Chapter 13: Psychological Disorders SW

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On Monday, September 16, 2013, a gunman killed 12 people as the workday began at the Washington Navy Yard in Washington, DC. Aaron Alexis, 34, had a troubled history: he thought that he was being controlled by radio waves, and a month earlier, he had complained of noises coming from the linen closet in his military housing. He called the police to complain about voices in his head and being under surveillance by “shadowy forces” (Thomas, Levine, Date, & Cloherty, 2013).

Figure 1.1: A wreath is laid in memoriam to victims of the Washington Navy Yard shooting. (credit: modification of work by D. Myles Cullen, US Department of Defense)

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While Alexis’s actions cannot be excused, it is clear that he had some form of mental illness. Mental illness is not necessarily a cause of violence; it is far more likely that the mentally ill will be victims rather than perpetrators of violence (Stuart, 2003). If, however, Alexis had received the help he needed, this tragedy might have been averted.

This chapter will clarify what psychological disorders are, how they are diagnosed and classified, their symptoms, and insights into their causes.

1.1 References


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CHAPTER 1. 13.0 INTRODUCTION TO PSYCHOLOGICAL DISORDERS

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CHAPTER 1. 13.0 INTRODUCTION TO PSYCHOLOGICAL DISORDERS

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CHAPTER 1. 13.0 INTRODUCTION TO PSYCHOLOGICAL DISORDERS


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Chapter 2

13.1 What Are Psychological Disorders?

A psychological disorder is a condition characterized by abnormal thoughts, feelings, and behaviors. Psychopathology is the study of psychological disorders, including their symptoms, etiology (i.e., their causes), and treatment. The term psychopathology can also refer to the manifestation of a psychological disorder. Although consensus can be difficult, it is extremely important for mental health professionals to agree on what kinds of thoughts, feelings, and behaviors are truly abnormal in the sense that they genuinely indicate the presence of psychopathology. Certain patterns of behavior and inner experience can easily be labeled as abnormal and clearly signify some kind of psychological disturbance. The person who washes his hands 40 times per day and the person who claims to hear the voices of demons exhibit behaviors and inner experiences that most would regard as abnormal: beliefs and behaviors that suggest the existence of a psychological disorder. But, consider the nervousness a young man feels when talking to attractive women or the loneliness and longing for home a freshman experiences during her first semester of college—these feelings may not be regularly present, but they fall in the range of normal. So, what kinds of thoughts, feelings, and behaviors represent a true psychological disorder? Psychologists work to distinguish psychological disorders from inner experiences and behaviors that are merely situational, idiosyncratic, or unconventional.

2.1 DEFINITION OF A PSYCHOLOGICAL DISORDER

Perhaps the simplest approach to conceptualizing psychological disorders is to label behaviors, thoughts, and inner experiences that are atypical, distressful, dysfunctional, and sometimes even dangerous, as signs of a disorder. For example, if you ask a classmate for a date and you are rejected, you probably would feel a little dejected. Such feelings would be normal. If you felt extremely depressed—so much so that you lost interest in activities, had difficulty eating or sleeping, felt utterly worthless, and contemplated suicide—your feelings would be atypical, would deviate from the norm, and could signify the presence of a psychological disorder. Just because something is atypical, however, does not necessarily mean it is disordered.

If we can agree that merely being atypical is an insufficient criterion for a having a psychological disorder, is it reasonable to consider behavior or inner experiences that differ from widely expected cultural values or expectations as disordered? Using this criterion, a woman who walks around a subway platform wearing a heavy winter coat in July while screaming obscenities at strangers may be considered as exhibiting symptoms of a psychological disorder. Her actions and clothes violate socially accepted rules governing appropriate dress and behavior; these characteristics are atypical.

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2.2 CULTURAL EXPECTATIONS

Violating cultural expectations is not, in and of itself, a satisfactory means of identifying the presence of a psychological disorder. Since behavior varies from one culture to another, what may be expected and considered appropriate in one culture may not be viewed as such in other cultures. For example, returning a stranger's smile is expected in the United States because a pervasive social norm dictates that we reciprocate friendly gestures. A person who refuses to acknowledge such gestures might be considered socially awkward—perhaps even disordered—for violating this expectation. However, such expectations are not universally shared. Cultural expectations in Japan involve showing reserve, restraint, and a concern for maintaining privacy around strangers. Japanese people are generally unresponsive to smiles from strangers (Patterson et al., 2007). Eye contact provides another example. In the United States and Europe, eye contact with others typically signifies honesty and attention. However, most Latin-American, Asian, and African cultures interpret direct eye contact as rude, confrontational, and aggressive (Pazain, 2010). Thus, someone who makes eye contact with you could be considered appropriate and respectful or brazen and offensive, depending on your culture.

Hallucinations (seeing or hearing things that are not physically present) in Western societies is a violation of cultural expectations, and a person who reports such inner experiences is readily labeled as psychologically disordered. In other cultures, visions that, for example, pertain to future events may be regarded as normal experiences that are positively valued (Bourguignon, 1970). Finally, it is important to recognize that cultural norms change over time: what might be considered typical in a society at one time may no longer be viewed this way later, similar to how fashion trends from one era may elicit quizzical looks decades later—imagine how a headband, legwarmers, and the big hair of the 1980s would go over on your campus today.

DIG DEEPER: In the 1950s and 1960s, the concept of mental illness was widely criticized. One of the major criticisms focused on the notion that mental illness was a “myth that justifies psychiatric intervention in socially disapproved behavior” (Wakefield, 1992). Thomas Szasz (1960), a noted psychiatrist, was perhaps the biggest proponent of this view. Szasz argued that the notion of mental illness was invented by society (and the mental health establishment) to stigmatize and subjugate people whose behavior violates accepted social and legal norms. Indeed, Szasz suggested that what appear to be symptoms of mental illness are more appropriately characterized as “problems in living” (Szasz, 1960).

In his 1961 book, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, Szasz expressed his disdain for the concept of mental illness and for the field of psychiatry in general (Oliver, 2006). The basis for Szasz’s attack was his contention that detectable abnormalities in bodily structures and functions (e.g., infections and organ damage or dysfunction) represent the defining features of genuine illness or disease, and because symptoms of purported mental illness are not accompanied by such detectable abnormalities, so-called psychological disorders are not disorders at all. Szasz (1961/2010) proclaimed that “disease or illness can only affect the body; hence, there can be no mental illness” (p. 267).

Today, we recognize the extreme level of psychological suffering experienced by people with psychological disorders: the painful thoughts and feelings they experience, the disordered behavior they demonstrate, and the levels of distress and impairment they exhibit. This makes it very difficult to deny the reality of mental illness.

However controversial Szasz’s views and those of his supporters might have been, they have influenced the mental health community and society in several ways. First, lay people, politicians, and professionals now often refer to mental illness as mental health “problems,” implicitly acknowledging the “problems in living” perspective Szasz described (Buchanan-Barker & Barker, 2009). Also influential was Szasz’s view of homosexuality. Szasz was perhaps the first psychiatrist to openly challenge the idea that homosexuality represented a form of mental illness or disease (Szasz, 1965). By challenging the idea that homosexuality represented a form a mental illness, Szasz helped pave the way for the social and civil rights that gay and lesbian people now have (Barker, 2010). His work
also inspired legal changes that protect the rights of people in psychiatric institutions and allow such individuals a greater degree of influence and responsibility over their lives (Buchanan-Barker & Barker, 2009).

2.3 HARMFUL DYSFUNCTION

If none of the criteria discussed so far is adequate by itself to define the presence of a psychological disorder, how can a disorder be conceptualized? Many efforts have been made to identify the specific dimensions of psychological disorders, yet none is entirely satisfactory. No universal definition of psychological disorder exists that can apply to all situations in which a disorder is thought to be present (Zachar & Kendler, 2007). However, one of the more influential conceptualizations was proposed by Wakefield (1992), who defined psychological disorder as a harmful dysfunction. Wakefield argued that natural internal mechanisms—that is, psychological processes honed by evolution, such as cognition, perception, and learning—have important functions, such as enabling us to experience the world the way others do and to engage in rational thought, problem solving, and communication. For example, learning allows us to associate a fear with a potential danger in such a way that the intensity of fear is roughly equal to the degree of actual danger. Dysfunction occurs when an internal mechanism breaks down and can no longer perform its normal function. But, the presence of a dysfunction by itself does not determine a disorder. The dysfunction must be harmful in that it leads to negative consequences for the individual or for others, as judged by the standards of the individual’s culture. The harm may include significant internal anguish (e.g., high levels of anxiety or depression) or problems in day-to-day living (e.g., in one’s social or work life).

2.4 THE AMERICAN PSYCHIATRIC ASSOCIATION (APA) DEFINITION

Many of the features of the harmful dysfunction model are incorporated in a formal definition of psychological disorder developed by the American Psychiatric Association (APA). According to the APA (2013), a psychological disorder is a condition that is said to consist of the following:

- **There are significant disturbances in thoughts, feelings, and behaviors.** A person must experience inner states (e.g., thoughts and/or feelings) and exhibit behaviors that are clearly disturbed—that is, unusual, but in a negative, self-defeating way. Often, such disturbances are troubling to those around the individual who experiences them. For example, an individual who is uncontrollably preoccupied by thoughts of germs spends hours each day bathing, has inner experiences, and displays behaviors that most would consider atypical and negative (disturbed) and that would likely be troubling to family members.

- **The disturbances reflect some kind of biological, psychological, or developmental dysfunction.** Disturbed patterns of inner experiences and behaviors should reflect some flaw (dysfunction) in the internal biological, psychological, and developmental mechanisms that lead to normal, healthy psychological functioning. For example, the hallucinations observed in schizophrenia could be a sign of brain abnormalities.

- **The disturbances lead to significant distress or disability in one’s life.** A person’s inner experiences and behaviors are considered to reflect a psychological disorder if they cause the person considerable distress, or greatly impair his ability to function as a normal individual (often referred to as functional impairment, or occupational and social impairment). As an illustration, a person’s fear of social situations might be so distressing that it causes the person to avoid all social situations (e.g., preventing that person from being able to attend class or apply for a job).

- **The disturbances do not reflect expected or culturally approved responses to certain events.** Disturbances in thoughts, feelings, and behaviors must be socially unacceptable responses to certain events that often happen in life. For example, it is perfectly natural (and expected) that a
person would experience great sadness and might wish to be left alone following the death of a close family member. Because such reactions are in some ways culturally expected, the individual would not be assumed to signify a mental disorder.

Some believe that there is no essential criterion or set of criteria that can definitively distinguish all cases of disorder from nondisorder (Lilienfeld & Marino, 1999). In truth, no single approach to defining a psychological disorder is adequate by itself, nor is there universal agreement on where the boundary is between disordered and not disordered. From time to time we all experience anxiety, unwanted thoughts, and moments of sadness; our behavior at other times may not make much sense to ourselves or to others. These inner experiences and behaviors can vary in their intensity, but are only considered disordered when they are highly disturbing to us and/or others, suggest a dysfunction in normal mental functioning, and are associated with significant distress or disability in social or occupational activities.

2.5 Summary

Psychological disorders are conditions characterized by abnormal thoughts, feelings, and behaviors. Although challenging, it is essential for psychologists and mental health professionals to agree on what kinds of inner experiences and behaviors constitute the presence of a psychological disorder. Inner experiences and behaviors that are atypical or violate social norms could signify the presence of a disorder; however, each of these criteria alone is inadequate. Harmful dysfunction describes the view that psychological disorders result from the inability of an internal mechanism to perform its natural function. Many of the features of harmful dysfunction conceptualization have been incorporated in the APA’s formal definition of psychological disorders. According to this definition, the presence of a psychological disorder is signaled by significant disturbances in thoughts, feelings, and behaviors; these disturbances must reflect some kind of dysfunction (biological, psychological, or developmental), must cause significant impairment in one’s life, and must not reflect culturally expected reactions to certain life events.

2.6 Review Questions

Exercise 2.1  
(Solution on p. 20.)
In the harmful dysfunction definition of psychological disorders, dysfunction involves

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a. the inability of an psychological mechanism to perform its function  
b. the breakdown of social order in one’s community  
c. communication problems in one’s immediate family  
d. all the above

Exercise 2.2  
(Solution on p. 20.)
Patterns of inner experience and behavior are thought to reflect the presence of a psychological disorder if they

--------

a. are highly atypical  
b. lead to significant distress and impairment in one’s life  
c. embarrass one’s friends and/or family  
d. violate the norms of one’s culture
2.7 Critical Thinking Question

Exercise 2.3

Discuss why thoughts, feelings, or behaviors that are merely atypical or unusual would not necessarily signify the presence of a psychological disorder. Provide an example.
Solutions to Exercises in Chapter 2

Solution to Exercise 2.1 (p. 18)
A

Solution to Exercise 2.2 (p. 18)
B

Solution to Exercise 2.3 (p. 19)
Just because something is atypical or unusual does not mean it is disordered. A person may experience atypical inner experiences or exhibit unusual behaviors, but she would not be considered disordered if they are not distressing, disturbing, or reflecting a dysfunction. For example, a classmate might stay up all night studying before exams; although atypical, this behavior is unlikely to possess any of the other criteria for psychological disorder mentioned previously.
Chapter 3

13.2 Diagnosing and Classifying Psychological Disorders

A first step in the study of psychological disorders is carefully and systematically discerning significant signs and symptoms. How do mental health professionals ascertain whether or not a person’s inner states and behaviors truly represent a psychological disorder? Arriving at a proper diagnosis—that is, appropriately identifying and labeling a set of defined symptoms—is absolutely crucial. This process enables professionals to use a common language with others in the field and aids in communication about the disorder with the patient, colleagues and the public. A proper diagnosis is an essential element to guide proper and successful treatment. For these reasons, classification systems that organize psychological disorders systematically are necessary.

3.1 THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM)

Although a number of classification systems have been developed over time, the one that is used by most mental health professionals in the United States is the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association (2013). (Note that the American Psychiatric Association differs from the American Psychological Association; both are abbreviated APA.) The first edition of the DSM, published in 1952, classified psychological disorders according to a format developed by the U.S. Army during World War II (Clegg, 2012). In the years since, the DSM has undergone numerous revisions and editions. The most recent edition, published in 2013, is the DSM-5 (APA, 2013). The DSM-5 includes many categories of disorders (e.g., anxiety disorders, depressive disorders, and dissociative disorders). Each disorder is described in detail, including an overview of the disorder (diagnostic features), specific symptoms required for diagnosis (diagnostic criteria), prevalence information (what percent of the population is thought to be afflicted with the disorder), and risk factors associated with the disorder.

The DSM-5 also provides information about comorbidity; the co-occurrence of two disorders. For example, the DSM-5 mentions that 41% of people with obsessive-compulsive disorder (OCD) also meet the diagnostic criteria for major depressive disorder. Drug use is highly comorbid with other mental illnesses; 6 out of 10 people who have a substance use disorder also suffer from another form of mental illness (National Institute on Drug Abuse [NIDA], 2007).

The DSM has changed considerably in the half-century since it was originally published. The first two editions of the DSM, for example, listed homosexuality as a disorder; however, in 1973, the APA voted to remove it from the manual (Silverstein, 2009). Additionally, beginning with the DSM-III in 1980, mental disorders have been described in much greater detail, and the number of diagnosable conditions has grown

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steadily, as has the size of the manual itself. DSM-I included 106 diagnoses and was 130 total pages, whereas DSM-III included more than 2 times as many diagnoses (265) and was nearly seven times its size (886 total pages) (Mayes & Horowitz, 2005). Although DSM-5 is longer than DSM-IV, the volume includes only 237 disorders, a decrease from the 297 disorders that were listed in DSM-IV. The latest edition, DSM-5, includes revisions in the organization and naming of categories and in the diagnostic criteria for various disorders (Regier, Kuhl, & Kupfer, 2012), while emphasizing careful consideration of the importance of gender and cultural difference in the expression of various symptoms (Fisher, 2010).

Some believe that establishing new diagnoses might overpathologize the human condition by turning common human problems into mental illnesses (The Associated Press, 2013). Indeed, the finding that nearly half of all Americans will meet the criteria for a DSM disorder at some point in their life (Kessler et al., 2005) likely fuels much of this skepticism. The DSM-5 is also criticized on the grounds that its diagnostic criteria have been loosened, thereby threatening to “turn our current diagnostic inflation into diagnostic hyperinflation” (Frances, 2012, para. 22). For example, DSM-IV specified that the symptoms of major depressive disorder must not be attributable to normal bereavement (loss of a loved one). The DSM-5, however, has removed this bereavement exclusion, essentially meaning that grief and sadness after a loved one’s death can constitute major depressive disorder.

3.2 THE INTERNATIONAL CLASSIFICATION OF DISEASES

A second classification system, the International Classification of Diseases (ICD), is also widely recognized. Published by the World Health Organization (WHO), the ICD was developed in Europe shortly after World War II and, like the DSM, has been revised several times. The categories of psychological disorders in both the DSM and ICD are similar, as are the criteria for specific disorders; however, some differences exist. Although the ICD is used for clinical purposes, this tool is also used to examine the general health of populations and to monitor the prevalence of diseases and other health problems internationally (WHO, 2013). The ICD is in its 10th edition (ICD-10); however, efforts are now underway to develop a new edition (ICD-11) that, in conjunction with the changes in DSM-5, will help harmonize the two classification systems as much as possible (APA, 2013).

A study that compared the use of the two classification systems found that worldwide the ICD is more frequently used for clinical diagnosis, whereas the DSM is more valued for research (Mezzich, 2002). Most research findings concerning the etiology and treatment of psychological disorders are based on criteria set forth in the DSM (Olmanns & Castonguy, 2013). The DSM also includes more explicit disorder criteria, along with an extensive and helpful explanatory text (Regier et al., 2012). The DSM is the classification system of choice among U.S. mental health professionals, and this chapter is based on the DSM paradigm.

3.3 THE COMPASSIONATE VIEW OF PSYCHOLOGICAL DISORDERS

As these disorders are outlined, please bear two things in mind. First, remember that psychological disorders represent extremes of inner experience and behavior. If, while reading about these disorders, you feel that these descriptions begin to personally characterize you, do not worry—this moment of enlightenment probably means nothing more than you are normal. Each of us experiences episodes of sadness, anxiety, and preoccupation with certain thoughts—times when we do not quite feel ourselves. These episodes should not be considered problematic unless the accompanying thoughts and behaviors become extreme and have a disruptive effect on one’s life. Second, understand that people with psychological disorders are far more than just embodiments of their disorders. We do not use terms such as schizophrenics, depressives, or phobics because they are labels that objectify people who suffer from these conditions, thus promoting biased and disparaging assumptions about them. It is important to remember that a psychological disorder is not what a person is; it is something that a person has—through no fault of his or her own. As is the case with cancer or diabetes, those with psychological disorders suffer debilitating, often painful conditions that are not of
their own choosing. These individuals deserve to be viewed and treated with compassion, understanding, and dignity.

3.4 Summary

The diagnosis and classification of psychological disorders is essential in studying and treating psychopathology. The classification system used by most U.S. professionals is the DSM-5. The first edition of the DSM was published in 1952, and has undergone numerous revisions. The 5th and most recent edition, the DSM-5, was published in 2013. The diagnostic manual includes a total of 237 specific diagnosable disorders, each described in detail, including its symptoms, prevalence, risk factors, and comorbidity. Over time, the number of diagnosable conditions listed in the DSM has grown steadily, prompting criticism from some. Nevertheless, the diagnostic criteria in the DSM are more explicit than that of any other system, which makes the DSM system highly desirable for both clinical diagnosis and research.

3.5 Review Questions

Exercise 3.1  
(Solution on p. 24.)

The letters in the abbreviation DSM-5 stand for ________.

a. Diseases and Statistics Manual of Medicine 
b. Diagnosable Standards Manual of Mental Disorders  
c. Diseases and Symptoms Manual of Mental Disorders  
d. Diagnostic and Statistical Manual of Mental Disorders 

Exercise 3.2  
(Solution on p. 24.)

A study based on over 9,000 U.S. residents found that the most prevalent disorder was ________.

a. major depressive disorder  
b. social anxiety disorder  
c. obsessive-compulsive disorder  
d. specific phobia 

3.6 Critical Thinking Questions

Exercise 3.3  
(Solution on p. 24.)

Describe the DSM-5. What is it, what kind of information does it contain, and why is it important to the study and treatment of psychological disorders?

Exercise 3.4  
(Solution on p. 24.)

The International Classification of Diseases (ICD) and the DSM differ in various ways. What are some of the differences in these two classification systems?
Solutions to Exercises in Chapter 3

Solution to Exercise 3.1 (p. 23)
D

Solution to Exercise 3.2 (p. 23)
A

Solution to Exercise 3.3 (p. 23)
The DSM-5 is the classification system of psychological disorders preferred by most U.S. mental health professionals, and it is published by the American Psychiatric Association (APA). It consists of broad categories of disorders and specific disorders that fall within each category. Each disorder has an explicit description of its symptoms, as well as information concerning prevalence, risk factors, and comorbidity. The DSM-5 provides a common language that enables mental health professionals to communicate effectively about sets of symptoms.

Solution to Exercise 3.4 (p. 23)
The ICD is used primarily for making clinical diagnoses and more broadly for examining the general health of populations and monitoring the international prevalence of diseases and other health problems. While the DSM is also used for diagnostic purposes, it is also highly valued as a research tool. For example, much of the data regarding the etiology and treatment of psychological disorders are based on diagnostic criteria set forth in the DSM.
Chapter 4

13.3 Anxiety Disorders

Everybody experiences anxiety from time to time. Although anxiety is closely related to fear, the two states possess important differences. Fear involves an instantaneous reaction to an imminent threat, whereas anxiety involves apprehension, avoidance, and cautiousness regarding a potential threat, danger, or other negative event (Craske, 1999). While anxiety is unpleasant to most people, it is important to our health, safety, and well-being. Anxiety motivates us to take actions—such as preparing for exams, watching our weight, showing up to work on time—that enable us to avert potential future problems. Anxiety also motivates us to avoid certain things—such as running up debts and engaging in illegal activities—that could lead to future trouble. Most individuals' level and duration of anxiety approximates the magnitude of the potential threat they face. For example, suppose a single woman in her late 30s who wishes to marry is concerned about the possibility of having to settle for a spouse who is less attractive and educated than desired. This woman likely would experience anxiety of greater intensity and duration than would a 21-year-old college junior who is having trouble finding a date for the annual social. Some people, however, experience anxiety that is excessive, persistent, and greatly out of proportion to the actual threat; if one's anxiety has a disruptive influence on one's life, this is a strong indicator that the individual is experiencing an anxiety disorder.

Anxiety disorders are characterized by excessive and persistent fear and anxiety, and by related disturbances in behavior (APA, 2013). Although anxiety is universally experienced, anxiety disorders cause considerable distress. As a group, anxiety disorders are common: approximately 25%-30% of the U.S. population meets the criteria for at least one anxiety disorder during their lifetime (Kessler et al., 2005). Also, these disorders appear to be much more common in women than they are in men; within a 12-month period, around 23% of women and 14% of men will experience at least one anxiety disorder (National Comorbidity Survey, 2007). Anxiety disorders are the most frequently occurring class of mental disorders and are often comorbid with each other and with other mental disorders (Kessler, Ruscio, Shear, & Wittchen, 2009).

4.1 SPECIFIC PHOBIA

Phobia is a Greek word that means fear. A person diagnosed with a specific phobia (formerly known as simple phobia) experiences excessive, distressing, and persistent fear or anxiety about a specific object or situation (such as animals, enclosed spaces, elevators, or flying) (APA, 2013). Even though people realize their level of fear and anxiety in relation to the phobic stimulus is irrational, some people with a specific phobia may go to great lengths to avoid the phobic stimulus (the object or situation that triggers the fear and anxiety). Typically, the fear and anxiety a phobic stimulus elicits is disruptive to the person's life. For example, a man with a phobia of flying might refuse to accept a job that requires frequent air travel, thus negatively affecting his career. Clinicians who have worked with people who have specific phobias have encountered many kinds of phobias, some of which are shown in Table 4.1: Specific Phobias.

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Specific Phobias

<table>
<thead>
<tr>
<th>Phobia</th>
<th>Feared Object or Situation</th>
</tr>
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<tbody>
<tr>
<td>Acrophobia</td>
<td>heights</td>
</tr>
<tr>
<td>Aerophobia</td>
<td>flying</td>
</tr>
<tr>
<td>Arachnophobia</td>
<td>spiders</td>
</tr>
<tr>
<td>Claustrophobia</td>
<td>enclosed spaces</td>
</tr>
<tr>
<td>Cynophobia</td>
<td>dogs</td>
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<tr>
<td>Hematophobia</td>
<td>blood</td>
</tr>
<tr>
<td>Ophidiophobia</td>
<td>snakes</td>
</tr>
<tr>
<td>Taphophobia</td>
<td>being buried alive</td>
</tr>
<tr>
<td>Trypanophobia</td>
<td>injections</td>
</tr>
<tr>
<td>Xenophobia</td>
<td>strangers</td>
</tr>
</tbody>
</table>

Table 4.1

Specific phobias are common; in the United States, around 12.5% of the population will meet the criteria for a specific phobia at some point in their lifetime (Kessler et al., 2005). One type of phobia, **agoraphobia**, is listed in the DSM-5 as a separate anxiety disorder. Agoraphobia, which literally means “fear of the marketplace,” is characterized by intense fear, anxiety, and avoidance of situations in which it might be difficult to escape or receive help if one experiences symptoms of a panic attack (a state of extreme anxiety that we will discuss shortly). These situations include public transportation, open spaces (parking lots), enclosed spaces (stores), crowds, or being outside the home alone (APA, 2013). About 1.4% of Americans experience agoraphobia during their lifetime (Kessler et al., 2005).

### 4.2 SOCIAL ANXIETY DISORDER

**Social anxiety disorder** (formerly called social phobia) is characterized by extreme and persistent fear or anxiety and avoidance of social situations in which the person could potentially be evaluated negatively by others (APA, 2013). As with specific phobias, social anxiety disorder is common in the United States; a little over 12% of all Americans experience social anxiety disorder during their lifetime (Kessler et al., 2005).

The heart of the fear and anxiety in social anxiety disorder is the person’s concern that he may act in a humiliating or embarrassing way, such as appearing foolish, showing symptoms of anxiety (blushing), or doing or saying something that might lead to rejection (such as offending others). The kinds of social situations in which individuals with social anxiety disorder usually have problems include public speaking, having a conversation, meeting strangers, eating in restaurants, and, in some cases, using public restrooms. Although many people become anxious in social situations like public speaking, the fear, anxiety, and avoidance experienced in social anxiety disorder are highly distressing and lead to serious impairments in life. Adults with this disorder are more likely to experience lower educational attainment and lower earnings (Katzelnick et al., 2001), perform more poorly at work and are more likely to be unemployed (Mitra, Beard, Weissberg, & Keller, 2011), and report greater dissatisfaction with their family lives, friends, leisure activities, and income (Stein & Kean, 2000).

When people with social anxiety disorder are unable to avoid situations that provoke anxiety, they typically perform **safety behaviors**: mental or behavioral acts that reduce anxiety in social situations by reducing the chance of negative social outcomes. Safety behaviors include avoiding eye contact, rehearsing sentences before speaking, talking only briefly, and not talking about oneself (Alden & Bieling, 1998). Other examples of safety behaviors include the following (Markle, 2013):

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- assuming roles in social situations that minimize interaction with others (e.g., taking pictures, setting up equipment, or helping prepare food)
- asking people many questions to keep the focus off of oneself
- selecting a position to avoid scrutiny or contact with others (sitting in the back of the room)
- wearing bland, neutral clothes to avoid drawing attention to oneself
- avoiding substances or activities that might cause anxiety symptoms (such as caffeine, warm clothing, and physical exercise)

Although these behaviors are intended to prevent the person with social anxiety disorder from doing something awkward that might draw criticism, these actions usually exacerbate the problem because they do not allow the individual to disconfirm his negative beliefs, often eliciting rejection and other negative reactions from others (Alden & Bieling, 1998).

People with social anxiety disorder may resort to self-medication, such as drinking alcohol, as a means to avert the anxiety symptoms they experience in social situations (Battista & Kocovski, 2010). The use of alcohol when faced with such situations may become negatively reinforcing: encouraging individuals with social anxiety disorder to turn to the substance whenever they experience anxiety symptoms. The tendency to use alcohol as a coping mechanism for social anxiety, however, can come with a hefty price tag: a number of large scale studies have reported a high rate of comorbidity between social anxiety disorder and alcohol use disorder (Morris, Stewart, & Ham, 2005).

As with specific phobias, it is highly probable that the fears inherent to social anxiety disorder can develop through conditioning experiences. For example, a child who is subjected to early unpleasant social experiences (e.g., bullying at school) may develop negative social images of herself that become activated later in anxiety-provoking situations (Hackmann, Clark, & McManus, 2000). Indeed, one study reported that 92% of a sample of adults with social anxiety disorder reported a history of severe teasing in childhood, compared to only 35% of a sample of adults with panic disorder (McCabe, Antony, Summerfeldt, Liss, & Swinson, 2003).

One of the most well-established risk factors for developing social anxiety disorder is behavioral inhibition (Clauss & Blackford, 2012). Behavioral inhibition is thought to be an inherited trait, and it is characterized by a consistent tendency to show fear and restraint when presented with unfamiliar people or situations (Kagan, Reznick, & Snidman, 1988). Behavioral inhibition is displayed very early in life; behaviorally inhibited toddlers and children respond with great caution and restraint in unfamiliar situations, and they are often timid, fearful, and shy around unfamiliar people (Fox, Henderson, Marshall, Nichols, & Ghera, 2005). A recent statistical review of studies demonstrated that behavioral inhibition was associated with more than a sevenfold increase in the risk of development of social anxiety disorder, demonstrating that behavioral inhibition is a major risk factor for the disorder (Clauss & Blackford, 2012).

4.3 PANIC DISORDER

Imagine that you are at the mall one day with your friends and—suddenly and inexplicably—you begin sweating and trembling, your heart starts pounding, you have trouble breathing, and you start to feel dizzy and nauseous. This episode lasts for 10 minutes and is terrifying because you start to think that you are going to die. When you visit your doctor the following morning and describe what happened, she tells you that you have experienced a panic attack. If you experience another one of these episodes two weeks later and worry for a month or more that similar episodes will occur in the future, it is likely that you have developed panic disorder.

People with panic disorder experience recurrent (more than one) and unexpected panic attacks, along with at least one month of persistent concern about additional panic attacks, worry over the consequences of the attacks, or self-defeating changes in behavior related to the attacks (e.g., avoidance of exercise or unfamiliar situations) (APA, 2013). As is the case with other anxiety disorders, the panic attacks cannot result from the physiological effects of drugs and other substances, a medical condition, or another mental disorder. A panic attack is defined as a period of extreme fear or discomfort that develops abruptly and
reaches a peak within 10 minutes. Its symptoms include accelerated heart rate, sweating, trembling, choking sensations, hot flashes or chills, dizziness or lightheadedness, fears of losing control or going crazy, and fears of dying (APA, 2013). Sometimes panic attacks are expected, occurring in response to specific environmental triggers (such as being in a tunnel); other times, these episodes are unexpected and emerge randomly (such as when relaxing). According to the DSM-5, the person must experience unexpected panic attacks to qualify for a diagnosis of panic disorder.

Panic attacks themselves are not mental disorders. Indeed, around 23% of Americans experience isolated panic attacks in their lives without meeting the criteria for panic disorder (Kessler et al., 2006), indicating that panic attacks are fairly common. Panic disorder is, of course, much less common, afflicting 4.7% of Americans during their lifetime (Kessler et al., 2005). Many people with panic disorder develop agoraphobia, which is marked by fear and avoidance of situations in which escape might be difficult or help might not be available if one were to develop symptoms of a panic attack. People with panic disorder often experience a comorbid disorder, such as other anxiety disorders or major depressive disorder (APA, 2013).

4.4 Summary

Anxiety disorders are a group of disorders in which a person experiences excessive, persistent, and distressing fear and anxiety that interfere with normal functioning. Anxiety disorders include specific phobia: a specific unrealistic fear; social anxiety disorder: extreme fear and avoidance of social situations; panic disorder: suddenly overwhelmed by panic even though there is no apparent reason to be frightened; agoraphobia: an intense fear and avoidance of situations in which it might be difficult to escape; and generalized anxiety disorder: a relatively continuous state of tension, apprehension, and dread.

4.5 Review Questions

Exercise 4.1
In which of the following anxiety disorders is the person in a continuous state of excessive, pointless worry and apprehension?

a. panic disorder
b. generalized anxiety disorder
c. agoraphobia
d. social anxiety disorder

Exercise 4.2
Which of the following would constitute a safety behavior?

a. encountering a phobic stimulus in the company of other people
b. avoiding a field where snakes are likely to be present
c. avoiding eye contact
d. worrying as a distraction from painful memories

4.6 Critical Thinking Question

Exercise 4.3
Describe how cognitive theories of the etiology of anxiety disorders differ from learning theories.
Solutions to Exercises in Chapter 4

Solution to Exercise 4.1 (p. 28)
B

Solution to Exercise 4.2 (p. 28)
C

Solution to Exercise 4.3 (p. 28)

Learning theories suggest that some anxiety disorders, especially specific phobia, can develop through a number of learning mechanisms. These mechanisms can include classical and operant conditioning, modeling, or vicarious learning. Cognitive theories, in contrast, assume that some anxiety disorder, especially panic disorder, develop through cognitive misinterpretations of anxiety and other symptoms.
5.1 OBSESSIVE-COMPULSIVE DISORDER

People with obsessive-compulsive disorder (OCD) experience thoughts and urges that are intrusive and unwanted (obsessions) and/or the need to engage in repetitive behaviors or mental acts (compulsions). A person with this disorder might, for example, spend hours each day washing his hands or constantly checking and rechecking to make sure that a stove, faucet, or light has been turned off.

Obsessions are more than just unwanted thoughts that seem to randomly jump into our head from time to time, such as recalling an insensitive remark a coworker made recently, and they are more significant than day-to-day worries we might have, such as justifiable concerns about being laid off from a job. Rather, obsessions are characterized as persistent, unintentional, and unwanted thoughts and urges that are highly intrusive, unpleasant, and distressing (APA, 2013). Common obsessions include concerns about germs and contamination, doubts (“Did I turn the water off?”), order and symmetry (“I need all the spoons in the tray to be arranged a certain way”), and urges that are aggressive or lustful. Usually, the person knows that such thoughts and urges are irrational and thus tries to suppress or ignore them, but has an extremely difficult time doing so. These obsessive symptoms sometimes overlap, such that someone might have both contamination and aggressive obsessions (Abramowitz & Siqueland, 2013).

Compulsions are repetitive and ritualistic acts that are typically carried out primarily as a means to minimize the distress that obsessions trigger or to reduce the likelihood of a feared event (APA, 2013). Compulsions often include such behaviors as repeated and extensive hand washing, cleaning, checking (e.g., that a door is locked), and ordering (e.g., lining up all the pencils in a particular way), and they also include such mental acts as counting, praying, or reciting something to oneself. Compulsions characteristic of OCD are not performed out of pleasure, nor are they connected in a realistic way to the source of the distress or feared event. Approximately 2.3% of the U.S. population will experience OCD in their lifetime (Ruscio, Stein, Chiu, & Kessler, 2010) and, if left untreated, OCD tends to be a chronic condition creating lifelong interpersonal and psychological problems (Norberg, Calamari, Cohen, & Riemann, 2008).

5.2 BODY DYSMORPHIC DISORDER

An individual with body dysmorphic disorder is preoccupied with a perceived flaw in her physical appearance that is either nonexistent or barely noticeable to other people (APA, 2013). These perceived physical defects cause the person to think she is unattractive, ugly, hideous, or deformed. These preoccupations can focus on any bodily area, but they typically involve the skin, face, or hair. The preoccupation with imagined defects is often maintained by beliefs that making the defect less obvious or nonexistent will make the person more attractive (APA, 2013).
PHYSICAL AWES DRIVES THE PERSON TO ENGAGE IN REPEETITIVE AND RITUALISTIC BEHAVIORAL AND MENTAL ACTS, SUCH AS CONSTANTLY LOOKING IN THE MIRROR, TRYING TO HIDE THE OFFENDING BODY PART, COMPARISONS WITH OTHERS, AND, IN SOME EXTREME CASES, COSMETIC SURGERY (PHILLIPS, 2005). AN ESTIMATED 2.4% OF THE ADULTS IN THE UNITED STATES MEET THE CRITERIA FOR BODY DYSMORPHIC DISORDER, WITH SLIGHTLY HIGHER RATES IN WOMEN THAN IN MEN (APA, 2013).

5.3 HOARDING DISORDER

Although hoarding was traditionally considered to be a symptom of OCD, considerable evidence suggests that hoarding represents an entirely different disorder (Mataix-Cols et al., 2010). People with hoarding disorder cannot bear to part with personal possessions, regardless of how valueless or useless these possessions are. As a result, these individuals accumulate excessive amounts of usually worthless items that clutter their living areas. Often, the quantity of cluttered items is so excessive that the person is unable use his kitchen, or sleep in his bed. People who suffer from this disorder have great difficulty parting with items because they believe the items might be of some later use, or because they form a sentimental attachment to the items (APA, 2013). Importantly, a diagnosis of hoarding disorder is made only if the hoarding is not caused by another medical condition and if the hoarding is not a symptom of another disorder (e.g., schizophrenia) (APA, 2013).

5.4 Summary

Obsessive-compulsive and related disorders are a group of DSM-5 disorders that overlap somewhat in that they each involve intrusive thoughts and/or repetitive behaviors. Perhaps the most recognized of these disorders is obsessive-compulsive disorder, in which a person is obsessed with unwanted, unpleasant thoughts and/or compulsively engages in repetitive behaviors or mental acts, perhaps as a way of coping with the obsessions. Body dysmorphic disorder is characterized by the individual becoming excessively preoccupied with one or more perceived flaws in his physical appearance that are either nonexistent or unnoticeable to others. Preoccupation with the perceived physical defects causes the person to experience significant anxiety regarding how he appears to others. Hoarding disorder is characterized by persistent difficulty in discarding or parting with objects, regardless of their actual value, often resulting in the accumulation of items that clutter and congest her living area.

5.5 Review Questions

Exercise 5.1

Which of the following best illustrates a compulsion?

a. mentally counting backward from 1,000
b. persistent fear of germs
c. thoughts of harming a neighbor
d. falsely believing that a spouse has been cheating

Exercise 5.2

Research indicates that the symptoms of OCD ____________.

a. are similar to the symptoms of panic disorder
b. are triggered by low levels of stress hormones
c. are related to hyperactivity in the orbitofrontal cortex
d. are reduced if people are asked to view photos of stimuli that trigger the symptoms
5.6 Critical Thinking Questions

Exercise 5.3
Discuss the common elements of each of the three disorders covered in this section: obsessive-compulsive disorder, body dysmorphic disorder, and hoarding disorder.

(Solution on p. 34.)
Solutions to Exercises in Chapter 5

Solution to Exercise 5.1 (p. 32)
A

Solution to Exercise 5.2 (p. 32)
C

Solution to Exercise 5.3 (p. 33)

Each of the three disorders is characterized by repetitive thoughts and urges, as well as an uncontrollable need to engage in repetitive behavior and mental acts. For example, repetitive thoughts include concerns over contamination (OCD), imaged physical defects (body dysmorphic disorder), and over discarding one’s possessions (hoarding disorder). An uncontrollable need to engage in repetitive behaviors and mental acts include persistent hand-washing (OCD), constantly looking in the mirror (body dysmorphic disorder), and engaging in efforts to acquire new possessions (hoarding disorder).
Chapter 6

13.5 Posttraumatic Stress Disorder

Extremely stressful or traumatic events, such as combat, natural disasters, and terrorist attacks, place the people who experience them at an increased risk for developing psychological disorders such as posttraumatic stress disorder (PTSD). Throughout much of the 20th century, this disorder was called shell shock and combat neurosis because its symptoms were observed in soldiers who had engaged in wartime combat. By the late 1970s it had become clear that women who had experienced sexual traumas (e.g., rape, domestic battery, and incest) often experienced the same set of symptoms as did soldiers (Herman, 1997). The term posttraumatic stress disorder was developed given that these symptoms could happen to anyone who experienced psychological trauma.

6.1 A BROADER DEFINITION OF PTSD

PTSD was listed among the anxiety disorders in previous DSM editions. In DSM-5, it is now listed among a group called Trauma-and-Stressor-Related Disorders. For a person to be diagnosed with PTSD, she be must exposed to, witness, or experience the details of a traumatic experience (e.g., a first responder), one that involves “actual or threatened death, serious injury, or sexual violence” (APA, 2013, p. 271). These experiences can include such events as combat, threatened or actual physical attack, sexual assault, natural disasters, terrorist attacks, and automobile accidents. This criterion makes PTSD the only disorder listed in the DSM in which a cause (extreme trauma) is explicitly specified.

Symptoms of PTSD include intrusive and distressing memories of the event, flashbacks (states that can last from a few seconds to several days, during which the individual relives the event and behaves as if the event were occurring at that moment [APA, 2013]), avoidance of stimuli connected to the event, persistently negative emotional states (e.g., fear, anger, guilt, and shame), feelings of detachment from others, irritability, proneness toward outbursts, and an exaggerated startle response (jumpiness). For PTSD to be diagnosed, these symptoms must occur for at least one month.

Roughly 7% of adults in the United States, including 9.7% of women and 3.6% of men, experience PTSD in their lifetime (National Comorbidity Survey, 2007), with higher rates among people exposed to mass trauma and people whose jobs involve duty-related trauma exposure (e.g., police officers, firefighters, and emergency medical personnel) (APA, 2013). Nearly 21% of residents of areas affected by Hurricane Katrina suffered from PTSD one year following the hurricane (Kessler et al., 2008), and 12.6% of Manhattan residents were observed as having PTSD 2–3 years after the 9/11 terrorist attacks (DiGrande et al., 2008).

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6.2 Critical Thinking Question

Exercise 6.1
(Solution on p. 37.)
List some of the risk factors associated with the development of PTSD following a traumatic event.
Solutions to Exercises in Chapter 6

Solution to Exercise 6.1 (p. 36)
Risk factors associated with PTSD include gender (female), low socioeconomic status, low intelligence, personal and family history of mental illness, and childhood abuse or trauma. Personality factors, including neuroticism and somatization, may also serve as risk factors. Also, certain versions of a gene that regulates serotonin may constitute a diathesis.
Chapter 7

13.6 Mood Disorders

Blake cries all day and feeling that he is worthless and his life is hopeless, he cannot get out of bed. Crystal stays up all night, talks very rapidly, and went on a shopping spree in which she spent $3,000 on furniture, although she cannot afford it. Maria recently had a baby, and she feels overwhelmed, teary, anxious, and panicked, and believes she is a terrible mother—practically every day since the baby was born. All these individuals demonstrate symptoms of a potential mood disorder.

Mood disorders are characterized by severe disturbances in mood and emotions—most often depression, but also mania and elation (Rothschild, 1999). All of us experience fluctuations in our moods and emotional states, and often these fluctuations are caused by events in our lives. We become elated if our favorite team wins the World Series and dejected if a romantic relationship ends or if we lose our job. At times, we feel fantastic or miserable for no clear reason. People with mood disorders also experience mood fluctuations, but their fluctuations are extreme, distort their outlook on life, and impair their ability to function.

The DSM-5 lists two general categories of mood disorders. Depressive disorders are a group of disorders in which depression is the main feature. Depression is a vague term that, in everyday language, refers to an intense and persistent sadness. Depression is a heterogeneous mood state—it consists of a broad spectrum of symptoms that range in severity. Depressed people feel sad, discouraged, and hopeless. These individuals lose interest in activities once enjoyed, often experience a decrease in drives such as hunger and sex, and frequently doubt personal worth. Depressive disorders vary by degree, but this chapter highlights the most well-known: major depressive disorder (sometimes called unipolar depression).

Bipolar and related disorders are a group of disorders in which mania is the defining feature. Mania is a state of extreme elation and agitation. When people experience mania, they may become extremely talkative, behave recklessly, or attempt to take on many tasks simultaneously. The most recognized of these disorders is bipolar disorder.

7.1 MAJOR DEPRESSIVE DISORDER

According to the DSM-5, the defining symptoms of major depressive disorder include “depressed mood most of the day, nearly every day” (feeling sad, empty, hopeless, or appearing tearful to others), and loss of interest and pleasure in usual activities (APA, 2013). In addition to feeling overwhelmingly sad most of each day, people with depression will no longer show interest or enjoyment in activities that previously were gratifying, such as hobbies, sports, sex, social events, time spent with family, and so on. Friends and family members may notice that the person has completely abandoned previously enjoyed hobbies; for example, an avid tennis player who develops major depressive disorder no longer plays tennis (Rothschild, 1999).

To receive a diagnosis of major depressive disorder, one must experience a total of five symptoms for at least a two-week period; these symptoms must cause significant distress or impair normal functioning, and

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they must not be caused by substances or a medical condition. At least one of the two symptoms mentioned above must be present, plus any combination of the following symptoms (APA, 2013):

- significant weight loss (when not dieting) or weight gain and/or significant decrease or increase in appetite;
- difficulty falling asleep or sleeping too much;
- psychomotor agitation (the person is noticeably fidgety and jittery, demonstrated by behaviors like the inability to sit, pacing, hand-wringing, pulling or rubbing of the skin, clothing, or other objects) or psychomotor retardation (the person talks and moves slowly, for example, talking softly, very little, or in a monotone);
- fatigue or loss of energy;
- feelings of worthlessness or guilt;
- difficulty concentrating and indecisiveness; and
- suicidal ideation: thoughts of death (not just fear of dying), thinking about or planning suicide, or making an actual suicide attempt.

Major depressive disorder is considered episodic: its symptoms are typically present at their full magnitude for a certain period of time and then gradually abate. Approximately 50%–60% of people who experience an episode of major depressive disorder will have a second episode at some point in the future; those who have had two episodes have a 70% chance of having a third episode, and those who have had three episodes have a 90% chance of having a fourth episode (Rothschild, 1999). Although the episodes can last for months, a majority a people diagnosed with this condition (around 70%) recover within a year. However, a substantial number do not recover; around 12% show serious signs of impairment associated with major depressive disorder after 5 years (Boland & Keller, 2009). In the long-term, many who do recover will still show minor symptoms that fluctuate in their severity (Judd, 2012).

### 7.1.1 Results of Major Depressive Disorder

Major depressive disorder is a serious and incapacitating condition that can have a devastating effect on the quality of one’s life. The person suffering from this disorder lives a profoundly miserable existence that often results in unavailability for work or education, abandonment of promising careers, and lost wages; occasionally, the condition requires hospitalization. The majority of those with major depressive disorder report having faced some kind of discrimination, and many report that having received such treatment has stopped them from initiating close relationships, applying for jobs for which they are qualified, and applying for education or training (Lasalvia et al., 2013). Major depressive disorder also takes a toll on health. Depression is a risk factor for the development of heart disease in healthy patients, as well as adverse cardiovascular outcomes in patients with preexisting heart disease (Whooley, 2006).

### 7.1.2 Risk Factors for Major Depressive Disorder

Major depressive disorder is often referred to as the common cold of psychiatric disorders. Around 6.6% of the U.S. population experiences major depressive disorder each year; 16.9% will experience the disorder during their lifetime (Kessler & Wang, 2009). It is more common among women than among men, affecting approximately 20% of women and 13% of men at some point in their life (National Comorbidity Survey, 2007). The greater risk among women is not accounted for by a tendency to report symptoms or to seek help more readily, suggesting that gender differences in the rates of major depressive disorder may reflect biological and gender-related environmental experiences (Kessler, 2003).

Lifetime rates of major depressive disorder tend to be highest in North and South America, Europe, and Australia; they are considerably lower in Asian countries (Hasin, Fenton, & Weissman, 2011). The rates of major depressive disorder are higher among younger age cohorts than among older cohorts, perhaps because people in younger age cohorts are more willing to admit depression (Kessler & Wang, 2009).

A number of risk factors are associated with major depressive disorder: unemployment (including homemakers); earning less than $20,000 per year; living in urban areas; or being separated, divorced, or widowed.
Comorbid disorders include anxiety disorders and substance abuse disorders (Kessler & Wang, 2009).

### 7.2 SUBTYPES OF DEPRESSION

The DSM-5 lists several different subtypes of depression. These subtypes—what the DSM-5 refer to as specifiers—are not specific disorders; rather, they are labels used to indicate specific patterns of symptoms or to specify certain periods of time in which the symptoms may be present. One subtype, *seasonal pattern,* applies to situations in which a person experiences the symptoms of major depressive disorder only during a particular time of year (e.g., fall or winter). In everyday language, people often refer to this subtype as the winter blues.

Another subtype, *peripartum onset* (commonly referred to as *postpartum depression*), applies to women who experience major depression during pregnancy or in the four weeks following the birth of their child (APA, 2013). These women often feel very anxious and may even have panic attacks. They may feel guilty, agitated, and be weepy. They may not want to hold or care for their newborn, even in cases in which the pregnancy was desired and intended. In extreme cases, the mother may have feelings of wanting to harm her child or herself. In a horrific illustration, a woman named Andrea Yates, who suffered from extreme peripartum-onset depression (as well as other mental illnesses), drowned her five children in a bathtub (Roche, 2002). Most women with peripartum-onset depression do not physically harm their children, but most do have difficulty being adequate caregivers (Fields, 2010). A surprisingly high number of women experience symptoms of peripartum-onset depression. A study of 10,000 women who had recently given birth found that 14% screened positive for peripartum-onset depression, and that nearly 20% reported having thoughts of wanting to harm themselves (Wisner et al., 2013).

People with *persistent depressive disorder* (previously known as dysthymia) experience depressed moods most of the day nearly every day for at least two years, as well as at least two of the other symptoms of major depressive disorder. People with persistent depressive disorder are chronically sad and melancholy, but do not meet all the criteria for major depression. However, episodes of full-blown major depressive disorder can occur during persistent depressive disorder (APA, 2013).

### 7.3 BIPOLAR DISORDER

A person with *bipolar disorder* (commonly known as *manic depression*) often experiences mood states that vacillate between depression and mania; that is, the person’s mood is said to alternate from one emotional extreme to the other (in contrast to unipolar, which indicates a persistently sad mood).

To be diagnosed with bipolar disorder, a person must have experienced a manic episode at least once in his life; although major depressive episodes are common in bipolar disorder, they are not required for a diagnosis (APA, 2013). According to the DSM-5, a *manic episode* is characterized as a “distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy lasting at least one week,” that lasts most of the time each day (APA, 2013, p. 124). During a manic episode, some experience a mood that is almost euphoric and become excessively talkative, sometimes spontaneously starting conversations with strangers; others become excessively irritable and complain or make hostile comments. The person may talk loudly and rapidly, exhibiting *flight of ideas,* abruptly switching from one topic to another. These individuals are easily distracted, which can make a conversation very difficult. They may exhibit grandiosity, in which they experience inflated but unjustified self-esteem and self-confidence. For example, they might quit a job in order to “strike it rich” in the stock market, despite lacking the knowledge, experience, and capital for such an endeavor. They may take on several tasks at the same time (e.g., several time-consuming projects at work) and yet show little, if any, need for sleep; some may go for days without sleep. Patients may also recklessly engage in pleasurable activities that could have harmful consequences, including spending sprees, reckless driving, making foolish investments, excessive gambling, or engaging in sexual encounters with strangers (APA, 2013).
During a manic episode, individuals usually feel as though they are not ill and do not need treatment. However, the reckless behaviors that often accompany these episodes—which can be antisocial, illegal, or physically threatening to others—may require involuntary hospitalization (APA, 2013). Some patients with bipolar disorder will experience a rapid-cycling subtype, which is characterized by at least four manic episodes (or some combination of at least four manic and major depressive episodes) within one year.

7.3.1 Risk Factors for Bipolar Disorder

Bipolar disorder is considerably less frequent than major depressive disorder. In the United States, 1 out of every 167 people meets the criteria for bipolar disorder each year, and 1 out of 100 meet the criteria within their lifetime (Merikangas et al., 2011). The rates are higher in men than in women, and about half of those with this disorder report onset before the age of 25 (Merikangas et al., 2011). Around 90% of those with bipolar disorder have a comorbid disorder, most often an anxiety disorder or a substance abuse problem. Unfortunately, close to half of the people suffering from bipolar disorder do not receive treatment (Merikangas & Tohen, 2011). Suicide rates are extremely high among those with bipolar disorder: around 36% of individuals with this disorder attempt suicide at least once in their lifetime (Novick, Swartz, & Frank, 2010), and between 15%–19% complete suicide (Newman, 2004).

7.4 THE BIOLOGICAL BASIS OF MOOD DISORDERS

Mood disorders have been shown to have a strong genetic and biological basis. Relatives of those with major depressive disorder have double the risk of developing major depressive disorder, whereas relatives of patients with bipolar disorder have over nine times the risk (Merikangas et al., 2011). The rate of concordance for major depressive disorder is higher among identical twins than fraternal twins (50% vs. 38%, respectively), as is that of bipolar disorder (67% vs. 16%, respectively), suggesting that genetic factors play a stronger role in bipolar disorder than in major depressive disorder (Merikangas et al. 2011).

People with mood disorders often have imbalances in certain neurotransmitters, particularly norepinephrine and serotonin (Thase, 2009). These neurotransmitters are important regulators of the bodily functions that are disrupted in mood disorders, including appetite, sex drive, sleep, arousal, and mood. Medications that are used to treat major depressive disorder typically boost serotonin and norepinephrine activity, whereas lithium—used in the treatment of bipolar disorder—blocks norepinephrine activity at the synapses.

Since the 1950s, researchers have noted that depressed individuals have abnormal levels of cortisol, a stress hormone released into the blood by the neuroendocrine system during times of stress (Mackin & Young, 2004). When cortisol is released, the body initiates a fight-or-flight response in reaction to a threat or danger. Many people with depression show elevated cortisol levels (Holsboer & Ising, 2010), especially those reporting a history of early life trauma such as the loss of a parent or abuse during childhood (Baes, Tofoli, Martins, & Juruena, 2012). Such findings raise the question of whether high cortisol levels are a cause or a consequence of depression. High levels of cortisol are a risk factor for future depression (Halligan, Herbert, Goodyer, & Murray, 2007), and cortisol activates activity in the amygdala while deactivating activity in the PFC (McEwen, 2005)—both brain disturbances are connected to depression. Thus, high cortisol levels may have a causal effect on depression, as well as on its brain function abnormalities (van Praag, 2005). Also, because stress results in increased cortisol release (Michaud, Matheson, Kelly, Anisman, 2008), it is equally reasonable to assume that stress may precipitate depression.

7.5 Summary

Mood disorders are those in which the person experiences severe disturbances in mood and emotion. They include depressive disorders and bipolar and related disorders. Depressive disorders include major depressive disorder, which is characterized by episodes of profound sadness and loss of interest or pleasure in usual...
activities and other associated features, and persistent depressive disorder, which marked by a chronic state of sadness. Bipolar disorder is characterized by mood states that vacillate between sadness and euphoria; a diagnosis of bipolar disorder requires experiencing at least one manic episode, which is defined as a period of extreme euphoria, irritability, and increased activity. Mood disorders appear to have a genetic component, with genetic factors playing a more prominent role in bipolar disorder than in depression. Both biological and psychological factors are important in the development of depression. People who suffer from mental health problems, especially mood disorders, are at heightened risk for suicide.

**7.6 Review Questions**

**Exercise 7.1** *(Solution on p. 44.)*

Common symptoms of major depressive disorder include all of the following except ________.

a. periods of extreme elation and euphoria  
b. difficulty concentrating and making decisions  
c. loss of interest or pleasure in usual activities  
d. psychomotor agitation and retardation

**Exercise 7.2** *(Solution on p. 44.)*

Suicide rates are ________ among men than among women, and they are ________ during the winter holiday season than during the spring months.

a. higher; higher  
b. lower; lower  
c. higher; lower  
d. lower; higher

**7.7 Critical Thinking Question**

**Exercise 7.3** *(Solution on p. 44.)*

Describe several of the factors associated with suicide.
Solutions to Exercises in Chapter 7

Solution to Exercise 7.1 (p. 43)
A

Solution to Exercise 7.2 (p. 43)
C

Solution to Exercise 7.3 (p. 43)
The risk of suicide is high among people with mental health problems, including mood disorders and substance abuse problems. The risk is also high among those who have made a prior suicide attempt and who have lethal means to commit suicide. Rates of suicide are higher among men and during the springtime, and they are higher in the mountain states of the west than in other regions of the United States. Research has also shown that suicides can have a “contagious” effect on people, and that it is associated with serotonin dysfunction.
Chapter 8

13.7 Schizophrenia

Schizophrenia is a devastating psychological disorder that is characterized by major disturbances in thought, perception, emotion, and behavior. About 1% of the population experiences schizophrenia in their lifetime, and usually the disorder is first diagnosed during early adulthood (early to mid-20s). Most people with schizophrenia experience significant difficulties in many day-to-day activities, such as holding a job, paying bills, caring for oneself (grooming and hygiene), and maintaining relationships with others. Frequent hospitalizations are more often the rule rather than the exception with schizophrenia. Even when they receive the best treatments available, many with schizophrenia will continue to experience serious social and occupational impairment throughout their lives.

What is schizophrenia? First, schizophrenia is not a condition involving a split personality; that is, schizophrenia is not the same thing as dissociative identity disorder (better known as multiple personality disorder). These disorders are sometimes confused because the word schizophrenia first coined by the Swiss psychiatrist Eugen Bleuler in 1911, derives from Greek words that refer to a “splitting” (schizo) of psychic functions (phrene) (Green, 2001).

Schizophrenia is considered a psychotic disorder, or one in which the person’s thoughts, perceptions, and behaviors are impaired to the point where she is not able to function normally in life. In informal terms, one who suffers from a psychotic disorder (that is, has a psychosis) is disconnected from the world in which most of us live.

8.1 SYMPTOMS OF SCHIZOPHRENIA

The main symptoms of schizophrenia include hallucinations, delusions, disorganized thinking, disorganized or abnormal motor behavior, and negative symptoms (APA, 2013). A hallucination is a perceptual experience that occurs in the absence of external stimulation. Auditory hallucinations (hearing voices) occur in roughly two-thirds of patients with schizophrenia and are by far the most common form of hallucination (Andreasen, 1987). The voices may be familiar or unfamiliar, they may have a conversation or argue, or the voices may provide a running commentary on the person’s behavior (Tsuang, Farone, & Green, 1999).

Less common are visual hallucinations (seeing things that are not there) and olfactory hallucinations (smelling odors that are not actually present).

Delusions are beliefs that are contrary to reality and are firmly held even in the face of contradictory evidence. Many of us hold beliefs that some would consider odd, but a delusion is easily identified because it is clearly absurd. A person with schizophrenia may believe that his mother is plotting with the FBI to poison his coffee, or that his neighbor is an enemy spy who wants to kill him. These kinds of delusions are known as paranoid delusions, which involve the (false) belief that other people or agencies are plotting to harm the person. People with schizophrenia also may hold grandiose delusions, beliefs that one holds special power, unique knowledge, or is extremely important. For example, the person who claims to be Jesus

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Christ, or who claims to have knowledge going back 5,000 years, or who claims to be a great philosopher is experiencing grandiose delusions. Other delusions include the belief that one’s thoughts are being removed (thought withdrawal) or thoughts have been placed inside one’s head (thought insertion). Another type of delusion is somatic delusion, which is the belief that something highly abnormal is happening to one’s body (e.g., that one’s kidneys are being eaten by cockroaches).

Disorganized thinking refers to disjointed and incoherent thought processes—usually detected by what a person says. The person might ramble, exhibit loose associations (jump from topic to topic), or talk in a way that is so disorganized and incomprehensible that it seems as though the person is randomly combining words. Disorganized thinking is also exhibited by blatantly illogical remarks (e.g., “Fenway Park is in Boston. I live in Boston. Therefore, I live at Fenway Park.”) and by tangentiality: responding to others’ statements or questions by remarks that are either barely related or unrelated to what was said or asked. For example, if a person diagnosed with schizophrenia is asked if she is interested in receiving special job training, she might state that she once rode on a train somewhere. To a person with schizophrenia, the tangential (slightly related) connection between job training and riding a train are sufficient enough to cause such a response.

Disorganized or abnormal motor behavior refers to unusual behaviors and movements: becoming unusually active, exhibiting silly child-like behaviors (giggling and self-absorbed smiling), engaging in repeated and purposeless movements, or displaying odd facial expressions and gestures. In some cases, the person will exhibit catatonic behaviors, which show decreased reactivity to the environment, such as posturing, in which the person maintains a rigid and bizarre posture for long periods of time, or catatonic stupor, a complete lack of movement and verbal behavior.

Negative symptoms are those that reflect noticeable decreases and absences in certain behaviors, emotions, or drives (Green, 2001). A person who exhibits diminished emotional expression shows no emotion in his facial expressions, speech, or movements, even when such expressions are normal or expected. Avolition is characterized by a lack of motivation to engage in self-initiated and meaningful activity, including the most basic of tasks, such as bathing and grooming. Alogia refers to reduced speech output; in simple terms, patients do not say much. Another negative symptom is asociality, or social withdrawal and lack of interest in engaging in social interactions with others. A final negative symptom, anhedonia, refers to an inability to experience pleasure. One who exhibits anhedonia expresses little interest in what most people consider to be pleasurable activities, such as hobbies, recreation, or sexual activity.

8.2 CAUSES OF SCHIZOPHRENIA

There is considerable evidence suggesting that schizophrenia has a genetic basis. The risk of developing schizophrenia is nearly 6 times greater if one has a parent with schizophrenia than if one does not (Goldstein, Buka, Seidman, & Tsuang, 2010). Additionally, one’s risk of developing schizophrenia increases as genetic relatedness to family members diagnosed with schizophrenia increases (Gottesman, 2001).

8.2.1 Brain Anatomy

Brain imaging studies reveal that people with schizophrenia have enlarged ventricles, the cavities within the brain that contain cerebral spinal fluid (Green, 2001). This finding is important because larger than normal ventricles suggest that various brain regions are reduced in size, thus implying that schizophrenia is associated with a loss of brain tissue. In addition, many people with schizophrenia display a reduction in gray matter (cell bodies of neurons) in the frontal lobes (Lawrie & Abukmeil, 1998), and many show less frontal lobe activity when performing cognitive tasks (Buchsbaum et al., 1990). The frontal lobes are important in a variety of complex cognitive functions, such as planning and executing behavior, attention, speech, movement, and problem solving. Hence, abnormalities in this region provide merit in explaining why people with schizophrenia experience deficits in these of areas.

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8.2.2 Events During Pregnancy

Why do people with schizophrenia have these brain abnormalities? A number of environmental factors that could impact normal brain development might be at fault. High rates of obstetric complications in the births of children who later developed schizophrenia have been reported (Cannon, Jones, & Murray, 2002). In addition, people are at an increased risk for developing schizophrenia if their mother was exposed to influenza during the first trimester of pregnancy (Brown et al., 2004). Research has also suggested that a mother's emotional stress during pregnancy may increase the risk of schizophrenia in offspring. One study reported that the risk of schizophrenia is elevated substantially in offspring whose mothers experienced the death of a relative during the first trimester of pregnancy (Khashan et al., 2008).

8.2.3 Marijuana

Another variable that is linked to schizophrenia is marijuana use. Although a number of reports have shown that individuals with schizophrenia are more likely to use marijuana than are individuals without schizophrenia (Thornicroft, 1990), such investigations cannot determine if marijuana use leads to schizophrenia, or vice versa. However, a number of longitudinal studies have suggested that marijuana use is, in fact, a risk factor for schizophrenia. A classic investigation of over 45,000 Swedish conscripts who were followed up after 15 years found that those individuals who had reported using marijuana at least once by the time of conscription were more than 2 times as likely to develop schizophrenia during the ensuing 15 years than were those who reported never using marijuana; those who had indicated using marijuana 50 or more times were 6 times as likely to develop schizophrenia (Andréasson, Allbeck, Engström, & Rydberg, 1987). More recently, a review of 35 longitudinal studies found a substantially increased risk of schizophrenia and other psychotic disorders in people who had used marijuana, with the greatest risk in the most frequent users (Moore et al., 2007). Other work has found that marijuana use is associated with an onset of psychotic disorders at an earlier age (Large, Sharma, Compton, Slade, & Niessen, 2011). Overall, the available evidence seems to indicate that marijuana use plays a causal role in the development of schizophrenia, although it is important to point out that marijuana use is not an essential or sufficient risk factor as not all people with schizophrenia have used marijuana and the majority of marijuana users do not develop schizophrenia (Casadio, Fernandes, Murray, & Di Forti, 2011). One plausible interpretation of the data is that early marijuana use may disrupt normal brain development during important early maturation periods in adolescence (Trezza, Cuomo, & Vander- schuren, 2008). Thus, early marijuana use may set the stage for the development of schizophrenia and other psychotic disorders, especially among individuals with an established vulnerability (Casadio et al., 2011).

8.3 SCHIZOPHRENIA: EARLY WARNING SIGNS

Early detection and treatment of conditions such as heart disease and cancer have improved survival rates and quality of life for people who suffer from these conditions. A new approach involves identifying people who show minor symptoms of psychosis, such as unusual thought content, paranoia, odd communication, delusions, problems at school or work, and a decline in social functioning—which are coined prodromal symptoms—and following these individuals over time to determine which of them develop a psychotic disorder and which factors best predict such a disorder. A number of factors have been identified that predict a greater likelihood that prodromal individuals will develop a psychotic disorder: genetic risk (a family history of psychosis), recent deterioration in functioning, high levels of unusual thought content, high levels of suspicion or paranoia, poor social functioning, and a history of substance abuse (Fusar-Poli et al., 2013). Further research will enable a more accurate prediction of those at greatest risk for developing schizophrenia, and thus to whom early intervention efforts should be directed.
8.4 Summary

Schizophrenia is a severe disorder characterized by a complete breakdown in one’s ability to function in life; it often requires hospitalization. People with schizophrenia experience hallucinations and delusions, and they have extreme difficulty regulating their emotions and behavior. Thinking is incoherent and disorganized, behavior is extremely bizarre, emotions are flat, and motivation to engage in most basic life activities is lacking. Considerable evidence shows that genetic factors play a central role in schizophrenia; however, adoption studies have highlighted the additional importance of environmental factors. Neurotransmitter and brain abnormalities, which may be linked to environmental factors such as obstetric complications or exposure to influenza during the gestational period, have also been implicated. A promising new area of schizophrenia research involves identifying individuals who show prodromal symptoms and following them over time to determine which factors best predict the development of schizophrenia. Future research may enable us to pinpoint those especially at risk for developing schizophrenia and who may benefit from early intervention.

8.5 Review Questions

Exercise 8.1  
Clifford falsely believes that the police have planted secret cameras in his home to monitor his every movement. Clifford’s belief is an example of ________.

a. a delusion  
b. a hallucination  
c. tangentiality  
d. a negative symptom

Exercise 8.2  
A study of adoptees whose biological mothers had schizophrenia found that the adoptees were most likely to develop schizophrenia ________.

a. if their childhood friends later developed schizophrenia  
b. if they abused drugs during adolescence  
c. if they were raised in a disturbed adoptive home environment  
d. regardless of whether they were raised in a healthy or disturbed home environment

8.6 Critical Thinking Question

Exercise 8.3  
Why is research following individuals who show prodromal symptoms of schizophrenia so important?
Solutions to Exercises in Chapter 8

Solution to Exercise 8.1 (p. 48)
A

Solution to Exercise 8.2 (p. 48)
C

Solution to Exercise 8.3 (p. 48)
This kind of research is important because it enables investigators to identify potential warning signs that predict the onset of schizophrenia. Once such factors are identified, interventions may be developed.

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13.8 Dissociative Disorders

Dissociative disorders are characterized by an individual becoming split off, or dissociated, from her core sense of self. Memory and identity become disturbed; these disturbances have a psychological rather than physical cause. Dissociative disorders listed in the DSM-5 include dissociative amnesia, depersonalization/derealization disorder, and dissociative identity disorder.

9.1 DISSOCIATIVE AMNESIA

Amnesia refers to the partial or total forgetting of some experience or event. An individual with dissociative amnesia is unable to recall important personal information, usually following an extremely stressful or traumatic experience such as combat, natural disasters, or being the victim of violence. The memory impairments are not caused by ordinary forgetting. Some individuals with dissociative amnesia will also experience dissociative fugue (from the word “to flee” in French), whereby they suddenly wander away from their home, experience confusion about their identity, and sometimes even adopt a new identity (Cardeña & Gleaves, 2006). Most fugue episodes last only a few hours or days, but some can last longer. One study of residents in communities in upstate New York reported that about 1.8% experienced dissociative amnesia in the previous year (Johnson, Cohen, Kasen, & Brook, 2006).

Some have questioned the validity of dissociative amnesia (Pope, Hudson, Bodkin, & Oliva, 1998); it has even been characterized as a “piece of psychiatric folklore devoid of convincing empirical support” (McNally, 2003, p. 275). Notably, scientific publications regarding dissociative amnesia rose during the 1980s and reached a peak in the mid-1990s, followed by an equally sharp decline by 2003; in fact, only 13 cases of individuals with dissociative amnesia worldwide could be found in the literature that same year (Pope, Barry, Bodkin, & Hudson, 2006). Further, no description of individuals showing dissociative amnesia following a trauma exists in any fictional or nonfictional work prior to 1800 (Pope, Pollakoff, Parker, Boynes, & Hudson, 2006). However, a study of 82 individuals who enrolled for treatment at a psychiatric outpatient hospital found that nearly 10% met the criteria for dissociative amnesia, perhaps suggesting that the condition is underdiagnosed, especially in psychiatric populations (Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006).

9.2 DEPERSONALIZATION/DEREALIZATION DISORDER

Depersonalization/derealization disorder is characterized by recurring episodes of depersonalization, derealization, or both. Depersonalization is defined as feelings of “unreality or detachment from, or unfamiliarity with, one’s whole self or from aspects of the self” (APA, 2013, p. 302). Individuals who experience depersonalization might believe their thoughts and feelings are not their own; they may feel robotic as though they lack control over their movements and speech; they may experience a distorted sense of time

\footnote{This content is available online at \text{<http://cnx.org/content/m55919/1.1/>}.}

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and, in extreme cases, they may sense an “out-of-body” experience in which they see themselves from the vantage point of another person. **Derealization** is conceptualized as a sense of “unreality or detachment from, or unfamiliarity with, the world, be it individuals, inanimate objects, or all surroundings” (APA, 2013, p. 303). A person who experiences derealization might feel as though he is in a fog or a dream, or that the surrounding world is somehow artificial and unreal. Individuals with depersonalization/derealization disorder often have difficulty describing their symptoms and may think they are going crazy (APA, 2013).

### 9.3 DISSOCIATIVE IDENTITY DISORDER

By far, the most well-known dissociative disorder is **dissociative identity disorder** (formerly called multiple personality disorder). People with dissociative identity disorder exhibit two or more separate personalities or identities, each well-defined and distinct from one another. They also experience memory gaps for the time during which another identity is in charge (e.g., one might find unfamiliar items in her shopping bags or among her possessions), and in some cases may report hearing voices, such as a child’s voice or the sound of somebody crying (APA, 2013). The study of upstate New York residents mentioned above (Johnson et al., 2006) reported that 1.5% of their sample experienced symptoms consistent with dissociative identity disorder in the previous year.

Dissociative identity disorder (DID) is highly controversial. Some believe that people fake symptoms to avoid the consequences of illegal actions (e.g., “I am not responsible for shoplifting because it was my other personality”). In fact, it has been demonstrated that people are generally skilled at adopting the role of a person with different personalities when they believe it might be advantageous to do so. As an example, Kenneth Bianchi was an infamous serial killer who, along with his cousin, murdered over a dozen females around Los Angeles in the late 1970s. Eventually, he and his cousin were apprehended. At Bianchi’s trial, he pled not guilty by reason of insanity, presenting himself as though he had DID and claiming that a different personality (“Steve Walker”) committed the murders. When these claims were scrutinized, he admitted faking the symptoms and was found guilty (Schwartz, 1981).

A second reason DID is controversial is because rates of the disorder suddenly skyrocketed in the 1980s. More cases of DID were identified during the five years prior to 1986 than in the preceding two centuries (Putnam, Guroff, Silberman, Barban, & Post, 1986). Although this increase may be due to the development of more sophisticated diagnostic techniques, it is also possible that the popularization of DID—helped in part by Sybil, a popular 1970s book (and later film) about a woman with 16 different personalities—may have prompted clinicians to overdiagnose the disorder (Piper & Merskey, 2004). Casting further scrutiny on the existence of multiple personalities or identities is the recent suggestion that the story of Sybil was largely fabricated, and the idea for the book might have been exaggerated (Nathan, 2011).

Despite its controversial nature, DID is clearly a legitimate and serious disorder, and although some people may fake symptoms, others suffer their entire lives with it. People with this disorder tend to report a history of childhood trauma, some cases having been corroborated through medical or legal records (Carréña & Gleaves, 2006). Research by Ross et al. (1990) suggests that in one study about 95% of people with DID were physically and/or sexually abused as children. Of course, not all reports of childhood abuse can be expected to be valid or accurate. However, there is strong evidence that traumatic experiences can cause people to experience states of dissociation, suggesting that dissociative states—including the adoption of multiple personalities—may serve as a psychologically important coping mechanism for threat and danger (Daenberg et al., 2012).

### 9.4 Summary

The main characteristic of dissociative disorders is that people become dissociated from their sense of self, resulting in memory and identity disturbances. Dissociative disorders listed in the DSM-5 include dissociative amnesia, depersonalization/derealization disorder, and dissociative identity disorder. A person with dissociative amnesia is unable to recall important personal information, often after a stressful or traumatic...
experience.

Depersonalization/derealization disorder is characterized by recurring episodes of depersonalization (i.e., detachment from or unfamiliarity with the self) and/or derealization (i.e., detachment from or unfamiliarity with the world). A person with dissociative identity disorder exhibits two or more well-defined and distinct personalities or identities, as well as memory gaps for the time during which another identity was present.

Dissociative identity disorder has generated controversy, mainly because some believe its symptoms can be faked by patients if presenting its symptoms somehow benefits the patient in avoiding negative consequences or taking responsibility for one’s actions. The diagnostic rates of this disorder have increased dramatically following its portrayal in popular culture. However, many people legitimately suffer over the course of a lifetime with this disorder.

9.5 Review Questions

Exercise 9.1
Dissociative amnesia involves ________.

- a. memory loss following head trauma
- b. memory loss following stress
- c. feeling detached from the self
- d. feeling detached from the world

Exercise 9.2
Dissociative identity disorder mainly involves ________.

- a. depersonalization
- b. derealization
- c. schizophrenia
- d. different personalities

9.6 Critical Thinking Question

Exercise 9.3
The prevalence of most psychological disorders has increased since the 1980s. However, as discussed in this section, scientific publications regarding dissociative amnesia peaked in the mid-1990s but then declined steeply through 2003. In addition, no fictional or nonfictional description of individuals showing dissociative amnesia following a trauma exists prior to 1800. How would you explain this phenomenon?
Solutions to Exercises in Chapter 9

Solution to Exercise 9.1 (p. 53)
B

Solution to Exercise 9.2 (p. 53)
D

Solution to Exercise 9.3 (p. 53)
Several explanations are possible. One explanation is that perhaps there is little scientific interest in this phenomenon, maybe because it has yet to gain consistent scientific acceptance. Another possible explanation is that perhaps the dissociative amnesia was fashionable at the time publications dealing with this topic peaked (1990s); perhaps since that time it has become less fashionable.
Chapter 10

13.9 Personality Disorders

The term *personality* refers loosely to one’s stable, consistent, and distinctive way of thinking about, feeling, acting, and relating to the world. People with *personality disorders* exhibit a personality style that differs markedly from the expectations of their culture, is pervasive and inflexible, begins in adolescence or early adulthood, and causes distress or impairment (APA, 2013). Generally, individuals with these disorders exhibit enduring personality styles that are extremely troubling and often create problems for them and those with whom they come into contact. Their maladaptive personality styles frequently bring them into conflict with others, disrupt their ability to develop and maintain social relationships, and prevent them from accomplishing realistic life goals.

The DSM-5 recognizes 10 personality disorders, organized into 3 different clusters. Cluster A disorders include *paranoid personality disorder, schizoid personality disorder,* and *schizotypal personality disorder*. People with these disorders display a personality style that is odd or eccentric. Cluster B disorders include antisocial personality disorder, *histrionic personality disorder,* narcissistic personality disorder, and borderline personality disorder. People with these disorders usually are impulsive, overly dramatic, highly emotional, and erratic. Cluster C disorders include *avoidant personality disorder, dependent personality disorder,* and *obsessive-compulsive personality disorder* (which is not the same thing as obsessive-compulsive disorder). People with these disorders often appear to be nervous and fearful. Table 10.1: DSM-5 Personality Disorders provides a description of each of the DSM-5 personality disorders:

### DSM-5 Personality Disorders

<table>
<thead>
<tr>
<th>DSM-5 Personality Disorder</th>
<th>Description</th>
<th>Cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid Personality Disorder</td>
<td>harbors a pervasive and unjustifiable suspiciousness and mistrust of others; reluctant to confide in or become close to others; reads hidden demeaning or threatening meaning into benign remarks or events; takes offense easily and bears grudges; not due to schizophrenia or other psychotic disorders</td>
<td>A</td>
</tr>
</tbody>
</table>

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### Schizoid

- lacks interest and desire to form relationships with others; aloof and shows emotional coldness and detachment; indifferent to approval or criticism of others; lacks close friends or confidants; not due to schizophrenia or other psychotic disorders, not an autism spectrum disorder

### Schizotypal

- exhibits eccentricities in thought, perception, emotion, speech, and behavior; shows suspiciousness or paranoia; has unusual perceptual experiences; speech is often idiosyncratic; displays inappropriate emotions; lacks friends or confidants; not due to schizophrenia or other psychotic disorder, or to autism spectrum disorder

### Antisocial

- continuously violates the rights of others; history of antisocial tendencies prior to age 15; often lies, fights, and has problems with the law; impulsive and fails to think ahead; can be deceitful and manipulative in order to gain profit or pleasure; irresponsible and often fails to hold down a job or pay financial debts; lacks feelings for others and remorse over misdeeds

*continued on next page*
<table>
<thead>
<tr>
<th>Personality Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Histrionic</td>
<td>Excessively overdramatic, emotional, and theatrical; feels uncomfortable when not the center of others’ attention; behavior is often inappropriately seductive or provocative; speech is highly emotional but often vague and diffuse; emotions are shallow and often shift rapidly; may alienate friends with demands for constant attention</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>Overinflated and unjustified sense of self-importance and preoccupied with fantasies of success; believes he is entitled to special treatment from others; shows arrogant attitudes and behaviors; takes advantage of others; lacks empathy</td>
</tr>
<tr>
<td>Borderline</td>
<td>Unstable in self-image, mood, and behavior; cannot tolerate being alone and experiences chronic feelings of emptiness; unstable and intense relationships with others; behavior is impulsive, unpredictable, and sometimes self-damaging; shows inappropriate and intense anger; makes suicidal gestures</td>
</tr>
<tr>
<td>Avoidant</td>
<td>Socially inhibited and oversensitive to negative evaluation; avoids occupations that involve interpersonal contact because of fears of criticism or rejection; avoids relationships with others unless guaranteed to be accepted unconditionally; feels inadequate and views self as socially inept and unappealing; unwilling to take risks or engage in new activities if they may prove embarrassing</td>
</tr>
</tbody>
</table>

*continued on next page*
CHAPTER 10. PERSONALITY DISORDERS

Dependent | allows others to take over and run her life; is submissive, clingy, and fears separation; cannot make decisions without advice and reassurance from others; lacks self-confidence; cannot do things on her own; feels uncomfortable or helpless when alone | C

Obsessive-Compulsive | pervasive need for perfectionism that interferes with the ability to complete tasks; preoccupied with details, rules, order, and schedules; excessively devoted to work at the expense of leisure and friendships; rigid, inflexible, and stubborn; insists things be done his way; miserly with money | C

Table 10.1

Slightly over 9% of the U.S. population suffers from a personality disorder, with avoidant and schizoid personality disorders the most frequent (Lezenweger, Lane, Loranger, & Kessler, 2007). Two of these personality disorders, borderline personality disorder and antisocial personality disorder, are regarded by many as especially problematic.

10.1 BORDERLINE PERSONALITY DISORDER

The “borderline” in borderline personality disorder was originally coined in the late 1930s in an effort to describe patients who appeared anxious, but were prone to brief psychotic experiences—that is, patients who were thought to be literally on the borderline between anxiety and psychosis (Freeman, Stone, Martin, & Reinecke, 2005). Today, borderline personality disorder has a completely different meaning. Borderline personality disorder is characterized chiefly by instability in interpersonal relationships, self-image, and mood, as well as marked impulsivity (APA, 2013). People with borderline personality disorder cannot tolerate the thought of being alone and will make frantic efforts (including making suicidal gestures and engaging in self-mutilation) to avoid abandonment or separation (whether real or imagined). Their relationships are intense and unstable; for example, a lover may be idealized early in a relationship, but then later vilified at the slightest sign she appears to no longer show interest. These individuals have an unstable view of self and, thus, might suddenly display a shift in personal attitudes, interests, career plans, and choice of friends. For example, a law school student may, despite having invested tens of thousands of dollars toward earning a law degree and despite having performed well in the program, consider dropping out and pursuing a career in another field. People with borderline personality disorder may be highly impulsive and may engage in reckless and self-destructive behaviors such as excessive gambling, spending money irresponsibly, substance abuse, engaging in unsafe sex, and reckless driving. They sometimes show intense and inappropriate anger that they have difficulty controlling, and they can be moody, sarcastic, bitter, and verbally abusive.

The prevalence of borderline personality disorder in the U.S. population is estimated to be around 1.4% (Lezenweger et al., 2007), but the rates are higher among those who use mental health services; approximately 10% of mental health outpatients and 20% of psychiatric inpatients meet the criteria for diagnosis (APA, 2013). Additionally, borderline personality disorder is comorbid with anxiety, mood, and substance use disorders (Lezenweger et al., 2007).

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10.2 ANTISOCIAL PERSONALITY DISORDER

Most human beings live in accordance with a moral compass, a sense of right and wrong. Most individuals learn at a very young age that there are certain things that should not be done. We learn that we should not lie or cheat. We are taught that it is wrong to take things that do not belong to us, and that it is wrong to exploit others for personal gain. We also learn the importance of living up to our responsibilities, of doing what we say we will do. People with antisocial personality disorder, however, do not seem to have a moral compass. These individuals act as though they neither have a sense of nor care about right or wrong. Not surprisingly, these people represent a serious problem for others and for society in general.

According to the DSM-5, the individual with antisocial personality disorder (sometimes referred to as a psychopath or sociopath) shows no regard at all for other people’s rights or feelings. This lack of regard is exhibited in a number of ways and can include repeatedly performing illegal acts, lying to or conning others, impulsivity and recklessness, irritability and aggressiveness toward others, and failure to act in a responsible way (e.g., leaving debts unpaid) (APA, 2013). The worst part about antisocial personality disorder, however, is that people with this disorder have no remorse over one’s misdeeds; these people will hurt, manipulate, exploit, and abuse others and not feel any guilt. Signs of this disorder can emerge early in life; however, a person must be at least 18 years old to be diagnosed with antisocial personality disorder.

People with antisocial personality disorder seem to view the world as self-serving and unkind. They seem to think that they should use whatever means necessary to get by in life. They tend to view others not as living, thinking, feeling beings, but rather as pawns to be used or abused for a specific purpose. They often have an over-inflated sense of themselves and can appear extremely arrogant. They frequently display superficial charm; for example, without really meaning it they might say exactly what they think another person wants to hear. They lack empathy: they are incapable of understanding the emotional point-of-view of others. People with this disorder may become involved in illegal enterprises, show cruelty toward others, leave their jobs with no plans to obtain another job, have multiple sexual partners, repeatedly get into fights with others, and show reckless disregard for themselves and others (e.g., repeated arrests for driving while intoxicated) (APA, 2013).

A useful way to conceptualize antisocial personality disorder is boiling the diagnosis down to three major concepts: disinhibition, boldness, and meanness (Patrick, Fowles, & Krueger, 2009). Disinhibition is a propensity toward impulse control problems, lack of planning and forethought, insistence on immediate gratification, and inability to restrain behavior. Boldness describes a tendency to remain calm in threatening situations, high self-assurance, a sense of dominance, and a tendency toward thrill-seeking. Meanness is defined as “aggressive resource seeking without regard for others,” and is signaled by a lack of empathy, disdain for and lack of close relationships with others, and a tendency to accomplish goals through cruelty (Patrick et al., 2009, p. 913).

10.3 Summary

Individuals with personality disorders exhibit a personality style that is inflexible, causes distress and impairment, and creates problems for themselves and others. The DSM-5 recognizes 10 personality disorders, organized into three clusters. The disorders in Cluster A include those characterized by a personality style that is odd and eccentric. Cluster B includes personality disorders characterized chiefly by a personality style that is impulsive, dramatic, highly emotional, and erratic, and those in Cluster C are characterized by a nervous and fearful personality style. Two Cluster B personality disorders, borderline personality disorder and antisocial personality disorder, are especially problematic. People with borderline personality disorder show marked instability in mood, behavior, and self-image, as well as impulsivity. They cannot stand to be alone, are unpredictable, have a history of stormy relationships, and frequently display intense and inappropriate anger. Genetic factors and adverse childhood experiences (e.g., sexual abuse) appear to be important in its development. People with antisocial personality disorder display a lack of regard for the rights of others; they are impulsive, deceitful, irresponsible, and unburdened by any sense of guilt. Genetic factors and socialization both appear to be important in the origin of antisocial personality disorder. Research has also shown that
those with this disorder do not experience emotions the way most other people do.

10.4 Review Questions

**Exercise 10.1**
People with borderline personality disorder often ________.

- a. try to be the center of attention
- b. are shy and withdrawn
- c. are impulsive and unpredictable
- d. tend to accomplish goals through cruelty

**Exercise 10.2**
Antisocial personality disorder is associated with ________.

- a. emotional deficits
- b. memory deficits
- c. parental overprotection
- d. increased empathy

10.5 Critical Thinking Question

**Exercise 10.3**
Imagine that a child has a genetic vulnerability to antisocial personality disorder. How might this child’s environment shape the likelihood of developing this personality disorder?
Solutions to Exercises in Chapter 10

Solution to Exercise 10.1 (p. 60)  
C

Solution to Exercise 10.2 (p. 60)  
A

Solution to Exercise 10.3 (p. 60)
The environment is likely to be very instrumental in determining the likelihood of developing antisocial personality disorder. Research has shown that adverse family environments (e.g., divorce or marital problems, legal problems, and drug use) are connected to antisocial personality disorder, particularly if one is genetically vulnerable. Beyond one’s family environment, peer group delinquency and community variables (e.g., economic deprivation, community disorganization, drug use, and the presence of adult antisocial models) heighten the risk of violent behavior.
Chapter 11

13.10 Disorders in Childhood

Most of the disorders we have discussed so far are typically diagnosed in adulthood, although they can and sometimes do occur during childhood. However, there are a group of conditions that, when present, are diagnosed early in childhood, often before the time a child enters school. These conditions are listed in the DSM-5 as neurodevelopmental disorders, and they involve developmental problems in personal, social, academic, and intellectual functioning (APA, 2013). In this section, we will discuss two such disorders: attention deficit/hyperactivity disorder and autism.

11.1 ATTENTION DEFICIT/HYPERACTIVITY DISORDER

Diego is always active, from the time he wakes up in the morning until the time he goes to bed at night. His mother reports that he came out the womb kicking and screaming, and he has not stopped moving since. He has a sweet disposition, but always seems to be in trouble with his teachers, parents, and after-school program counselors. He seems to accidentally break things; he lost his jacket three times last winter, and he never seems to sit still. His teachers believe he is a smart child, but he never finishes anything he starts and is so impulsive that he does not seem to learn much in school.

Diego likely has attention deficit/hyperactivity disorder (ADHD). The symptoms of this disorder were first described by Hans Hoffman in the 1920s. While taking care of his son while his wife was in the hospital giving birth to a second child, Hoffman noticed that the boy had trouble concentrating on his homework, had a short attention span, and had to repeatedly go over easy homework to learn the material (Jellinek & Herzog, 1999). Later, it was discovered that many hyperactive children—those who are fidgety, restless, socially disruptive, and have trouble with impulse control—also display short attention spans, problems with concentration, and distractibility. By the 1970s, it had become clear that many children who display attention problems often also exhibit signs of hyperactivity. In recognition of such findings, the DSM-III (published in 1980) included a new disorder: attention deficit disorder with and without hyperactivity, now known as attention deficit/hyperactivity disorder (ADHD).

A child with ADHD shows a constant pattern of inattention and/or hyperactive and impulsive behavior that interferes with normal functioning (APA, 2013). Some of the signs of inattention include great difficulty with and avoidance of tasks that require sustained attention (such as conversations or reading), failure to follow instructions (often resulting in failure to complete school work and other duties), disorganization (difficulty keeping things in order, poor time management, sloppy and messy work), lack of attention to detail, becoming easily distracted, and forgetfulness. Hyperactivity is characterized by excessive movement, and includes fidgeting or squirming, leaving one’s seat in situations when remaining seated is expected, having trouble sitting still (e.g., in a restaurant), running about and climbing on things, blurt out responses before another person’s question or statement has been completed, difficulty waiting one’s turn for something, and interrupting and intruding on others. Frequently, the hyperactive child comes across as noisy and boisterous.

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The child's behavior is hasty, impulsive, and seems to occur without much forethought; these characteristics may explain why adolescents and young adults diagnosed with ADHD receive more traffic tickets and have more automobile accidents than do others (Thompson, Molina, Pelham, & Gnagy, 2007).

ADHD occurs in about 5% of children (APA, 2013). On the average, boys are 3 times more likely to have ADHD than are girls; however, such findings might reflect the greater propensity of boys to engage in aggressive and antisocial behavior and thus incur a greater likelihood of being referred to psychological clinics (Barkley, 2006). Children with ADHD face severe academic and social challenges. Compared to their non-ADHD counterparts, children with ADHD have lower grades and standardized test scores and higher rates of expulsion, grade retention, and dropping out (Loe & Feldman, 2007). They also are less well-liked and more often rejected by their peers (Hoza et al., 2005).

Previously, ADHD was thought to fade away by adolescence. However, longitudinal studies have suggested that ADHD is a chronic problem, one that can persist into adolescence and adulthood (Barkley, Fischer, Smallish, & Fletcher, 2002). A recent study found that 29.3% of adults who had been diagnosed with ADHD decades earlier still showed symptoms (Barbaresi et al., 2013). Somewhat troubling, this study also reported that nearly 81% of those whose ADHD persisted into adulthood had experienced at least one other comorbid disorder, compared to 47% of those whose ADHD did not persist.

11.1.1 Life Problems from ADHD

Children diagnosed with ADHD face considerably worse long-term outcomes than do those children who do not receive such a diagnosis. In one investigation, 135 adults who had been identified as having ADHD symptoms in the 1970s were contacted decades later and interviewed (Klein et al., 2012). Compared to a control sample of 136 participants who had never been diagnosed with ADHD, those who were diagnosed as children:

- had worse educational attainment (more likely to have dropped out of high school and less likely to have earned a bachelor's degree);
- had lower socioeconomic status;
- held less prestigious occupational positions;
- were more likely to be unemployed;
- made considerably less in salary;
- scored worse on a measure of occupational functioning (indicating, for example, lower job satisfaction, poorer work relationships, and more firings);
- scored worse on a measure of social functioning (indicating, for example, fewer friendships and less involvement in social activities);
- were more likely to be divorced; and
- were more likely to have non-alcohol-related substance abuse problems. (Klein et al., 2012)

Longitudinal studies also show that children diagnosed with ADHD are at higher risk for substance abuse problems. One study reported that childhood ADHD predicted later drinking problems, daily smoking, and use of marijuana and other illicit drugs (Molina & Pelham, 2003). The risk of substance abuse problems appears to be even greater for those with ADHD who also exhibit antisocial tendencies (Marshal & Molina, 2006).

11.2 AUTISM SPECTRUM DISORDER

A seminal paper published in 1943 by psychiatrist Leo Kanner described an unusual neurodevelopmental condition he observed in a group of children. He called this condition early infantile autism, and it was characterized mainly by an inability to form close emotional ties with others, speech and language abnormalities, repetitive behaviors, and an intolerance of minor changes in the environment and in normal routines (Bregman, 2005). What the DSM-5 refers to as autism spectrum disorder today, is a direct extension of Kanner's work.
Autism spectrum disorder is probably the most misunderstood and puzzling of the neurodevelopmental disorders. Children with this disorder show signs of significant disturbances in three main areas: (a) deficits in social interaction, (b) deficits in communication, and (c) repetitive patterns of behavior or interests. These disturbances appear early in life and cause serious impairments in functioning (APA, 2013). The child with autism spectrum disorder might exhibit deficits in social interaction by not initiating conversations with other children or turning their head away when spoken to. These children do not make eye contact with others and seem to prefer playing alone rather than with others. In a certain sense, it is almost as though these individuals live in a personal and isolated social world others are simply not privy to or able to penetrate. Communication deficits can range from a complete lack of speech, to one word responses (e.g., saying “Yes” or “No” when replying to questions or statements that require additional elaboration), to echoed speech (e.g., parroting what another person says, either immediately or several hours or even days later), to difficulty maintaining a conversation because of an inability to reciprocate others’ comments. These deficits can also include problems in using and understanding nonverbal cues (e.g., facial expressions, gestures, and postures) that facilitate normal communication.

Repetitive patterns of behavior or interests can be exhibited a number of ways. The child might engage in stereotyped, repetitive movements (rocking, head-banging, or repeatedly dropping an object and then picking it up), or she might show great distress at small changes in routine or the environment. For example, the child might throw a temper tantrum if an object is not in its proper place or if a regularly-scheduled activity is rescheduled. In some cases, the person with autism spectrum disorder might show highly restricted and fixated interests that appear to be abnormal in their intensity. For instance, the person might learn and memorize every detail about something even though doing so serves no apparent purpose. Importantly, autism spectrum disorder is not the same thing as intellectual disability, although these two conditions are often comorbid. The DSM-5 specifies that the symptoms of autism spectrum disorder are not caused or explained by intellectual disability.

11.2.1 Life Problems From Autism Spectrum Disorder

Autism spectrum disorder is referred to in everyday language as autism; in fact, the disorder was termed “autistic disorder” in earlier editions of the DSM, and its diagnostic criteria were much narrower than those of autism spectrum disorder. The qualifier “spectrum” in autism spectrum disorder is used to indicate that individuals with the disorder can show a range, or spectrum, of symptoms that vary in their magnitude and severity: some severe, others less severe. The previous edition of the DSM included a diagnosis of Asperger’s disorder, generally recognized as a less severe form of autistic disorder; individuals diagnosed with Asperger’s disorder were described as having average or high intelligence and a strong vocabulary, but exhibiting impairments in social interaction and social communication, such as talking only about their special interests (Wing, Gould, & Gillberg, 2011). However, because research has failed to demonstrate that Asperger’s disorder differs qualitatively from autistic disorder, the DSM-5 does not include it, which is prompting concerns among some parents that their children may no longer be eligible for special services (“Asperger’s Syndrome Dropped,” 2012). Some individuals with autism spectrum disorder, particularly those with better language and intellectual skills, can live and work independently as adults. However, most do not because the symptoms remain sufficient to cause serious impairment in many realms of life (APA, 2013).

Currently, estimates indicate that nearly 1 in 88 children in the United States has autism spectrum disorder; the disorder is 5 times more common in boys (1 out of 54) than girls (1 out of 252) (CDC, 2012). Rates of autistic spectrum disorder have increased dramatically since the 1980s. For example, California saw an increase of 273% in reported cases from 1987 through 1998 (Byrd, 2002); between 2000 and 2008, the rate of autism diagnoses in the United States increased 78% (CDC, 2012). Although it is difficult to interpret this increase, it is possible that the rise in prevalence is the result of the broadening of the diagnosis, increased efforts to identify cases in the community, and greater awareness and acceptance of the diagnosis. In addition, mental health professionals are now more knowledgeable about autism spectrum disorder and are better equipped to make the diagnosis, even in subtle cases (Novella, 2008).
11.3 Summary

Neurodevelopmental disorders are a group of disorders that are typically diagnosed during childhood and are characterized by developmental deficits in personal, social, academic, and intellectual realms; these disorders include attention deficit/hyperactivity disorder (ADHD) and autism spectrum disorder. ADHD is characterized by a pervasive pattern of inattention and/or hyperactive and impulsive behavior that interferes with normal functioning. Genetic and neurobiological factors contribute to the development of ADHD, which can persist well into adulthood and is often associated with poor long-term outcomes. The major features of autism spectrum disorder include deficits in social interaction and communication and repetitive movements or interests. As with ADHD, genetic factors appear to play a prominent role in the development of autism spectrum disorder; exposure to environmental pollutants such as mercury have also been linked to the development of this disorder. Although it is believed by some that autism is triggered by the MMR vaccination, evidence does not support this claim.

11.4 Review Questions

**Exercise 11.1**
Which of the following is not a primary characteristic of ADHD?

a. short attention span
b. difficulty concentrating and distractibility
c. restricted and fixed interest
d. excessive fidgeting and squirming

(Solution on p. 67.)

**Exercise 11.2**
One of the primary characteristics of autism spectrum disorder is ________.

a. bed-wetting
b. difficulty relating to others
c. short attention span
d. intense and inappropriate interest in others

(Solution on p. 67.)

11.5 Critical Thinking Questions

**Exercise 11.3**
Compare the factors that are important in the development of ADHD with those that are important in the development of autism spectrum disorder.
Solutions to Exercises in Chapter 11

Solution to Exercise 11.1 (p. 66)
C

Solution to Exercise 11.2 (p. 66)
B

Solution to Exercise 11.3 (p. 66)

Genetic factors appear to play a major role in the development of both ADHD and autism spectrum disorder: studies show higher rates of concordance among identical twins than among fraternal twins for both disorders. In ADHD, genes that regulate dopamine have been implicated; in autism spectrum disorder, de novo genetic mutations appear to be important. Imaging studies suggest that abnormalities in the frontal lobes may be important in the development of ADHD. Parenting practices are not connected to the development of either disorder. Although environmental toxins are generally unimportant in the development of ADHD, exposure to cigarette smoke during the prenatal period has been linked to the development of the disorder; a number of environmental factors are thought to be associated with an increased risk for autism spectrum disorder: exposure to pollutants, an urban versus rural residence, and vitamin D deficiency. Although some people continue to believe that MMR vaccinations can cause autism spectrum disorder (due to an influential paper that was later retracted), there is no scientific evidence that supports this assertion.
Glossary

A agoraphobia
anxiety disorder characterized by intense fear, anxiety, and avoidance of situations in which it might be difficult to escape if one experiences symptoms of a panic attack

antisocial personality disorder
characterized by a lack of regard for others’ rights, impulsivity, deceitfulness, irresponsibility, and lack of remorse over misdeeds

anxiety disorder
characterized by excessive and persistent fear and anxiety, and by related disturbances in behavior

attention deficit/hyperactivity disorder
childhood disorder characterized by inattentiveness and/or hyperactive, impulsive behavior

atypical
describes behaviors or feelings that deviate from the norm

autism spectrum disorder
childhood disorder characterized by deficits in social interaction and communication, and repetitive patterns of behavior or interests

B bipolar and related disorders
group of mood disorders in which mania is the defining feature

bipolar disorder
mood disorder characterized by mood states that vacillate between depression and mania

body dysmorphic disorder
involves excessive preoccupation with an imagined defect in physical appearance

borderline personality disorder
instability in interpersonal relationships, self-image, and mood, as well as impulsivity; key features include intolerance of being alone and fear of abandonment, unstable relationships, unpredictable behavior and moods, and intense and inappropriate anger
catatonic behavior
decreased reactivity to the environment; includes posturing and catatonic stupor
comorbidity
co-occurrence of two disorders in the same individual

delusion
belief that is contrary to reality and is firmly held, despite contradictory evidence

depersonalization/derealization disorder
dissociative disorder in which people feel detached from the self (depersonalization), and the world feels artificial and unreal (derealization)
derelative disorder
one of a group of mood disorders in which depression is the defining feature

diagnosis
determination of which disorder a set of symptoms represents

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)
authoritative index of mental disorders and the criteria for their diagnosis; published by the American Psychiatric Association (APA)

disorganized thinking
disjointed and incoherent thought processes, usually detected by what a person says
disorganized/abnormal motor behavior

highly unusual behaviors and movements (such as child-like behaviors), repeated and purposeless movements, and displaying odd facial expressions and gestures

dissociative amnesia

dissociative disorder characterized by an inability to recall important personal information, usually following an extremely stressful or traumatic experience

dissociative disorders

group of DSM-5 disorders in which the primary feature is that a person becomes dissociated, or split off, from his or her core sense of self, resulting in disturbances in identity and memory

dissociative fugue

symptom of dissociative amnesia in which a person suddenly wanders away from one’s home and experiences confusion about his or her identity

dissociative identity disorder

dissociative disorder (formerly known as multiple personality disorder) in which a person exhibits two or more distinct, well-defined personalities or identities and experiences memory gaps for the time during which another identity emerged

dopamine hypothesis

theory of schizophrenia that proposes that an overabundance of dopamine or dopamine receptors is responsible for the onset and maintenance of schizophrenia

dopamine hypothesis

theory of schizophrenia that proposes that an overabundance of dopamine or dopamine receptors is responsible for the onset and maintenance of schizophrenia

dopamine hypothesis

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dopamine hypothesis

theory of schizophrenia that proposes that an overabundance of dopamine or dopamine receptors is responsible for the onset and maintenance of schizophrenia

symptom of mania that involves an abruptly switching in conversation from one topic to another

g generalized anxiety disorder

characterized by a continuous state of excessive, uncontrollable, and pointless worry and apprehension

grandiose delusion

characterized by beliefs that one holds special power, unique knowledge, or is extremely important

H hallucination

perceptual experience that occurs in the absence of external stimulation, such as the auditory hallucinations (hearing voices) common to schizophrenia

harmful dysfunction

model of psychological disorders resulting from the inability of an internal mechanism to perform its natural function

hoarding disorder

characterized by persistent difficulty in parting with possessions, regardless of their actual value or usefulness

hopelessness theory

cognitive theory of depression proposing that a style of thinking that perceives negative life events as having stable and global causes leads to a sense of hopelessness and then to depression

I International Classification of Diseases (ICD)

authoritative index of mental and physical diseases, including infectious diseases, and the criteria for their diagnosis; published by the World Health Organization (WHO)

L locus coeruleus

area of the brainstem that contains norepinephrine, a neurotransmitter that triggers the body’s fight-or-flight response; has been implicated in panic disorder
M major depressive disorder
commonly referred to as “depression” or “major depression,” characterized by sadness or loss of pleasure in usual activities, as well other symptoms

mania
state of extreme elation and agitation

manic episode
period in which an individual experiences mania, characterized by extremely cheerful and euphoric mood, excessive talkativeness, irritability, increased activity levels, and other symptoms

mood disorder
one of a group of disorders characterized by severe disturbances in mood and emotions; the categories of mood disorders listed in the DSM-5 are bipolar and related disorders and depressive disorders

N negative symptom
characterized by decreases and absences in certain normal behaviors, emotions, or drives, such as an expressionless face, lack of motivation to engage in activities, reduced speech, lack of social engagement, and inability to experience pleasure

neurodevelopmental disorder
one of the disorders that are first diagnosed in childhood and involve developmental problems in academic, intellectual, social functioning

O obsessive-compulsive and related disorders

group of overlapping disorders listed in the DSM-5 that involves intrusive, unpleasant thoughts and/or repetitive behaviors

obsessive-compulsive disorder
characterized by the tendency to experience intrusive and unwanted thoughts and urges (obsession) and/or the need to engage in repetitive behaviors or mental acts (compulsions) in response to the unwanted thoughts and urges

orbitofrontal cortex
area of the frontal lobe involved in learning and decision-making

P panic attack
period of extreme fear or discomfort that develops abruptly; symptoms of panic attacks are both physiological and psychological

panic disorder
anxiety disorder characterized by unexpected panic attacks, along with at least one month of worry about panic attacks or self-defeating behavior related to the attacks

paranoid delusion
characterized by beliefs that others are out to harm them

peripartum onset
subtype of depression that applies to women who experience an episode of major depression either during pregnancy or in the four weeks following childbirth

persistent depressive disorder
depressive disorder characterized by a chronically sad and melancholy mood

personality disorder
group of DSM-5 disorders characterized by an inflexible and pervasive personality style that differs markedly from the expectations of one’s culture and causes distress and impairment; people with these disorders have a personality style that frequently brings them into conflict with others and disrupts their ability to develop and maintain social relationships

posttraumatic stress disorder (PTSD)
experiencing a profoundly traumatic event leads to a constellation of symptoms that include intrusive and distressing memories of the event, avoidance of stimuli connected to the event, negative emotional states, feelings of detachment from others, irritability, proneness toward outbursts, hypervigilance, and a tendency to startle easily; these symptoms must occur for at least one month
**prodromal symptom**
in schizophrenia, one of the early minor symptoms of psychosis

**psychological disorder**
condition characterized by abnormal thoughts, feelings, and behaviors

**psychopathology**
study of psychological disorders, including their symptoms, causes, and treatment; manifestation of a psychological disorder

**R rumination**
in depression, tendency to repetitively and passively dwell on one’s depressed symptoms, their meanings, and their consequences

**safety behavior**
mental and behavior acts designed to reduce anxiety in social situations by reducing the chance of negative social outcomes; common in social anxiety disorder

**schizophrenia**
severe disorder characterized by major disturbances in thought, perception, emotion, and behavior with symptoms that include hallucinations, delusions, disorganized thinking and behavior, and negative symptoms

**seasonal pattern**
subtype of depression in which a person experiences the symptoms of major depressive disorder only during a particular time of year

**social anxiety disorder**
characterized by extreme and persistent fear or anxiety and avoidance of social situations in which one could potentially be evaluated negatively by others

**somatic delusion**
belief that something highly unusual is happening to one’s body or internal organs

**specific phobia**
anxiety disorder characterized by excessive, distressing, and persistent fear or anxiety about a specific object or situation

**suicidal ideation**
thoughts of death by suicide, thinking about or planning suicide, or making a suicide attempt

**suicide**
death caused by intentional, self-directed injurious behavior

**ventricle**
one of the fluid-filled cavities within the brain
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Module: "13.6 Mood Disorders SW"
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Module: "13.7 Schizophrenia SW"
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Module: "13.8 Dissociative Disorders SW"
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Module: "13.9 Personality Disorders SW"
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Module: "13.10 Disorders in Childhood SW"
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Chapter 13: Psychological Disorders SW

psychological disorders, diagnosis, classification, perspectives, anxiety disorders, obsessive-compulsive disorders, post-traumatic stress disorder, mood disorders, schizophrenia, dissociative disorders, personality disorders, disorders in childhood.

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