19%

of disorders having a variety of causes and involving many parts of the brain (Kendler & Gardner, 1998).

Most recently, neuroimaging has suggested a link between a part of the cerebral cortex called *area 25*, located at the base of the frontal cortex, just over the roof of the mouth. In depressed brains, where many functions seem to slow down, area 25 shows up on scans as “hot,” says neuroscientist Helen Mayberg (Dobbs, 2006b). Moreover, when therapies for depression work—either drugs or psychotherapy—area 25 calms down. No one is sure exactly what area 25 is or exactly how it works, although Mayberg suspects that it acts as a sort of “switch” that controls the brain’s “alarm system.” Whatever it does, area 25 does not act alone but rather as a whole suite of brain modules that, together, produce depression.

SAD Adding to this rather confusing picture, it seems that lack of sunlight can also initiate a special form of depression that most commonly appears during the long, dark winter months among people who live in high latitudes (Lewy et al., 2006). (See Figure 12.1.) Aptly named, **seasonal affective disorder**, or **SAD**, is related to levels of the light-sensitive hormone melatonin, which regulates our internal biological clocks (Campbell & Murphy, 1998; Oren & Terman, 1998). Based on this knowledge, researchers have developed an effective therapy that regulates melatonin by exposing SAD sufferers daily to bright artificial light. Some therapists report that combining light therapy with cognitive-behavioral therapy or antidepressants works even better in treating SAD (DeAngelis, 2006).

Psychological Factors Biology alone cannot entirely explain depression. We must also understand it as a mental, social, and behavioral condition. Initially, a negative event, such as losing a job, can make anyone feel depressed, but low self-esteem and a pessimistic attitude can fuel a cycle of depressive thought patterns that psychologists call *rumination* (Law, 2005; Nolen-Hoeksema & Davis, 1999). Those

CONNECTION • CHAPTER 8

The “biological clock,” located in the hypothalamus, regulates our circadian rhythms.

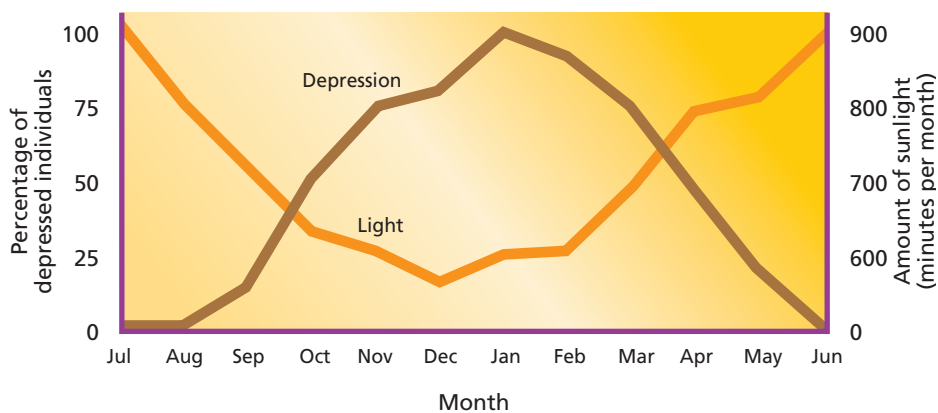
Seasonal affective disorder (SAD)

A form of depression believed to be caused by deprivation of sunlight.

FIGURE 12.1**Relationship between Light and SAD**

People who suffer from seasonal affective disorder are most likely to experience symptoms of depression during months with shortened periods of sunlight.

(Source: Adaptation of Fig. 1, p. 74, from “Seasonal Affective Disorder: A Description of the Syndrome and Preliminary Findings with Light Therapy,” by N. E. Rosenthal et al., *Archives of General Psychiatry*, 41(1984), pp. 72–80. American Medical Association.)



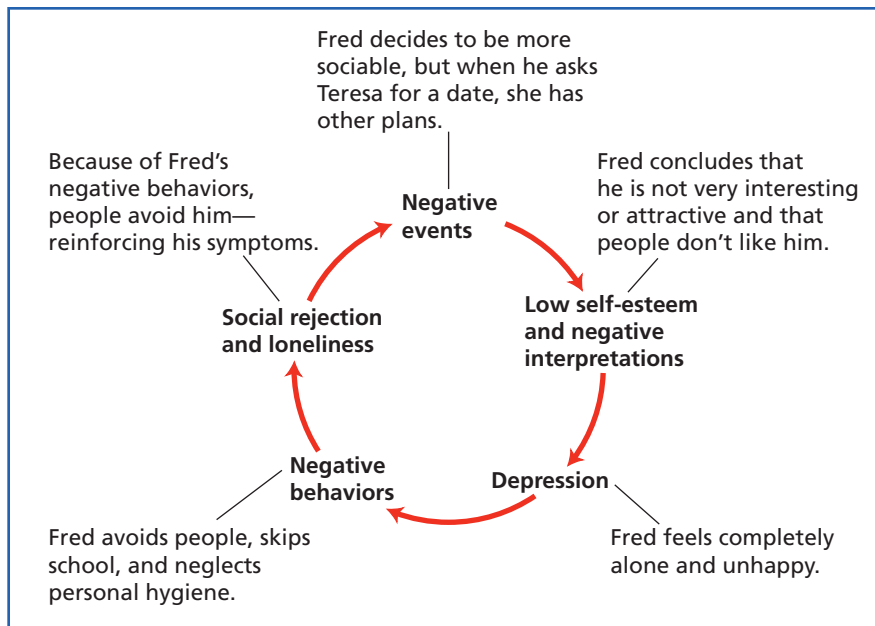


FIGURE 12.2
The Cognitive-Behavioral Cycle of Depression

As you follow Fred around the cycle, note how his depression feeds on itself.

who ruminate will dwell on depressive thoughts, going over and over them again. While this may initially garner sympathy, it soon turns other people away, leaving the individual with depression isolated and even more depressed. (See Figure 12.2.)

Probably because of low self-esteem, depression-prone people are more likely to perpetuate the depression cycle by attributing negative events to their own personal flaws or external conditions that they feel helpless to change (Azar, 1994). Martin Seligman calls this **learned helplessness**. The resulting negative self-evaluation generates a depressed mode, which leads in turn to negative behaviors such as crying. These behaviors encourage others to avoid those suffering from depression. Consequently, they feel rejected and lonely, which also feeds the cycle of their despair (Coyne et al., 1991).

The cognitive approach to depression points out that negative thinking styles are learned—and therefore modifiable. So, if you are depressed, working to change the way you *think*—perhaps blaming yourself less and focusing more on constructive plans for doing better—can ultimately change how you feel and how you act. Indeed, Peter Lewinsohn and his colleagues have found that they can treat many cases of depression effectively with cognitive-behavioral techniques. (Lewinsohn et al., 1980, 1990; Lewinsohn & Gottlib, 1995) Their approach intervenes at several points in the cycle of depression to teach people how to change their helpless thinking, to cope adaptively with unpleasant situations, and to build more rewards into their lives.

Who Becomes Depressed? Clinicians have noted that women have higher depression rates than do men (Holden, 2005). According to Susan Nolen-Hoeksema (2001), the difference may lie in the differing response styles of men and women. When women experience sadness, she says, they tend to think about the possible causes and implications of their feelings. In contrast, men attempt to distract themselves from depressed feelings, either by shifting their attention to something else or by doing something physical that will take their minds off their mood. This model suggests that the more *ruminative* response of women—characterized by a tendency to concentrate on problems—increases women's vulnerability to depression (Shea, 1998). Another possible source of the gender discrepancy in depression may involve norms that encourage women to seek help but discourage men from doing so. Thus, the difference may be, at least in part, due to differences in reporting depressive feelings.

Learned helplessness A condition in which depressed individuals learn to attribute negative events to their own personal flaws or external conditions that the person feels helpless to change. People with learned helplessness can be thought of as having an extreme form of *external locus of control*.

The incidence of depression and the age at which it strikes are changing—at least in the United States. According to Seligman, depression is between 10 and 20 times as common as it was 50 years ago (National Press Club, 1999). In the mid-1900s, most casualties of depression were middle-aged women, but now depression is more often a teenage problem—still more prevalent in females than in males (National Institute of Mental Health, 2000). Seligman, who has studied depression extensively, blames this increase in occurrence and decrease in age to three factors: (1) an out-of-control individualism and self-centeredness that focuses on individual success and failure, rather than group accomplishments; (2) the self-esteem movement, which has taught a generation of schoolchildren that they should always feel good about themselves, irrespective of their efforts and achievements; and (3) a culture of *victimology*, which reflexively points the finger of blame for one’s own mistakes at someone else, causing people to think of themselves as victims.

Bipolar Disorder The other mood disorder we will consider also involves periods of depression—but, in addition, alternating periods of extreme elation. Formerly known as *manic–depressive disorder*, the condition is now listed in the *DSM-IV* as **bipolar disorder**. The alternating periods of *mania* (excessive elation or manic excitement) and the profound sadness of depression represent the two “poles.”

During the *manic phase*, the individual becomes euphoric, energetic, hyperactive, talkative, and emotionally wound tight like a spring. It is not unusual for people, swept up in mania, to spend their life savings on extravagant purchases or to engage promiscuously in a number of sexual liaisons or other potentially high-risk actions. When the mania diminishes, they are left to deal with the damage they have created during their frenetic period. Soon, in the *depressive phase*, a dark wave of melancholy sweeps over the mind, producing symptoms indistinguishable from the “unipolar” form of depression we discussed earlier. Biologically speaking, however, these two forms of depression differ: We know this because the antidepressant drugs that work well on major depression are not usually effective for bipolar disorder—sometimes even making it worse.

Research has established a genetic component in bipolar disorder, although the exact genes involved have not been pinpointed (Bradbury, 2001). While only 1% of the general population has bipolar attacks, having an identical twin afflicted with the problem inflates one’s chances to about 70% (Allen, 1976; Tsuang & Faraone, 1990). The fact that bipolar disorder usually responds well to medication also suggests biological factors at work.

Anxiety Disorders: Fear, anxiety, panic attacks

- Generalized anxiety disorder
- Panic disorder
- Agoraphobia
- Specific phobias
- Obsessive–compulsive disorder

Bipolar disorder A mental abnormality involving swings of mood from mania to depression.

Anxiety disorder Mental problem characterized mainly by anxiety. Anxiety disorders include panic disorder, specific phobias, and obsessive–compulsive disorder.

Anxiety Disorders

Would you pick up a snake or let a tarantula rest on your shoulder? For some people the mere thought of snakes or spiders is enough to send chills of fear down their spines. Everyone, of course, has experienced anxiety or fear in threatening or dangerous situations. But pathological anxiety is far more severe than the normal anxiety associated with life’s challenges. It is also relatively common—even more common than major depression (Barlow, 2000). One estimate says that over our lifetimes 30% of us—more women than men—will experience symptoms that are serious enough to qualify as one of the **anxiety disorders** recognized in the DSM (Hébert, 2006; Holden, 2005).

Here we will review four major disorders that have anxiety as their main feature: (1) *generalized anxiety disorder*, (2) *panic disorder*, (3) *phobic disorder*, and (4) *obsessive–compulsive disorder* (shown in the chart in the margin). You will note that the major differences among them have to do with the focus and duration of anxiety: Is anxiety present most of the time or only occasionally? Does the anxiety seem to come from nowhere—unrelated to the individual’s environment? Does it come from an external object or situation, such as the sight of

blood or a snake? Does it involve the victim's own ritualistic behavior, as in a person who compulsively avoids stepping on cracks in the sidewalk?

Generalized Anxiety Disorder Some people spend months or years of their lives coping with anxiety. Charles, a heavy-equipment operator, says he has dizzy spells, headaches, cold sweats, and frequent feelings of anxiety. But he has no clue why he feels anxious. It is “free-floating” anxiety, as clinicians sometimes call it, and they would diagnose his condition as **generalized anxiety disorder**. People with this problem have a pervasive and persistent sense of anxiety. They are not just worried or fearful about specific situations or objects, such as heights or spiders. Nor does the anxiety come in waves, punctuated by periods of relative calm. Instead, they feel anxious much of the time, without knowing why.

How common is this condition? According to the National Institute of Mental Health (2008a), about 6.8 million adult Americans suffer from generalized anxiety disorder, affecting about twice as many women as men. It comes on gradually, with the highest risk during the first half of life.

Panic Disorder While calmly eating lunch, an unexpected wave of panic sweeps over you, seemingly from nowhere. Your heart races, your body shakes, you feel dizzy, your hands become clammy and sweaty, you are afraid that you might be dying. You are having a *panic attack*.

The distinguishing feature of **panic disorder** is a recurring strong feeling of anxiety that occurs “out of the blue,” has no connection with present events (Barlow, 2001). As in generalized anxiety disorder, the feeling is one of “free-floating anxiety.” Attacks usually last for only a few minutes and then subside (McNally, 1994). Because of the unexpected nature of these “hit-and-run” attacks, *anticipatory anxiety* often develops as an added complication. The dread of the next attack and of being helpless and suddenly out of control can lead a person to avoid public places, yet fear being left alone. Cognitive-behavioral theorists view panic attacks as conditioned responses to physical sensations that may have initially been learned during a period of stress (Antony et al., 1992).

Biologically, we have evidence of a genetic influence in panic disorder (Hettema et al., 2001). The brain mechanism responsible for this condition apparently lies in the limbic system—especially in the amygdala (Hébert, 2006; Mobbs et al., 2007). Significantly, it is part of the brain's notorious unconscious arousal pathway, described by Joseph LeDoux (1996). Overstimulation of these circuits can produce lasting physical changes that make the individual more susceptible to anxiety attacks in the future (Rosen & Schulkin, 1998).

To complicate matters, many victims of panic disorder suffer additional symptoms of **agoraphobia**. This condition involves panic that develops when they find themselves in situations from which they cannot easily escape, such as crowded public places or open spaces (Antony et al., 1992; Magee et al., 1996). The term *agoraphobia* can be literally translated from the ancient Greek as “fear of the marketplace.” Victims of agoraphobia often fear that, if they experience an attack in one of these locations, help might not be available or the situation will be embarrassing to them. These fears deprive afflicted persons of their freedom, and some become prisoners in their own homes. If the disorder becomes extreme, they cannot hold a job or carry on normal daily activities.

It's entirely possible that you may know someone who has panic disorder or agoraphobia, because these disorders occur in nearly 4% of the population in a given year, much more commonly in women than in men (Kessler et al., 2005). Fortunately, the treatment outlook is good. Medical therapy involves antianxiety drugs to relieve the panic attacks. Purely psychological treatment is also effective: Studies have shown that cognitive-behavioral therapy may equal or outperform drug therapy in combating panic attacks (“Cognitive-Behavior Therapy,” 1991; Craske et al., 1991).

CONNECTION • CHAPTER 9

The brain has two main emotional pathways; one operates mainly at an unconscious level.

Generalized anxiety disorder A psychological problem characterized by persistent and pervasive feelings of anxiety, without any external cause.

Panic disorder A disturbance marked by panic attacks that have no obvious connection with events in the person's present experience. Unlike generalized anxiety disorder, the victim is usually free of anxiety between panic attacks.

Agoraphobia A fear of public places and open spaces, commonly accompanying panic disorder.

TABLE 12.3 Phobias

DSM-IV category	Object/Situation	Incidence
Agoraphobia	Crowds, open spaces	Common (3.5–7% of adults)
Social phobias	Fear of being observed or doing something humiliating	common (11–15%)
Specific phobias	Varies by category	(up to 16% of adults)
Animals	Cats (ailurophobia) Dogs (cynophobia) Insects (insectophobia) Spiders (arachnophobia) Birds (avisophobia) Horses (equinophobia) Snakes (ophidiophobia) Rodents (rodentophobia)	
Inanimate objects or situations	Closed spaces (claustrophobia) Dirt (mysophobia) Thunder (brontophobia) Lightning (astraphobia) Heights (acrophobia) Darkness (nyctophobia) Fire (pyrophobia)	
Bodily conditions	Illness or injury (nosophobia) Sight of blood (hematophobia) Cancer (cancerophobia) Venereal disease (venerophobia) Death (thanatophobia)	
Other specific phobias	Numbers (numerophobia) The number 13 (triskaidekaphobia) Strangers, foreigners (xenophobia) String (linonophobia) Books (bibliophobia) Work (ergophobia)	rare rare rare rare rare rare

Note: Hundreds of phobias have been described and given scientific names; this table provides only a sample. Some of the rare and strange-sounding phobias may have been observed in a single patient.

Phobic Disorders In contrast with panic disorder, **phobias** involve a persistent and irrational fear of a specific object, activity, or situation—a response all out of proportion to the circumstances. (These are sometimes called *specific phobias*, as contrasted with the broader fears found in agoraphobia.) Many of us respond fearfully to certain stimuli, such as spiders or snakes—or perhaps to multiple-choice tests! But such emotional responses only qualify as full-fledged phobic disorders when they cause substantial disruption to our lives.

And they do cause substantial disruption for lots of people, affecting more than 10 million Americans each year (Winerman, 2005b). While some specific phobias are quite rare, as in a fear of a certain type of insect, others, such as an extreme fear of public speaking, are quite common—so common that they seem almost the norm (Stein et al., 1996). Other common phobic disorders include *social phobias*, which are irrational fears of normal social situations, and fear of heights (acrophobia), snakes (ophidiophobia), and closed-in spaces (claustrophobia). Still other phobias, some quite rare, appear in Table 12.3.

Phobia One of a group of anxiety disorders involving a pathological fear of a specific object or situation.

What causes phobias? Long ago, John Watson and Rosalie Rayner demonstrated that fears can be learned. And we also have good evidence that fears and phobias can be *unlearned* through cognitive-behavioral therapy based on conditioning (Mineka & Zinbarg, 2006). But learning may not tell the whole story, says Martin Seligman (1971), who has argued that humans are biologically predisposed to learn some kinds of fears more easily than others. This **preparedness hypothesis** suggests that we carry an innate biological tendency, acquired through natural selection, to respond quickly and automatically to stimuli that posed a survival threat to our ancestors (Öhman & Mineka, 2001). This explains why we develop phobias for snakes and lightning much more easily than we develop fears for automobiles and electrical outlets—objects that have posed a danger only in recent times. Again, the underlying brain mechanism includes the amygdala and the quick-and-dirty emotion pathway mapped by Joseph LeDoux and his colleagues (Schafe et al., 2005; Wilensky et al., 2007).

Obsessive–Compulsive Disorder Seventeen-year-old Jim seemed to be a normal adolescent with many talents and interests. Then, almost overnight, he was transformed into a lonely outsider, excluded from social life by his psychological disabilities. Specifically, he developed an obsession with washing. Haunted by the notion that he was dirty—in spite of what his senses told him—Jim began to spend more and more time cleansing himself. At first his ritual ablutions were confined to weekends and evenings, but soon they consumed all his time, forcing him to drop out of school (Rapoport, 1989).

Jim had developed **obsessive–compulsive disorder**, or **OCD**, a condition characterized by patterns of persistent, unwanted thoughts and behaviors. Obsessive–compulsive disorder affects about 1% of us in any given year, regardless of culture (Steketee & Barlow, 2002). And, to put your mind at ease: Nearly everyone occasionally has had some OCD symptoms in a mild form.

The *obsession* component of OCD consists of thoughts, images, or impulses that recur or persist despite a person's efforts to suppress them. For example, a person with an obsessive fear of germs may avoid using bathrooms outside his or her home or refuse to shake hands with strangers. And because sufferers realize that their obsessive thoughts and compulsive rituals are senseless they often go to great lengths to hide their compulsive behavior from other people. This, of course, places restrictions on their domestic, social, and work lives. Not surprisingly, OCD patients have extremely high divorce rates.

You probably have had some sort of mild obsessional experience, such as petty worries (“Did I remember to lock the door?”) or a haunting phrase or melody that kept running through your mind. Such thoughts are normal if they occur only occasionally and have not caused significant disruptions of your life. As we have noted in other disorders, it is a matter of degree.

Compulsions, the other half of obsessive–compulsive disorder, are repetitive, purposeful acts performed according to certain private “rules,” in response to an obsession. OCD victims feel that their compulsive behavior will, somehow, reduce the tension associated with their obsessions. These urges may include irresistible urges to clean, to check that lights or appliances have been turned off, and to count objects or possessions. When they are calm, people with obsessive–compulsive disorder view the compulsion as senseless, but when their anxiety rises, they can't resist performing the compulsive behavior ritual to relieve tension. Part of the pain experienced by people with OCD comes from realizing the utter irrationality of their obsessions and their powerlessness to eliminate them.

The tendency for OCD to run in families suggests a genetic link. Another hint comes from the finding that many people with OCD also display tics, unwanted involuntary movements, such as exaggerated eye blinks. In these patients, brain imaging often shows oddities in the deep motor control areas, suggesting something amiss in the brain (Resnick, 1992). OCD expert Judith

CONNECTION • CHAPTER 3

Watson and Rayner's infamous experiment with Little Albert showed that fears could be learned by classical conditioning.



A common form of social phobia involves an extreme fear of public speaking.

Preparedness hypothesis The notion that we have an innate tendency, acquired through natural selection, to respond quickly and automatically to stimuli that posed a survival threat to our ancestors.

Obsessive–compulsive disorder (OCD) A condition characterized by patterns of persistent, unwanted thoughts and behaviors.



Obsessive-compulsive disorder makes people engage in senseless, ritualistic behaviors, such as repetitive hand washing.

CONNECTION • CHAPTER 3

In classical and operant conditioning, extinction involves the suppression of a response as the result of learning a competing response.

Rapoport tells us to think of compulsions as “fixed software packages” programmed in the brain. Once activated, she theorizes, the patient gets caught in a behavioral “loop” that cannot be switched off (Rapoport, 1989).

Studies show a biological contribution, evidenced in the tendency of this disorder to run in families. Adding weight to the biological argument, certain drugs that are commonly prescribed for depression can alleviate both the obsessions and the compulsive rituals (Poling et al., 1991). In further support of a biological basis for OCD, investigators have found that these drugs can reverse compulsive behavior in animals, such as dogs, that display a preoccupation with grooming themselves (Ross, 1992).

Again, however, we must note that biology cannot explain everything. Some victims of OCD have clearly *learned* that their anxiety-provoking thoughts are connected to harmful consequences (Barlow, 2000). Further evidence that learning plays a role can be seen in the results of behavioral therapy, which is effective in reducing compulsive actions. The behavioral strategy for treating compulsive hand washing, for example, calls for a form of *extinction*, in which the therapist soils the patient’s hands and prevents him or her from washing for progressively longer periods. Indeed, behavioral therapy can produce changes that show up in PET scans of OCD sufferers’ brains (Schwartz et al., 1996). The general principle is this: When we change behavior, we inevitably change the brain, demonstrating once again that biology and behavior are inseparable.

Somatoform Disorders

“Soma” means *body*. Thus, we use the term **somatoform disorders** for psychological problems appearing in the form of bodily symptoms or physical complaints, such as weakness or excessive worry about disease, as in the person who constantly frets about getting cancer. While the somatoform disorders are not especially common—occurring in about 2% of the population—they have captured the popular imagination under their more common names: “hysteria” and “hypochondria” (Holmes, 2001).

The *DSM-IV* recognizes several types of somatoform disorders, but we will cover only two: *conversion disorder* and *hypochondriasis*, shown in the chart in the margin. And, while we’re talking about somatoform disorders, please note their potential for confusion with *psychosomatic disorders*, in which mental conditions—especially stress—lead to actual physical disease. The *DSM-IV* places psychosomatic disorders under a separate heading, “Psychological Factors Affecting Medical Condition.”

Somatoform Disorders:

Physical symptoms or overconcern with one’s health

- Conversion disorder
- Hypochondriasis

Somatoform disorders Psychological problem appearing in the form of bodily symptoms or physical complaints, such as weakness or excessive worry about disease. The somatoform disorders include conversion disorder and hypochondriasis.

Conversion disorder A type of somatoform disorder, marked by paralysis, weakness, or loss of sensation but with no discernible physical cause.

Conversion Disorder Paralysis, weakness, or loss of sensation—with no discernible physical cause—distinguishes **conversion disorder** (formerly called “hysteria”). Patients with this diagnosis may, for example, be blind, deaf, unable to walk, or insensitive to touch in part of their bodies. (“Glove anesthesia,” shown in Figure 12.3, is a classic form of sensory loss in conversion disorder.) Significantly, individuals with this condition have no organic disease that shows up on neurological examinations, laboratory tests, or X-rays. In conversion disorder, the problem really seems to be “all in the mind.”

The term *conversion disorder* carries with it some baggage from the Freudian past. Originally, the term implied an unconscious displacement (or *conversion*) of anxiety into physical symptoms—although most clinicians no longer subscribe to that explanation. The diagnosis, however, has a reputation for being used as a “dumping ground” for patients—especially female patients—who present physical symptoms but no obvious medical abnormality (Kinetz, 2006).

Some cases of conversion disorder are now thought to stem from physical stress responses. Another possibility, suggested by David Oakley (1999) of the University College in London, is that a common brain mechanism underlies con-

version disorder and hypnosis. Accordingly, he suggests that conversion disorder and related mental problems be reclassified as *auto-suggestive disorders*.

No one knows why, but conversion disorder was much commoner a century ago in Europe and the United States. The problem has declined in industrialized countries, probably due to increased public understanding of physical and mental disorders (American Psychiatric Association, 1994; Nietzel et al., 1998). Meanwhile, it is still relatively common in economically undeveloped regions, such as parts of China (Spitzer et al., 1989) and Africa (Binitie, 1975) and among poorly educated persons in the U.S. (Barlow & Durand, 2005).

Hypochondriasis “Hypochondriacs” worry about getting sick. Every ache and pain signals a disease. Because of their exaggerated concern about illness, patients with **hypochondriasis** often bounce from physician to physician until they find one who will listen to their complaints and prescribe some sort of treatment—often minor tranquilizers or placebos. Naturally, these individuals represent easy marks for health fads and scams. They also find their way to the fringes of the medical community, where disreputable practitioners may encourage them to buy extensive treatments.

On the other side of the problem we find the clinician who is too eager to conclude that the patient’s concerns are imaginary—much as we found with conversion disorder. That is, some physicians seem to have a mental set to see hypochondria when they find no physical evidence of disease. This, of course, can have disastrous consequences, as when a mistaken impression of hypochondriasis blinds the physician to a very real and very serious physical disease, such as cancer.

Dissociative Disorders

The common denominator for all the **dissociative disorders** is “fragmentation” of the personality—a sense that parts of the personality have detached (dissociated) from others. Among the dissociative disorders, we find some of the most fascinating forms of mental pathology, including *dissociative fugue*, *depersonalization disorder*, and the controversial *dissociative identity disorder* (formerly called “multiple personality”), made famous by the fictional Dr. Jekyll and Mr. Hyde. (See the chart in the margin on the next page.) Unfortunately, the underlying causes of dissociative disorders remain unclear.

Dissociative Amnesia You may know an *amnesia* victim who has suffered a memory loss as the result of a severe blow to the head, perhaps in an auto accident. In many cases, memory loss is selective, with memories for the immediate and remote unaffected. That is, the amnesia victim may be able to repeat back what you have just said and also recall childhood events. What’s missing are specific categories of memory, such as recollections of yesterday’s events.

The cause is not always physical trauma. Sometimes, people may develop a purely psychological form of amnesia, known as **dissociative amnesia**, as the result of a psychologically traumatic or highly stressful experience. In this disorder, the memory loss typically involves a specific event or series of events. It may also involve the inability to remember aspects of one’s own identity.

Dissociative amnesia has a close kinship with *posttraumatic stress disorder*, which we will discuss more extensively in Chapter 14. In both conditions, memory loss is related to a stressful incident or period in the person’s life. We should note, however, that dissociative amnesia can be a controversial diagnosis when it is associated with recovered memories of childhood abuse. As we discussed in connection with memory, some psychologists have raised important questions about the accuracy of such recovered memories. And, as the *DSM-IV* states, dissociative amnesia may have “been overdiagnosed in individuals who are highly suggestible” (p. 479).

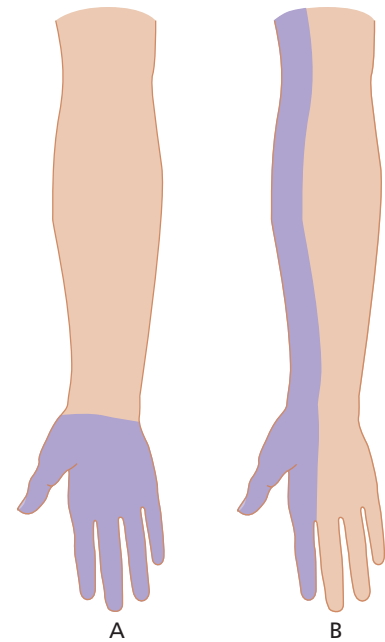


FIGURE 12.3
Glove Anesthesia

The form of conversion disorder known as “glove anesthesia” (A) involves a loss of sensation in the hand, as though the patient were wearing a thick glove. This cannot be a neurological disorder because the pattern of “anesthesia” does not correspond to the actual pattern of nerves in the hand, shown in (B).

Hypochondriasis A somatoform disorder involving excessive concern about health and disease; also called hypochondria.

Dissociative disorders One of a group of pathologies involving “fragmentation” of the personality, in which some parts of the personality have become detached, or dissociated, from other parts.

Dissociative amnesia A psychologically induced loss of memory for personal information, such as one’s identity or residence.

Dissociative Disorders:

Nonpsychotic fragmentation of the personality

- Dissociative amnesia
- Dissociative fugue
- Depersonalization disorder
- Dissociative identity disorder



This is “Jane Doe,” a victim of dissociative fugue who has never recovered the memory of her identity or her past.

Dissociative fugue Essentially the same as dissociative amnesia but with the addition of “flight” from one’s home, family, and job. *Fugue* (pronounced FEWG) means “flight.”

Depersonalization disorder An abnormality involving the sensation that mind and body have separated, as in an “out-of-body” experience.

Dissociative identity disorder A condition in which an individual displays multiple identities, or personalities; formerly called “multiple personality disorder.”

Dissociative Fugue Now consider the very real story of “Jane Doe,” a woman with *dissociative fugue*, who was found near death in a Florida park, where she was incoherent and suffering the effects of exposure. In contrast with victims of dissociative amnesia, Jane Doe had a pervasive memory loss: no memory of her identity or any ability to read or write. Therapy revealed general information about the kind of past she must have had, but no good clues to her origins. After a nationwide television appeal, Jane Doe and her doctors were flooded with calls from possible relatives, the most promising of which was an Illinois couple, certain she was their daughter. They had not heard from her for over four years, since she had moved from Illinois to Florida. Despite their confidence that they had found her, she was never able to remember her past or what had happened to her (Carson et al., 2000).

Jane Doe’s **dissociative fugue** was a combination of *amnesia* and *fugue*, or “flight.” In such persons amnesia takes the form of a lost sense of identity, while fugue may cause them to flee their homes, families, and jobs. Some victims appear disoriented and perplexed. Others may travel to distant locations and take up new lives, appearing unconcerned about the unremembered past. Usually the fugue state lasts only hours or days, followed by complete and rapid recovery. A few cases may continue for months—or, as with Jane Doe, for years.

Heavy alcohol use may predispose a person to dissociative fugue. This suggests that it may involve some brain impairment—although no certain cause has been established. Like dissociative amnesia, fugue occurs more often in those under prolonged high stress, especially in times of war and other calamities. Some psychologists also suspect memory dissociation and repression accompany instances of sexual and physical childhood abuse (Spiegel & Cardeña, 1991). As with dissociative amnesia, this conjecture, however, is disputed.

Depersonalization Disorder Yet another form of dissociation involves a sensation that mind and body have separated. Patients with **depersonalization disorder** commonly report “out-of-body experiences” or feelings of being external observers of their own bodies. Some patients feel as if they are in a dream. (Fleeting, mild forms of this are common, so there is no cause for alarm!) A study of 30 such cases found that obsessive–compulsive disorder and certain personality disorders often accompany this condition (Simeon et al., 1997). The causes are unknown.

People undergoing severe physical trauma, such as a life-threatening injury in an auto accident, may also report symptoms of depersonalization. So do some patients who have had near-death experiences. The effect is also common with recreational drugs. Usually the sensation passes rather quickly, although it can recur. In such individuals, investigators have attributed the disorder to hallucinations and to natural changes in the brain that occur during shock (Siegel, 1980), and one study has found patients with depersonalization disorder to have abnormalities in the visual, auditory, and somatosensory cortex (Simeon et al., 2000).

Dissociative Identity Disorder Robert Louis Stevenson’s famous story of Dr. Jekyll and Mr. Hyde has become a misleading stereotype of **dissociative identity disorder**. In reality, most such cases occur in women, and most display more than two identities (Ross et al., 1989). Unlike the homicidal Mr. Hyde in Stevenson’s yarn, seldom do people with dissociative identity disorder pose a danger to others.

Although it was once thought to be rare, some specialists now believe that this controversial condition has always been common but hidden or misdiagnosed. Others believe that it is primarily the result of suggestion by the therapist (Piper & Mersky, 2004a,b). Proponents of the diagnosis say that dissociative identity disorder usually first appears in childhood (Vincent & Pickering, 1988). Its victims frequently report having been sexually abused (Putnam et al., 1986; Ross et al., 1990). If so, the formation of multiple identities or selves (sometimes referred to as *alters*) may be a form of defense by the dominant self to protect itself from terrifying events.

Dissociative identity disorder (DID) has now become a familiar diagnosis because of its portrayal in books such as *Sybil* (Schreiber, 1973) and *The Flock* (Casey & Wilson, 1991) and films such as the 1996 production *Primal Fear*. Each emerging “personality” contrasts in some significant way with the original self. For example, the new alter might be outgoing if the original personality is shy, tough if the original is weak, and sexually assertive if the other is fearful and sexually naive. These alternate identities, each apparently with its own consciousness, emerge suddenly—usually under stress.

What lies behind this mysterious disturbance? Psychodynamic theories explain it as a fracturing of the ego as a result of ego defense mechanisms that do not allow energy from conflicts and traumas to escape from the unconscious mind. Cognitive theories see it as a form of role playing or mood-state dependency, a form of memory bias in which events experienced in a given mood are more easily recalled when the individual is again in that mood state (Eich et al., 1997). Others suggest that at least some cases are frauds (as in the case of a student, charged with plagiarizing a term paper, who claimed that he had multiple personalities and that one of them copied the paper without the knowledge of his dominant personality). Some observers have even suggested that the disorder exists only in the minds of a few therapists (Piper, 1998). In this view, espoused by memory expert Elizabeth Loftus, patients may initially be led by the suggestive questioning of their therapists, who seek to uncover what they suspect are repressed memories of trauma and molestation (Loftus & Ketcham, 1994).

In an unfortunate choice of terms, dissociative identity disorder is sometimes called “split personality.” This causes confusion because schizophrenia (which literally means “split mind”) has *no* relationship to dissociative identity disorder at all. In schizophrenia, the “split” refers to a psychotic split from reality, not to a fracturing of one personality into many personalities. Nor is dissociative identity disorder a psychotic disorder. We suggest that the reader avoid confusion by avoiding the term “split personality.”

CONNECTION • CHAPTER 4

Loftus is a leading critic of “recovered” memories of sexual abuse.

Schizophrenia

Schizophrenia is the disorder that people have in mind when they use the terms “madness,” “psychosis,” or “insanity.” In psychological terms, **schizophrenia** is a severe form of psychopathology in which personality seems to disintegrate, emotional life becomes disrupted, and cognitive processes distorted. (It was also the diagnosis given to all but one of Rosenhan’s pseudopatients.)

The schizophrenic world may grow bleak and devoid of meaning, or it may become so filled with sensation that everything appears in a confusion of multiple realities layered with hallucinations and delusions. In schizophrenia, emotions often become blunted, thoughts turn bizarre, language may take strange twists, and memory becomes fragmented (Danion et al., 1999). The disorder breaks the unity of the mind, often sending its victims on meaningless mental detours, sometimes spouting sequences of “clang” associations (associations involving similar-sounding words) and producing confused verbalizations that clinicians call “word salads.” Here is an example of schizophrenic speech:

The lion will have to change from dogs into cats until I can meet my father and mother and we dispart some rats. I live on the front of Whitton’s head. You have to work hard if you don’t get into bed. . . . It’s all over for a squab true tray and there ain’t no squabs, there ain’t no men, there ain’t no music, there ain’t no nothing besides my mother and my father who stand alone upon the Island of Capri where is no ice. Well it’s my suitcase sir. (Rogers, 1982)

In a lifetime, more than one of every 100 Americans—more than 2 million over the age of 18—will become afflicted. For as yet unknown reasons, men are

Schizophrenia (pronounced *skits-o-FRENNY-a*) A psychotic disorder involving distortions in thoughts, perceptions, and/or emotions.

Schizophrenia: Psychotic deterioration of the personality, including disturbances in affect, thinking, and socialization

- Disorganized type
- Catatonic type
- Paranoid type
- Undifferentiated type
- Residual type

more often afflicted, with the first appearance of schizophrenia typically occurring in men before they are 25 and for women between 25 and 45 years of age (Holden, 2005; National Institute of Mental Health, 2008b).

Major Types of Schizophrenia Many investigators consider schizophrenia a constellation of separate disorders. Here are the five most common forms:

- *Disorganized type* represents everyone's image of mental illness, featuring incoherent speech, hallucinations, delusions, and bizarre behavior. A patient who talks to imaginary people most likely has this diagnosis.
- *Catatonic type*, involving a spectrum of motor dysfunctions, appears in two forms. Persons with the more common catatonic stupor may remain motionless for hours—even days—sometimes holding rigid, statue-like postures. In the other form, called catatonic excitement, patients become agitated and hyperactive.
- *Paranoid type* features delusions and hallucinations but no catatonic symptoms and none of the incoherence of disorganized schizophrenia. The paranoid delusions of persecution or of grandiosity (highly exaggerated self-importance) found in this type of schizophrenia are less well organized—more illogical—than those of the patient with a purely delusional disorder.
- *Undifferentiated type* serves as a catchall category for schizophrenic symptoms that do not clearly meet the requirements for any of the other categories above.
- *Residual type* is the diagnosis for individuals who have suffered from a schizophrenic episode in the past but currently have no major symptoms such as hallucinations or delusional thinking. Instead, their thinking is mildly disturbed, or their emotional lives are impoverished. The diagnosis of residual type may indicate that the disease is entering remission, or becoming dormant. (This diagnosis was assumed in most of Rosenhan's pseudopatients, whom we met at the beginning of the chapter.)

In Table 12.4, you can see what would be required for a diagnosis of schizophrenia, according to criteria in the *DSM-IV*. See whether you think the symptoms presented by the Rosenhan's pseudopatients would warrant such a diagnosis under today's standards.

The fact that most such patients display a hodgepodge of symptoms places them into the “undifferentiated” category, further clouding our picture of schiz-

TABLE 12.4 Criteria for a Diagnosis of Schizophrenia

- Two or more of the following symptoms, present for a significant portion of time during a one-month period (less if successfully treated):
 1. Delusions
 2. Hallucinations
 3. Disorganized speech
 4. Grossly disorganized or catatonic behavior
 5. Negative symptoms

(Only one symptom is required if the delusions are bizarre, or if the hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or if two or more voices are conversing with each other.)
- Dysfunction in work, interpersonal relations, or self-care
- Signs of disturbance for at least six months, with at least two months of symptoms listed above

Source: Adapted from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., 1994, pp. 285–286.

izophrenia. Trying to make more sense of the problem, many investigators now merely divide the symptoms of schizophrenia into *positive* and *negative* categories (Javitt & Coyle, 2004; Sawa & Snyder, 2002). *Positive symptoms* refer to active processes, such as delusions and hallucinations, while *negative symptoms* refer to passive processes and deficiencies, such as social withdrawal, “flat” affect (lack of emotional expression), lack of pleasure in life, and poverty of thinking.

Patient responses to drug therapy support the positive–negative division: Those with positive symptoms usually respond to antipsychotic drugs, while those with negative symptoms do not (Andreasen et al., 1995; Heinrichs, 1993). But even this distinction has its problems. The negative form of schizophrenia often looks like major depression. In addition, both positive and negative symptoms may occur in a single patient. All these difficulties have led some researchers to conclude that schizophrenia is a name for many separate disturbances.

Possible Causes of Schizophrenia No longer do most theorists look through the Freudian lens to see schizophrenia as the result of defective parenting or repressed childhood trauma (Johnson, 1989). Studies show that adopted children with no family history of the disorder run no increased risk of developing schizophrenia when placed in a home with a parent who has schizophrenia (Gottesman, 1991). Thus, an emerging consensus among psychiatrists and psychologists views schizophrenia as fundamentally a brain disorder—or a group of disorders (Sawa & Snyder, 2002).

Support for this brain-disorder view comes from many quarters. As we have noted, the antipsychotic drugs (sometimes called *major tranquilizers*)—which interfere with the brain’s dopamine receptors—can suppress the symptoms of positive schizophrenic symptoms (Carlsson, 1978; Snyder, 1986). On the other hand, drugs that stimulate dopamine production (e.g., the amphetamines) can actually produce schizophrenic reactions. Recently, attention has turned to deficiencies in the neurotransmitter glutamate (Javitt & Coyle, 2004). Other evidence of a biological basis for schizophrenia comes in the form of brain abnormalities shown by brain scans (Conklin & Iacono, 2004; National Institute of Mental Health, 2005). (See Figure 12.4.) In that vein, an especially provocative

CONNECTION • CHAPTER 13

Many antipsychotic drugs work by reducing the activity of the neurotransmitter dopamine in the brain.

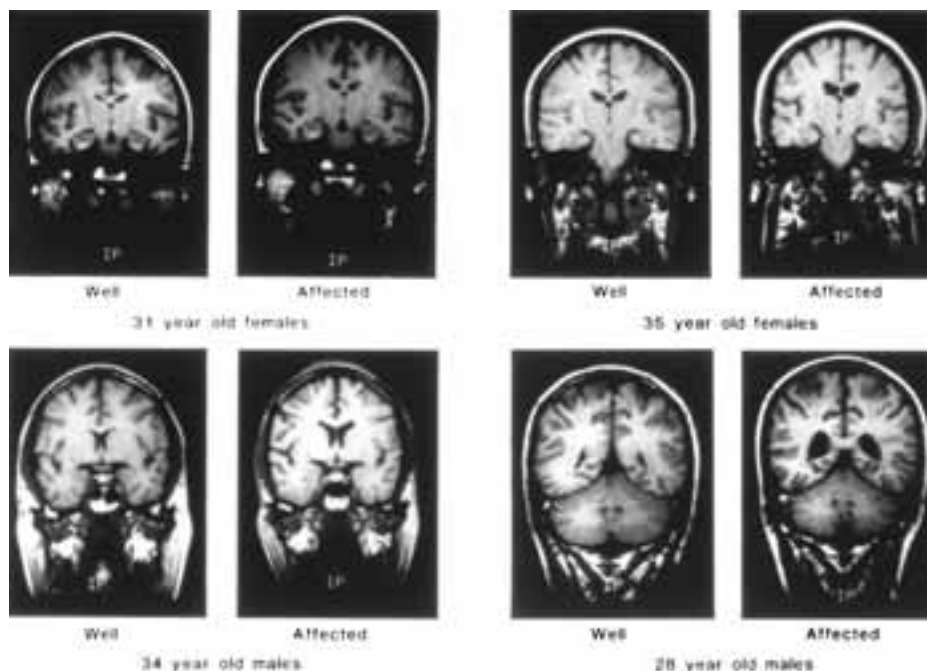


FIGURE 12.4

MRI Scans of a Twin with Schizophrenia and a Twin without Schizophrenia

The normal twin is on the left. Note the enlarged ventricles (fluid-filled spaces) in the brain of the schizophrenic twin on the right.

new finding from MRI studies suggests that the schizophrenic brain fails to synchronize its neural firing across the cortex (Bower, 2005; Symond et al., 2005).

Yet another line of evidence for the biological basis of schizophrenia comes from family studies (Conklin & Iacono, 2004; Holden, 2003a). While no gene has been linked to schizophrenia with certainty, we do know that the closer one's relationship to a person with the disorder, the greater one's chances of developing it (Gottesman, 1991, 2001). This conclusion comes from impressive studies of identical twins reared apart and from adoption studies of children having blood relatives who have been diagnosed with schizophrenia. While only about 1% of us in the general population develop schizophrenia, the child of a parent with schizophrenia incurs a risk about 14 times higher than normal. The worst case would be to have an identical twin who has developed the condition. In that event, the other twin's chances of developing schizophrenia jump to nearly 50%.

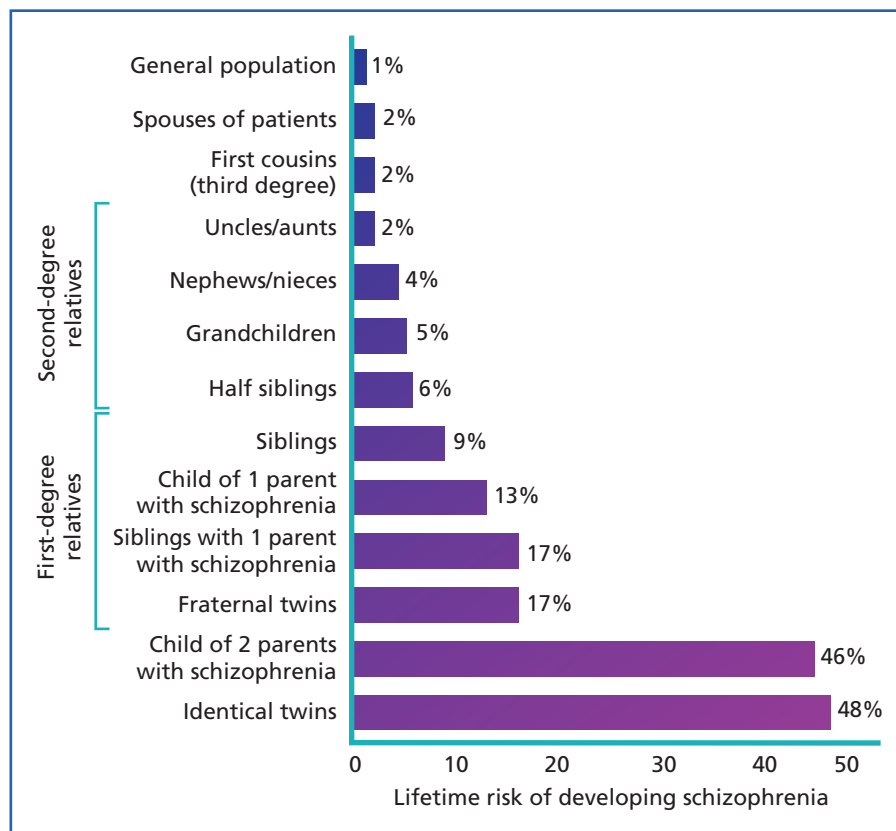
As with the mood disorders, biology does not tell the whole story of schizophrenia. We can see the effect of the environment, for example, in the fact that 90% of the relatives of patients who have schizophrenia do not develop the disorder themselves (Barnes, 1987). Even in identical twins who share exactly the same genes, the *concordance rate* (the rate at which the disorder is shared by both) for schizophrenia is only about 50%. That is, in half the cases in which schizophrenia strikes identical twins, it leaves one twin untouched. (See Figure 12.5.)

A hopeful Finnish study found that being raised in a healthy family environment can actually lower the risk of schizophrenia in adopted children who have a genetic predisposition to the disease (Tienari et al., 1987). Apparently, schizophrenia requires a biological predisposition plus some unknown environmental agent to "turn on" the hereditary tendency (Cromwell, 1993; Iacono & Grove, 1993). This agent could be a chemical toxin, stress, or some factor we have not yet dreamed of. Taken as a whole, this research suggests that genetic factors may

FIGURE 12.5
Genetic Risk of Developing Schizophrenia

The graph shows average risks for developing schizophrenia in persons with a schizophrenic relative. Data were compiled from family and twin studies conducted in European populations between 1920 and 1987; the degree of risk correlates highly with the degree of genetic relatedness.

(Source: Fig. 10, p. 96, "Genetic Risk of Developing Schizophrenia," from SCHIZOPHRENIA GENESIS: The Origins of Madness, by Irving Gottesman. Copyright © 1991. Reprinted by permission of W. H. Freeman and Company/Worth Publishers.)



not themselves be sufficient for the disorder to develop (Nicol & Gottesman, 1983). In view of all the evidence, we must remember that psychological disorder is always an interaction of biological, cognitive, and environmental factors, as our first Core Concept of the chapter suggested.

This broader perspective is often called the **diathesis–stress hypothesis**. It says that biological factors may place the individual at risk for schizophrenia (as well as many other disorders), but environmental stressors transform this potential into an actual disorder (Walker & Diforio, 1997). (The word *diathesis* refers to a predisposition or physical condition that makes one susceptible to disease.) Thus, schizophrenia can be seen as a stress response by one who is predisposed to the disorder. In this view, then, susceptible individuals may never develop schizophrenia if they are spared certain damaging conditions or stressors that might push them “over the edge.”

Developmental Disorders

Developmental problems can appear at any age, but several common ones are first seen in childhood, including *autism*, *attention-deficit hyperactivity disorder (ADHD)*, and *dyslexia*. Here we will give you a brief description of these disorders, because you have already encountered them in earlier chapters. (See the chart in the margin.)

Autism A complex and mysterious disorder, **autism** involves an impoverished ability to “read” other people, use language, and interact socially. To illustrate, imagine the following situation: Sally and Shania are playing together, when Sally puts a piece of candy in a box and then leaves the room. While Sally is gone, Shania opens the box, removes the candy, and stashes it in her purse. When Sally comes back, where will she look for the candy? Normal children will say that Sally will look in the box. Children with autism are most likely to say (if they communicate at all) that Sally will look in the purse. Thus, the child has a poorly developed *theory of mind* (Frith, 1993). Children with severe autism cannot imagine themselves in Sally’s place, believing something they know is not the case. As a result of this deficit, the child has difficulty in social relationships, usually existing in a world of extreme social isolation.

Besides the theory-of-mind deficiencies and social isolation, most persons with autism also have language difficulties. In fact, many never achieve functional language at all. Perhaps because of all these difficulties, many are classified as mentally retarded (although most mentally retarded persons are not autistic). In severe cases, such children may engage in destructive self-stimulation, such as head-banging. Often they will also display repetitive behavior, such as rocking, for extended periods. Typically a physician or the parents first suspect the disorder at about 1½ to 2 years of age, when the child fails to develop language (Kabot et al., 2003).

Recently, neuroscience and epidemiology have produced some other leads in the puzzle of autism. Some evidence suggests a link between autism and toxic materials in the environment (Neimark, 2007). But creating the most excitement is the discovery of “mirror neurons” and a possible link to autism. Studies show that autistic children have either fewer mirror neurons in their brains, or else the mirror neurons they do have are defective (Miller, 2005; Ramachandran & Oberman, 2006). The interesting thing about this finding is that the mirror neurons are supposed to do exactly what persons with autism cannot do: sense what other people’s intentions are (Dobbs, 2006a; Rizzolatti et al., 2006). It remains to be seen whether these developments can be translated into effective therapies.

How prevalent is autism? The numbers are disputed. The National Institute of Health estimates that some form of the disorder occurs in about 1 in 500 children. Although you may have seen news reports of a rising incidence of autism in recent decades, experts attribute this primarily to an expanded defini-

Developmental Disorders:

Disorders usually first diagnosed in infancy, childhood, or adolescence

- Autism
- Dyslexia
- Attention-deficit hyperactivity disorder (ADHD)

CONNECTION • CHAPTER 13

A *theory of mind* involves the understanding that others may have different beliefs, desires, and emotions that underlie their behavior.

Diathesis–stress hypothesis In reference to schizophrenia, the proposal that says that genetic factors place the individual at risk while environmental stress factors transform this potential into an actual schizophrenic disorder.

Autism A developmental disorder marked by disabilities in language, social interaction, and the ability to understand another person’s state of mind.

CONNECTION • CHAPTER 2

“Mirror neurons” in the brain “reflect” other people’s responses.

tion of the disorder that came into wide use in the 1990s (Gernsbacher et al., 2005). Most experts believe that autism is fundamentally a brain disorder. At present there is no cure, although there are treatment programs that can improve socialization and speech—but they are intensive and relatively expensive.

Dyslexia Reading is a key that opens many doors in a modern, information-driven society. But those doors can remain closed for people who have difficulty in reading—people with dyslexia. The disorder affects about one of five children to some degree, often leading to poor school performance. And because school is so important in our society, it often leads to diminished self-esteem and eventually to lost career opportunities (Shaywitz, 1996).

Contrary to popular presumption, dyslexia is not a visual disorder. It doesn't cause letters and words to “jump around” or reverse themselves. Research over the last 15 years suggests, instead, that the disorder involves the abnormalities in the brain's language processing circuits (Breier et al., 2003). Ironically, another “cause” may be language itself: Speakers of English—with its bizarre ways of spelling, including some 1120 ways to spell only 40 different sounds—are much more likely to develop dyslexia than are Italian speakers, who must contend with only 33 combinations of letters for 25 sounds (Helmuth, 2001c; Paulesu et al., 2001).

In a sense, dyslexia may not even be a distinct disorder. Researcher Sally Shaywitz and her colleagues have made a case that there is no marker that sets individuals with dyslexia entirely apart from others who are merely average readers. She argues that dyslexia is simply the diagnosis we give to an arbitrarily defined group of people occupying the lower end of the reading-abilities spectrum (Shaywitz et al., 1990).

Everyone does agree that dyslexia involves reading difficulties. Everyone also agrees that recent years have seen great strides made in understanding the neurological basis of the disorder, developing treatments, and debunking some of the myths surrounding dyslexia (smart people *can* have dyslexia: Einstein apparently did!). Currently, the most effective treatments include special reading programs that emphasize the matching of sounds to letter combinations.

Attention-Deficit Hyperactivity Disorder (ADHD) Some children have more trouble than others sitting still and focusing attention on a task, such as solving a math problem or listening to directions from the teacher. Many things can cause these symptoms, including distracting problems at home, abuse from peers, or merely a cultural tradition that places low value on the tasks that demand quiet attention. Besides those, there seems to be a brain-based condition, known as attention-deficit hyperactivity disorder (ADHD), that can interfere with even the best of intentions to focus attention and sit quietly (Barkley, 1998). The disorder is estimated to affect some 3 to 5% of school-age children (Brown, 2003b).

ADHD is a controversial diagnosis, and its treatment is even more controversial (Sax & Kautz, 2003). Critics have claimed that ADHD is overdiagnosed, often being used to describe normal rambunctiousness or to blame children for the mistakes made by unskilled parents and teachers. In addition, drug treatment consisting of stimulant drugs strikes many people as being wrongheaded. On the other hand, many careful studies have demonstrated that properly administered drug therapy, along with behavioral therapy, can improve attention and diminish hyperactivity in a majority (about 70%) of individuals diagnosed with ADHD (Daley, 2004; MTA Cooperative Treatment Group, 2004).

CONNECTION • CHAPTER 1

Hyperactivity is not caused by eating sugar.

Dyslexia A reading disability, thought by some experts to involve a brain disorder.

Attention-deficit hyperactivity disorder (ADHD) A developmental disability involving short attention span, distractibility, and extreme difficulty in remaining inactive for any period.

Adjustment Disorders and Other Conditions

Although the large majority of everyday psychological problems involve making choices and dealing with confusion, frustration, and loss, the *DSM-IV* gives these problems short shrift under *adjustment disorders* and under the awkwardly

named category, *other conditions that may be a focus of clinical attention*. Together, these categories represent a catch basin for relatively mild problems that do not fit well under other headings. They span a diverse range of conditions that include mild depression, physical complaints, marital problems, academic problems, job problems, parent–child problems, bereavement, and even *malinger* (faking an illness). Consequently, the largest group of people suffering from mental problems may fit these headings—even though the *DSM-IV* devotes disproportionately little space to them. Ironically, because these adjustment difficulties are so prevalent, sufferers who turn to psychologists and psychiatrists account for a large proportion of the patient load seen by professionals in private practice.

Gender Differences in Mental Disorders

No one knows exactly why, but the data show large gender differences in susceptibility to various mental disorders (Holden, 2005). We have seen, for example, that women more often suffer from mood disorders, especially depression. Women also are diagnosed more often with anxiety disorders and eating disorders. In contrast, men are overwhelmingly more likely to have personality disorders that involve aggressive or control-related disorders, such as drug and alcohol abuse and violence. Thus men, far more often than women, are diagnosed as having antisocial personality disorder. As we have noted, one possibility is that social norms encourage more women than men to report feelings of depression. At the same time, social norms may encourage men to “act out” their feelings in a more physical manner.

Another possibility is that the differences originate in biology. For example, men’s brains seem to be more strongly *lateralized* (that is, they tend to have specific cortical functions more localized on one side of the brain or the other). This may explain why men are less likely than women to recover language after a left-side stroke. Some neuroscientists also suspect that the “one-sidedness” of the male brain may contribute to the much higher incidence of schizophrenia and most developmental disorders, such as autism, dyslexia, and attention deficit hyperactivity disorder (ADHD) in males (Holden, 2005). Similarly, there may be some, as yet undiscovered, biological difference that underlies women’s greater susceptibility to depression. Unfortunately, deciding between the social and biological explanations for gender differences in mental disorders awaits further research. Don’t be surprised, however, if the final answer reflects the nature–nurture interaction: It probably involves both.

CONNECTION • CHAPTER 10

Personality disorders are generally conditions of long standing that affect fundamental personality traits.

● PSYCHOLOGYMATTERS

● Shyness

● Being shy is a common problem, but it is not a *DSM-IV* disorder. Rather, ● **shyness** is a distressing pattern of avoiding or withdrawing from social contact. ● At the extreme, shy behavior may become a social phobia or an avoidant personality disorder, as afflicted individuals seek to limit or escape from social interactions. As we have seen many times before, it is a matter of degree. The tragedy ● of shyness is that such people may suffer from loneliness and from lost opportunities to pursue interests and relationships.

● What are the origins of this often-painful problem? For some people it may ● begin at birth: Shyness is one of three basic temperaments that have been ● observed among infants and traced through adult life (Kagan et al., 1988, 1994). ● Jerome Kagan has also recently proposed that shyness may have its origin in an ● overly excitable amygdala (Kagan, 2001). But shyness and other forms of social ● anxiety are also *learned* responses, so that even those who are not “born shy” ● can acquire shy behavior patterns.



Shyness may be painful, but it is not a DSM-IV disorder.

Shyness A common temperamental condition but not a disorder recognized by the *DSM-IV*.

- On a hopeful note, shyness does not have to be a permanent condition. Many
- people overcome it on their own. Organizations such as Toastmasters help peo-
- ple build verbal skills and confidence in social situations. And many others have
- found the help they need in cognitive-behavioral therapy groups.

Check Your Understanding

1. **ANALYSIS:** What are the main differences between the medical model and the psychological model of mental disorder?
2. **RECALL:** Describe one kind of evidence suggesting that depression has a biological basis.
3. **APPLICATION:** According to the *preparedness hypothesis*, which one of the following phobias would you expect to be most common?
 - a. fear of snakes (ophidiophobia)
 - b. fear of books (bibliophobia)
 - c. fear of horses (equinophobia)
 - d. fear of the number 13 (triskaidekaphobia)
4. **RECALL:** Which of the following is most common: schizo-
phrenia, depression, phobias, dissociative identity disorder?
5. **RECALL:** What mental processes may be disrupted by schizophrenia?
6. **RECALL:** In which type of anxiety disorder is the anxiety focused on a particular object or situation?
7. **UNDERSTANDING THE CORE CONCEPT:** The *DSM-IV* groups most mental disorders by their
 - a. treatments.
 - b. causes.
 - c. symptoms.
 - d. theoretical basis.

Answers 1. The medical model views mental disorders as diseases—as something wrong with the individual—while the psychological model encompasses biology, the environment, and mental processes. The medical model also tends to emphasize the disorder often responds favorably to drugs; people with depression tend to have distinctive patterns on the EEG and on brain scans. 2. Depression runs in families; the disorder often responds favorably to drugs; people with depression tend to have a fear of snakes; All the others are relatively modern objects that have not existed long enough to be incorporated into our biological natures. 3. a—fear of snakes. 4. Depression. 5. Schizophrenia may disrupt virtually all mental processes, including thinking, perception, motivation, and emotion. 6. Phobias. 7. c

12.3 KEY QUESTION WHAT ARE THE CONSEQUENCES OF LABELING PEOPLE?

“Mad.” “Maniac.” “Mentally ill.” “Crazy.” “Insane.” “Disturbed.” “Neurotic.” These, along with all the official diagnostic terms that appear in the *DSM-IV*, are labels used by the public, the courts, and mental health professionals to describe people who display mental disturbances. Ideally, of course, an accurate diagnostic label leads to good communication among mental health professionals and an effective treatment program for the afflicted individual. Sometimes, however, labels create confusion and hurt. **Labeling** can turn people into stereotypes, masking their personal characteristics and the unique circumstances that contribute to their disorders. And, if that is not enough, labels can provoke prejudices and social rejection.

Labeling Refers to the undesirable practice of attaching diagnoses of mental disorders to people and then using them as stereotypes—treating the afflicted individuals as if the labels explained their whole personalities. Psychiatric labels can also stigmatize people.

In this section we will begin with the problem of labeling as it affects the individual. Then we will pursue the issue of labeling in a larger context: Does *psychological disorder* mean the same thing in all cultures? Finally, we will bring the topic home with a critical look at the dangers of applying diagnostic labels to your friends and family. The Core Concept that organizes all this says:

core
concept

Ideally, accurate diagnoses lead to proper treatments, but diagnoses may also become labels that depersonalize individuals and ignore the social and cultural contexts in which their problems arise.

Diagnostic Labels, Labeling, and Depersonalization

Labeling a person as mentally disturbed can have both serious and long-lasting consequences, aside from the mental disturbance itself. Not so with a physical illness. A person may suffer a broken leg or an attack of appendicitis, but when the illness is over, the diagnosis moves into the past. Not so with mental disorders. A label of “depression” or “mania” or “schizophrenia” can be a stigma that follows a person forever (Farina et al., 1996; Wright et al., 2000). But what about a mistaken diagnosis? As Rosenhan pointed out, a mistaken diagnosis of cancer is cause for celebration, but almost never is a diagnosis of mental disorder retracted. As you will recall in the “pseudopatient” study, discussed at the beginning of the chapter, the glaring fact of normalcy never emerged—a fact that Rosenhan attributed to being labeled as schizophrenic.

The diagnostic label may also become part of a cycle of neglect resulting from the inferior status accorded people with mental disorders. Sadly, in our society, to have severe mental problems is to be stigmatized and devalued. And, as seen in the Rosenhan study, the mentally ill also suffer **depersonalization**—that is, robbing people of their individuality and identity by treating them impersonally, as objects rather than as individuals. Depersonalization can easily result from labeling, but, as in Rosenhan’s study, it can also result from an impersonal environment, as in some mental hospitals. All of this, of course, lowers self-esteem and reinforces disordered behavior. Thus, society extracts costly penalties from those who deviate from its norms—and in the process it perpetuates the problem of mental disorder.

Perhaps the most extreme reaction against labeling has come from radical psychiatrist Thomas Szasz, who claimed that mental illness is a “myth” (1961, 1977). Szasz argued that the symptoms used as evidence of mental illness are merely medical labels that give professionals an excuse to intervene in what are really social problems: deviant people violating social norms. Once labeled, these people can be treated simply for their “problem of being different.”

We must keep in mind, therefore, that the goal of diagnosis is not just to fit a person into a neat diagnostic box or to identify those who are “different.” Instead, a diagnosis should initiate a process that leads to a greater understanding of a person and to the development of a plan to help. A diagnosis should be a beginning, not an end.

The Cultural Context of Psychological Disorder

Few other clinicians would go as far as Thomas Szasz, but many advocate an **ecological model** that takes the individual’s external world into account (Levine & Perkins, 1987). In this view, abnormality is seen as an interaction between individuals and the social and cultural context. Disorder results from a mismatch between a person’s behavior and the needs of the situation. If you are a private investigator, for example, it might pay to have a slightly suspicious, or “paranoid,” complexion to your personality, but if you are a nurse or a teacher, this same characteristic might be called “deviant.”

In support of an ecological model, studies show beyond doubt that culture influences both the prevalence of psychological disorders and the symptoms that disturbed people display (Jenkins & Barrett, 2004; Matsumoto, 1996). For example, work done by the World Health Organization (1973, 1979) in Colombia, Czechoslovakia, Denmark, India, Nigeria, Taiwan, Britain, the United States, and the former USSR established that the incidence of schizophrenia varies from culture to culture. More recent studies also support this conclusion (Jablensky, 2000).

Even within a culture, there can be huge generational differences. As Seligman points out, if you live in the United States, your lifetime chance of being

Depersonalization Depriving people of their identity and individuality by treating them as objects rather than as individuals. Depersonalization can be a result of labeling.

Ecological model Similar to the social-cognitive-behavioral model but with an emphasis on the social and cultural context.

diagnosed with depression depends on your age (Barber, 2008). For those born early in the 20th century, the chances are about 1%. The rate rises to 5% for those born in midcentury, and for those born in the 1960s or later the lifetime incidence of depression rises to 10 to 15%.

Psychiatry, too, is beginning to note the effects of culture on psychopathology. The *DSM-IV*, in fact, has a section devoted to culture-specific disorders (although this section recognizes no disorders that are found specifically in the United States). According to psychiatrists Arthur Kleinman and Alex Cohen (1997), psychiatry has clung too long to three persistent myths:

1. The myth that mental disorders have a similar prevalence in all cultures.
2. The myth that biology creates mental disorder, while culture merely shapes the way a person experiences it.
3. The myth that culture-specific disorders occur only in exotic places, rather than here at home.

But are cultural differences so great that a person who hallucinates might be labeled schizophrenic in our culture but visionary or shaman (a healer or seer) in another? Jane Murphy (1976) set out to answer this question in a study of two non-Western groups, the Eskimos of northwest Alaska and the Yorubas of rural tropical Nigeria, societies selected because of their wide geographic separation and cultural dissimilarity. In both groups she found separate terms and distinct social roles for the shaman and for the psychotic individual. Similar findings have since come from studies of cultures all over the world (Draguns, 1980). If mental illness is a socially defined myth, as Szasz asserts, it is a myth nurtured by cultures everywhere.

PSYCHOLOGYMATTERS

Using Psychology to Learn Psychology

Don't do it! Don't use your new knowledge of psychological disorders to diagnose your family and friends. Violating this caveat causes grief for many a psychology student.

We realize how tempting it is to apply what you are learning to the people in your life. Some of the disorders that we have considered here are common. So, as you go through this chapter, you will almost certainly notice signs of anxiety, paranoia, depression, mania, and various other impairments of perception, memory, or emotion that remind you of your friends and relatives. It is a variation on the tendency, discussed earlier, to see signs of psychological disorder in oneself. You should recognize this as a sign that you are acquiring some new knowledge about psychological disorder. But we suggest that you keep these thoughts to yourself.

Remember that reading one chapter does not make you an expert on psychopathology; so you should be cautious about making amateur diagnoses. What you especially should not do is to tell someone that you think he or she has schizophrenia, bipolar disorder, obsessive-compulsive disorder—or any other mental condition.

Having said that, we should also note that erring too far in the opposite direction by ignoring signs of pathology could also be hazardous. If someone you know is struggling with significant mental problems—and even if he or she asks for your opinion—you should refrain from putting a label on the problem. But you can and should encourage that person to see a competent professional for diagnosis and possible treatment.

We will discuss more about how treatment is done—in the next chapter.

Check Your Understanding

1. **RECALL:** Which one of the following statements is true?
 - a. Mental disorders have a similar prevalence in all cultures.
 - b. In general, biology creates mental disorder, while culture merely shapes the way a person experiences it.
 - c. Culture-specific stressors occur primarily in developing countries.
 - d. Cultures around the world seem to distinguish

between people with mental disorders and people who are visionaries or prophets.

2. **ANALYSIS:** Why did Rosenhan claim that mental patients are *depersonalized*?
3. **UNDERSTANDING THE CORE CONCEPT:** What are the positive and negative consequences of diagnostic labeling?

Answers: 1. d. 2. Rosenhan found that the mental hospital staff rarely interacted with the patients; when they did, they treated the patients as objects, not persons. 3. On the positive side, diagnostic labels help mental health professionals communicate about patients' symptoms and formulate a treatment plan. On the negative side, people who are labeled can be looked upon as a mere label ("a schizophrenic"), in addition, psychiatric labels carry a strong social stigma.

Critical Thinking Applied: Insane Places Revisited—Another Look at the Rosenhan Study

Probably no other experiment in the history of psychology has caused such a furor as did Rosenhan's "pseudopatient" study. And no wonder: By raising questions about the reliability of psychiatric diagnosis, it threatened the very foundations of psychiatry and clinical psychology. Rosenhan summarized his study by saying, "It is clear that we cannot distinguish the sane from the insane in psychiatric hospitals." If Rosenhan was right, the whole mental health enterprise might be built on nothing but opinion. But was this the correct conclusion?

What Are the Issues?

Our first task in evaluating Rosenhan is to identify the issues at the heart of the controversy. For Rosenhan, the issue was the reliability of psychiatric diagnosis and the question of whether mental disorder can be distinguished from normalcy. But his critics claim that the experiment wasn't even designed to answer the question Rosenhan had posed, and so his conclusions were fatally flawed. Perhaps it shouldn't surprise us that the two sides in such a heated dispute have focused on different issues.

What Critical Thinking Questions Should We Ask?

From a critical thinking standpoint, then, the central question involves the extent to which the reasoning on both sides is accurate or flawed. To what extent do the

arguments of Rosenhan and his critics avoid common errors and fallacies? Let's look at the specifics.

Insanity Is Not a Diagnosis Robert Spitzer (1973), the leader of the charge against Rosenhan, pointed out that *sanity* and *insanity* are legal terms, as we have seen. Because these terms have no meaning in psychology or psychiatry, says Spitzer, Rosenhan's argument is essentially meaningless. While we can agree that Rosenhan was indeed sloppy with his terminology, your authors suggest that his conclusion has the effect of tossing the baby out with the bath water. In fact, Spitzer admits that Rosenhan apparently uses *insanity* to mean *psychosis*. Score one point for the critics.

Unfair! Rosenhan's critics also claimed that the study was unfair because people don't usually lie about their symptoms so that they can be admitted to mental hospitals. So, we should not fault a psychiatrist for assuming that a person asking for help is sincere. Moreover, doctors and hospitals can be held liable if they don't admit people who might pose a danger to themselves or the community (Ostow, 1973). Rosenhan countered that, even if the doctors were erring on the side of caution, the fact that the patients were "sane" should have been detected, if not at admission, then at some time during their hospitalization. Again, we score a tie.

Not Enough Data A third criticism targets the narrative approach Rosenhan used in his report of the pseudopatient study. The article tells a vivid story, but it

is, in fact, sparse in data. Rosenhan's conclusions are mostly driven by his impressions, rather than by facts—an irony, in view of his criticism of psychiatric diagnosis as contaminated by unreliable “impressions.” We award this one to Rosenhan's critics.

Conclusions Applied to the Wrong Group A fourth and most telling criticism accuses Rosenhan of a beginner's mistake. The failure of psychiatrists to detect “sanity” in the pseudopatients, said Spitzer (1973), tells us nothing about their ability to diagnose real patients—who aren't lying about their symptoms. True enough. But Rosenhan (1973b) replied that his study is only one small part of a vast literature attesting to the unreliability of psychiatric diagnosis: Different psychiatrists quite commonly give different diagnoses to the same patient. We give Rosenhan the edge on this point.

Basis We can see the dispute as one between two camps that each perceived themselves under siege by the other. Psychiatrists thought the original study was a frontal assault on the integrity of their profession, so they responded in kind. The counterattack on Rosenhan impugned his integrity as a researcher. The relevant critical thinking question: Could each side's stance be contaminated by bias? The answer is a resounding yes.

So, where does that leave us?

What Conclusions Can We Draw?

Without doubt, Rosenhan is guilty of using the terms *sane* and *insane* inappropriately. He is also guilty of overstatement and sensationalism, as when he says:

The facts of the matter are that we have known for a long time that [psychiatric] diagnoses are often not useful or reliable, but we have nevertheless continued to use them. We now know that we cannot distinguish insanity from sanity.

Even so, the fact that not one of the pseudopatients was ever discovered to be mentally sound is a startling finding.

Power of the Situation in Mental Hospitals Even more important, in our opinion, is a point to which the critics did not respond: Mental hospitals, said Rosenhan, are not primarily places of treatment. Rather, they are places in which patients are labeled, medicated, and ignored by the staff. Most of the time, Rosenhan found, ward attendants and nurses sequestered themselves in a small staff cubicle that patients called “the cage.” Psychiatrists were even less available, making only rare appearances on the wards. When patients approached staff members with questions, they were often given curt replies or ignored.

Rosenhan was not the first person to decry mental hospitals as impersonal places, but he did offer some ideas as to why this is so. One factor rests on society's attitudes toward the mentally ill, attitudes that are colored by fear, distrust, and misunderstanding. These attitudes, said Rosenhan, have an effect on mental health workers.

A second factor involves *labeling*: the pernicious effect of a psychiatric diagnosis. Once a diagnosis is made, doctors are extremely reluctant to change their minds. Part of the reason has to do with pride, but an even bigger problem stems from the lack of contact the staff—and especially the doctors—have with patients. Therapy in mental hospitals, then, is largely a matter of medications. And time.

As we noted at the beginning of the chapter, Rosenhan does not fault the doctors, nurses, ward attendants, or other staff members. He suggested that the problem lay in “the situation”—the whole hospital environment, which depersonalizes patients and discourages staff from interacting with patients. But that was 1973. What about now? Do these problems still plague mental hospitals?

A New Controversy Erupts A brand new controversy erupted in 2005, with the publication of a book entitled *Opening Skinner's Box*. In it, author Lauren Slater describes her own reenactment of Rosenhan's classic experiment. In nine visits to different mental hospitals, Slater told doctors that she heard a voice saying, “Thud.” Although she was never hospitalized, she claims that she was “prescribed a total of 25 antipsychotics and 60 antidepressants.” In most cases she was diagnosed as having “depression with psychotic features.” Slater asserts that her experience supports Rosenhan.

Slater's assertion did not go unnoticed by Robert Spitzer, who still sees the Rosenhan experiment as “an embarrassment” (Jaffe, 2006). Spitzer and two of his colleagues were provoked to write a critique of Slater published in the *Journal of Nervous and Mental Disease* (2005). In that piece, they fired back a salvo consisting of their own study in which they provided 74 psychiatrists with a written vignette based on Slater's “experiment.” They claim that only three gave a diagnosis of psychotic depression. (We would note, however, that Slater's experiment has its own biases: We would guess that virtually every psychiatrist in the world is intimately familiar with the Rosenhan study, and Slater's study would immediately bring it to mind for most of the participants.)

The bottom line? Rosenhan put his finger on some important problems with mental hospitals and psychiatric diagnoses. But he did *not* prove that diagnoses of most mental patients are useless or completely unreliable. And, for our purposes, that conclusion makes the perfect transition to the next chapter, where we will study the treatment of mental disorders.

Chapter Summary

12.1 What Is Psychological Disorder?

Core Concept 12.1: The medical model takes a “disease” view, while psychology sees psychological disorder as an interaction of biological, mental, social, and behavioral factors.

Psychopathology is common in America. Three classic signs suggest severe psychological disorder: **hallucinations**, **delusions**, and *extreme affective disturbances*. But beyond these, the signs of disorder are more subtle, and a diagnosis depends heavily on clinical judgment.

Our modern conception of abnormality has evolved from attributing disorders to demon possession or imbalances of humors to the current **medical model**, which sees psychopathology as “illness” or “disease”—a perspective with which many psychologists disagree. The broader psychological model, the **social-cognitive-behavioral approach**, includes social, mental, and behavioral factors, as well as biological ones. Aside from the three classic signs of disorder, psychopathology is usually judged by the degree to which a person

exhibits distress, maladaptiveness, irrationality, unpredictability, and unconventionality.

It is normal to experience symptoms of psychological disorders on occasion, so psychology students are often unjustifiably concerned that they have a mental disorder. Frequent signs of abnormality, however, should prompt a consult with a mental health professional.

The plea of **insanity** is often misunderstood by the public, because it is infrequently used and even more infrequently successful. The term *insanity* is a legal term, not a psychological or psychiatric diagnosis.

Affect (p. 532)

Psychopathology (p. 531)

Delusions (p. 532)

Social-cognitive-behavioral approach (p. 535)

Hallucinations (p. 532)

Insanity (p. 537)

Medical model (p. 533)

MyPsychLab Resources 12.1:

Watch: Current Diagnostic Models: Sue Mineka

12.2 How Are Psychological Disorders Classified in the DSM-IV?

Core Concept 12.2: The *DSM-IV*, the most widely used system, classifies disorders by their mental and behavioral symptoms.

The most widely used system for classifying mental disorders is the *DSM-IV*, which derives from psychiatry and has a bias toward the medical model. The *DSM-IV* recognizes more than 300 specific disorders, categorized by symptoms rather than by cause. It has no category for “normal” functioning. Unlike its predecessor, it does not use the term **neurosis**; the term **psychosis** is restricted to a loss of contact with reality.

Among the *DSM-IV* categories are the **mood disorders** (*affective disorders*), which involve emotional disturbances. **Major depression** is the most common affective disorder, while **bipolar disorder** occurs less commonly. Strong gender differences have also been noted. All mental disorders are believed to have some biological basis.

The *anxiety disorders* include **generalized anxiety disorder**, **panic disorder**, **phobias**, and **obsessive-compulsive disorder**. Although they may have some basis in temperament, they are also affected by experience. The

somatoform disorders involve the mind-body relationship in various ways. Persons with **conversion disorder** have physical symptoms but no organic disease, while those with **hypochondriasis** suffer from exaggerated concern about illness.

The controversial **dissociative disorders** include **dissociative amnesia**, **dissociative fugue**, **depersonalization disorder**, and **dissociative identity disorder**. All disrupt the integrated functioning of memory, consciousness, or personal identity. Among the psychotic disorders, **schizophrenia** is the most common. It is characterized by extreme distortions in perception, thinking, emotion, behavior, and language. It has five forms: *disorganized*, *catatonic*, *paranoid*, *undifferentiated*, and *residual*. Evidence for the causes of schizophrenia has been found in a variety of factors including genetics, abnormal brain structure, and biochemistry.

The *DSM-IV* also lists a variety of *developmental disorders*, including **autism**, **dyslexia**, and **attention-deficit hyperactivity disorder**. There are significant gender differences across the spectrum of mental disorder, especially in depression and antisocial personality disorder.

The most common disorders of all are classified in the *DSM-IV* as the *adjustment disorders* and “other

conditions that may be a focus of clinical attention.” These include a wide range of problems in living. **Shyness** is a widespread problem—and a treatable one—but it is not officially a disorder, unless it goes to the extreme of a *social phobia* or *avoidant personality disorder*.

Agoraphobia (p. 545)	Dissociative amnesia (p. 549)
Anxiety disorders (p. 544)	Dissociative disorders (p. 549)
Attention-deficit hyperactivity disorder (ADHD) (p. 556)	Dissociative fugue (p. 550)
Autism (p. 555)	Dissociative identity disorder (p. 550)
Bipolar disorder (p. 544)	DSM-IV (p. 539)
Conversion disorder (p. 548)	Dyslexia (p. 556)
Depersonalization disorder (p. 550)	Generalized anxiety disorder (p. 545)
Diathesis–stress hypothesis (p. 555)	Hypochondriasis (p. 549)
	Learned helplessness (p. 543)

Major depression (p. 540)

Mood disorders (p. 540)

Neurosis (p. 539)

Obsessive–compulsive disorder (p. 547)

Panic disorder (p. 545)

Phobias (p. 546)

Preparedness hypothesis (p. 547)

MyPsychLab Resources 12.2:

Watch: Bipolar Disorder: Craig

Watch: Donald: Panic Disorder

Watch: Panic Disorder: Jerry

Watch: Anxiety Disorders

Watch: Schizophrenia: Larry

Watch: Depression: Helen

Psychosis (p. 539)

Schizophrenia (p. 551)

Seasonal affective disorder (SAD) (p. 542)

Shyness (p. 557)

Somatoform disorders (p. 547)

12.3 What Are the Consequences of Labeling People?

Core Concept 12.3: Ideally, accurate diagnoses lead to proper treatments, but diagnoses may also become labels that depersonalize individuals and ignore the social and cultural contexts in which their problems arise.

Labeling someone as psychologically or mentally disordered is ultimately a matter of human judgment. Yet even professional judgments can be biased by prejudices. Those labeled with psychological disorders may suffer **depersonalization** in ways that most physically ill people do not.

Culture has an effect on whether a behavior is called normal, abnormal, or merely unusual, although cross-cultural research suggests that people everywhere distinguish between psychotic individuals and those whom they label shamans, prophets, or visionaries.

Ideally, accurate diagnoses lead to proper treatments, but diagnoses may also become labels that depersonalize individuals and ignore the social and cultural contexts in which their problems arise. Readers are cautioned not to apply diagnostic labels to people.

Depersonalization (p. 559)

Labeling (p. 558)

Ecological model (p. 559)

Discovering Psychology Viewing Guide



Watch the following video by logging into MyPsychLab (www.mypsychlab.com). After you have watched the videos, complete the activities that follow.



PROGRAM 21: PSYCHOPATHOLOGY

PROGRAM REVIEW

- Psychopathology is defined as the study of
 - organic brain disease.
 - perceptual and cognitive illusions.
 - clinical measures of abnormal functioning.
 - mental disorders.
- What is the key criterion for identifying a person as having a mental disorder?
 - The person has problems.
 - The person's functioning is clearly abnormal.
 - The person's ideas challenge the status quo.
 - The person makes other people feel uncomfortable.
- Which is true about mental disorders?
 - They are extremely rare, with less than one-tenth of 1% of Americans suffering from any form of mental illness.
 - They are not that uncommon, with about one-fifth of Americans suffering from some form of recently diagnosed mental disorder.
 - The number of Americans with psychotic disorders fluctuates with the calendar, with more cases of psychosis during the weekends than during weekdays.
 - The actions of people with mental disorders are unpredictable.
- Fran is a mental health specialist who has a Ph.D. in psychology. She would be classified as a
 - psychiatrist.
 - clinical psychologist.
 - social psychologist.
 - psychoanalyst.
- What happened after David Rosenhan and his colleagues were admitted to mental hospitals by pretending to have hallucinations and then behaved normally?
 - Their sanity was quickly observed by the staff.
 - It took several days for their deception to be realized.
 - In most cases, the staff disagreed with each other about these "patients."
 - Nobody ever detected their sanity.
- Olivia is experiencing dizziness, muscle tightness, shaking, and tremors. She is feeling apprehensive. These symptoms most resemble those found in cases of
 - anxiety disorders.
 - affective disorders.
 - psychoses.
 - schizophrenia.
- Prior to the eighteenth century, people with psychological problems were most likely to be
 - placed in a mental hospital.
 - tortured, trained, or displayed for public amusement.
 - encouraged to pursue the arts.
 - treated through psychotherapy only.
- When Sigmund Freud studied patients with anxiety, he determined that their symptoms were caused by
 - actual childhood abuse, both physical and sexual.
 - imbalances in body chemistry.
 - childhood conflicts that had been repressed.
 - cognitive errors in the way patients viewed the world.
- Which of the following statements about clinical depression is true?
 - Most depressed people commit suicide.
 - Depression is characterized by excessive elation of mood.
 - Depression is often called the cancer of mental illness.
 - In its milder forms, depression is experienced by almost everyone.
- People lose touch with reality in cases of
 - neurosis but not psychosis.
 - psychosis but not neurosis.

- c. both psychosis and neurosis.
d. all psychoses and some neuroses.
11. The term *neurosis* is no longer used by psychologists and psychiatrists as a diagnostic category because
- it has been replaced by the term *psychosis*.
 - it is generally understood by everyone in our society.
 - it does not include chronic anxiety.
 - it is considered too general and imprecise.
12. Irving Gottesman and Fuller Torrey have been studying twins to learn more about schizophrenia. If the brain of a twin with schizophrenia is compared with the brain of a normal twin, the former has
- less cerebrospinal fluid.
 - larger ventricles.
 - a larger left hemisphere.
 - exactly the same configuration as the latter.
13. For Teresa LaFromboise, the major issue influencing mental disorders among Native Americans is
- the prevalence of genetic disorders.
 - alcohol's impact on family structure.
 - the effect of imposing white American culture.
 - isolation due to rural settings.
14. According to experts, what proportion of Americans suffer from some form of mental illness?
- about one-fifth
 - less than one in ten thousand
 - about two-thirds
 - about one in a thousand
15. Which of the following people would argue that psychopathology is a myth?
- Philippe Pinel
 - Thomas Szasz
 - Teresa LaFromboise
 - Sigmund Freud
16. What might a severe viral infection do to a woman who has a genetic predisposition toward schizophrenia?
- make her schizophrenic
 - destroy the genetic marker and make her mentally more stable
 - redirect the predisposition toward a different class of mental illness
 - kill her with greater likelihood than if she did not have a predisposition toward mental illness
17. Which of the following has been nicknamed “the common cold of psychopathology” because of its frequency?
- phobia
 - personality disorder
 - schizophrenia
 - depression
18. All of the following are typically true about schizophrenia, *except* that
- less than one-third improve with treatment.
 - the people who have it are aware that they are mentally ill.
 - about 1% of the world's total population is schizophrenic.
 - it is associated with impaired thinking, emotion, and perception.
19. Who is credited as being the first to introduce the idea that insane people are ill?
- Sigmund Freud
 - Jean Charcot
 - Emil Kraepelin
 - Philippe Pinel
20. Which of the following is characterized by boundless energy, optimism, and risk-taking behavior?
- a manic episode
 - paranoid schizophrenia
 - anxiety disorders
 - depression

QUESTIONS TO CONSIDER

- If a person is mentally ill and has violated the law, under what circumstances should he or she be considered responsible for the criminal actions? Under what circumstances should we consider the person to be rehabilitatable?
- Why has the *DSM* been criticized?
- Is homosexuality a deviant behavior?
- Are standards for psychological health the same for men and women? Why are most patients women?
- How can you tell whether your own behavior, anxieties, and moods are within normal limits or whether they signal mental illness?

ACTIVITIES

- Collect the advice columns in the daily papers for a week or two (such as “Ann Landers” or “Dear Abby”). What kinds of problems do people write about? How often does the columnist refer people to a psychologist, psychiatrist, or other professional

- for counseling? Why do people write to an anonymous person for advice about their problems?
2. Ask several people (who are not psychology professionals) to define the terms *emotionally ill*, *mentally ill*, and *insane*. Ask them to describe behaviors that characterize each term. Do some terms indicate more extreme behavior than others? How do their definitions compare with the ones in your text? What can you conclude about the attitudes and understanding of mental illness shown by the people you interviewed?
 3. Read through the *DSM-IV-TR* with an eye toward seeing that it is a statistically based manual. The behaviors that define mental illness fall on the same continuum as those that define mental health. Notice whether there are any classifications within the *DSM-IV-TR* for which some of the criteria are a partial match to you.