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Psychological Disorders

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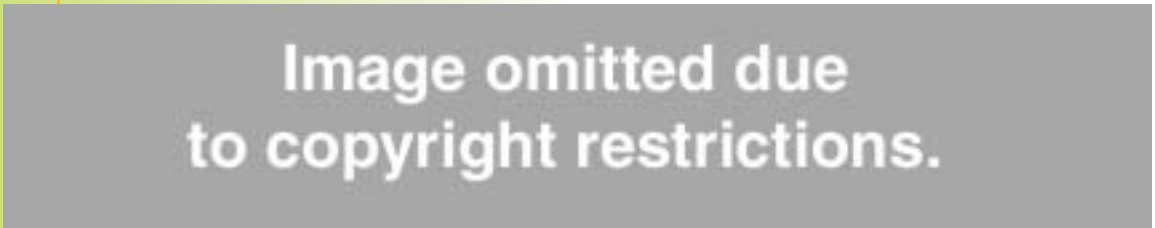

It was early in January, and Sybil Dorsett was working with other students in the chemistry lab at Columbia University in New York. Suddenly the loud crash of breaking glass made her heart pound and her head throb. The room seemed to be whirling around, and the acrid smell of chemicals filled the air, stinging her nostrils.

That smell—so much like the old drugstore back in her native Wisconsin—and the broken glass, like a half-forgotten, far-off memory at home in her dining room when she was a little girl. Again Sybil heard the accusing voice, "You broke it." Frantically she seized her chemistry notes, stuffed them into her brown zipper folder, and ran for the door with all eyes—those of the professor and the other students—following her in astonishment.

Sybil ran down the long, dark hall on the third floor of the chemistry building, pushed the elevator button, and waited. Seconds seemed like hours.

The next thought that entered Sybil's awareness was that of clutching for her brown folder, but it was gone. Gone, too, were the elevator she was waiting for and the long, dark hallway. She found herself walking down a dark, deserted

street in a strange city. An icy wind whipped her face, and thick snowflakes filled the air. This wasn't New York. Where could she be? And how could she have gotten here in the few seconds between waiting for the elevator and now? Sybil walked on, bewildered, and finally came to a newsstand, where she bought a local paper. She was in Philadelphia. The date on the newspaper told her that five days had passed since she stood waiting for the elevator. Where had she been? What had she done?

A victim of sadistic physical abuse since early childhood, Sybil had experienced blackouts—missing days, weeks, and even longer periods, which seemed to have been taken from her life. Unknown to Sybil, other, very different personalities emerged during those periods to take control of her mind and body. Sixteen separate selves, 14 female and 2 male, lived within Sybil, each with different talents and abilities, emotions, ways of speaking and acting, moral values, and ambitions.

For many years Sybil (later identified as Shirley Mason) worked with her psychiatrist and eventually integrated her 16 personalities. After that, she lived a quiet, reclusive life, painting and running an arts business. She remained close to her therapist and eventually died of cancer at the age of 75 on February 26, 1998 (Miller & Kantrowitz, 1999). (Based on Schreiber, 1973.)

What you have just read is not fiction. These and even stranger experiences are part of the real-life story of "Sybil," who suffered from an unusual phenomenon, dissociative identity disorder, better known as multiple personality. Her life story, told in the book *Sybil*, and the life story of Chris Sizemore, told in the film *The Three Faces of Eve*, are two of the best-known cases of this disorder.

How can we know whether *our* behaviour is normal or abnormal? At what point do our fears, thoughts, mood changes, and actions move from normal to mentally disturbed? This chapter explores many psychological disorders, their symptoms, and their possible causes. But first let us ask the obvious question: What is abnormal?

What Is Abnormal?

What criteria might be used to differentiate normal from abnormal behaviour?

Because Sybil's case is such an extreme example, virtually everyone would agree that her behaviour was abnormal. But most abnormal behaviour is not so extreme and clear-cut. There are not two clearly separate and distinct kinds of human beings: one kind always mentally healthy and well-adjusted, and another kind always abnormal and mentally disturbed. Behaviour lies along a continuum, with most of us fairly well-adjusted and experiencing only occasional maladaptive thoughts or behaviour. At one extreme of the continuum are the unusually mentally healthy; at the other extreme are the seriously disturbed, like Sybil.

Abnormal behaviour is defined by each culture. For example, homelessness is considered abnormal in some cultures and completely normal in others.

But where along the continuum does behaviour become abnormal? Several questions can help determine what behaviour is abnormal:

- *Is the behaviour considered strange within the person's own culture?* What is considered normal and abnormal in one culture will not necessarily always be considered so in another. Even within the same culture, conceptions about what is normal can change from time to time.
- *Does the behaviour cause personal distress?* When people experience considerable emotional distress without any life experience that warrants it, they may be diagnosed as having a psychological or mental disorder. But not all people with psychological disorders feel distress. Some feel perfectly comfortable, even happy with the way they are and the way they feel.
- *Is the behaviour maladaptive?* Some experts believe that the best way to differentiate between normal and abnormal behaviour is to consider whether the behaviour is adaptive or maladaptive—that is, whether it leads to healthy or impaired functioning. Maladaptive behaviour interferes with the quality of people's lives and can cause a great deal of distress to family members, friends, and coworkers.
- *Is the person a danger to self or others?* Another consideration is whether people are a threat or danger to themselves or others. In order to be committed to a mental institution, a person has to be judged both mentally ill and a danger to himself or herself or to others.
- *Is the person legally responsible for his or her acts?* Traditionally, the term *insanity* was used to label those who behaved abnormally. "Not guilty due to mental disorder" is a legal phrase used by the Canadian courts to declare people not legally responsible for their acts; the term, however, is not used by mental health professionals.

Perspectives on the Causes and Treatment of Psychological Disorders

What are five current perspectives that attempt to explain the causes of psychological disorders?

The earliest explanation of psychological disorders was that disturbed people were possessed by evil spirits or demons. At present, there are five main perspectives that attempt to explain the causes of psychological disorders and to recommend the best methods of treatment: biological, psychodynamic, learning, cognitive, and humanistic. They are summarized in Review & Reflect 12.1.

Mental health professionals often disagree about the causes of abnormal behaviour and the best treatments; there is less disagreement about diagnosis. Standard criteria have been established and are used by most mental health professionals to diagnose psychological disorders.

REVIEW & REFLECT 12.1
Perspectives on Psychological Disorders: Summary

Perspective	Cause of Psychological Disorders	Treatment
Biological perspective	A psychological disorder is a symptom of an underlying physical disorder caused by a structural or biochemical abnormality in the brain, by genetic inheritance, or by infection.	Diagnose and treat like any other physical disorder Drugs, electroconvulsive therapy, or psychosurgery
Psychodynamic perspective	Early childhood experiences; unconscious sexual or aggressive conflicts; imbalance among id, ego, and superego.	Bring disturbing repressed material to consciousness and help patient work through unconscious conflicts Psychoanalysis
Learning perspective	Abnormal thoughts, feelings, and behaviours are learned and sustained like any other behaviours; or there is a failure to learn appropriate behaviour.	Use classical and operant conditioning and modelling to extinguish abnormal behaviours and to increase adaptive behaviour Behaviour therapy, behaviour modification
Cognitive perspective	Faulty and negative thinking can cause psychological disorders.	Change faulty, irrational, and/or negative thinking Beck's cognitive therapy, rational-emotive therapy
Humanistic perspective	Psychological disorders result from blocking of normal tendency toward self-actualization.	Increase self-acceptance and self-understanding; help patient become more inner-directed Client-centred therapy, Gestalt therapy

Defining and Classifying Psychological Disorders

What is the DSM-IV?

In 1952 the American Psychiatric Association (APA) published a diagnostic system for describing and classifying psychological disorders. Over the years this system has been revised several times. In 1994 the APA published its most recent edition—the *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition), commonly referred to as the **DSM-IV**. It describes about 290 specific psychological disorders and lists the criteria for diagnosing them. The DSM-IV is the most widely accepted diagnostic system in Canada and the United States and is used by researchers, therapists, and mental health workers. It enables a diverse group of professionals to speak the same language when diagnosing, treating, researching, and conversing about a variety of psychological disorders. Review & Reflect 12.2 summarizes the major categories of disorders in the DSM-IV.

You may have heard the terms *neurotic* and *psychotic* used in relation to mental disturbances. The term **neurosis** (now obsolete) used to be applied to disorders that cause people considerable personal distress and some impairment in functioning but do not cause them to lose contact with reality or to violate important social norms. A **psychosis** is a more serious disturbance that greatly impairs everyday functioning. It can cause people to lose touch with reality and to suffer from delusions or hallucinations, or both; it sometimes requires hospitalization. The term *psychosis* is still used by mental health professionals.

REVIEW & REFLECT 12.1
Perspectives on Psychological Disorders: Summary

Disorder	Symptoms	Examples
Anxiety disorders	Disorders characterized by anxiety and avoidance behaviour.	Panic disorder Social phobia Obsessive-compulsive disorder Posttraumatic stress disorder
Somatoform disorders	Disorders in which physical symptoms are present that are psychological in origin rather than due to a medical condition.	Hypochondriasis Pain disorder Conversion disorder
Dissociative disorders	Disorders in which one handles stress or conflict by forgetting important personal information or one's whole identity, or by compartmentalizing the trauma or conflict into a split-off alter personality.	Dissociative amnesia Dissociative fugue Dissociative identity disorder
Schizophrenia and other psychotic disorders	Disorders characterized by the presence of psychotic symptoms including hallucinations, delusions, disorganized speech, bizarre behaviour, or loss of contact with reality.	Schizophrenia, disorganized type Schizophrenia, paranoid type Schizophrenia, catatonic type Delusional disorder, jealous type
Mood disorders	Disorders characterized by periods of extreme or prolonged depression or mania, or both.	Major depressive disorder Bipolar disorder
Personality disorders	Disorders characterized by long-standing, inflexible, maladaptive patterns of behaviour beginning early in life and causing personal distress or problems in social and occupational functioning.	Antisocial personality disorder Histrionic personality disorder Narcissistic personality disorder Borderline personality disorder
Substance-related disorders	Disorders in which undesirable behavioural changes result from substance abuse, dependence, or intoxication.	Alcohol abuse Cocaine abuse Cannabis dependence
Disorders usually first diagnosed in infancy, childhood, or adolescence	Disorders that include mental disability, learning disorders, communication disorders, pervasive developmental disorders, attention-deficit and disruptive behaviour disorders, tic disorders, and elimination disorders.	Conduct disorder Autism Tourette's syndrome Stuttering
Sleep disorders	Disorders including dyssomnias (disturbance in the amount, quality, or timing of sleep) and parasomnias (abnormal occurrences during sleep).	Primary insomnia Narcolepsy Sleep terror disorder Sleepwalking disorder
Eating disorders	Disorders characterized by severe disturbances in eating behaviour.	Anorexia nervosa Bulimia nervosa

Source: Based on DSM-IV (APA, 1994).

DSM-IV: *The Diagnostic and Statistical Manual of Mental Disorders* (fourth edition); it describes about 290 mental disorders and the symptoms that must be present for diagnosing each disorder.

neurosis (new-RO-sis): An obsolete term for a disorder causing personal distress and some impairment in functioning, but not causing one to lose contact with reality or to violate important social norms.

psychosis (sy-CO-sis): A severe psychological disorder, sometimes requiring hospitalization, in which one typically loses contact with reality, suffers delusions and/or hallucinations, and has a seriously impaired ability to function in everyday life.

Remember It! What Is Abnormal?

1. It is relatively easy to differentiate normal behaviour from abnormal behaviour. (true/false)
2. Match the perspective with its suggested cause of abnormal behaviour.

____ 1) faulty learning	a. psychodynamic
____ 2) unconscious, unresolved conflicts	b. biological
____ 3) blocking of the natural tendency toward self-actualization	c. learning
____ 4) genetic inheritance or biochemical or structural abnormalities in the brain	d. humanistic
____ 5) faulty thinking	e. cognitive

3. The DSM-IV is a manual published by the American Psychiatric Association that is used to
   a. diagnose psychological disorders.
   b. explain the causes of psychological disorders.
   c. outline treatments for various psychological disorders.
   d. assess the effectiveness of treatment programs.

Answers: 1. false 2. 1) c 2) a 3) d 4) b 5) e 3. a

Anxiety Disorders: When Anxiety Is Extreme

When is anxiety healthy, and when is it unhealthy?

Anxiety is a vague, general uneasiness or feeling that something bad is about to happen. Anxiety may be associated with a particular situation or object, or it may be free-floating—not associated with anything specific. None of us is a stranger to anxiety. We have all felt it.

Some anxiety is normal and appropriate. Imagine that you are driving on a highway late at night when you notice that your gas tank indicator is on empty. A wave of anxiety sweeps over you, and you immediately begin to look for a service station. You are feeling normal anxiety—a response to a real danger or threat. Normal anxiety prompts us to take useful action and is therefore healthy. Anxiety is abnormal if it is out of proportion to the seriousness of the situation, if it does not fade soon after the danger is past, or if it occurs in the absence of real danger (Goodwin, 1986).

Some of the psychological disorders characterized by severe anxiety are generalized anxiety disorder, panic disorder, phobias, and obsessive-compulsive disorder.

Generalized Anxiety Disorder

Generalized anxiety disorder is the diagnosis given to people who experience *excessive* anxiety and worry that they find difficult to control. They may be unduly worried about their finances or their own health or the health of family members. They may worry unnecessarily about their performance at work or their ability to function socially. Their excessive anxiety may cause them to feel tense, on edge, tired, and irritable, and to have difficulty concentrating and sleeping. Their symptoms may include trembling, palpitations, sweating, dizziness, nausea, diarrhea, and frequent urination. It is estimated that about 5 percent of North Americans will suffer from generalized anxiety disorder sooner or later. Kendler and colleagues (1992b) estimate the heritability of generalized anxiety disorder to be about 30 percent. Previously thought of as a mild disorder, generalized anxiety disorder is now considered to substantially reduce the quality of life for those who suffer from it (Brawman-Mintzer & Lydiard, 1997; Kranzler, 1996).

Panic Disorder

What are the symptoms of a panic disorder?

Mindy Markowitz is an attractive, stylishly dressed, 25-year-old art director for a trade magazine. She is seeking

treatment for her "panic attacks," which have been escalating over the past year. These attacks—she now has two or three a day—begin with a sudden and intense wave of "horrible fear" that seems to come out of nowhere. Some of these strike her during the day, some wake her from sleep. She begins to tremble, sweats profusely, and feels nauseated. She also feels as though she is gagging and fears that she will lose control and do something crazy, like run screaming into the street. (Adapted from Spitzer et al., 1989, p. 154)

During **panic attacks**—attacks of overwhelming anxiety, fear, or terror—people commonly report a pounding heart, uncontrollable trembling or shaking, and a feeling of being choked or smothered. They may report being afraid that they are going to die or that they are "going crazy."

Markowitz was diagnosed with **panic disorder**, which is characterized by recurrent, unpredictable panic attacks that cause apprehension about the occurrence and consequences of further attacks. This apprehension can cause people to avoid situations that have been associated with previous panic attacks.

The biological perspective sheds some light on panic disorder. PET scans reveal that even in a nonpanic state, many panic-disorder patients show a greatly increased blood flow to parts of the right hemisphere of the limbic system—the part of the brain involved in emotion (Reiman et al., 1989). Family and twin studies, too, suggest that genetic factors play a role in panic disorder (Goldstein et al., 1994).

Faravelli and Pallanti (1989) found that high stress, particularly in the form of significant losses or threatening events, may be the precipitating factor in the first panic attack. Once people have had an attack, they may develop extreme anxiety that it will happen again (Gorman et al., 1989). Clark and colleagues (1997) offer a cognitive theory suggesting that panic attacks are associated with a catastrophic misinterpretation of bodily sensations. Roth and colleagues (1992) suggest that when panic disorder patients know that a stressor is coming, their anticipatory anxiety may set the stage for a panic attack.

Panic disorder can have significant social and health consequences (Sherbourne et al., 1996). Panic disorder patients tend to overuse the health-care system (Katon, 1996) and are at increased risk for abuse of alcohol and other drugs (Marshall, 1997).

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Phobias: Persistent, Irrational Fears

What are the characteristics of the three categories of phobias?

People suffering from a **phobia** experience a persistent, irrational fear of some specific object, situation, or activity that poses no real danger (or whose danger they blow out of proportion). Phobics realize their fear is irrational; they nevertheless feel compelled to avoid the feared object or situation. There are three classes of phobias—agoraphobia, social phobia, and specific phobia.

Agoraphobia

A person with **agoraphobia** has an intense fear of being in a situation where immediate escape is not possible or help would not be readily available. In some cases an individual's entire life must be planned around avoiding feared situations such as busy streets, crowded stores, restaurants, or public transportation. An agoraphobic often will not leave home unless accompanied by a friend or family member—and in severe cases, not even then.

anxiety: A generalized feeling of apprehension, fear, or tension that may be associated with a particular object or situation or may be free-floating, not associated with anything specific.

generalized anxiety disorder: An anxiety disorder in which people experience excessive anxiety or worry that they find difficult to control.

panic attack: An attack of overwhelming anxiety, fear, or terror.

panic disorder: An anxiety disorder in which a person experiences recurrent unpredictable attacks of overwhelming anxiety, fear, or terror.

phobia (FO-bee-ah): A persistent, irrational fear of an object, situation, or activity that the person feels compelled to avoid.

agoraphobia (AG-or-uh-FO-bee-uh): An intense fear of being in a situation where immediate escape is not possible or help is not immediately available in case of incapacitating anxiety.

People with agoraphobia have an intense fear of public places and are often reluctant to leave home.

Although agoraphobia can occur without panic attacks, it typically begins during the early adult years with repeated panic attacks (Horwath et al., 1993). The intense fear of having another attack causes the person to avoid any place or situation where previous attacks have occurred. Some researchers believe that agoraphobia is actually an extreme form of panic disorder (Sheehan, 1983; Thyer et al., 1985).

A person is at greater risk of having agoraphobia if other family members have it. The closer the relative, the higher the risk (Rosenbaum et al., 1994). Some agoraphobics have been treated successfully with psychotherapy (Shear & Weiner, 1997); others have responded well to antidepressants (Marshall, 1997).

Social Phobia

Those with **social phobia** have an irrational fear of social or performance situations in which they might embarrass or humiliate themselves in front of others—where they might shake, blush, sweat, or in some other way appear clumsy, foolish, or incompetent. They may fear eating, talking, or writing in front of others, or doing anything else that would cause people to think poorly of them. Can you imagine being unable to cash a cheque, use a credit card, or even make notes or take a written exam in class because you feared writing in front of other people?

Although less debilitating than agoraphobia, social phobia in its extreme form can seriously harm people's prospects at work and at school, and severely restrict their social life (Greist, 1995). Those with social phobia often turn to alcohol and tranquilizers to lessen their anxiety in social situations (Kushner et al., 1990).

Specific Phobia

Specific phobia is a catchall category for any phobias other than agoraphobia and social phobia. The categories of specific phobias, in order of frequency of occurrence, are as follows: (1) situational phobias (fear of elevators, airplanes, enclosed places, public transportation, tunnels, bridges); (2) fear of the natural environment (storms, water, heights); (3) blood/injection/injury phobia (fear of seeing blood or injury, receiving an injection); and (4) animal phobias (fear of dogs, snakes, insects, mice). Two types of situational phobia—claustrophobia (fear of closed spaces) and acrophobia (fear of heights)—are the specific phobias treated most often by therapists. *Try It!* will introduce you to some others.

People with specific phobias generally fear the same things others fear, but their fears are grossly exaggerated. A fear is not considered a phobia unless it causes a great deal of distress or interferes with a person's life in a major way. Phobics experience intense anxiety when they are faced with the object or situation they fear, even to the point of shaking or screaming.

Try It!

Identifying Some Specific Phobias

Can you match the following specific phobias with their descriptions?

____ 1. Acrophobia	a. Fear of high places
____ 2. Anthropophobia	b. Fear of fire
____ 3. Arachnophobia	c. Fear of animals
____ 4. Monophobia	d. Fear of human beings
____ 5. Pyrophobia	e. Fear of spiders
____ 6. Zoophobia	f. Fear of being alone

Answers: 1. a 2. d 3. e 4. f 5. b 6. c

Phobics will go to great lengths to avoid the feared object or situation. Some people with blood-injury phobia will not seek medical care even if it is a matter of life and death (Marks, 1988). Few of us are thrilled at the prospect of visiting the dentist, but some people with a dental phobia will actually let their teeth rot rather than visit the dentist.

Causes of Phobias

What do psychologists believe are some probable causes of phobias?

It is likely that most specific and social phobias result from learning; that is, direct conditioning, modelling, or the transmission of information (Eysenck, 1987; Thyer et al., 1985). Frightening experiences, most experts agree, set the stage for phobias, although not all phobics recall the experience that produced the phobia. A person with a dog phobia may be able to trace its beginning to a painful dog bite (King et al., 1997); a fear of heights may date from a frightening fall down a flight of stairs (Beck & Emory, 1985). A person may be humiliated by performing poorly in front of others and develop a social phobia (Rosenbaum et al., 1994).

Phobias may be acquired through observational learning. For example, children who hear their parents talk about frightening experiences with the dentist or with bugs or snakes or thunderstorms may develop similar fears themselves. In many cases phobias are acquired through a combination of conditioning and observational learning (Merckelbach et al., 1996).

Genes appear to play a role in specific phobias (particularly animal phobias), social phobia, and agoraphobia. People are at three times the risk if a close relative suffers from a phobia (Fyer et al., 1993).

Obsessive-Compulsive Disorder

What is obsessive-compulsive disorder?

What is wrong with a person who is endlessly counting, checking, or performing other time-consuming rituals over and over? Why would a person wash his or her hands 100 times a day until they are raw and bleeding? People with another form of anxiety disorder, **obsessive-compulsive disorder (OCD)**, suffer from recurrent obsessions, or compulsions, or both.

Obsessions

Have you ever had a tune or the words of a song run through your mind over and over without being able to stop it? If so, you have experienced obsessive thinking in a mild form. Imagine how miserable you would be if every time you touched something you thought you were being contaminated, or if the thought of stabbing your mother kept popping into your mind. **Obsessions** are persistent, recurring, involuntary thoughts, images, or impulses that invade consciousness and cause great distress.

Common themes of obsessions include worry about contamination and doubt as to whether a certain act was performed (Insel, 1990). People with obsessional doubt may have a persistent fear that they failed to turn off the stove or put out a cigarette. Other types of obsessions centre on aggression, religion, or sex. One minister reported obsessive thoughts of running naked down the church aisle and shouting obscenities at his congregation.

Do people ever act on their obsessive thoughts? It is not unheard of, but it is extremely rare. Yet many people are so horrified by their obsessions that they think they are going crazy.

Compulsions

A person who has a **compulsion** feels literally compelled to repeat certain acts over and over or to perform specific rituals repeatedly. The individual knows such acts are irrational and senseless, but resistance to performing them would result in an intolerable buildup of anxiety—anxiety that can be relieved only by yielding to the compulsion. Many of us have engaged in compulsive behaviour from time to time (e.g., stepping over cracks on the sidewalk, counting

social phobia: An irrational fear and avoidance of social situations in which people believe they might embarrass or humiliate themselves by appearing clumsy, foolish, or incompetent.

specific phobia: A catchall category for any phobia other than agoraphobia and social phobia.

obsessive-compulsive disorder (OCD): An anxiety disorder in which a person suffers from obsessions and/or compulsions.

obsession: A persistent, recurring, involuntary thought, image, or impulse that invades consciousness and causes great distress.

compulsion: A persistent, irresistible, irrational urge to perform an act or ritual repeatedly.

stairs). The behaviour becomes a psychological problem only when the person cannot resist performing it, when it is very time-consuming, and when it interferes with the person's normal activities and relationships.

Compulsions usually involve cleanliness, counting, checking, touching objects, hoarding, or excessive ordering (Leckman et al., 1997; Summerfeldt et al., 1999). Sometimes compulsive acts or rituals resemble "magical" thinking and must be performed faithfully in order to ward off some danger. People with OCD do not enjoy the time-consuming rituals—the endless counting, checking, hand washing, or cleaning. They realize that their behaviour is not normal but they simply cannot help themselves, as shown in the following example:

> Mike, a 32-year-old patient, performed checking rituals that were preceded by a fear of harming other people. When driving, he had to stop the car often and return to check whether he had run over people, particularly babies. Before flushing the toilet, he had to check to be sure that a live insect had not fallen into the toilet, because he did not want to be responsible for killing a living thing. At home he repeatedly checked to see that the doors, stoves, lights, and windows were shut or turned off. … Mike performed these and many other checking rituals for an average of four hours a day. (Kozak et al., 1988, p. 88)

Are there many Mikes out there, or is his case unusual? Mike's checking compulsion is quite extreme. That being said, between 1.1 and 1.8 percent of Canadians, Americans, Puerto Ricans, Germans, Koreans, and New Zealanders (Weissman et al., 1994) suffer from obsessive-compulsive disorder.

About 70 percent of people in treatment for OCD have both obsessions and compulsions. This was long assumed to be the most common pattern. It has since been found, however, that in the general population, 50 percent of OCD cases involve obsessions only, 34 percent compulsions only, and 16 percent both obsessions and compulsions (Weissman et al., 1994). When both occur together, the compulsion most often serves to relieve the anxiety caused by the obsession. All age groups with this disorder—children, adolescents, and adults—show strikingly similar thoughts and rituals (Swedo et al., 1989).

Causes of Obsessive-Compulsive Disorder

For many years obsessive-compulsives were seen as extremely insecure individuals who viewed the world as threatening and unpredictable. Their ritualistic behaviour was thought to be a means for imposing some order, structure, and predictability on the world. From the psychodynamic perspective, obsessive-compulsive behaviour protects individuals from recognizing the real reasons for their anxiety—repressed hostility or unacceptable sexual urges. Thus a person, without knowing quite why, might wash hands compulsively to atone for "dirty thoughts."

Some evidence points to a biological basis for obsessive-compulsive disorder in some patients. Several twin and family studies suggest that a genetic factor may be involved (Rasmussen & Eisen, 1990). PET scans of OCD patients have revealed abnormally high rates of glucose consumption in two regions of the brain involved in emotional reactions (Rauch et al., 1994).

The most significant finding seems to be that many OCD patients have an imbalance in levels of the neurotransmitter serotonin (Pigott, 1996). Such patients are often helped by an antidepressant that restores the balance of serotonin (Murphy & Pigott, 1990). But because the drug treatment does not work for all OCD patients, some researchers suggest that OCD may have several different causes (Goodman et al., 1989).

Most people with OCD never get treatment; they know their symptoms are bizarre and are afraid to seek help for fear other people will think they are "crazy" (Rasmussen & Eisen, 1992).

Somatoform and Dissociative Disorders

Somatoform Disorders: Physical Symptoms with Psychological Causes

What are two somatoform disorders, and what symptoms do they share?

The word *soma* means "body." The **somatoform disorders** involve bodily symptoms that cannot be explained by known medical conditions. Although they are psychological in origin, patients are sincerely convinced

Remember It! Anxiety Disorders

1. Anxiety serves no useful function. (true/false)
2. Match the psychological disorder with the example.

____ 1) Renée refuses to eat in front of others for fear her hand will shake.

____ 2) John is excessively anxious about his health and his job, even though there is no concrete reason for it.

____ 3) Betty has been housebound for four years.

____ 4) Jackson gets hysterical when a dog approaches him.

____ 5) Laura has incapacitating attacks of anxiety that come over her suddenly.

____ 6) Max repeatedly checks his doors, windows, and appliances before he goes to bed.

a. panic disorder
b. agoraphobia
c. specific phobia
d. generalized anxiety disorder
e. social phobia
f. obsessive-compulsive disorder

3. Most phobias result from frightening experiences and observational learning. (true/false)
4. Obsessive-compulsive disorder appears to be caused primarily by psychological rather than biological factors. (true/false)

Answers: 1. false 2. 1) e 2) d 3) b 4) c 5) a 6) f 3. true 4. false

that their symptoms spring from real physical disorders. People with somatoform disorders are not consciously faking illness to avoid work or other activities. Hypochondriasis and conversion disorder are two types of somatoform disorders.

Hypochondriasis

People with **hypochondriasis** are overly concerned about their health. They are preoccupied with the fear that their bodily symptoms are a sign of some serious disease, but their symptoms are not usually consistent with known physical disorders. Even when a medical examination reveals no physical problem, hypochondriacs are not convinced. They may "doctor shop," going from one physician to another, seeking confirmation of their worst fears. Unfortunately, hypochondriasis is not easily treated, and there is usually a poor chance of recovery.

Conversion Disorder: When Thoughts and Fears Can Paralyze

A man is suddenly struck blind, or an arm, a leg, or some other part of his body becomes paralyzed. Extensive medical tests find nothing wrong—no possible physical reason for the blindness or the paralysis. How can this be?

A diagnosis of **conversion disorder** is made when there is a loss of motor or sensory functioning in some part of the body that (a) is not due to a physical cause and (b) solves a psychological problem. Psychologists think that conversion disorder can act as an unconscious defence against any intolerable anxiety situation that the individual cannot otherwise escape. For example, a soldier who desperately fears going into battle may escape the anxiety by developing a paralysis or some other physically disabling symptom.

You would expect normal people to show great distress if they suddenly lost their sight or hearing or became paralyzed. Yet many patients with con-

somatoform disorders (so-MAT-uh-form): Disorders in which physical symptoms are present that are due to psychological rather than physical causes.

hypochondriasis (HI-poh-kahn-DRY-uh-sis): A somatoform disorder in which persons are preoccupied with their health and convinced they have some serious disorder despite reassurance from doctors to the contrary.

conversion disorder: A somatoform disorder in which a loss of motor or sensory functioning in some part of the body has no physical cause but solves some psychological problem.

version disorder exhibit a calm and cool indifference to their symptoms, called "la belle indifference." Furthermore, many seem to enjoy the attention, sympathy, and concern their disability brings them.

Dissociative Disorders: Mental Escapes

We are consciously aware of who we are. Our memories, our identity, our consciousness, and our perception of the environment are integrated. But some people, in response to unbearable stress, develop a **dissociative disorder** and lose this integration. Their consciousness becomes dissociated either from their identity or from their memories of important personal events. Dissociative disorders provide a mental escape from intolerable circumstances. Three types of dissociative disorders are dissociative amnesia, dissociative fugue, and dissociative identity disorder (commonly known as "multiple personality").

Dissociative Amnesia: "Who Am I?"

What is dissociative amnesia?

Amnesia is a complete or partial loss of the ability to recall personal information or identify past experiences that cannot be attributed to ordinary forgetfulness or substance use. Popular books, movies, and TV shows have used amnesia as a central theme in which, usually after a blow to the head, characters cannot remember who they are or anything about their past. In **dissociative amnesia**, however, no physical cause such as a blow to the head is present. Rather, a traumatic experience—a *psychological* blow, so to speak—or an unbearable anxiety situation causes the person to escape by "forgetting." Patients with dissociative amnesia can have a loss of memory about specific periods of their life or a complete loss of memory for their entire identity. For example, if a man experienced the very traumatic event of watching his child be struck and killed by a car, he might avoid facing the trauma by developing some form of dissociative amnesia. Yet such people do not forget everything. They forget only items of personal reference such as their name, their age, and where they live. They may also fail to recognize their parents, other relatives, and friends. But they do not forget how to read and write or solve problems, and their basic personality structure remains intact.

Dissociative Fugue: "Where Did I Go and What Did I Do?"

What is dissociative fugue?

Even more puzzling than dissociative amnesia is **dissociative fugue**. In a fugue state, people not only forget their identity, they also physically leave the scene and travel away from home. Some take on a new identity that is usually more outgoing and uninhibited than their former identity (APA, 1994). The fugue state may last for hours, days, or even months. The fugue is usually a reaction to some severe psychological stress, such as a natural disaster, a serious family quarrel, a deep personal rejection, or military service in wartime.

For most people, recovery from dissociative fugue is usually rapid, although there may be some amnesia for the initial stressor that brought on the fugue state. When people recover from the fugue, they often have no memory of events that occurred during the episode.

Dissociative Identity Disorder: Multiple Personality

What are some of the identifying symptoms of dissociative identity disorder?

In **dissociative identity disorder**, two or more distinct, unique personalities exist in the same individual, as in the case of Sybil, described at the beginning of this chapter. In 50 percent of cases of dissociative identity disorder, there are more than 10 different personalities (Sybil had 16). The change from one personality to another often occurs suddenly—usually during stress. The *host personality* is "the one who has executive control of the body the greatest percentage of time" (Kluft, 1984, p. 23). The alternate or *alter personalities* may differ radically in intelligence, speech, accent, vocabulary, posture, body language, hairstyle, taste in clothes, manners, and even handwriting. And incredibly, within the same individual, the alter personalities may differ in gender, age, and even sexual orientation. Almost all people with this disorder have "a number of child and infant personalities" (Putnam, 1992, p. 34). Some alters may be right-handed, others left-handed. Some alters may need different prescription glasses, have specific food allergies, or show different responses to alcohol or medications (Putnam et al., 1986). There are usually promiscuous alters who act on forbidden impulses (Putnam, 1992).

Remember It! Somatoform and Dissociative Disorders

1. Match the psychological disorder with the example.

____ 1) Mark is convinced he has some serious disease although his doctors can find nothing physically wrong.

____ 2) David was found far away from his hometown, calling himself by another name and having no memory of his past.

____ 3) Theresa suddenly loses her sight, but doctors can find no physical reason for the problem.

____ 4) Larry has no memory of being in the boat with other family members on the day his older brother drowned.

____ 5) Nadine has no memory for blocks of time in her life and often finds clothing in her closet that she cannot remember buying.

a. dissociative identity disorder
b. dissociative fugue
c. dissociative amnesia
d. hypochondriasis
e. conversion disorder

2. Somatoform disorders have physiological rather than psychological causes. (true/false)
3. Dissociative disorders are psychological in origin. (true/false)

Answers: 1. 1) d 2) b 3) e 4) c 5) a 2. false 3. true

Many multiple-personality patients report hearing voices and sometimes the sounds of crying or screaming or laughter. For this reason, such patients have often been misdiagnosed as schizophrenic.

In 80 percent of the cases of dissociative identity disorder, the host personality does not know of the alters, but "the alter personalities will possess varying levels of awareness for one another" (Putnam 1989, p. 114). The host and alter personalities commonly show amnesia for certain periods of time or for important life episodes (e.g., their wedding, the birth of a child). There is the common complaint of "lost time"—periods for which a given personality has no memory because he or she was not in control of the body.

CAUSES OF DISSOCIATIVE IDENTITY DISORDER Dissociative identity disorder usually begins in early childhood, but the condition is rarely diagnosed before adolescence (Vincent & Pickering, 1988). Colin Ross and his colleagues (1989) at the University of Manitoba studied many cases of people diagnosed with dissociative identity disorder. They found that about 90 percent of the treated cases were women. More than 95 percent had an early history of severe physical and/or sexual abuse (Gleaves, 1996; Ross et al., 1990). The splitting off of separate personalities is apparently a way of coping with such intolerable abuse. How can we account for the 5 percent of multiple-personality patients who were not abused? The psychodynamic perspective suggests that alternate personalities may come forth to express sexual or aggressive impulses that would be unacceptable to the original personality. However, this suggestion has not been experimentally verified. Regardless of cause, this disorder can be treated, often by psychotherapy, and empirical evidence suggests patients respond well to treatment (Ellason & Ross, 1997).

dissociative disorders: Disorders in which, under stress, one loses the integration of consciousness, identity, and memories of important personal events.

dissociative amnesia: A dissociative disorder in which there is a loss of memory for limited periods in one's life or for one's entire personal identity.

dissociative fugue (FEWG): A dissociative disorder in which one has a complete loss of memory for one's entire identity, travels away from home, and may assume a new identity.

dissociative identity disorder: A dissociative disorder in which two or more distinct personalities occur in the same individual, each taking over at different times; also called multiple personality.

Schizophrenia

To a mild degree we can identify with most people who suffer from most psychological disorders. We can imagine being anxious, fearful, depressed; we can picture ourselves having an obsession or a compulsion. But schizophrenia is so far removed from our common, everyday experience that it is all but impossible for us to imagine what it is like to be schizophrenic.

Schizophrenia is the most serious of the psychological disorders. It affects about one person in a hundred. Schizophrenia usually begins in adolescence or early adulthood, although it can appear later in life. It is probably the most devastating of all the psychological disorders because of the social disruption and misery it brings to those who suffer from it and to their families.

LINK IT!

www.schizophrenia.ca
Schizophrenia Society of Canada

www.schizophrenia.com
The Schizophrenia Home Page

The Symptoms of Schizophrenia: Many and Varied

There are many symptoms associated with schizophrenia. Any given individual with the disorder may have one or more of the major symptoms, but there is no one single symptom or brain abnormality that is shared by all schizophrenics (see Andreasen, 1999). The symptoms of schizophrenia fall into two categories: positive and negative.

Positive Symptoms

What are some of the major positive symptoms of schizophrenia?

Positive symptoms are so named not because they are desirable, but rather because they are present (as opposed to absent). Positive symptoms include hallucinations, delusions, disorganized thinking and speech, and grossly disorganized or bizarre behaviour (McGlashan & Fenton, 1992).

HALLUCINATIONS One of the clearest symptoms that suggests schizophrenia is the presence of **hallucinations**—imaginary sensations. Schizophrenic patients may see, hear, feel, taste, or smell strange things in the absence of any stimulus in the environment. Hearing voices is the most common type of hallucination. Schizophrenic patients may believe they hear the voice of God or Satan, the voices of family members or friends, and even their own voice broadcasting aloud what they are thinking. Most often the voices are unpleasant, accusing or cursing the patient or engaging in a running commentary on his or her behaviour. Sometimes the voices are menacing and order the patient to kill someone or commit suicide.

Visual hallucinations are less common than auditory ones. They are usually in black and white and commonly take the form of friends, relatives, God, Jesus, or the devil. Schizophrenics may also experience bodily sensations that are exceedingly frightening and painful. They may feel they are being beaten, burned, or sexually violated. One schizophrenic complained that "spiders were crawling all through his heart and vessels, eating his brain, and although he could not see them, he thought he could feel them crawling on his skin" (Salama & England, 1990, p. 86).

DELUSIONS Imagine how upset you would be if you believed that your every thought was being broadcast aloud for everyone to hear. What if you were convinced that some strange agent or force was stealing your thoughts or inserting in your head thoughts that were not your own? These are examples of **delusions**—false beliefs that are not generally shared by others in the culture. Usually patients cannot be persuaded that their beliefs are false, even in the face of strong evidence.

Delusions may be of several different types. Schizophrenics with **delusions of grandeur** may believe they are a famous person (the Queen or Jesus Christ, for example) or a powerful or important person who possesses some great knowledge, ability, or authority. Those with **delusions of persecution** have the false notion that some person or agency is trying to harass, cheat, spy on, conspire against, injure, kill, or in some other way harm them.

DISTURBANCES IN THE FORM OF THOUGHT OR SPEECH Schizophrenia is often marked by thought disturbance. The most common type involves a loosening of associations—the individual does not follow one line of thought to completion, but on the basis of vague connections shifts from one subject to another. The speech

of schizophrenics is often very difficult, if not impossible, to understand. The content of the message may be extremely vague, or the person may invent words or use them inappropriately (Chaika, 1985):

> I am writing on paper. The pen I am using is from a factory called "Perry & Co." This factory is in England.... The city of London is in England. I know this from my school-days. Then, I always liked geography. My last teacher in that subject was … a man with black eyes. I also like black eyes. There are also blue and gray eyes and other sorts, too. I have heard it said that snakes have green eyes. All people have eyes. There are some, too, who are blind. (Bleuler, 1950, p. 17)

GROSSLY DISORGANIZED BEHAVIOUR Grossly disorganized behaviour can include such things as childlike silliness, inappropriate sexual behaviour (masturbating in public), dishevelled appearance, and peculiar dress. There may also be unpredictable agitation, including shouting and swearing, and unusual or inappropriate motor behaviour, including strange gestures, facial expressions, or postures.

INAPPROPRIATE AFFECT Schizophrenics may have grossly **inappropriate affect** —that is, their facial expressions, tone of voice, and gestures may not reflect the emotion that would be expected under the circumstances. A person might cry when watching a TV comedy and laugh when watching a news story showing bloody bodies being removed from a fatal automobile accident.

Negative Symptoms

What are some of the major negative symptoms of schizophrenia?

Negative symptoms of schizophrenia involve a loss of or deficiency in thoughts and behaviours that are characteristic in normal functioning. Negative symptoms may include social withdrawal, apathy, loss of motivation, lack of goal-directed activity, very limited speech, slow movements, and poor hygiene and grooming (McGlashan & Fenton, 1992). Some schizophrenic patients show *flat affect*—practically no emotional response at all. They may speak in a monotone, and their facial expressions may be blank and emotionless. Such patients may act and move more like robots than humans.

Some researchers who have followed schizophrenics over a number of years have found that those with negative symptoms seem to have the poorest outcomes (Belitsky & McGlashan, 1993; Fenton & McGlashan, 1994). They tend to withdraw from others and retreat into their own world. Often their functioning is too impaired for them to hold a job or even care for themselves.

Brain Abnormalities in Some Schizophrenics

Several abnormalities in brain structure and function have been found in schizophrenic patients. Among these are defects in the neural circuitry of the cerebral cortex (Andreasen, 1999) and abnormally low neural activity in the frontal lobes (Buchsbaum et al., 1996). Some studies have revealed a decreased volume of the hippocampus, the amygdala (Nelson et al., 1998), and the thalamus (Buchsbaum et al., 1996). In many schizophrenics, there is a deficit in cortical grey matter (Lim et al., 1996), and the ventricles are larger than in the normal brain (Lieberman et al., 1992).

Types of Schizophrenia

What are the four subtypes of schizophrenia?

Various behavioural characteristics are shared by most schizophrenics; there are also certain features that distinguish one subtype of schizophrenia from

schizophrenia (SKIT-soh-FREE-nee-ah): A severe psychological disorder characterized by loss of contact with reality, hallucinations, delusions, inappropriate or flat affect, some disturbance in thinking, social withdrawal, and/or other bizarre behaviour.

hallucination: A sensory perception in the absence of any external sensory stimulus; an imaginary sensation.

delusion: A false belief, not generally shared by others in the culture, that cannot be changed despite strong evidence to the contrary.

delusion of grandeur: A false belief that one is a famous person or that one has some great knowledge, ability, or authority.

delusion of persecution: An individual's false belief that a person or group is trying in some way to harm him or her.

inappropriate affect: A symptom common in schizophrenia in which an individual's behaviour (including facial expression, tone of voice, and gestures) does not reflect the emotion that would be expected under the circumstances–for example, a person laughs at a tragedy, cries at a joke.

A person with catatonic schizophrenia may become frozen in an unusual position, like a statue, for hours at a time.

another. Four main types of schizophrenia exist: catatonic, disorganized, paranoid, and undifferentiated.

People with **catatonic schizophrenia** may display complete stillness and stupor, or great excitement and agitation. Frequently they alternate rapidly between the two. They may become frozen in a strange posture or position, as shown in the photograph, and remain there for hours without moving.

Disorganized schizophrenia is the most serious type, marked by extreme social withdrawal, hallucinations, delusions, silliness, inappropriate laughter, grimaces, grotesque mannerisms, and other bizarre behaviour. These people show flat or inappropriate affect and are frequently incoherent. They often exhibit obscene behaviour, masturbate openly, and swallow almost any kind of object or material. Disorganized schizophrenia tends to occur at an earlier age than the other types, and it results in the most severe disintegration of the personality (Beratis et al., 1994). Patients with this type of schizophrenia have the poorest chance of recovery (Fenton & McGlashan, 1991; Kane, 1993).

People with **paranoid schizophrenia** usually suffer from delusions of grandeur or persecution. They may be convinced that they have an identity other than their own. Their delusions may include the belief that they possess great ability or talent, or that they have some special mission. They may believe that they are in charge of the hospital or on a secret assignment for the government. Paranoid schizophrenics often show exaggerated anger and suspiciousness. If they have delusions of persecution and feel that they are being harassed or threatened, they may become violent in an attempt to defend themselves against their imagined persecutors. Usually the behaviour of the paranoid schizophrenic is not so obviously disturbed as that of the catatonic or disorganized type, and the chance for recovery is better (Fenton & McGlashan, 1991; Kendler et al., 1984).

Undifferentiated schizophrenia is a general catchall category for individuals who clearly have symptoms of schizophrenia but whose symptoms either do not conform to the criteria of any other type of schizophrenia or conform to more than one type.

The Causes of Schizophrenia

What are some suggested causes of schizophrenia?

During the 1950s and 1960s, many psychiatrists and some researchers pointed to unhealthy patterns of communication and interaction in the entire family as the breeding ground for schizophrenia (Bateson et al., 1956; Lidz et al., 1965). However, unhealthy family interaction patterns could be the *result* rather than the *cause* of schizophrenia. There is no convincing evidence to justify pointing the finger of blame at mothers, fathers, or other family members (Johnson, 1989; Torrey, 1983).

Research evidence continues to mount that biology is a factor in many cases of schizophrenia.

Genetic Inheritance

Research suggests that schizophrenia tends to run in families and that genetic factors play a major role (Gottesman, 1991; Kendler et al., 1993; Mortensen et al., 1999). Figure 12.1 shows how the likelihood of developing schizophrenia varies with the degree of relationship to a schizophrenic patient.

According to genetic theorists, what is inherited is not schizophrenia itself, but a predisposition to it (Zubin & Spring, 1977). People with a genetic predisposition may develop the disorder if exposed to sufficient environmental stressors, either in the womb or during childhood, adolescence, or adulthood. According to the **diathesis–stress model**, schizophrenia develops when there is *both* a genetic pre-

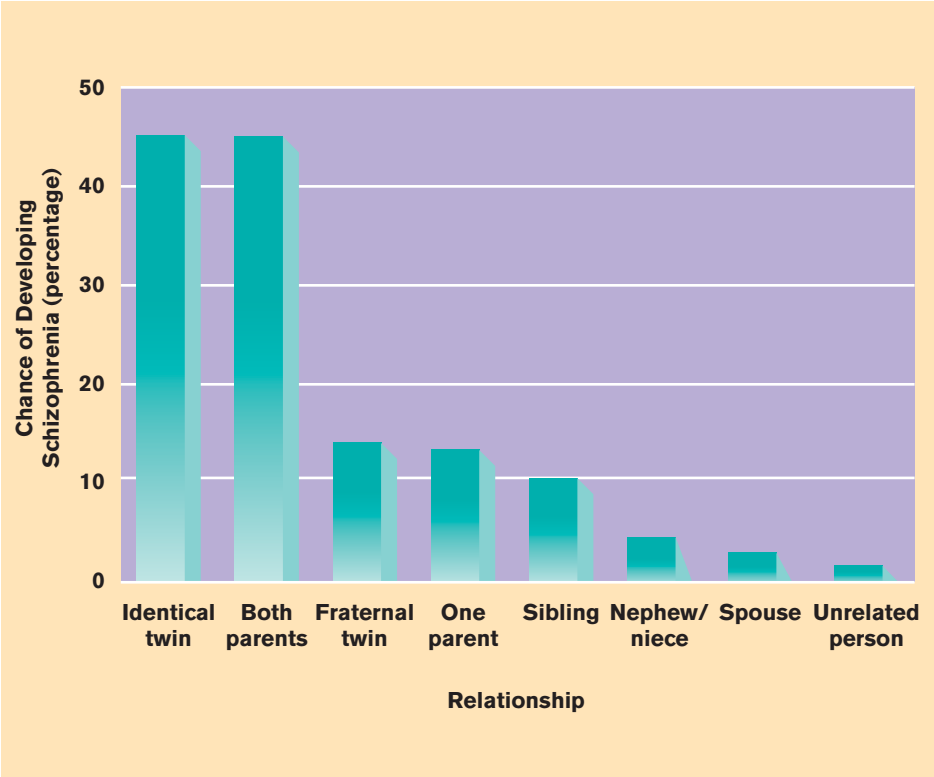


FIGURE 12.1
Genetic Similarity and Probability of Developing Schizophrenia **Research strongly indicates a genetic factor operating in many cases of schizophrenia. Identical twins have identical genes, and if one twin develops schizophrenia, the other twin has a 46 percent chance of developing it also. In fraternal twins the chance is only 14 percent. A person with one schizophrenic parent has a 13 percent chance of developing schizophrenia, but a 46 percent chance if both parents are schizophrenic. (Data from Nicol & Gottesman, 1983.)**

disposition toward the disorder (diathesis) and more stress than the person can handle (Fowles, 1992).

Whether predisposed people develop the disorder may depend on their life circumstances (Fowles, 1992; Johnson, 1989). Schizophrenia is more common in highly urbanized areas than in rural areas because of the greater stress of city life coupled with higher exposure to pollutants, toxins, and infectious diseases (Torrey & Bowler, 1990).

Excessive Dopamine Activity

Abnormal activity in the brain's dopamine systems is common in many schizophrenics (Winn, 1994). Much of the dopamine activity occurs in the limbic system, which is involved in human emotions (Davis et al., 1991). Drugs found to be effective in reducing the symptoms of schizophrenia block dopamine action (Iverson, 1979; Torrey, 1983), although about one-third of patients do not show improvement with such drugs (Wolkin et al., 1989).

The recent discovery of three more dopamine receptors, bringing the total to five in all, may increase our understanding of schizophrenia. As we reviewed in Chapter 2, drugs are being developed whose action is aimed at particular dopamine receptors (Seeman, 1995). Many questions remain about the causes of schizophrenia. Most likely, various factors play a role, including genetic predispositions, biochemical processes, environmental conditions, and life experiences.

catatonic schizophrenia (KAT-uh-TAHN-ik): A type of schizophrenia characterized by extreme stillness or stupor and/or periods of great agitation and excitement; patients may assume an unusual posture and remain in it for long periods.

disorganized schizophrenia: The most serious type of schizophrenia, marked by inappropriate affect, silliness, laughter, grotesque mannerisms, and bizarre behaviour.

paranoid schizophrenia (PAIR-uh-noid): A type of schizophrenia characterized by delusions of grandeur or persecution.

undifferentiated schizophrenia: A catchall category; marked by symptoms that do not conform to the other types or that conform to more than one type.

diathesis–stress model: The idea that people with a constitutional predisposition (diathesis) toward a disorder, such as schizophrenia, may develop the disorder if they are subjected to sufficient environmental stress.

Remember It!

Schizophrenia

1. Match the symptom of schizophrenia with the example.

____ 1) Joe believes he is Moses.
____ 2) Elena thinks her family is spreading rumours about her.
____ 3) Peter hears voices cursing him.
____ 4) Marco laughs at tragedies and cries when he hears a joke.

a. delusions of grandeur
b. hallucinations
c. inappropriate affect
d. delusions of persecution

2. Match the subtype of schizophrenia with the example:

____ 1) Louise stands for hours in the same strange position.
____ 2) Ron believes that CSIS is plotting to kill him.
____ 3) Harry makes silly faces, laughs a lot, and masturbates openly.
____ 4) Sue has the symptoms of schizophrenia but does not fit any one type.

a. paranoid schizophrenia
b. disorganized schizophrenia
c. catatonic schizophrenia
d. undifferentiated schizophrenia

3. There is substantial research evidence that all of the following help to cause schizophrenia *except*
   a. genetic factors.
   b. stress in people predisposed to the disorder.
   c. excessive dopamine activity.
   d. unhealthy family interaction patterns.

Answers: 1. 1) a 2) d 3) b 4) c
2. 1) c 2) a 3) b 4) d 3. d

Mood Disorders

Mood disorders involve moods or emotions that are extreme and unwarranted. In the most serious disorders, mood ranges from the depths of severe depression to the heights of extreme elation. Mood disorders fall into two broad categories: depressive and bipolar.

LINK IT!

www.ndmda.org
National Depressive and Manic-Depressive Association

ww2.med.jhu.edu/drada
Depression and Related Affective Disorders Association (DRADA)

Depressive Disorders and Bipolar Disorder: Emotional Highs and Lows

Major Depressive Disorder

What are the symptoms of major depressive disorder?

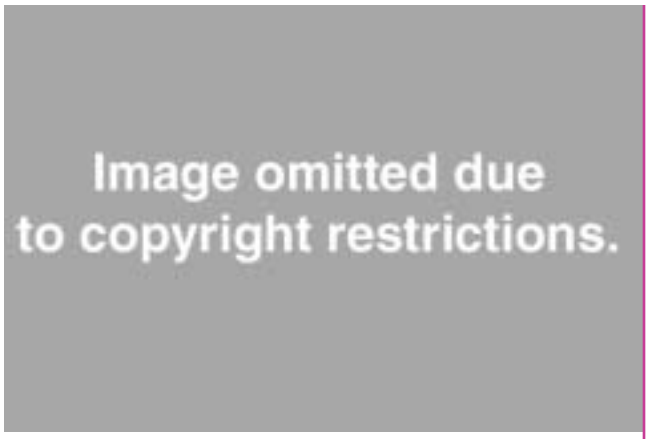
It is normal to feel blue, down, sad, or depressed in response to many of life's common experiences—death of a loved one, loss of a job, or an unhappy ending to a long-term relationship. Major depression, however, is not normal. People with **major depressive disorder** feel an overwhelming sadness, despair, and hopelessness, and they usually lose their ability to experience pleasure. They may have appetite and weight changes, sleep disturbance, loss of energy, and difficulty thinking or concentrating. Key symptoms of major depressive disorder are psychomotor disturbances (Sobin & Sackheim, 1997). For example, body movements and speech are so slow that they seem to be doing everything in slow motion. Some depressed patients experience the other extreme: they are constantly moving and fidgeting, wringing their hands, and pacing. Depression can be so severe that its vic-

tims actually experience delusions or hallucinations, which are symptoms of psychotic depression (Coryell, 1996). The most common of all serious mental disorders, depression strikes people of all social classes, cultures, and nations around the world.

Women are reported to be twice as likely as men to suffer from depression (Culbertson, 1997), with one notable exception. Among Jews, males are equally as likely as females to have major depression (Levav et al., 1997). In recent years there has been an increase in depression in adolescents, particularly in adolescent girls and perhaps among Native people and homosexual young people (Petersen et al., 1993).

Why are women so much more likely to suffer from depression than men? Are they somehow biologically predisposed? Are they subject to more life stress than men? At least one major study has suggested that the higher rate of depression in women is largely due to social and cultural factors. The risk for depression in women is greater because they must play so many roles—mother, wife, lover, friend, daughter, neighbour (Scattolon & Stoppard, 1999). In fulfilling those roles, women are likely to put the needs of others ahead of their own. Having young children poses a particular risk. Women also suffer other stresses disproportionately, such as poverty and physical and sexual abuse. Canadian researchers also identified women's perceptions of "being demoralized" as a common theme among depressed women (Hurst, 1999). Typically, women became demoralized following betrayal, abuse, and being left out. Pribor and Dinwiddie (1992) found an alarming incidence of depression—88.5 percent—among female incest victims.

While some patients suffer only one major episode of depression, most (50 to 60 percent) will have a recurrence (APA, 1994). Risk of recurrence is greatest for females (Winokur et al., 1993), for those who experienced depression before age 20 (Brown, 1996), and for those with a family history of mood disorders (Akiskal, 1989). Recurrences may be frequent or infrequent. For 20 to 35 percent of patients, the depressive episodes are chronic, lasting two years or longer. Recurring episodes tend to be increasingly more severe and long-lasting (Greden, 1994; Maj et al., 1992). Unfortunately, about 80 percent of those suffering from depression never even receive treatment (Holden, 1986). About 15 percent of people with a major depressive disorder commit suicide (Coppen, 1994). To learn more about suicide, read the following *World of Psychology* box.



People experiencing major depression feel overwhelming sadness, despair, and hopelessness.

Many people suffer from a milder form of depression called *dysthymia,* which is nonetheless chronic (lasting two years or longer). Individuals with dysthymia suffer from depressed mood but have fewer of the symptoms associated with major depressive disorder.

Seasonal Depression

Many people find that their moods seem to change with the seasons (Kasper et al., 1989). People suffering from **seasonal affective disorder (SAD)** experience a significant depression that tends to come and go with the seasons (Wehr & Rosenthal, 1989). There is a spring/summer depression that remits in winter; but the most common type, winter depression, seems to be triggered by light deficiency (Molin et al., 1996). During the winter months, when the days are shorter, some people become very depressed and tend to sleep and eat more, gain weight, and crave carbohydrates

mood disorders: Disorders characterized by extreme and unwarranted disturbances in feeling or mood, which can include depressive or manic episodes, or both.

major depressive disorder: A mood disorder characterized by feelings of great sadness, despair, guilt, worthlessness, and hopelessness, and, in extreme cases, suicidal intentions.

seasonal affective disorder (SAD): A mood disorder in which depression comes and goes with the seasons.

WORLD OF PSYCHOLOGY

Teen Suicide in Canada

The rate of suicide among 15- to 19-year-olds has quadrupled over the past three decades, from 3.2 per 100 000 in 1962 to 13.5 per 100 000 now. Among industrialized nations, Canada now ranks third in rate of teen suicides (Nemeth, 1994). Teenage males are much more likely to commit suicide than teenage females (IASP, 1999; Leenaars & Lester, 1990), and especially males living in the Yukon and Northwest Territories (see Figure 12.2). Factors that may push a teenager "over the edge" include an underlying psychiatric condition, a precipitating circumstance such as the breakup of a relationship, family conflict, a disciplinary crisis, and school problems (Heikkinen et al., 1993). There is an elevated risk of suicide among adolescents who have been in trouble with the police or who have been incarcerated (Brent et al., 1993).

Researchers at the Université du Québec à Montréal suggest that poor care from fathers is related to suicide attempts (Tousignant et al., 1993). The suicide rate is highest among those who have made a previous suicide attempt (Beck et al., 1990). What is especially disconcerting is that young males who attempt suicide use more lethal methods than young females (Sigurdson et al., 1994).

Preventing Suicide

Although there are cultural differences in suicide rates, the methods used, the reasons, and the warning signs for suicide are very similar across ethnic, gender, and age groups. Most suicidal individuals communicate their intent; in fact, about 90 percent of them leave clues (Shneidman, 1994). They may communicate verbally: "You won't be seeing me again," "You won't have to worry about me any more," "Life isn't worth living." They may leave behavioural clues—for example, they may give away their most valued possessions; withdraw from friends, family, and associates; take unnecessary risks; show personality changes; act and look depressed; and lose interest in favourite activities. These warning signs should always be taken seriously. Suicidal individuals need compassion, emotional support, and the opportunity to express the feelings and problems that are the source of their psychological pain.

Hopelessness is a common characteristic of suicidal individuals (Beck et al., 1993; Wetzel & Reich, 1989). Proposing solutions or alternatives that could lessen hopelessness may lower the likelihood of suicide. Most people contemplating suicide are not totally committed to self-destruction. This may explain why many potential victims leave warnings or use less lethal means in attempted suicide.

But we should not be amateur psychologists if we are dealing with a suicidal person. Probably the best service you can render is to encourage the person to get professional help. There are 24-hour-a-day suicide hotlines all over the country. A call might save a life. One number to call is Kids Help Phone (1-800-668-6868).

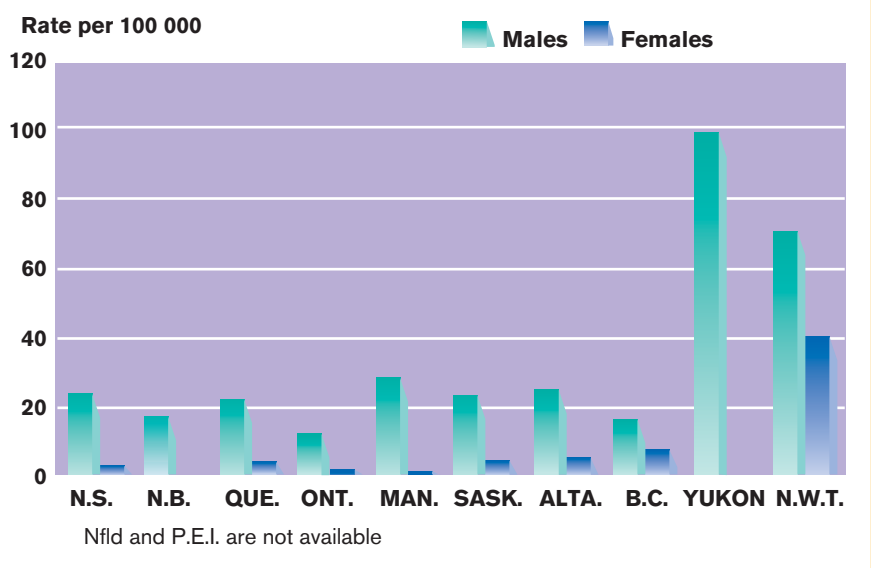


FIGURE 12.2
Teen Suicide Rates in Canada
Adapted from Fine, 1990.

The depressed moods of seasonal affective disorder (SAD) usually occur during the winter, when days are short, and can be improved using light therapy.

(Rosenthal et al., 1986; Wurtman & Wurtman, 1989). During the spring and summer months, they are in higher spirits and are more energetic, and say they function better (Wehr et al., 1986).

Reasoning that the obvious difference between the seasons was the amount and intensity of light, Rosenthal and colleagues (1985) exposed patients with winter depression to bright light, which simulated the longer daylight hours of summer. After several days of the light treatment, most of the participants improved.

In a recent Canadian study, admissions for manic depression and mixed states were examined over a 75-year period for one large psychiatric hospital. The researchers recorded when admissions occurred to see if there were seasonal variations. Contrary to expectations, the researchers found no seasonal pattern for manic depression but there was the expected seasonal peak for mixed state admissions (Whitney et al., 1999).

Bipolar Disorder

What are the extremes of mood suffered in bipolar disorder?

Another type of mood disorder is **bipolar disorder**, in which patients experience two radically different moods: extreme highs (called "manic episodes," or "mania") and extreme lows (major depression), usually with relatively normal periods in between. A **manic episode** is marked by excessive euphoria, inflated self-esteem, wild optimism, and hyperactivity. During a manic episode, people are wound up and full of energy. They rarely sleep, are frantically engaged in a flurry of activity, and talk loud and fast, skipping from one topic to another.

You may wonder what is wrong with being euphoric, energetic, and optimistic. Obviously nothing, as long as it is warranted. But people in a manic state have temporarily lost touch with reality. Their high-spirited optimism is not merely irrational, it is delusional. They may go on wild spending sprees or waste large sums of money on grand get-rich-quick schemes. If family members try to stop them or talk them out of their irrational plans, they are likely to become irritable, hostile, enraged, or even dangerous. Quite often, patients must be hospitalized during manic episodes to protect them and others from the disastrous consequences of their poor judgment.

Bipolar disorder is much less common than major depressive disorder. Its lifetime prevalence rate is about the same for males (1.6 percent) as for females (1.7 percent) (Kessler et al., 1994). Unfortunately, some 89 percent of those with bipolar disorder have recurrences (Winokur et al., 1994). In 60 to 70 percent of the cases, the manic episodes directly precede or follow the depressive episodes (APA, 1994). The good news is that 70 to 80 percent of patients return to normal after an episode (APA, 1994). However, some people with bipolar disorder are "rapid cyclers," who experience four or more episodes per year. Like depression, bipolar disorder may also follow a seasonal pattern (Faedda et al., 1993).

Causes of Major Depressive Disorder and Bipolar Disorder

What are some suggested causes of major depressive disorder and bipolar disorder?

The biological and cognitive perspectives offer some insight into the causes of mood disorders and suggest treatments that have been helpful to many people.

bipolar disorder: A mood disorder in which manic episodes alternate with periods of depression, usually with relatively normal periods in between.

manic episode (MAN-ik): A period of extreme elation, euphoria, and hyperactivity, often accompanied by delusions of grandeur and by hostility if activity is blocked.

The Biological Perspective

Biological factors such as genetic inheritance and abnormal brain chemistry play a major role in bipolar disorder and major depressive disorder. PET scans have revealed abnormal patterns of brain activity in both of these disorders (Drevets et al., 1992; George et al., 1993).

THE ROLE OF GENETIC INHERITANCE Does depression tend to run in families? Apparently so: people who have relatives with a mood disorder are at higher risk of developing mood disturbances, and this risk is due to shared genetic factors rather than shared environmental factors (Kendler et al., 1992d). On the basis of a study of 1721 identical and fraternal female twins, Kendler and colleagues (1993) estimated the heritability of major depression to be 70 percent. A person is three times more likely to develop depression if a close relative has had an early onset of depression and if the depression was recurring rather than single-episode (Bland et al., 1986; Weissman et al., 1984). Several recent twin studies have found genetic influences on depression to be similar in male twins and female twins (Kendler & Prescott, 1999; Lyons et al., 1998).

The genetic link is much stronger in bipolar disorder than in depression. The odds of developing bipolar disorder are 24 times greater among persons who have first-degree relatives (parents, children, or siblings) with the disorder (Weissman et al., 1984).

THE ROLE OF SEROTONIN AND NOREPINEPHRINE We all know that mood can be altered by the substances people put into their bodies. Alcohol, caffeine, various other uppers and downers, and a host of additional psychoactive substances are known to alter mood. Researchers now know that our moods are also altered and regulated by our own body's biochemicals, which of course include the neurotransmitters. Norepinephrine and serotonin are two neurotransmitters thought to play an important role in mood disorders. Both are localized in the limbic system and the hypothalamus, parts of the brain that help regulate emotional behaviour. Too little norepinephrine is associated with depression, and too much is related to mania (Schildkraut, 1970). It is interesting to note that amphetamines, which cause an emotional "high," are reported to stimulate the release of both serotonin and norepinephrine.

An important question remains: Do these biochemical differences in the brain cause psychological changes or result from them? Theorists who emphasize psychological causes see biochemical changes as the result, not the cause, of mood disorders.

Remember It!

Mood Disorders

1. Sanju has periods during which he is so depressed that he becomes suicidal. At other times he is energetic and euphoric. He would probably receive the diagnosis of
   a. dysthymia.
   b. seasonal mood disorder.
   c. bipolar disorder.
   d. major depressive disorder.
2. Match the theory of depression with the proposed cause.
   ____ 1) negative thoughts about oneself, the world, and one's future
   ____ 2) a deficiency of serotonin and norepinephrine
   ____ 3) turning resentment and hostility inward
   ____ 4) a family history of depression

   a. psychodynamic theory
   b. cognitive theory
   c. genetic theory
   d. biochemical theory

Answers: 1. d 2. 1) b 2) d 3) a 4) c

The Cognitive Perspective

Cognitive explanations, such as that of Aaron Beck (1967, 1991), maintain that depression is characterized by distortions in thinking. According to Beck, depressed individuals view themselves, their world, and their future negatively. They see their interactions with the world as defeating—a series of burdens and obstacles that end mostly in failure. Depressed persons believe they are deficient, unworthy, and inadequate, and they attribute their perceived failures to their own physical, mental, or moral inadequacies. Finally, according to the cognitive perspective, depressed patients believe that their future holds no hope. They may reason: "Everything always turns out wrong." "I never win." "Things will never get better." "It's no use."

In a review of a number of studies, Haaga and colleagues (1991) found that depression is related to distorted thinking. The cognitive perspective has much to offer for us to apply in our daily lives. Read the *Apply It!* box at the end of this chapter to learn more.

Other Psychological Disorders

Personality Disorders: Troublesome Behaviour Patterns

What are the main attributes of personality disorders?

A **personality disorder** is a long-standing, inflexible, maladaptive pattern of behaving and relating to others. It usually begins in childhood or adolescence (Widiger et al., 1988). People with this type of disorder tend to have problems in their social relationships and in their work; they may experience personal distress as well. Some realize that their behaviour is a problem, yet they seem unable to change. More commonly, they are self-centred and do not see themselves as responsible for their difficulties. Rather, they tend to blame other people or situations for their problems.

The DSM-IV lists ten categories of personality disorders; five are explained briefly in Table 12.1. Of particular interest is antisocial personality disorder.

LINK IT!

www.soulselfhelp.on.ca
Borderline Personality Disorder

Antisocial Personality Disorder

All too often we read or hear about people who commit horrible crimes and show no remorse whatsoever. Baffled, we ask ourselves how a person could do such things. Many of these people have antisocial personality disorder. Clifford Olson, the infamous serial killer, is thought to be one.

People with **antisocial personality disorder** have a "pervasive pattern of disregard for, and viola-

TABLE 12.1

Examples of DSM-IV Categories of Personality Disorders

Type of Disorder	Symptoms
Paranoid	Person is highly suspicious, untrusting, guarded, hypersensitive, easily slighted, lacking in emotion; holds grudges.
Antisocial personality	Person shows callous disregard for the rights and feelings of others; is manipulative, impulsive, selfish, aggressive, irresponsible, reckless; is willing to break the law, lie, cheat, or exploit others for personal gain, without remorse; fails to hold job.
Histrionic	Individual seeks attention and approval; is overly dramatic, self-centred, shallow; is demanding, manipulative, easily bored, suggestible; craves excitement; often is attractive and sexually seductive.
Narcissistic	Person has exaggerated sense of self-importance and entitlement, and is self-centred, arrogant, demanding, exploitive, envious; craves admiration and attention; lacks empathy.
Borderline	Individual is unstable in mood, behaviour, self-image, and social relationships; has intense fear of abandonment; exhibits impulsive and reckless behaviour, inappropriate anger; makes suicidal gestures and performs self-mutilating acts.

Source: Based on DSM-IV (APA, 1994).

personality disorder: A continuing, inflexible, maladaptive pattern of inner experience and behaviour that causes great distress or impaired functioning and differs significantly from the patterns expected in the person's culture.

antisocial personality disorder: A disorder marked by lack of feeling for others; selfish, aggressive, irresponsible behaviour; and willingness to break the law, lie, cheat, or exploit others for personal gain.

tion of, the rights of others that begins in childhood or early adolescence and continues into adulthood" (APA, 1994, p. 645). As children, they lie, steal, vandalize, initiate fights, skip school, and run away from home; they may be physically cruel to others. By early adolescence they usually drink excessively, use drugs, and engage in promiscuous sex. In adulthood, the antisocial personality typically fails to keep a job, to act as a responsible parent, to honour financial commitments, and to obey the law. Research suggests that 2 to 3 percent of Canadians suffer from this disorder (Weissman, 1993).

Many antisocial types are intelligent, and they may seem charming and very likable at first. Men make up a greater percentage of antisocial types than do women: as many as 5.8 percent of American men have this disorder, compared with less than 1.3 percent of American women (Kessler et al., 1994). One of the original studies of antisocial personality disorder revealed that persons who have it seem to lack the ability to love or to feel loyalty or compassion (Checkley, 1941). They seem to have no conscience; they feel little or no guilt or remorse for their actions, no matter how cruel or despicable those actions may be (Hare, 1995).

Years ago, people with antisocial personality disorder were referred to as "psychopaths" or "sociopaths." Con men, quack doctors, impostors, and today many drug pushers, pimps, delinquents, and criminals could be diagnosed as having this disorder. Some come to the attention of the authorities; others do not.

IT HAPPENED IN CANADA

Sex Change and Gender Identity

In 1965 twin boys, Bruce and Brian Reimer, were born in Winnipeg. There was nothing exceptional about the Reimer boys until at eight months of age doctors recommended that they be circumcised to correct their constricted foreskins. That's when things went wrong. The exact nature of the error that was to follow is not known–either the doctor used the wrong setting for an electronic cauterizing machine or used it incorrectly. In any case, Bruce's penis was severely burned, eventually falling off a few days later. This outcome started a chain of events that ended with Bruce becoming Brenda. The 19-month-old Bruce was introduced to Dr. John Money, the leading expert in sexual identity. It was Money who suggested the sex-change surgery, believing that gender identity developed as the child matured and that Bruce would stand a better chance as a girl than as an incomplete male. Bruce was castrated. Brenda was raised as a female and started estrogen therapy at 12.

The experimental data from Money indicated that everything was going well–Brenda was a well-adjusted girl. In reality, however, Brenda was not well adjusted–she didn't feel like a girl. At 14 she was finally told of her real sexual identity, and from that point on she was determined to live her life as a man. She became David, had a mastectomy, took testosterone, and had surgery to partially build a penis. David did not have a gender identity disorder–all the struggles he had experienced with his gender identity started to make sense–he was on the road to recovery. Eventually he married and is raising a family. David's willingness to share his story has cast doubt on the practice of sex-reassignment surgery for infants who have suffered accidental disfigurement or small abnormalities of their genitalia. (Based on Colapinto, 2000.)

Sexual and Gender Identity Disorders

What are the sexual and gender identity disorders?

The DSM-IV has two categories of sexual disorders: sexual dysfunctions and paraphilias. **Sexual dysfunctions** are persistent problems that cause marked distress and interpersonal difficulty; they may involve sexual desire, sexual arousal, or the pleasure associated with sex or orgasm. A person with a **paraphilia** has recurrent sexual urges, fantasies, or behaviours involving children, other non-consenting partners, non-human objects, or suffering or humiliation. To be diagnosed as having a paraphilia, the person must experience considerable psychological distress or an impairment in functioning in an important area of his or her life. **Gender identity disorders** involve difficulties accepting one's identity as male or female.

Table 12.2 describes a number of the sexual disorders listed in the DSM-IV. Note that homosexuality is *not* considered a sexual disorder.

Current Canadian research on pedophilia is described in *On the Cutting Edge in Canada*.

TABLE 12.2
DSM-IV Categories of Sexual Disorders

Type of Disorder	Symptoms
Paraphilias	Disorders in which recurrent sexual urges, fantasies, and behaviours involve non-human objects, children, other non-consenting persons, or the suffering or humiliation of the individual or his/her partner.
Fetishism	A disorder in which sexual urges, fantasies, and behaviour involve an inanimate object, such as women's undergarments or shoes.
Transvestic fetishism	A disorder in which sexual urges, fantasies, and behaviour involve cross-dressing.
Pedophilia	A disorder in which sexual urges, fantasies, and behaviour involve sexual activity with a prepubescent child or children.
Exhibitionism	A disorder in which sexual urges, fantasies, and behaviour involve exposing one's genitals to an unsuspecting stranger.
Voyeurism	A disorder in which sexual urges, fantasies, and behaviour involve watching unsuspecting people naked, undressing, or engaging in sexual activity.
Sexual masochism	A disorder in which sexual urges, fantasies, and behaviour involve being beaten, humiliated, bound, or otherwise made to suffer.
Sexual sadism	A disorder in which sexual urges, fantasies, and behaviour involve inflicting physical or psychological pain and suffering on another.
Frotteurism	A disorder in which sexual urges, fantasies, and behaviour involve touching or rubbing against a non-consenting person, usually in a crowded place.
Other paraphilias	Disorders in which sexual urges, fantasies, and behaviour involve, among other things, animals, feces, urine, corpses, filth, or enemas.
Sexual dysfunctions	Disorders involving low sexual desire; the inability to attain or maintain sexual arousal; a delay or absence of orgasm; premature ejaculation; and genital pain associated with sexual activity.

Source: Based on DSM-IV (APA, 1994).

Try It!

Portrayals of Psychological Disorders

Make a list of movies, TV shows, or plays you have seen or heard about in which a character with a psychological disorder plays a prominent role. One example is given to get you started.

As Good As It Gets	Jack Nicholson	Obsessive compulsive disorder

By now, you should know a great deal about psychological disorders. Apply your knowledge in the *Try It!*

sexual dysfunction: A persistent or recurrent problem that causes marked distress and interpersonal difficulty and that may involve any or some combination of the following: sexual desire, sexual arousal, or the pleasure associated with sex, or orgasm.

paraphilia: A sexual disorder in which sexual urges, fantasies, and behaviour generally involve children, other non-consenting partners, non-human objects, or the suffering and humiliation of oneself or one's partner.

gender identity disorders: Disorders characterized by a problem accepting one's identity as male or female.

on the cutting edge in canada

Pedophilia

A pedophile is an adult who is sexually attracted to prepubescent children. Pedophilia is both uncommon and very difficult to treat. One problem is that it comes in many forms. For instance, although most pedophiles are males, some prefer their victims to be a specific gender or age, whereas others do not.

Canadian researchers are renowned for their work on pedophilia. Some particularly prominent people include the late Dr. Kurt Freund and Michael Kuban (1993) at the Clarke Institute for Psychiatry, who examined the relation between childhood experiences and pedophilia. They found that many pedophiles reported that they had been sexually abused by adults during their childhood. Dr. William Marshall and colleagues (2000) at Queen's University also found high levels of sexual abuse in this population. Seto and colleagues (1999) at the Centre for Addiction and Mental Health in Toronto recently tested a theory that suggests that parental incest would occur only when parents are uninvolved in parenting and/or their pedophilic interest was at such a high level that it would override taboos against inbreeding. It was expected that pedophile biological fathers who were involved in their child's upbringing would have much higher pedophilic interest than others. The theory was not supported. They did not find differences in pedophilic interest. They did, however, note the importance of measuring pedophilic interest, and they are pursuing other explanations for sexual molestation within families.

Remember It!

Other Psychological Disorders

1. Which statement is true of personality disorders?
   a. Personality disorders usually begin in adulthood.
   b. Persons with these disorders usually realize their problem.
   c. Personality disorders typically cause problems in social relationships and at work.
   d. Persons with these disorders typically seek professional help.
2. Tim lies, cheats, and exploits others without feeling guilty. He most likely has _____ personality disorder.
   a. avoidant
   b. histrionic
   c. antisocial
   d. narcissistic
3. What is the name for disorders in which sexual urges, fantasies, and behaviours involve children, other non-consenting partners, or non-human objects?
   a. paraphilias
   b. gender identity disorders
   c. dysfunctional object disorder
   d. sexual dysfunctions
4. What is the general term used to describe disturbances in sexual desire, sexual arousal, or the ability to attain orgasm?
   a. paraphilias
   b. gender identity disorders
   c. dysfunctional object disorder
   d. sexual dysfunctions

Answers: 1. c 2. c 3. a 4. d

Apply It!

Depression: Bad Thoughts, Bad Feelings

Do you know that you can actually cause your own moods? Consider these thoughts: "I'll never pass this course." "He/she would never go out with me." "I can't do anything right." "I'm a failure." How do these thoughts make you feel? How about these thoughts? "My future looks bright and happy." "I have good friends and I am well liked." "I feel so happy I could laugh."

When it comes to physical health and well-being, you have probably heard it said, "You are what you eat." To a large extent, in the area of mental health, "You are what you think." Depression and other forms of mental misery can be fuelled by our own negative or irrational thoughts.

One step toward healthy thinking is to recognize and avoid the following five cognitive traps.

Cognitive Trap 1: The "Tyranny of the Should"

One certain path to unhappiness is to set unrealistic, unachievable standards for yourself. Unrealistic and unachievable standards are characterized by such words as *always, never, all, everybody,* and *everything*. Have you ever been tyrannized by any of the following *shoulds*?

> I should always be the perfect friend, lover, spouse, parent, student, teacher, [or] employee.
> I should never feel hurt and should always be calm.
> I should be able to solve all of my problems and the problems of others in no time.
> I should never be tired or fall ill.
> (Adapted from Horney, 1950, pp. 64–66.)

Cognitive Trap 2: Negative, "What If" Thinking

Much unhappiness stems from a preoccupation with what might be. These are examples of "what if" thinking: "What if she/he turns me down?" "What if I lose my job?" "What if I flunk this test?" And if a "what if" comes to pass, the third cognitive trap may be sprung.

Cognitive Trap 3: Making Mountains Out of Molehills

A molehill becomes a mountain when a single negative event is perceived as catastrophic or allowed to become a definition of our total worth. "I failed this test" might become "I'll never pass this course," "I'll never graduate from school," "I'm too dumb to be in college," or "I'm a failure."

Cognitive Trap 4: The Perfection–Failure Dichotomy

Only on the rarest occasions can anyone's performance be considered absolutely perfect or a total failure. But people who fall into this cognitive trap judge anything short of perfection as total failure.

Cognitive Trap 5: Setting Impossible Conditions for Happiness

Don't let your happiness hinge on perfection in yourself and others.

Not everyone will love you or even like you, approve of you, or agree with you. If any of these are conditions upon which your happiness depends, you are setting the stage for disappointment or even depression.

Developing Healthier Thinking Habits

If negative or irrational thoughts are part of your habitual repertoire, you need to develop healthier thinking habits. The next time you notice yourself entertaining negative thoughts or self-doubts, write them down and analyze them objectively and unemotionally. But don't go to the opposite extreme and substitute equally distorted positive thinking or mindless "happy talk." Self-delusion in either direction is not healthy. Your goal should be to monitor your thinking and systematically make it less distorted, more rational, more accurate, and more logical. For example:

- Instead of thinking, "It would be the end of everything if I lost my job!" think, "I would not want to lose my job, but I could find another."
- Instead of thinking, "I am a failure because this turned out so badly," substitute, "I am embarrassed about how this turned out, but I'll do better the next time."

Depression is a complex psychological disorder with both physiological and psychological causes. Not all depression can be controlled simply by a change in thinking. If symptoms such as those listed at the beginning of this box persist, seek professional treatment.

KEY TERMS

agoraphobia, p. 387
antisocial personality disorder, p. 404
anxiety, p. 386
bipolar disorder, p. 401
catatonic schizophrenia, p. 396
compulsion, p. 389
conversion disorder, p. 391
delusion, p. 394
delusion of grandeur, p. 394
delusion of persecution, p. 394
diathesis–stress model, p. 396
disorganized schizophrenia, p. 396
dissociative amnesia, p. 392
dissociative disorders, p. 392
dissociative fugue, p. 392
dissociative identity disorder, p. 392
DSM-IV, p. 384
gender identity disorders, p. 404
generalized anxiety disorder, p. 386
hallucination, p. 394
hypochondriasis, p. 391
inappropriate affect, p. 395
major depressive disorder, p. 398
manic episode, p. 401
mood disorders, p. 398
neurosis, p. 384
obsession, p. 389
obsessive compulsive disorder (OCD), p. 389
panic attack, p. 387
panic disorder, p. 387
paranoid schizophrenia, p. 396
paraphilia, p. 404
personality disorder, p. 403
phobia, p. 387
psychosis, p. 384
schizophrenia, p. 394
seasonal affective disorder (SAD), p. 399
sexual dysfunction, p. 404
social phobia, p. 388
somatoform disorders, p. 390
specific phobia, p. 388
undifferentiated schizophrenia, p. 396

THINKING CRITICALLY

Evaluation

Some psychological disorders are more common in women (depression, agoraphobia, and specific phobia), and some are more common in men (antisocial personality disorder, and substance abuse and dependence). Give some possible reasons why such gender differences exist in these disorders. Support your answer.

Point/Counterpoint

There is continuing controversy over whether specific psychological disorders are chiefly biological in origin (nature) or result primarily from learning and experience (nurture). Select any two disorders from this chapter and prepare arguments for both nature and nurture for both disorders.

Psychology in Your Life

Formulate a specific plan for your own life that will help you recognize and avoid the five cognitive traps that contribute to unhealthy thinking. You might enlist the help of a friend to monitor your negative statements.

SUMMARY & REVIEW

What Is Abnormal?

What criteria might be used to differentiate normal from abnormal behaviour?

Behaviour might be considered abnormal if it deviates radically from what is considered normal in one's own culture, if it leads to personal distress or impaired functioning, or if it results in one's being a danger to self and/or others.

What are five current perspectives that attempt to explain the causes of psychological disorders?

Five current perspectives on the causes of abnormal behaviour are (1) the biological perspective, which views it as a symptom of an underlying physical disorder; (2) the psychodynamic perspective, which maintains that it is caused by unconscious, unresolved conflicts; (3) the learning perspective, which argues that it is learned and sustained in the same way as other behaviour; (4) the cognitive perspective, which suggests that

it results from faulty thinking; and (5) the humanistic perspective, which views it as a result of the blocking of one's natural tendency toward self-actualization.

What is the DSM-IV?

The DSM-IV, published by the American Psychiatric Association, is the system most widely used in North America to diagnose psychological disorders.

Anxiety Disorders: When Anxiety Is Extreme

When is anxiety healthy, and when is it unhealthy?

Anxiety—a generalized feeling of apprehension, fear, or tension—is healthy if it is a response to a real danger or threat; it is unhealthy if it is inappropriate or excessive.

What are the symptoms of a panic disorder?

Panic disorder is marked by recurrent, unpredictable panic attacks: attacks of overwhelming anxiety, fear, or terror, during which people experience palpitations, trembling or shaking, choking or smothering sensations, and the feeling that they are going to die or go crazy.

What are the characteristics of the three categories of phobias?

The three categories of phobic disorders are (1) agoraphobia, fear of being in situations in which escape is impossible or help is not available in case of incapacitating anxiety; (2) social phobia, fear of social situations in which one might be embarrassed or humiliated by appearing clumsy or incompetent; and (3) specific phobia, a marked fear of a specific object or situation and a catchall category for all phobias other than agoraphobia or social phobia.

What do psychologists believe are some probable causes of phobias?

Phobias result primarily from frightening experiences or through observational learning. Genes may also play a role.

What is obsessive-compulsive disorder?

Obsessive-compulsive disorder is characterized by obsessions (persistent, recurring, involuntary thoughts, images, or impulses that cause great distress) and/or compulsions (persistent, irresistible, irrational urges to perform an act or ritual repeatedly).

Somatoform and Dissociative Disorders

What are two somatoform disorders, and what symptoms do they share?

Somatoform disorders involve bodily symptoms that cannot be explained by known medical conditions. Hypochondriasis involves a preoccupation with the fear that bodily symptoms are the sign of some serious disease. Conversion disorder involves a loss of motor or sensory functioning in some part of the body, such as paralysis or blindness.

What is dissociative amnesia?

People with dissociative amnesia have a loss of memory for limited periods of their life or for their entire personal identity.

What is dissociative fugue?

In dissociative fugue, people forget their entire identity, travel away from home, and may assume a new identity somewhere else.

What are some of the identifying symptoms of dissociative identity disorder?

In dissociative identity disorder (often called multiple personality), two or more distinct, unique personalities occur in the same person, each taking over at different times. Most patients are female and victims of early, severe physical and/or sexual abuse. They typically complain of periods of "lost time."

Schizophrenia

What are some of the major positive symptoms of schizophrenia?

The "positive" symptoms of schizophrenia are abnormal behaviours and characteristics, including hallucinations, delusions, disorganized thinking and speech, bizarre behaviour, and inappropriate affect.

What are some of the major negative symptoms of schizophrenia?

The "negative" symptoms of schizophrenia represent deficiencies in thoughts and behaviour and include social withdrawal, apathy, loss of motivation, very limited speech, slow movements, flat affect, and poor hygiene and grooming.

What are the four subtypes of schizophrenia?

The four subtypes of schizophrenia are catatonic, disorganized, paranoid, and undifferentiated.

What are some suggested causes of schizophrenia?

Some suggested causes of schizophrenia are a genetic predisposition, sufficient stress in people who are predisposed to the disorder, and excessive dopamine activity in the brain.

Mood Disorders

What are the symptoms of major depressive disorder?

Major depressive disorder is characterized by feelings of great sadness, despair, guilt, worthlessness, hopelessness, and, in extreme cases, suicidal intentions.

What are the extremes of mood suffered in bipolar disorder?

Bipolar disorder is a mood disorder in which a person suffers from manic episodes (periods of extreme elation, euphoria, and hyperactivity) alternating with major depression, usually with relatively normal periods in between.

What are some suggested causes of major depressive disorder and bipolar disorder?

Some of the proposed causes are (1) a genetic predisposition; (2) an imbalance in the neurotransmitters norepinephrine and serotonin; (3) a tendency to turn hostility and resentment inward rather than expressing it; (4) distorted and negative views of oneself, the world, and the future; and (5) stress.

Other Psychological Disorders

What are the main attributes of personality disorders?

Personality disorders are continuing, inflexible, maladaptive patterns of behaviour and inner experience that cause personal distress and/or impairment in social and occupational functioning.

What are the sexual and gender identity disorders?

Three categories of sexual disorders are sexual dysfunctions (problems with sexual desire, sexual arousal, or orgasm); paraphilias (needing unusual or bizarre objects, conditions, or acts for sexual gratification); and gender identity disorders (having a problem accepting one's identity as male or female).