**Chapter 16**

**Objective 1| Identify the criteria for judging whether behavior is psychologically disordered.**Psychologists and psychiatrists consider behavior disordered when it is deviant, distressful, and dysfunctional. The definition of deviant varies with context and culture. It also varies with time; for example, some children who might have been judged rambunctious a few decades ago now are being diagnosed with attention-deficit hyperactivity disorder.

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**Objective 2|** **Contrast the medical model of psychological disorders with the biopsychosocial approach to disordered behavior.** The medical model assumes that psychological disorders are mental illnesses that can be diagnosed on the basis of their symptoms and cured through therapy, sometimes in a hospital. The biopsychosocial approach assumes that disordered behavior, like other behavior, arises from genetic predispositions and physiological states; inner psychological dynamics; and socialcultural circumstances.

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**Objective 3|** **Describe the goals and content of the DSM-Invite American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSMIV), which currently describes 400 disorders and their prevalence.** The manual defines a structured interview technique that clinicians can use to reach a diagnosis. They answer objective questions, posed at five different levels, or axes, about the individual’s observable behaviors. The reliability of the classification is sufficiently high. DSM diagnoses are developed in coordination with International Classification of Diseases (ICD).

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**Objective 4|** **Discuss the potential dangers and benefits of using diagnostic labels.**Critics of the DSM-IV argue that diagnostic labels can stigmatize a person by biasing others’ interpretations and perceptions of past and present behaviors and by affecting the ways people react to the labeled person. The benefits of diagnostic labels are that they help mental health professionals communicate with one another about care and therapy, and they establish a common vocabulary for the exchange of ideas among researchers working on causes and treatments of disorders. Most health insurance policies in North America require an ICD diagnosis before they will pay for therapy. One label, “insanity”—used in some legal defenses—raises moral and ethical questions about how a society should treat people who have disorders and have committed crimes.

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**Objective 5| Define anxiety disorders, and explain how these conditions differ from normal feelings of stress, tension, or uneasiness.**Anxiety is part of our everyday experience. It is classified as a psychological disorder only when it becomes distressing or persistent or is characterized by maladaptive behaviors intended to reduce it.

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**Objective 6| Contrast the symptoms of generalized anxiety disorder and panic disorder.**People with generalized anxiety disorder (two-thirds of whom are women) feel persistently and uncontrollably tense and apprehensive and are in a state of autonomic nervous system arousal. They are unable to identify, or avoid, the cause of these feelings. People with panic disorder experience periodic minutes-long episodes of intense dread, which may include feelings of terror, chest pains, choking, or other frightening sensations. Anxiety is a component of both disorders, but the reactions in panic disorder are more extreme and may cause people to avoid situations where they have had panic attacks.

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**Objective 7 | Explain how a phobia differs from the fears we all experience.**Phobias differ from normal fears in their extremity and their potential effect on behavior. People with a phobia experience such persistent and irrational fears that they may be incapacitated by their attempts to avoid a specific object, animal, or situation.

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**Objective 8| Describe the symptoms of obsessive-compulsive disorder.**Persistent and repetitive thoughts and actions that characterize obsessive-compulsive disorder interfere with everyday living and cause the person distress. The obsession (the repetitive thought) may, for example, be a concern with dirt, germs, or toxins; the compulsion (the repetitive action) may, for example, be excessive hand washing, bathing, or some other form of grooming.

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**Objective 9| Describe the symptoms of post-traumatic stress disorder, and discuss survivor resiliency.** Four or more weeks of haunting memories, nightmares, social withdrawal, jumpy anxiety, and sleep problems are symptoms of PTSD (post-traumatic stress disorder). These symptoms appear following some traumatic event or events the individual witnessed or experienced but could not control. Some people are more resilient than others. On average, only about 10percent of women and 20 percent of men react to trauma by developing PTSD at some point in their lifetime. For those who survive the trauma, the experience can lead to a period of growth.

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**Objective 10| Discuss the contributions of the learning and biological perspectives to our understanding of the development of anxiety disorders.**Those working from the learning perspective view anxiety disorders as a product of fear conditioning, stimulus generalization, reinforcement of fearful behaviors, and observational learning of others’ fear. Those working from the biological perspective consider the role that fears of life threatening animals, objects, or situations played in natural selection and evolution; the genetic inheritance of a high level of emotional reactivity; and abnormal responses in the brain’s fear circuits.

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**Objective 11|** **Describe the symptoms of dissociative disorders, and explain why some critics are skeptical about dissociative identity disorder.** Dissociative disorders are conditions in which conscious awareness seems to become separated from previous memories, thoughts, and feelings. The most famous dissociative disorder is dissociative identity disorder, commonly known as multiple personality disorder. Critics note that this diagnosis increased dramatically in the late twentieth century, that it not found in many countries and is very rare in others, and that it may reflect role-playing by people who are very open to therapists’ suggestions. Some view this disorder as a manifestation of feelings of anxiety, or as a response learned when behaviors are reinforced by reductions in feelings of anxiety.

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**Objective 12|** **Define mood disorders, and contrast major depressive disorder and bipolar disorder.** Mood disorders are characterized by emotional extremes. A person with major depressive disorder experiences two or more weeks of seriously depressed moods and feelings of worthlessness, takes little interest in most activities, and derives little pleasure from them. These feelings are not caused by drugs or a medical condition. Although less disabling, dysthymic disorder is marked by two years of chronic low energy and poor self-esteem. People with bipolar disorder alternate between depression and mania, a hyperactive and wildly optimistic impulsive state. Major depressive disorder is much more common than is bipolar disorder.

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**Objective 13|** **Discuss the facts that an acceptable theory of depression must explain.** An acceptable theory of depression must account for the many behavioral and cognitive changes that accompany depression; its widespread occurrence; women’s greater susceptibility to the disorder; the tendency of depressive episodes to self-terminate; the link between stressful events and the onset of depression; and the increasing rates and earlier onset of depression.

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**Objective 14|** **Summarize the contributions of the biological perspective to the study of depression, and discuss the link between suicide and depression.** The biological perspective on depression focuses on genetic influences, in part through linkage analysis and association studies. Researchers working from this perspective also study abnormalities in brain structure and function, including those found in neurotransmitter systems. Their work has shown that a predisposition to depression does run in some families, that the neurotransmitters norepinephrine and serotonin are scarce during depression, that activity in the left frontal lobes is slowed during depression, and that stress-related damage to the hippocampus increases the risk of depression. Despair drives some people to suicide, and the risk is greatest when their energy returns as the depression begins to lift.

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**Objective 15|** **Summarize the contributions of the social-cognitive perspective to the study of depression, and describe the events in the cycle of depression.** The social-cognitive perspective has drawn attention to the power of self-defeating beliefs (arising in part from learned helplessness), and negative explanatory styles that view bad events as stable, global, and internally caused. Critics note that these characteristics may coincide with depression but not cause it. The cycle of depression consists of (1) negative stressful events (2) interpreted through a pessimistic explanatory style, creating a (3) hopeless depressed state, which (4) hampers the way the person thinks and acts, fueling more negative stressful events, such as rejection.

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**Objective 16|** **Describe the symptoms of schizophrenia, and differentiate delusions and hallucinations.** Schizophrenia is a group of disorders that typically strike during late adolescence, affect men very slightly more than women, and seem to occur in all cultures. Symptoms of schizophrenia are disorganized and delusional thinking (which may stem from a breakdown of selective attention), disturbed perceptions, and inappropriate emotions and actions. Delusions are false beliefs; hallucinations are sensory experiences without sensory stimulation.

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**Objective 17|** **Distinguish the five subtypes of schizophrenia, and contrast chronic and acute schizophrenia.**The subtypes of schizophrenia are paranoid (preoccupation with delusions or hallucinations, often of persecution or grandiosity), disorganized (disorganized speech or behavior, or flat affect or inappropriate emotions), catatonic (immobility, extreme negativism, and/or parrot like repetition of another’s speech or movements), undifferentiated (varied symptoms), and residual (withdrawal following hallucinations and delusions). Chronic (or process) schizophrenia emerges gradually, is often associated with negative symptoms (absence of appropriate behaviors), and carries a low chance of recovery. Acute (or reactive) schizophrenia develops rapidly (often in response to stress) in a previously well adjusted person, may be associated with positive symptoms (presence of inappropriate behaviors), and carries a greater chance of recovery.

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**Objective 18|** **Outline some abnormal brain chemistry, functions, and structures associated with schizophrenia, and discuss the possible link between prenatal viral infections and schizophrenia.**People with schizophrenia have increased receptors for the neurotransmitter dopamine, which may intensify the positive symptoms of schizophrenia. Research is under way on a possible link between negative symptoms and impaired glutamate activity. Brain abnormalities associated with schizophrenia include enlarged, fluid-filled cerebral cavities and corresponding decreases in the cortex. Brain scans reveal abnormal activity in the frontal lobes, thalamus, and amygdala. Malfunctions in multiple brain regions and their connections apparently interact to produce the symptoms of schizophrenia. Research support is mounting for the causal effects of a virus suffered in mid-pregnancy.

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**Objective 19|** **Discuss the evidence for a genetic contribution to the development of schizophrenia.** The odds of developing schizophrenia are approximately 1 in100 in the general population; 1 in 10 if a family member has it; and 1 in 2 if an identical twin has the disorder. Adoption studies show that an adopted child’s chances of developing the disorder are greater if the biological parents have schizophrenia, but not if the adopted parents have it. But 50 percent of those whose identical twins have schizophrenia do not develop the condition themselves, demonstrating that genetics is not the sole cause of this disorder.

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**Objective 20| Describe some psychological factors that may be early warning signs of schizophrenia in children.**No environmental event can by itself trigger schizophrenia, though some things may trigger the disorder in those genetically predisposed to it. Research has identified some early warning signs of schizophrenia, including a mother whose schizophrenia was severe and long-lasting; birth complications; separation from parents; short attention span and poor muscle coordination; disruptive or withdrawn behavior; emotional unpredictability; and poor peer relations and solo play.

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 **Objective 21|** **Contrast the three clusters of personality disorders, and describe the behaviors and brain activity associated with antisocial personality disorder.** Personality disorders are inflexible and enduring patterns of behavior that impair social functioning. The main component of the first cluster is anxiety; of the second cluster, eccentric behaviors; of the third cluster, dramatic or impulsive behaviors. Antisocial personality disorder is characterized by a lack of conscience and, sometimes, aggressive and ruthless behavior. Brain scans of some murderers with this disorder have shown reduced activity in the frontal lobes, an area of control for impulsive, aggressive behavior. There is no gene for antisocial personality disorder, though genetic predisposition may interact with environmental influences to produce it.

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**Objective 22|** **Discuss the prevalence of psychological disorders, and summarize the findings on the link between poverty and serious psychological disorders.** Research indicates that about 1 in 6 people has, or has had, a psychological disorder, usually by early adulthood. Poverty is a predictor of mental illness. Conditions and experiences associated with poverty contribute to the development of mental disorders, but the converse is also true. Some mental disorders, such as schizophrenia, can drive people into poverty.

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