

Psychology in the News

Celebrity Scandals Revive Sex-Addiction Debate

TUCSON, AZ, March 31, 2010. Motorcycle mogul Jesse James, Sandra Bullock's estranged husband, has reportedly checked himself into an Arizona rehab facility, the Sierra Tucson treatment center. News recently emerged that James has had several extramarital flings, including an 11-month affair with a reputed stripper, Michelle "Bombshell" McGee. The Tucson facility specializes in treating addictions, and because James is not known to have abused drugs or alcohol, speculation has centered on whether he is being treated for a sexual addiction. His representative told *People* magazine only that James had entered rehab "to deal with personal issues," adding that "he realized that this time was crucial to help himself, help his family, and help save his marriage."

A similar scandal erupted earlier this year with the revelation that champion golfer Tiger Woods had had more than a dozen extramarital affairs. Woods promptly checked himself into the Pine Grove clinic in Mississippi for rehabilitation. The details were not made public, but among the courses offered at the clinic are "shame reduction" and "setting sexual boundaries."

These and other high-profile cases of sexual infidelity have provoked controversy about whether people who have serial sexual affairs have a sexual "addiction." Palo Alto sex therapist Marty Klein thinks sex addiction is a bogus term that trivializes the meaning of true addiction, which is a physiological reliance on a substance like drugs or alcohol. "I don't see sex addicts," Klein says. "I see people who use sex in destructive ways." If an addiction is defined as any behavior that someone repeats despite the risk of serious consequences, almost any sexual affair might qualify, and so might visiting a prostitute or viewing pornography. Because the diagnosis is so vague, many mental health professionals and laypeople alike think it is mostly an excuse for cheating. As comic Jimmy Kimmel said, "'I'm addicted to sex' is the new, grown-up version of 'the dog ate my homework.'"

Some psychotherapists, however, consider sexual addiction to be a true disorder that involves an escalating preoccupation with sexual activity to cover up past pain or trauma. Therapists may prescribe a 12-step program, group therapy, and sometimes medication to help "addicts" regulate their cravings. A more neutral term, "hypersexual disorder," is expected to appear in a revision of the *Diagnostic and Statistical Manual of Mental Disorders* in 2013.



Jesse James, whose wife Sandra Bullock left him after learning he had had several affairs, checked into a rehab facility specializing in addictions, saying he wanted help with his problems.

Defining and Diagnosing Mental Disorders

Anxiety Disorders

Mood Disorders

Antisocial/Psychopathic Personality Disorder

Drug Abuse and Addiction

Dissociative Identity Disorder

Schizophrenia

Psychology in the News, Revisited

Taking Psychology with You: When a Friend is Suicidal

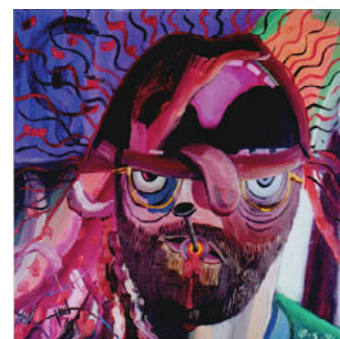
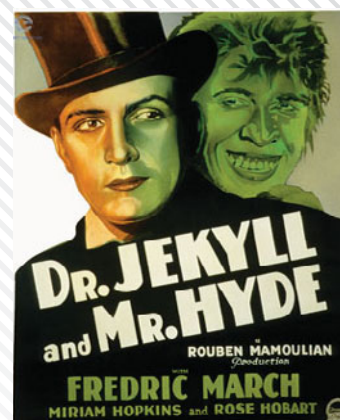
Psychological Disorders

Do Jesse James and Tiger Woods have a sexual addiction, a mental disorder comparable to alcohol or drug addiction? Or are they simply guys who believe that because they are rich, famous, and successful, they are entitled to all the sex they can get? How broadly should we define the term *addiction*? Should it include compulsive Internet use, shopping more than your budget can afford, or eating too much chocolate?

And how about college student Matthew Small, who had a 4.0 average until he began to immerse himself in the virtual World of Warcraft? He spent at least six hours a day collecting armor, swords, and other cyber-gear for his character. His close friends drifted away, and his grades slipped. One day he realized he had logged more than 1,000 hours playing the game in one semester and decided it was time to turn in his armor.

You don't have to be a psychologist to recognize the most extreme forms of abnormal behavior. When people think of mental illness, they usually think of people with delusions, people who behave in bizarre ways, or people who commit random murders and other heartless crimes. But most psychological problems are far less dramatic than the public's impression of them and far more common. Some people go through episodes of complete inability to function, yet get along fine between those episodes. Some people function adequately every day, yet suffer constant melancholy, always feeling below par. And some people cannot control their worries or tempers.

In this chapter, you will learn about the many psychological problems that cause people unhappiness and anguish, as well as about the severe disorders that really do make people unable to control their behavior. But be forewarned: One of the most common worries that people have is "Am I normal?" It is normal to fear being abnormal, especially when you are reading about psychological problems! But it is also normal to have problems. All of us on occasion have difficulties that seem too much to handle, and it is often unclear precisely when "normal" problems shade into "abnormal" ones.





YOU are about to learn...


- why insanity is not the same thing as having a mental disorder.
- how mental disorders differ from normal problems.
- why the standard professional guide to the diagnosis of mental disorders is controversial.
- why popular “projective” tests like the Rorschach inkblot test are not reliable.

Defining and Diagnosing Mental Disorders


Many people confuse unusual behavior—behavior that deviates from the norm—with mental disorder, but the two are not the same. A person may behave in ways that are statistically rare (collecting ceramic pigs, being a genius at math, committing murder) without having a mental illness. Conversely, some mental disorders, such as depression and anxiety, are extremely common. People also confuse mental disorder and insanity. In the law, the definition of *insanity* rests primarily on whether a person is aware of the consequences of his or her actions and can control his or her behavior. But *insanity* is a legal term only; a person may have a mental illness and yet be considered sane by the court.

If frequency of the problem is not a guide, and if insanity reflects only one extreme kind of mental illness, how then should we define a “mental

disorder”? Diagnosing mental problems is not as straightforward as diagnosing medical problems such as diabetes or appendicitis. One leading definition, which takes genetic and social factors into account, is that a mental disorder is a “harmful dysfunction.” That is, it involves behavior or an emotional state that is (1) *harmful* to oneself or others, and (2) *dysfunctional* because it is not performing its evolutionary function (Wakefield, 1992, 2006). For example, evolution has prepared us to feel afraid when we are in danger, so that we can escape; dysfunction occurs when this normal alarm mechanism fails to turn off after the danger is past. But if the dysfunction is not troubling to the individual or harmful to society, it is not a “mental disorder.” We have a friend who lives happily with her cat phobia. She just avoids cats.

This definition rules out behavior that simply departs from current social or cultural notions of what is healthy or normal: A student might think that getting tattooed all over his body is totally cool, but if his parents disagree, they don’t get to accuse him of having a mental disorder! On the other hand, the definition does include the behavior of people who think they are perfectly fine yet who cause enormous harm to themselves or others, such as a child who is unable to control the desire to set fires, a compulsive gambler who loses the family’s savings, or people who hear voices telling them to stalk a celebrity day and night.  **Simulate**

The main criticism of defining mental disorder as “harmful dysfunction” is that it is often unclear

 **Simulate Psychological Disorders on myspsychlab.com**




What is a mental disorder? In Papua New Guinea, all young men to go through an initiation rite in which small, deep cuts are made on their backs to create permanent scars that signify a crocodile’s scales (left). This common cultural practice would not be defined as a disorder. In contrast, most people would agree that a woman who mutilates herself for the sole purpose of inflicting injury and pain, as the patient on the right has done, has a mental disorder. But what about the scars on the arm of the 23-year-old woman from upstate New York (middle), who had them made by a “body artist”? She also has scars on her leg and her stomach, along with 29 piercings. Does she have a mental disorder?

what the evolutionary function or underlying pathology of a particular harmful behavior or emotional state might be. In this chapter, therefore, we define **mental disorder** as any condition that causes a person to suffer, is self-destructive, seriously impairs a person's ability to work or get along with others, or endangers others or the community. Mental disorders, like physical ailments, can range from mild to severe. By this definition, the great majority of people will have some mental health problem in the course of their lives.

Dilemmas of Diagnosis

Even armed with a general definition of mental disorder, psychologists have found that classifying mental disorders into distinct categories is not an easy job. In this section, we will see why this is so.

Classifying Disorders: The DSM The standard reference manual used to diagnose mental disorders is the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association (1994, 2000). The DSM's primary aim is *descriptive*: to provide clear diagnostic categories, so that clinicians and researchers can agree on which disorders they are talking about and then can study and treat these disorders. Its diverse diagnostic categories include attention deficit disorders, disorders due to brain damage from disease or drugs, eating disorders, problems with sexual identity or behavior, impulse-control disorders (such as violent rages and pathological gambling or stealing), personality disorders, and "problems in living," along with other major disorders we will be discussing in this chapter.

The DSM lists the symptoms of each disorder and, wherever possible, gives information about the typical age of onset, predisposing factors, course of the disorder, prevalence of the disorder, sex ratio of those affected, and cultural issues that might affect diagnosis. In making a diagnosis, clinicians are encouraged to take into account many factors, such as the client's personality traits, medical conditions, stresses at work and at home, and the duration and severity of the problem.  **Explore**

The DSM has had an extraordinary impact worldwide. Virtually all textbooks in psychiatry and psychology base their discussions of mental disorders on the DSM. With each new edition of the manual, the number of mental disorders has grown (see Figure 11.1). The first edition, published in 1952, was only 86 pages long and contained about 100 diagnoses. The DSM-IV, published in 1994 and slightly revised in 2000, is 900 pages long and

contains nearly 400 diagnoses of mental disorder. The DSM-V, due out in 2013, will contain even more diagnoses.

What is the reason for this explosion of mental disorders? Supporters of the new categories answer that it is important to distinguish disorders in a precise way so that clinicians can treat them properly. Critics point to an economic reason: Insurance companies require clinicians to assign their clients an appropriate DSM code number for whatever the client's problem is, which puts pressure on compilers of the manual to add more diagnoses so that physicians and psychologists will be compensated (Zur & Nordmarken, 2008).

Because of the DSM's powerful influence, it is important to be aware of its limitations and some of the inherent problems in the effort to classify and label mental disorders:

Thinking Critically about Diagnosing Disorders



1 The danger of overdiagnosis. If you give a small boy a hammer, the old saying goes, it will turn out that everything he runs into needs pounding. Likewise, say critics, if you give mental health professionals a diagnostic label, it will turn out that everyone they run into has the symptoms of the new disorder.

Consider attention deficit/hyperactivity disorder (ADHD), a diagnosis given to children and adults who are impulsive, messy, restless, and easily frustrated and who have trouble concentrating. Since ADHD was added to the DSM, the number of cases has skyrocketed in America, where it is diagnosed at least ten times as often as it is in Europe. Critics fear that parents, teachers, and mental health professionals are overdiagnosing this condition, especially in boys, who make up 80 to 90 percent of all cases of ADHD. The critics argue that normal boyish behavior—being rambunctious, refusing to nap, being playful, not listening to teachers in school—has been turned into a psychological problem (Cummings & O'Donohue, 2008; Panksepp, 1998). A longitudinal study of more than a hundred 4- to 6-year-olds found that the number of children who met the criteria for ADHD declined as the children got older (Lahey et al., 2005). Those who truly had the disorder remained highly impulsive and unable to concentrate, but others simply matured.

Likewise, the fastest-growing diagnosis given to young children is bipolar disorder, once thought to occur only in adolescents and adults; the number of diagnoses rose from 20,000 to 800,000 in just

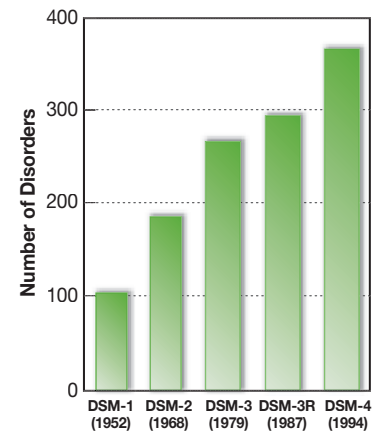


FIGURE 11.1
The Rising Number of Disorders in the DSM
Mental disorders in the DSM have increased nearly fourfold since the first edition (Houts, 2002).

 **Explore Axes of the DSM on mypsychlab.com**

mental disorder Any behavior or emotional state that causes an individual great suffering, is self-destructive, seriously impairs the person's ability to work or get along with others, or endangers others or the community.

one year (Moreno et al., 2007). Many experts think that only about 20 percent of the children currently diagnosed as bipolar meet the strict criteria for the disorder (Leibenluft & Rich, 2008). Partly for this reason, one of the groups working on the forthcoming DSM-V wants to add a new diagnosis: “temper dysregulation disorder with dysphoria (TDD),” which would apply to children who have “severe recurrent temper outbursts in response to common stressors”—about one-third of those now given a label of bipolar.

2 The power of diagnostic labels. Being given a diagnosis reassures people who are seeking an explanation for their emotional symptoms or those of their children (“Whew! So *that’s* what it is!”). But once a person has been given a diagnosis, other people begin to see that person primarily in terms of the label; it sticks like lint. For example, when a rebellious, disobedient teenager is diagnosed as having “oppositional defiant disorder,” or a child is labeled as having TDD, people tend to regard them as having a permanent, official condition. They then overlook other possible explanations for the person’s actions: Maybe the teenager is “defiant” because he has been mistreated or his parents don’t listen to him, and maybe a child has “recurrent temper outbursts” because his parents are not setting limits. And once a child is labeled, observers tend to ignore changes in his or her behavior—the times when the teenager is not being defiant or the situations in which a child gets along fine without having tantrums.

3 The confusion of serious mental disorders with normal problems. The DSM is not called “The Diagnostic and Statistical Manual of Mental Disorders and a Whole Bunch of Everyday Problems.” Yet each edition of the DSM has added more everyday problems, including “disorder of written expression” (having trouble writing clearly), “mathematics disorder” (not doing well in math), “religious or spiritual problem,” and “caffeine-induced sleep disorder” (which at least is easy to cure; just switch to decaf). Some critics fear that by lumping together normal difficulties with true mental illnesses, such as schizophrenia and major depression, the DSM implies that everyday problems are comparable to serious mental disorders (Houts, 2002). Revisers of the current DSM are debating whether to include “binge eating” and “shopping addiction,” behaviors that can certainly be troublesome in their extreme form, but which many (if not most) people experience on occasion.

4 The illusion of objectivity. Finally, some psychologists argue that the whole enterprise of

the DSM is a vain attempt to impose a veneer of science on an inherently subjective process (Houts, 2002; Kutchins & Kirk, 1997; Tiefer, 2004). Many decisions about what to include as a disorder, say these critics, are based not on empirical evidence but on group consensus. The problem is that group consensus often reflects prevailing attitudes and prejudices rather than objective evidence. It is easy to see how prejudice operated in the past. In the early years of the nineteenth century, a physician named Samuel Cartwright argued that many slaves were suffering from *drapetomania*, an urge to escape from slavery (Kutchins & Kirk, 1997; Landrine, 1988). (He made up the word from *drapetes*, the Latin word for “runaway slave,” and *mania*, meaning “mad” or “crazy.”) Thus, doctors could assure slave owners that a mental illness, not the intolerable condition of slavery, made slaves seek freedom. This diagnosis was very convenient for slave owners. Today, of course, we know that “drapetomania” was foolish and cruel.

Over the years, psychiatrists have quite properly rejected many other “disorders” that reflected cultural prejudices, such as lack of vaginal orgasm, childhood masturbation disorder, and homosexuality (Wakefield, 1992). But critics argue that some DSM disorders are still affected by contemporary



Harriet Tubman (on the left) poses with some of the people she helped to escape from slavery on her “underground railroad.” Slaveholders welcomed the idea that Tubman and others who insisted on their freedom had a mental disorder called “drapetomania.”

prejudices and values, such as decisions about how much sex is “too much” or “too little.” Emotional problems allegedly associated with menstruation remain in the DSM, but behavioral problems associated with testosterone have never even been considered for inclusion. In short, critics maintain, many diagnoses still stem from cultural biases about what constitutes normal or appropriate behavior.

Advantages of the DSM Defenders of the DSM agree that the boundaries between “normal problems” and “mental disorders” are fuzzy and often difficult to determine, because most psychological symptoms fall along a continuum from mild to severe (Helzer et al., 2008). But they believe that

when the manual is used correctly and diagnoses are made with valid objective tests, the DSM improves the reliability of diagnosis (Beutler & Malik, 2002; Widiger & Clark, 2000). This is important, they maintain, because the DSM’s categories help clinicians distinguish among disorders that share certain symptoms (such as anxiety, irritability, or delusions) and thereby select the most appropriate treatment.

Moreover, in response to criticism about cultural influences on mental disorders and their diagnoses, the DSM-IV included a list of **culture-bound syndromes**, sets of symptoms specific to the culture in which they occur (see Table 11.1). Thus, in Japan, where people are extremely sensitive to

culture-bound syndromes Symptoms or mental disorders that are specific to particular cultural contexts and practices.

TABLE 11.1
From Amok to Zar: Some Culture-Bound Syndromes

Problem Name	Where Recognized	Description
Amok	Malaysia; similar patterns elsewhere	Brooding followed by a violent outburst; often precipitated by a slight or insult; seems to be prevalent only among men
Ataque de nervios	Latin America and Mediterranean	An episode of uncontrollable shouting, crying, trembling, heat in chest rising to the head, verbal or physical aggression
Brain fag	West Africa	“Brain tiredness,” a mental and physical reaction to the challenges of schooling
Ghost sickness	Native American tribes	Preoccupation with death and the dead, with bad dreams, fainting, appetite loss, fear, hallucinations, etc.
Pibloktoq	Arctic and subarctic Inuit communities	Episodes of extreme excitement of up to 30 minutes, during which the individual behaves irrationally or violently
Qi-gong psychotic reaction	China	A short episode of mental symptoms after engaging in the Chinese folk practice of qi-gong, or “exercise of vital energy”
Taijin kyofusho	Japan	An intense fear that the body, its parts, or its functions displease, embarrass, or are offensive to others
Zar	North Africa and Middle East	Belief in possession by a spirit, causing shouting, laughing, head banging, weeping, withdrawal, etc.

Source: DSM-IV.

matters of social harmony and concerned about not offending other people, *taijin kyofusho* is a disorder in which a person feels intensely frightened and irrationally embarrassed that his or her body parts or functions are disgusting to others. Latinos may experience an *ataque de nervios*, an episode of uncontrollable screaming, crying, and agitation, and Malaysian men may run *amok* in a violent, even murderous outburst. Students everywhere may have special sympathy for sufferers of the West African syndrome of *brain fog*, mental exhaustion due to excessive studying.

By comparing mental and emotional symptoms across different times and places, researchers can distinguish universal disorders from those that are culture-bound. Bulimia nervosa, involving cycles of binge eating and vomiting to maintain weight, is a culture-bound syndrome that occurs primarily in the United States and is unknown in most other parts of the world; yet anorexia has been found throughout history and across cultures (Keel & Klump, 2003). Likewise, from the Inuit of Alaska to the Pacific Islanders to the Yoruba of Nigeria, some individuals have schizophrenic delusions, are severely depressed, have anxiety disorders, or cannot control their aggressive behavior (Butcher, Lim, & Nezami, 1998; Kleinman, 1988).

Dilemmas of Measurement

Clinical psychologists and psychiatrists usually arrive at a diagnosis by interviewing a patient and observing the person's behavior when he or she arrives at the office, hospital, or clinic. But many also use psychological tests to help them decide on a diagnosis. Such tests are also commonly used in schools (e.g., to determine whether a child has a learning disorder) and in court settings (e.g., to try to determine which parent should have custody in a divorce case, whether a child has been sexually abused, or whether a defendant is mentally competent).

Projective Tests Projective tests consist of ambiguous pictures, sentences, or stories that the test taker interprets or completes. A child or adult may be asked to draw a person, a house, or some other object, or to finish a sentence (such as “My father...” or “Women are...”). The psychodynamic assumption behind all projective tests is that the person's unconscious thoughts and feelings will be “projected” onto the test and revealed in the person's responses. (See Chapter 2 for a discussion of psychodynamic theories.)

Projective tests can help clinicians establish rapport with their clients and can encourage clients

to open up about anxieties and conflicts they might be ashamed to discuss. But the evidence is overwhelming that these tests lack reliability and validity, which makes them inappropriate for their most common uses—assessing personality traits or diagnosing mental disorders. They lack reliability because different clinicians often interpret the same person's scores differently, perhaps projecting their own beliefs and assumptions when they decide what a specific response means. The tests have low validity because they fail to measure what they are supposed to measure (Hunsley, Lee, & Wood, 2003). One reason is that responses to a projective test are significantly affected by sleepiness, hunger, medication, worry, verbal ability, the clinician's instructions, the clinician's personality (friendly and warm, or cool and remote?), and other events occurring that day.

One of the most popular projective tests is the *Rorschach inkblot test*, which was devised by the Swiss psychiatrist Hermann Rorschach in 1921. It consists of ten cards with symmetrical abstract patterns, originally formed by spilling ink on paper and folding the paper in half. The test taker reports what he or she sees in the inkblots, and the clinician interprets the answers according to the symbolic meanings emphasized by psychodynamic theories. Although the Rorschach is widely used among clinicians, efforts to confirm its reliability and validity have repeatedly failed. The Rorschach does not reliably diagnose depression, posttraumatic stress reactions, personality disorders, or serious mental disorders. Claims of the Rorschach's success often come from testimonials at workshops where clinicians are taught how to use the test, which is hardly an impartial way of assessing it (Wood et al., 2003).



A Rorschach inkblot. What do you see in it?

projective tests

Psychological tests used to infer a person's motives, conflicts, and unconscious dynamics on the basis of the person's interpretations of ambiguous stimuli.

Many psychotherapists use projective tests with young children to help them express feelings they cannot reveal verbally. But during the 1980s, some therapists began using projective methods for another purpose: to determine whether a child had been sexually abused. They claimed they could identify a child who had been abused by observing how the child played with “anatomically detailed” dolls (dolls with realistic genitals), and that is how many of them testified in hundreds of court cases (Ceci & Bruck, 1995).

Unfortunately, these therapists had not tested their beliefs by using a fundamental scientific procedure: comparison with a control group (see Chapter 1). They had not asked, “How do *nonabused* children play with these dolls?” When psychological scientists conducted controlled research to answer this question, they found that large percentages of nonabused children are also fascinated with the doll’s genitals. They will poke at them, grab them, pound sticks into a female doll’s vagina, and do other things that alarm adults! The crucial conclusion was that you cannot reliably diagnose sexual abuse on the basis of children’s doll play (Bruck et al., 1995; Hunsley, Lee, & Wood, 2003; Koocher et al., 1995). You can see how someone who does not understand the problems with projective tests might make inferences about a child’s behavior that are dangerously wrong.

Another situation in which projective tests are used widely but often inappropriately is in child custody assessments. Understandably, when faced with divorcing partners who are bitterly quarreling, calling each other names, and accusing each other of being a terrible parent, the courts long for an objective way to determine which one is better suited to have custody. But when a panel of psychological scientists impartially examined the leading psychological assessment measures, most of which are projective tests, they found that “these measures assess ill-defined constructs, and they do so poorly, leaving no scientific justification for their use in child custody evaluations” (Emery, Otto, & O’Donohue, 2005).

Objective Tests Many clinicians use **objective tests (inventories)**, standardized questionnaires that ask about the test taker’s behavior and feelings. Inventories are generally more reliable and valid than either projective methods or subjective clinical judgments (Dawes, 1994; Meyer et al., 2001). The leading objective test of major depression is the Beck Depression Inventory, and the most widely used diagnostic assessment for personality and emotional disorders is the *Minnesota Multiphasic*



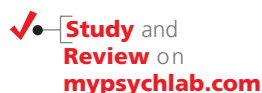
For years, many therapists used anatomically detailed dolls as a projective test to determine whether a child had been sexually abused. But the empirical evidence, including studies of nonabused children in a control group, shows that this practice is simply not valid. It can lead to false allegations because it often misidentifies nonabused children who are merely fascinated with the doll’s genitals.

Personality Inventory (MMPI). The MMPI is organized into ten categories, or *scales*, covering such problems as depression, paranoia, schizophrenia, and introversion. Four additional *validity scales* indicate whether a test taker is likely to be lying, defensive, or evasive while answering the items.

Inventories are only as good as their questions and how knowledgeably they are interpreted. Some test items on the MMPI fail to consider differences among cultural, regional, and socioeconomic groups. For example, Mexican, Puerto Rican, and Argentine respondents score differently from non-Hispanic Americans, on average, on the Masculinity–Femininity Scale. This difference does not reflect emotional problems but traditional Latino attitudes toward sex roles (Cabiya et al., 2000). Also, the MMPI sometimes labels a person’s responses as evidence of mental disorder when they are a result of understandable stresses, such as during divorce or other legal disputes, when participants are upset and angry (Guthrie & Mobley, 1994; Leib, 2008). However, testing experts continue to improve the reliability and validity of the MMPI in clinical assessment by restructuring the clinical scales to reflect current research on mental disorders and personality traits (Butcher & Perry, 2008; Sellbom, Ben-Porath, & Bagby, 2008).

We turn now to a closer examination of some of the disorders described in the DSM. Of course, we cannot cover all of them in one chapter, so we have singled out several that illustrate the range of psychological problems that afflict humanity, from the common to the very rare.

objective tests (inventories) Standardized objective questionnaires requiring written responses; they typically include scales on which people are asked to rate themselves.



Quick Quiz

Your mental health will be enhanced if you can answer these questions.

1. The primary purpose of the DSM is to (a) provide descriptive criteria for diagnosing mental disorders, (b) help psychologists assess normal as well as abnormal behavior, (c) describe the causes of common disorders, (d) keep the number of diagnostic categories of mental disorders to a minimum.
2. List four criticisms of the DSM.
3. Which of the following disorders is a culture-bound syndrome? (a) anorexia nervosa, (b) major depression, (c) bulimia, (d) schizophrenia, (e) panic attacks
4. What is the advantage of inventories, compared with clinical judgments and projective tests, in diagnosing mental disorders?

Answers:

1. a 2. It can foster overdiagnosis; it overlooks the power of diagnostic labels on the perceptions of others; it often confuses serious mental disorders with everyday problems in living; and it produces an illusion of objectivity. 3. c 4. Inventories have better reliability and validity.



YOU are about to learn...

- the difference between ordinary anxiety and an anxiety disorder.
- why the most disabling of all phobias is known as the “fear of fear.”
- why some people recover quickly after a trauma whereas others develop posttraumatic stress disorder.

Anxiety Disorders

Anyone who is waiting for important news or living in an unpredictable situation quite sensibly feels *anxiety*, a general state of apprehension or psychological tension. And anyone who is in a dangerous and unfamiliar situation, such as making a first parachute jump or facing a peevish python, quite sensibly feels flat-out fear. In the short run, these emotions are adaptive because they energize us to cope with danger. They ensure that we don’t make that first jump without knowing how to operate the parachute, and that we get away from that snake as fast as we can.

But sometimes fear and anxiety become detached from any actual danger, or these feelings continue even when danger and uncertainty are past. The result may be *chronic anxiety*, marked by long-lasting feelings of apprehension and doom; *panic attacks*, short-lived but intense feelings of anxiety; *phobias*, excessive fears of specific things or situations; or *obsessive-compulsive disorder*, in which repeated thoughts and rituals are used to ward off anxiety. Listen



generalized anxiety disorder A continuous state of anxiety marked by feelings of worry and dread, apprehension, difficulties in concentration, and signs of motor tension.

Anxiety and Panic

The chief characteristic of **generalized anxiety disorder** is excessive, uncontrollable anxiety or worry—a feeling of foreboding and dread—that occurs on a majority of days during a six-month period and that is not brought on by physical causes such as disease, drugs, or drinking too much coffee.

Some people suffer from generalized anxiety disorder without having lived through any specific anxiety-producing event. They may have a genetic predisposition to experience its symptoms—sweaty palms, a racing heart, shortness of breath—when they are in unfamiliar or uncontrollable situations. Genes may also be involved in causing abnormalities in the amygdala, the core structure for the acquisition of fear (see Chapter 13), and in the prefrontal cortex, which is associated with the ability to realize when danger has passed (Lonsdorf et al., 2009). But anxiety disorders may also stem from experience: Some chronically anxious people have a history, starting in childhood, of being unable to control or predict their environments (Barlow, 2000; Mineka & Zinbarg, 2006). Whatever the origin of generalized anxiety disorder, its sufferers have mental biases in the way they attend to and process threatening information. They perceive everything as an opportunity for disaster, a cognitive habit that fuels their worries and keeps their anxiety bubbling along (Mitte, 2008).

Posttraumatic Stress Disorder Stress symptoms, including insomnia and agitation, are entirely normal in the immediate aftermath of any crisis or trauma, such as war, rape, torture, natural disasters,

sudden bereavement, or terrorist attacks. But if the symptoms persist for one month or longer and begin to impair a person's functioning, the sufferer may have **posttraumatic stress disorder (PTSD)**. Symptoms of PTSD include reliving the trauma in recurrent, intrusive thoughts; a sense of detachment from others and a loss of interest in familiar activities; and increased physiological arousal, reflected in insomnia, irritability, and impaired concentration.

Most people who live through a traumatic experience eventually recover without developing PTSD (Bonanno et al., 2006). A national survey of Americans found that about 60 percent had experienced a traumatic event, but only 8 percent of the men and 20 percent of the women later developed PTSD (Kessler et al., 1995). Why, then, if most people recover from a traumatic experience, do others continue to have PTSD symptoms for years, sometimes for decades?

One answer, again, involves a genetic predisposition. Behavioral-genetic studies of twins in the general population and of combat veterans have found that PTSD symptoms have a heritable component (Stein et al., 2002). But PTSD has also been linked to certain personality and mental characteristics. A prospective study that followed children from their early years to about age 17 found that people who develop PTSD after a traumatic experience often have a prior history of psychological problems, such as anxiety and impulsive aggression. And they seem to lack the social, psychological, and neurological resources to avoid having preventable traumatic experiences in the first place or to cope with unavoidable ones (Breslau, Lucia, & Alvarado, 2006). PTSD sufferers, like others with anxiety disorders, are also more likely to have self-defeating, anxiety-producing ways of thinking that *preceded* the traumatic event. They tend to “catastrophize” about every little thing that goes wrong, to believe they are inadequate, and to feel that no one can be trusted (Bryant & Guthrie, 2005; Ozer et al., 2003).

Interestingly, in many PTSD sufferers, the hippocampus is smaller than average (McNally, 2003). The hippocampus is crucially involved in autobiographical memory. An abnormally small one may figure in the difficulty of some trauma survivors to react to their memories as events from their past, which may be why they keep reliving them in the present. An MRI study of identical twins, only one of whom in each pair had been in combat in Vietnam, showed that two things were necessary for a vet to develop chronic PTSD: serving in combat *and* having a smaller hippocampus than normal. Twins who had smaller hippocampi



This grief-stricken soldier has just learned that the body bag on the flight with him contains the remains of a close friend who was killed in action. Understandably, many soldiers suffer posttraumatic stress symptoms. But why do most eventually recover, whereas others have PTSD for many years?

but no military service did not develop PTSD, and neither did the twins who *did* experience combat but who had normal-sized hippocampi (Gilbertson et al., 2002).

In sum, many cases of long-lasting PTSD seem to be a result of impaired cognitive and neurological functioning that existed before the trauma took place, making it more likely that the trauma will trigger persistent, long-lasting symptoms.

Panic Disorder Another kind of anxiety disorder is **panic disorder**, in which a person has recurring attacks of intense fear or panic, often with feelings of impending doom or death. Panic attacks may last from a few minutes to (more rarely) several hours. Symptoms include trembling and shaking, dizziness, chest pain or discomfort, rapid heart rate, feelings of unreality, hot and cold flashes, sweating, and—as a result of all these scary physical reactions—a fear of dying, going crazy, or losing control. Many sufferers fear they are having a heart attack.

Although panic attacks seem to come out of nowhere, they in fact usually occur in the aftermath of stress, prolonged emotion, specific worries, or frightening experiences (McNally, 1998). A friend of ours was on a plane that was a target of a bomb threat while airborne at 33,000 feet. He coped beautifully at the time, but two weeks later, seemingly out of nowhere, he had a panic attack. Such delayed attacks after life-threatening scares are common. The essential difference between people

posttraumatic stress disorder (PTSD) An anxiety disorder in which a person who has experienced a traumatic or life-threatening event has symptoms such as psychic numbing, reliving of the trauma, and increased physiological arousal.

panic disorder An anxiety disorder in which a person experiences recurring panic attacks, periods of intense fear, and feelings of impending doom or death, accompanied by physiological symptoms such as rapid heart rate and dizziness.

Get Involved! What Scares You?

Everyone fears something. Stop for a moment to think about what you fear most. Is it heights? Snakes? Speaking in public? Ask yourself these questions: (1) How long have you feared this thing or situation? (2) How would you respond if you could not avoid this thing or situation? (3) How much would you be willing to rearrange your life to avoid this feared thing or situation? After considering these questions, would you regard your fear as a full-blown phobia or merely a normal source of apprehension?

who develop panic disorder and those who do not lies in how they *interpret* their bodily reactions (Barlow, 2000). Healthy people who have occasional panic attacks see them correctly as a result of a passing crisis or period of stress, comparable to another person's migraines. But people who develop panic disorder regard the attack as a sign of illness or impending death, and they begin to live their lives in restrictive ways, trying to avoid future attacks.

Fears and Phobias

Are you afraid of bugs, snakes, or dogs? Are you vaguely uncomfortable or so afraid that you can't stand to be around one? A **phobia** is an exaggerated fear of a specific situation, activity, or thing. Some common phobias—such as fear of snakes, insects, heights (acrophobia), thunder (brontophobia), or being trapped in enclosed spaces (claustrophobia)—may have evolved to be easily acquired in human beings because these fears reflected real dangers for the species (see Chapter 9). Some phobias, such as a fear of the color purple (porphyrophobia), dirt and germs (mysophobia), or the number 13 (triskaidekaphobia), may reflect idiosyncratic experiences, personality traits, or cultural traditions. Whatever its source, a phobia is truly frightening and often incapacitating for its sufferer. It is not just a tendency to say “ugh” at tarantulas or skip the snake display at the zoo.

People who have a *social phobia* become extremely anxious in situations in which they will be observed by others—eating in a restaurant, speaking in public, having to perform for an audience. They worry that they will do or say something that will be excruciatingly embarrassing and that other people will laugh at them or reject them. These phobias are more severe forms of the occasional shyness and social anxiety that everyone experiences. For people with a social phobia, the mere thought of being in a new situation with unfamiliar people is scary enough to cause sweating, trembling, nausea, and an overwhelming feeling of

inadequacy. So they don't go, increasing their isolation and imagined fears.

By far the most disabling fear disorder is **agoraphobia**. In ancient Greece, the *agora* was the social, political, business, and religious center of town, the public meeting place away from home. The fundamental fear in agoraphobia is of being trapped in a crowded public place, where escape might be difficult or where help might be unavailable if the person has a panic attack. Individuals with agoraphobia report many specific fears—of being in a crowded movie theater, driving in traffic or tunnels, or going to parties—but the underlying fear is of being away from a safe place, usually home, or a safe person, usually a parent or partner.

Agoraphobia typically begins with a panic attack that seems to have no cause. The attack is so unexpected and scary that the agoraphobic-to-be begins to avoid situations that he or she thinks may provoke another one. A woman we know had a panic attack while driving on a freeway. This was a perfectly normal posttraumatic response to the suicide of her husband a few weeks earlier. But thereafter she avoided freeways, as if the freeway, and not the suicide, had caused the attack. Because so many of the actions associated with agoraphobia arise as a mistaken effort to avoid a panic attack, psychologists regard agoraphobia as a “fear of fear” rather than simply a fear of places.

Obsessions and Compulsions

Obsessive-compulsive disorder (OCD) is characterized by recurrent, persistent, unwished-for thoughts or images (*obsessions*) and by repetitive, ritualized behaviors that the person feels must be carried out to avoid disaster (*compulsions*). Of course, many people have trivial compulsions and practice superstitious rituals. Baseball players are famous for them; one won't change his socks and another insists on eating chicken every day while he is on a hitting streak. Obsessions and compulsions become a disorder when they become uncontrollable and interfere with a person's life.

phobia An exaggerated, unrealistic fear of a specific situation, activity, or object.

agoraphobia A set of phobias, often set off by a panic attack, involving the basic fear of being away from a safe place or person.

obsessive-compulsive disorder (OCD) An anxiety disorder in which a person feels trapped in repetitive, persistent thoughts (*obsessions*) and repetitive, ritualized behaviors (*compulsions*) designed to reduce anxiety.

People who have obsessive thoughts often find them frightening or repugnant: thoughts of killing a child, of becoming contaminated by a handshake, or of having unknowingly hurt someone in a traffic accident. Obsessive thoughts take many forms, but they are alike in reflecting impaired ways of reasoning and processing information.

People who suffer from compulsions likewise feel they have no control over them. The most common compulsions are hand washing, counting, touching, and checking. A woman *must* check the furnace, lights, locks, and oven three times before she can sleep; a man *must* run up and down the stairs 60 times in 40 minutes or else start over from the beginning. OCD sufferers usually realize that their behavior is senseless, and they are often tormented by their rituals. But if they try to resist the compulsion, they feel mounting anxiety that is relieved only by giving in to it.

In many people with OCD, abnormalities in an area of the prefrontal cortex create a kind of cognitive rigidity, an inability to let go of intrusive thoughts, and behavioral rigidity, an inability to alter compulsive behavior after getting negative feedback (Chamberlain et al., 2008; Clarke et al., 2004). Normally, once danger has passed or a person realizes that there is no cause for fear, the brain's alarm signal turns off. In people with OCD, however, false alarms keep clanging and the emotional networks keep sending out mistaken fear messages (Schwartz et al., 1996). The sufferer feels in a constant state of danger and tries repeatedly to reduce the resulting anxiety.

OCD is not a single, unified disorder (Taylor, McKay, & Abramowitz, 2005). One subtype afflicts pathological hoarders who fill their homes with



Extreme hoarding is a form of obsessive-compulsive disorder. The person who lived here was unable to throw away any papers or magazines without feeling tremendous anxiety.

newspapers, bags of old clothing, used tissue boxes—all kinds of junk. They are tormented by fears of throwing out something they will need later. A PET-scan study that compared obsessive hoarders with other people with obsessive symptoms found that hoarders had less activity in parts of the brain involved in decision making, problem solving, spatial orientation, and memory (Saxena et al., 2004). Perhaps these deficits explain why hoarders keep things and why they often keep their papers and junk in the living room, kitchen, or even on the bed. Their inability to decide what to throw away creates a constant worry, and their difficulty in remembering where things are makes them feel the need to have them in sight.

Quick Quiz

We hope you don't feel anxious about matching each term on the left with its description on the right.

- | | |
|----------------------------------|---------------------------------------------------------|
| 1. social phobia | a. need to perform a ritual |
| 2. generalized anxiety disorder | b. fear of fear; of being trapped with no way of escape |
| 3. posttraumatic stress disorder | c. continuing sense of doom |
| 4. agoraphobia | d. repeated, unwanted thoughts |
| 5. compulsion | e. fear of meeting new people |
| 6. obsession | f. anxiety following severe shock |

Answers:

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



YOU are about to learn...

- the difference between major depression and the blues.
- four contributing factors in depression.
- how some people can think themselves into depression.

Mood Disorders

In the DSM, *mood disorders* include disturbances in emotion ranging from extreme depression to extreme mania. Of course, most people feel sad and joyful from time to time, and, at some time in their lives, will know the grief that follows the loss of someone they love. These feelings, however, are a far cry from the clinical disorders described by the DSM.

Depression

Major depression involves emotional, behavioral, cognitive, and physical changes severe enough to disrupt a person's ordinary functioning and lasting at least two weeks. Some episodes can last as long as 20 weeks, subside, and later recur. People with major depression feel despairing and worthless. They feel unable to get up and do things; it takes an enormous effort even to get dressed. They may overeat or stop eating, have difficulty falling asleep or sleeping through the night, have trouble concentrating, and feel tired all the time. They lose interest in activities that usually give them satisfaction and pleasure.

The DSM's definition excludes people whose depression is caused by bereavement, and whose acute but understandable feelings of grief eventually subside within a few months. But as a community survey of more than 8,000 people found, the symptoms of major depression that would constitute a mental disorder are often indistinguishable from symptoms of extreme sorrow following the loss of a job and social status in one's community, a disastrous financial investment, or the end of an important relationship (Wakefield et al., 2007).

Major depression occurs at least twice as often among women as among men, all over the world. However, because women are more likely than men to talk about their feelings and more likely to seek help, depression in males is probably underdiagnosed. Men who are depressed often try to mask their feelings by withdrawing, abusing alcohol or other drugs, driving recklessly, or behaving violently (Canetto, 1992; Kessler et al., 1995). As Susan Nolen-Hoeksema, a leading depression researcher, put it, "Women think and men drink."

major depression A mood disorder involving disturbances in emotion (excessive sadness), behavior (loss of interest in one's usual activities), cognition (thoughts of hopelessness), and body function (fatigue and loss of appetite).

bipolar disorder A mood disorder in which episodes of both depression and mania (excessive euphoria) occur.

vulnerability-stress models Approaches that emphasize how individual vulnerabilities interact with external stresses or circumstances to produce mental disorders.

Bipolar Disorder

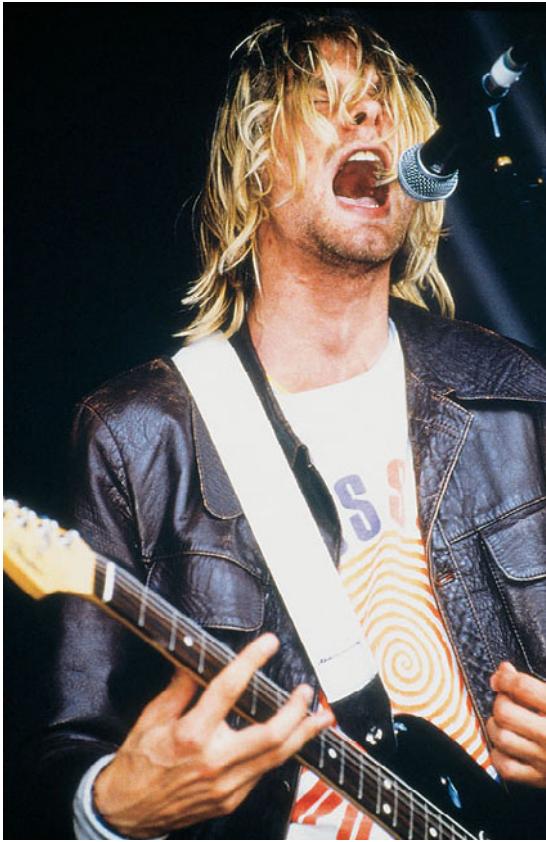
At the opposite pole from depression is *mania*, an abnormally high state of exhilaration. Mania is not the normal joy of being in love or winning the Pulitzer Prize. Instead of feeling fatigued and listless, the manic person is excessively wired and often irritable when thwarted. Instead of feeling hopeless and powerless, the person feels powerful and is full of plans; but these plans are usually based on delusional ideas, such as thinking that he or she has invented something that will solve the world's energy problems. People in a state of mania often get into terrible trouble by going on extravagant spending sprees or making rash decisions.

When people experience at least one episode of mania alternating with episodes of depression, they are said to have **bipolar disorder** (formerly called *manic-depressive disorder*). The great humorist Mark Twain had bipolar disorder, which he described as "periodical and sudden changes of mood... from deep melancholy to half-insane tempests and cyclones." Other writers, artists, musicians, and scientists have also suffered from this disorder (Jamison, 1992). During the highs, many of these creative people produce their best work, but the price of the lows is disastrous relationships, bankruptcy, and sometimes suicide. As noted earlier, bipolar disorder, once thought to emerge only in adulthood, is now being widely diagnosed among young children and adolescents, although the symptoms and mood swings often look different from those in adults, and the diagnosis in children remains controversial (Holden, 2008).

Origins of Depression

One of the great mysteries of depression is that most people who undergo a "depressing" experience do not become clinically depressed, and many people who are clinically depressed have not had "depressing" experiences (Monroe & Reid, 2009). Most researchers thus emphasize a **vulnerability-stress model**: A person's vulnerabilities (in genetic predispositions, personality traits, or habits of thinking) interact with stressful events (such as violence, death of a loved one, or losing a job) to produce most cases of major depression. Let's consider the evidence for the major contributing factors:

1 Genetic predispositions. Major depression is a moderately heritable disorder, so genes must be involved in some cases. But so far the search for specific genes has been unsuccessful. One focus of investigation has been the genes that regulate serotonin, a neurotransmitter involved in mood. An



Even people who are rich, successful, and adored by millions can suffer from major depression. The suicide of Nirvana's lead singer, Kurt Cobain, shocked and saddened his many fans.

early theory held that depression results from abnormally low levels of this neurotransmitter. However, many years of research have failed to support the notion that depression results from a simple neurotransmitter deficiency. Depleting animals of serotonin does not induce depression, nor does increasing brain serotonin necessarily alleviate it. The fact that some antidepressants raise serotonin levels (see Chapter 12) does not mean that low serotonin levels caused the depression—a common but mistaken inference (Lacasse & Leo, 2005).

In 2003, in a study of 847 New Zealanders who had been followed from birth to age 26, researchers reported that those who had a short form of a serotonin receptor gene called 5-HTT were much more likely to become severely depressed in the aftermath of major stressful events such as the loss of a job or a death in the family, compared to people with a long form of this gene. In fact, those with the long form were much less likely than others to become clinically depressed even after suffering emotional blows (Caspi et al., 2003). These findings

seemed to show unmistakably the interaction of genes and experience in causing depression in genetically vulnerable people and preventing depression in others. But these conclusions turned out to be premature. A subsequent meta-analysis of 14 studies that had investigated possible links among the 5-HTT gene, life stresses, and depression came up with nothing (Risch et al., 2009). The 5-HTT gene, whether alone or in interaction with life stresses, was not associated with an elevated risk of depression in either sex.

Nonetheless, the New Zealand study has stimulated a wave of research into gene-environment interactions in depression. Most researchers are confident that specific genes involved in some cases of depression will eventually be identified.

2 Violence, childhood physical abuse, and parental neglect. One of the most powerful environmental factors associated with clinical depression is repeated experience with violence. Inner-city adolescents of both sexes who are exposed to high rates of violence in their families or communities report higher levels of depression and more attempts to commit suicide than those who are not subjected to constant violence (Mazza & Reynolds, 1999). And domestic violence takes a particular toll on women. A longitudinal study, which followed men and women from ages 18 to 26, compared those in physically abusive relationships with those in nonabusive ones. Although depressed women were more likely to enter abusive relationships to begin with, involvement in a violent relationship independently increased their rates of depression and anxiety—but, interestingly, not men's (Ehrensaft, Moffitt, & Caspi, 2006).

Maltreatment in childhood, independent of all other childhood and adult risk factors, is associated with a particularly high risk of adult depressive episodes lasting a year or more (Brown & Harris, 2008; Widom, DuMont, & Czaja, 2007). A mechanism that might explain this increased risk is that prolonged stress in childhood and adolescence puts the body's responses to stress in overdrive, so that it overproduces the stress hormone cortisol (Gotlib et al., 2008). Depressed people tend to have high levels of cortisol, which can affect the hippocampus and amygdala, causing mood and memory abnormalities.

3 Losses of important relationships. A third line of investigation emphasizes the loss of important relationships in setting off depression in vulnerable individuals. When an infant is separated from a primary attachment figure, as in the Harlow studies of rhesus monkeys (see Chapter 3), the result is not only despair and passivity, but also harm to the

immune system, which can later lead to depressive illness (Hennessy, Schiml-Webb, & Deak, 2009). Many depressed people have a history of separations, losses, rejections, and impaired, insecure attachments (Hammen, 2009; Nolan, Flynn, & Garber, 2003; Weissman, Markowitz, & Klerman, 2000). As we noted earlier, however, people with a history of happy and secure attachments may also fall into prolonged depression because of the loss of a beloved lifelong partner (Wakefield et al., 2007).

4 Cognitive habits. Finally, depression involves specific, negative ways of thinking about one's situation (Beck, 2005). Depressed people typically believe that their situation is *permanent* ("Nothing good will ever happen to me") and *uncontrollable* ("I'm depressed because I'm ugly and horrible and I can't do anything about it"). Expecting nothing to get better, they do nothing to improve their lives and therefore remain unhappy (Abramson, Metalsky, & Alloy, 1989; Chorpita & Barlow, 1998). When depressed and nondepressed people are put into a sad mood and given a choice between looking at sad faces or happy faces, depressed people choose the sad faces—a metaphor for how they process the world in general, attending to everything that confirms the gloominess of life rather than any of its joys (Joormann & Gotlib, 2007). And when asked to recall happier times, nondepressed people cheer up. But depressed people feel even worse, as if the happy memory makes them feel that they will never be happy again (Joormann, Siemer, & Gotlib, 2007).

The cognitive biases associated with depression are not just correlates of the disorder. Longitudinal studies show that they play a causal role, interacting with severe life stresses to generate further depressive episodes (Monroe et al., 2007). Depressed people tend to *ruminate*—brooding about everything that is wrong in their lives, persuading themselves that no one cares about them, and dwelling on reasons to feel hopeless. They have trouble preventing these gloomy thoughts from entering and remaining in their working memory, which keeps them stewing in negative thoughts and unhappy past events (Joormann, 2010). In contrast, nondepressed people who undergo stressful events are usually able to distract themselves, look outward, and seek solutions. Beginning in adolescence, women are much more likely than men to develop a ruminating, introspective style, which contributes both to longer-lasting depressions in women and to the sex difference in reported rates.

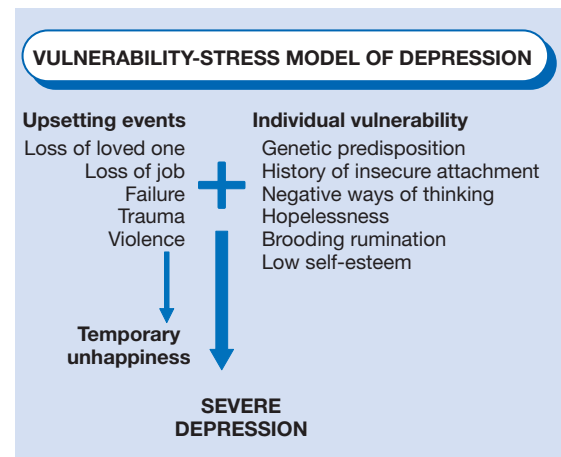
The findings about rumination are pretty interesting, because just about all of us know what it



Women are far more likely than men to ruminate and brood when they are sad, a habit that can easily turn into depression.

feels like to think that everything is hopeless, to brood over hurt feelings, to rehearse real and imagined insults ("Who does she think she is, anyway?"), and to wallow in our anxieties ("I'm never going to do well in this course—I can't possibly keep up"). When we think of examples like these, we can see why rumination might keep us stuck in an anxious, angry, or gloomy frame of mind. And, in fact, rumination predicts not only depression but also impaired thinking and problem solving, anxiety and worry, eating disorders, and drug abuse (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008; Zalta & Chambless, 2008).

The factors we have described—genetics, violence, loss of important people, and cognitive habits and biases—combine in different ways to produce any given case of depression. That is why the same sad event, such as flunking a course, being dumped by a lover, or losing a job, can affect two people entirely differently: One rolls with the punch and another is knocked flat.



Quick Quiz

Don't let another quiz make you vulnerable to depression!

1. Biological researchers find that depressed people have unusually high levels of the stress hormone _____.
2. What are four main contributing factors in depression?
3. Depressed people tend to believe that the reasons for their unhappiness are (a) controllable, (b) temporary, (c) out of their hands, (d) caused by the situation.
4. A news headline announces that a gene has been identified as the cause of depression. Does this mean that everyone with the gene will become depressed? How should critical thinkers interpret this research?

Answers:

1. cortisol 2. genetic factors; exposure to violence and childhood experiences of parental neglect and physical abuse; a history of insecure attachments and losses of close relationships; cognitive habits of negative thinking and rumination 3. c 4. No, it means that people with the gene are more likely to become depressed when they undergo severely stressful experiences. Critical thinkers would want to make sure the research is replicated, and they would realize that not all cases of depression are necessarily influenced by genetics.

✓ Study and Review on myspsychlab.com



YOU are about to learn...

- what a charming but heartless tycoon and a remorseless killer have in common.
- why some people are incapable of feeling guilt or pangs of conscience.

Antisocial/Psychopathic Personality Disorder

Personality disorders involve maladaptive traits that cause great distress or an inability to get along with others. One of the most researched types is **borderline personality disorder**, characterizing people who have a history of intense but unstable relationships in which they alternate between idealizing the partner and then devaluing the partner. They frantically try to avoid real or imagined abandonment by others, even if the “abandonment” is only a friend’s brief vacation. They are self-destructive and impulsive, suffer chronic feelings of emptiness, and often mutilate themselves or threaten to commit suicide. And they are emotionally volatile, careening from anger to euphoria to anxiety. (“Borderline” comes from the original definition of the disorder, as one that fell between being neurotic and being psychotic.)

The DSM-IV also contains several other kinds of personality disorders. The DSM-V will revise the current set of diagnoses significantly, but it will retain one that has fascinated the public for centuries: a disorder describing people who lack all

human connection to anyone else, people who can cheat, con, and kill without flinching.

Decades ago, in his influential book *The Mask of Sanity*, Hervey Cleckley (1976) popularized and standardized the term *psychopath* to describe a person who lacks conscience. A key characteristic of **psychopathy**, said Cleckley, is an inability to feel normal emotions. Psychopaths are incapable not only of remorse but also of fear of punishment and of shame, guilt, and empathy for those they have hurt. Because they lack emotional connections to others, they often behave cruelly and irresponsibly, as much for the thrill as for personal gain, and with no thought of the long-term consequences of their actions. If caught in a lie or a crime, psychopaths may seem sincerely sorry and promise to make amends, but it is all an act. Some psychopaths are violent and sadistic, able to kill a pet, a child, or a random adult without a twinge of regret, but others are charming and manipulative, able to direct their energies into con games or career advancement, abusing other people emotionally or economically rather than physically (Skeem et al., 2003; Skeem & Cooke, 2010). One researcher calls corporate psychopaths “snakes in suits” (Babiak & Hare, 2007).

Psychopaths are believed to exist in all cultures and throughout history, although they are more prevalent in individualistic Western societies. Even a close-knit culture such as the Yupik in Canada has a word for them—*kunlangeta* (Seabrook, 2008). An anthropologist once asked a member of the tribe what the group would do with a *kunlangeta*, and he said, “Somebody would have pushed him off the ice

borderline personality disorder A disorder characterized by intense but unstable relationships, impulsiveness, self-mutilating behavior, feelings of emptiness, and a fear of abandonment by others.

psychopathy A personality disorder characterized by a lack of remorse, empathy, anxiety, and other social emotions; the use of deceit and manipulation; and impulsive thrill seeking.

antisocial personality disorder (APD)

A personality disorder characterized by a lifelong pattern of irresponsible, antisocial behavior such as lawbreaking, violence, and other impulsive, reckless acts; likely to be combined with *psychopathy* in the DSM-V.

when nobody else was looking.” Psychopaths are feared and detested everywhere.

The DSM-IV replaced the term *psychopathy* with **antisocial personality disorder (APD)**, which applies to people who show “a pervasive pattern of disregard for, and violation of, the rights of others.” People with APD repeatedly break the law; they are impulsive and seek quick thrills; they show reckless disregard for their own safety or that of others; they often get into physical fights or assault others; and they are irresponsible, failing to hold jobs or meet obligations (Widiger et al., 1996). As you can see, this definition covers a grab-bag set of behaviors. It does not specify what the underlying mental disorder might be, and it could apply both to teenagers who fall in with a bad crowd for a few years and to disturbed individuals who have been aggressive since early childhood. The latter become what one researcher calls “lifetime persistent offenders”: Rule breaking and irresponsibility start in early childhood and take different forms at different ages: “biting and hitting at age 4, shoplifting and truancy at age 10, selling drugs and stealing cars at age 16, robbery and rape at age 22, and fraud and child abuse at age 30” (Moffitt, 1993, 2005).

The DSM-IV made the change in labeling to emphasize the behavioral signs of antisocial personality disorder. It put “lack of remorse,” the prime feature of psychopathy, far down on the list of criteria for APD and did not make it essential for the diagnosis. But to many clinicians, the defining essence of psychopaths is their heartlessness and lack of conscience; they may not behave violently or commit criminal acts at all (Skeem & Cooke, 2010). People who commit violent crimes may be reckless and irresponsible, these clinicians point out, yet

differ greatly in their motivations for behaving this way and in their capacity for empathy, remorse, guilt, and loyalty. It does not appear that the DSM-V is likely to resolve the question of whether and how psychopathy and antisocial personality disorder overlap; it is likely to have a combined diagnosis called *antisocial/psychopathic personality disorder*.

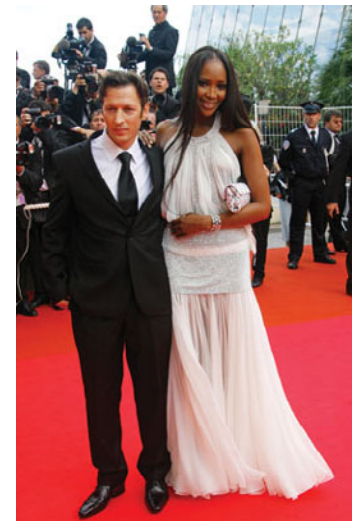
Despite the definitional problems, researchers have identified a number of factors that are involved in the central features of psychopathy and of being a “lifetime persistent offender”:

1 Abnormalities in the central nervous system.

Something certainly seems to be amiss in the emotional wiring of psychopaths, the wiring that allows all primates, not just human beings, to feel connected to others of their kind. The psychopath’s inability to feel emotional arousal suggests some aberration in the central nervous system (Hare, 1965, 1996; Lykken, 1995; Raine et al., 2000). Indeed, most psychopaths do not respond physiologically to the threat of punishment the way other people do, which may be why they can behave fearlessly in situations that would scare others to death.

Normally, when a person is anticipating danger, pain, or punishment, the electrical conductance of the skin changes, a classically conditioned response that indicates anxiety or fear. But psychopaths are slow to develop such responses, which suggests that they are unable to feel the anxiety necessary for learning that their actions will have unpleasant consequences (see Figure 11.2). Their lack of empathy for others also seems to have a physiological basis. When psychopaths are shown pictures of people crying and in distress, their skin conductance barely shifts, in contrast to that of

Some psychopaths are sadistic and violent. Gary L. Ridgway (left), the deadliest convicted serial killer in U.S. history, strangled 48 women, placing their bodies in “clusters” around the country. He did this because, he said coolly, he wanted to keep track of them. But others are confident men who use charm and elaborate scams to deceive and defraud. Christopher Rocancourt (right, with model Naomi Campbell) conned celebrities and others out of millions of dollars by adopting false identities, including movie producer, Brazilian race car driver, Russian prince, son of Sophia Loren, and financier. He was caught in Canada and spent a year in a correctional center—hosting media interviews and writing his autobiography.



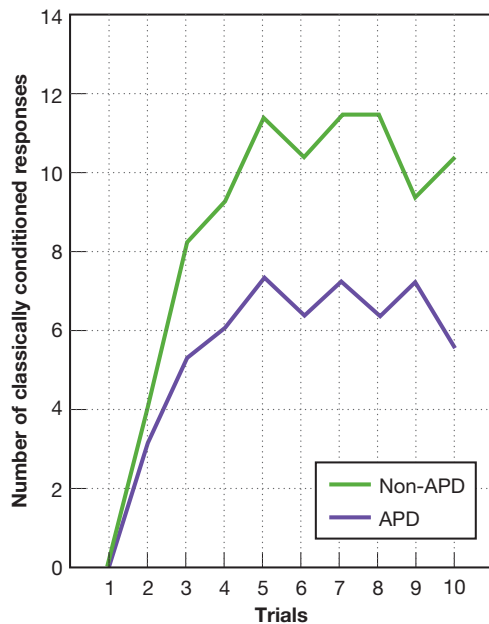


FIGURE 11.2
Emotions and Antisocial Personality Disorder

In several experiments, people with antisocial personality disorder (APD) were slow to develop classically conditioned responses to anticipated danger, pain, or shock—responses that indicate normal anxiety. This deficit may be related to the ability of psychopaths to behave in destructive ways without remorse or regard for the consequences (Hare, 1965, 1993).

nonpsychopaths, whose skin conductance shoots up (Blair et al., 1997). This emotional flatness may help distinguish psychopaths and violent career criminals from other aggressive individuals and lawbreakers who eventually give up their lives of crime (Lorber, 2004).

2 Impaired frontal lobe functioning. Psychopaths and violent career criminals often do not do as well as other individuals on neuropsychological tests of frontal lobe functioning, and they have less gray matter in the frontal lobes than other people do (Dinn & Harris, 2000; Raine, 2008). As we saw in Chapter 4, the frontal lobes are responsible for planning and impulse control, and impairments in this area can lead to an inability to control responses to frustration and provocation, to regulate emotions, and to understand the long-term consequences of indulging in immediate gratifications (Luengo et al., 1994; van Goozen et al., 2007). One PET-scan study found that cold-blooded, predatory murderers had less brain activity in the frontal lobe than did men who murdered in the heat of

passion or a control group of criminals who had not murdered anybody (Raine et al., 1998).

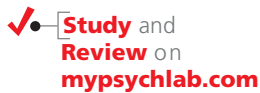
Frontal lobe damage can be inherited or result from disease, accident, or physical abuse (Milner & McCanne, 1991). An analysis of two young adults whose prefrontal cortex was damaged in infancy—one was run over by a car when she was 15 months old and the other had a brain tumor removed—showed that both grew up to be compulsive liars, thieves, and heartless rule breakers. They could not hold jobs, make plans, distinguish right from wrong, or feel empathy (Anderson et al., 1999).

3 Genetic influences. Several genes seem to be involved in a range of disorders that involve frontal lobe causes of impulsivity—not only APD but also alcoholism, drug dependence, and childhood conduct disorder (Dick, 2007; Fowles & Dindo, 2009). In a longitudinal study of boys who had been physically abused in childhood, those who had a variation in a crucial gene later had far more arrests for violent crimes than did abused boys who had a normal gene (Caspi et al., 2002). Although only 12 percent of the abused boys had this variant, they accounted for nearly half of all later convictions for violent crimes.

4 Environmental events. Genes, however, are not destiny. In the study we just described, boys who had the genetic variant but whose parents treated them lovingly did not grow up to be violent. Genes may affect the brain, in turn predisposing a child to heartlessness or violent behavior, but many environmental influences can disrupt that pathway and alter the ways that genes express themselves. Poor nutrition in the first three years of life has been linked with antisocial behavior up through adolescence; so has early separation from the mother; and so has brain damage caused by parental cruelty (Raine, 2008).

Keep in mind that some children may have no genetic predisposition to psychopathy or APD, but years of living in violent worlds may blunt their ability to empathize with the suffering of others and may teach them that violence is a survival strategy. A culture that rewards ruthless behavior in work and politics will generate many “snakes in suits,” and a culture that rewards the slaughter of innocents for purposes of political or religious genocide will generate many cases of “antisocial personality disorder.” And genetics will not be the reason.

As you can see, the diverse causes of psychopathy and lifelong APD involve an individual’s genetic predispositions, biological impairments, experiences in the world, and the culture the person lives in.



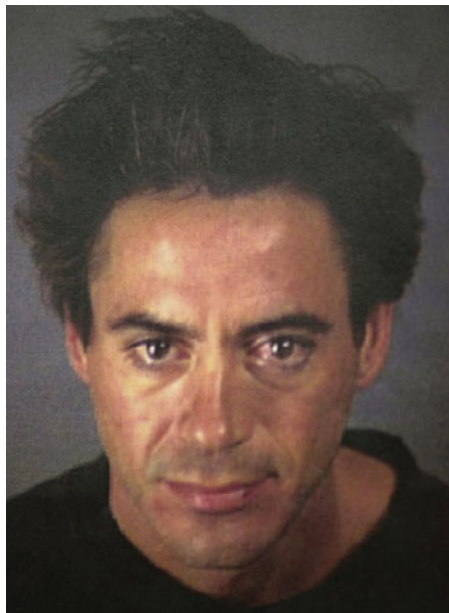
Quick Quiz

There is no such thing as test-avoidance personality disorder, so take this quiz.

- A. Can you diagnose each of the following disorders?
- Ann can barely get out of bed in the morning. She feels that life is hopeless and despairs of ever feeling good about herself.
 - Brad constantly feels a sense of impending doom; for days, he has been extremely worried about everything and can't relax.
 - Connie is emotionally dependent on others and panics or becomes angry when she thinks her friends have left her, even for vacation. She cuts herself and frequently threatens to commit suicide if she doesn't get what she wants.
 - Damon is the most charming of con artists; he can rob a widow of her life's savings without a moment's remorse.
- B. What is the central difference between psychopathy and antisocial personality disorder?
- C. Suppose you read that a gang member has killed a child in a drive-by shooting. Should you assume that he is a psychopath? What evidence would you need to answer that question?

Answers:

A. 1. major depression 2. generalized anxiety disorder 3. borderline personality disorder 4. psychopathy B. Psychopathy is characterized by lack of remorse, guilt, and empathy, whereas antisocial personality disorder is characterized by a history of reckless rule breaking, aggression, and irresponsibility. C. The gang member might or might not be a psychopath or even have antisocial personality disorder. He might have killed the child to conform to the norms of his fellow gang members, yet privately feel terrible remorse. You would need to know whether he has a behavioral history of violence and rule breaking, starting in childhood, and whether he is able to feel empathy and connection to anyone, such as his gang and family.



Robert Downey, Jr., went to prison numerous times for abusing cocaine, heroin, and Valium. He told a judge, "It's like I have a loaded gun in my mouth and my finger's on the trigger, and I like the taste of the gunmetal." Downey's addictions nearly destroyed his acting career.

YOU are about to learn...

- how genes might contribute to alcoholism.
- why alcoholism is more common in some cultures than others.
- why policies of abstinence from alcohol do not reduce problem drinking.
- why narcotics are not usually addictive when people take them for pain.

Drug Abuse and Addiction

Most people who use drugs (legal, illegal, or prescription) use them in moderation; but some people depend too much on them, and others abuse drugs even at the cost of their own health. The DSM-IV defines *substance abuse* as "a maladaptive pattern of substance use leading to clinically significant impairment or distress." Symptoms of such impairment include failure to hold a job, care for children, or complete schoolwork; use of the drug in hazardous situations (e.g., while driving a car or operating machinery); and frequent conflicts with

others about use of the drug or as a result of using the drug.

In Chapter 5, we described the major psychoactive drugs and their effects. In this section, focusing primarily on the example of alcoholism, we will consider the two dominant approaches to understanding addiction and drug abuse—the biological model and the learning model—and then see how they might be reconciled.

Biology and Addiction

The *biological model* holds that addiction, whether to alcohol or any other drug, is due primarily to a person's neurology and genetic predisposition. The clearest example of the biology of addiction is nicotine. Although smoking rates have declined over the past fifty years, nicotine addiction remains one of the most serious health problems in the United States and worldwide. Unlike other addictions, it can begin quickly, within a month after the first cigarette—and for some teenagers, after only one cigarette—because nicotine almost immediately changes neuron receptors in the brain that react chemically to the drug (DiFranza, 2008). Genes produce variation in these nicotine receptors, which is one reason that some people are especially vulnerable to becoming addicted to cigarettes and have tremendous withdrawal symptoms when they try to give them up, whereas other people, even if they have been heavy smokers, can quit cold turkey (Bierut et al., 2008).

For alcoholism, the picture is more complicated. Genes are involved in some kinds of alcoholism but not all. There is a heritable component in the kind of alcoholism that begins in early adolescence and is linked to impulsivity, antisocial behavior, and criminality (Dick, 2007; Dick et al., 2008; Schuckit et al., 2007), but not in the kind of alcoholism that begins in adulthood and is unrelated to other disorders. (Robert Downey, Jr., shown on page 386, said he had been addicted to drugs since the age of 7.)

Genes also affect alcohol sensitivity: how quickly people respond to alcohol, whether they tolerate it, and how much they need to drink before feeling high (Hu et al., 2008). In an ongoing longitudinal study of 450 young men, those who at age 20 had to drink more than others to feel any reaction were at increased risk of becoming alcoholic within the decade. This was true regardless of their initial drinking habits or family history of alcoholism (Schuckit, 1998).

In contrast, people who have a high sensitivity to alcohol are less likely to drink to excess, and this

may partly account for ethnic differences in alcoholism rates. One genetic factor causes low activity of an enzyme that is important in the metabolism of alcohol. People who lack this enzyme respond to alcohol with unpleasant symptoms, such as flushing and nausea. This genetic protection is common among Asians but rare among Europeans, which may be one reason that rates of alcoholism are much lower in Asian than in Caucasian populations; the Asian sensitivity to alcohol discourages them from drinking a lot (Heath et al., 2003). Not all Asians are the same in this regard, however. Korean-American college students have higher rates of alcohol-use disorders and family histories of alcoholism than do Chinese-American students (Duranceaux et al., 2008), and Native Americans have the same genetic protection that Asians do, yet they have much higher rates of alcoholism.

The usual way of looking at biological factors and addiction is to assume that the first causes the second. However, there is strong evidence that the relationship also works the other way: *Addictions can result from the abuse of drugs* (Crombag & Robinson, 2004). Many people become addicted not because their brains have led them to abuse drugs, but because the abuse of drugs has changed their brains. As you can see in Figure 11.3, heavy use of cocaine reduces the number of receptors for dopamine (Volkow et al., 2001); this is also true for alcohol and other drugs. Heavy drinking alters brain function, reduces the level of painkilling endorphins, produces nerve damage, and shrinks

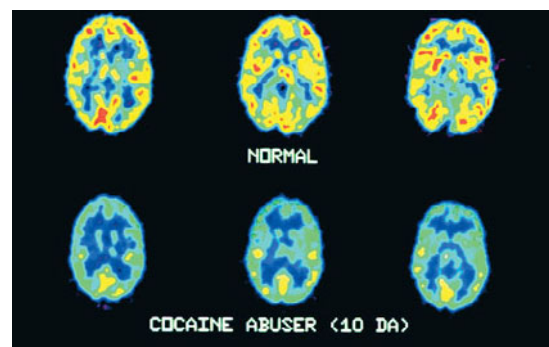


FIGURE 11.3
The Addicted Brain

PET studies show that the brains of cocaine addicts have fewer receptors for dopamine, a neurotransmitter involved in pleasurable sensations. (The more yellow and red in the brain image, the more receptors.) The brains of people addicted to methamphetamine, alcohol, and even food show a similar dopamine deficiency (Volkow et al., 2001).

the cerebral cortex. These changes can then create addiction, a craving for more of the drug. Rather than drinking alcohol for occasional pleasure, a person begins to drink as a relief from stressors and stays intoxicated for longer and longer times. At this point, long-term changes in the brain occur, and the person becomes alcoholic, drinking not for pleasure at all but simply to appease the craving (Heilig, 2008).

Thus, drug abuse, which begins as a voluntary action, can turn into drug addiction, a compulsive behavior that the addict finds almost impossible to control.

Learning, Culture, and Addiction

The *learning model* examines the role of the environment, learning, and culture in encouraging or discouraging drug abuse and addiction. Four major findings underscore the importance of understanding these factors:

1 **Addiction patterns vary according to cultural practices.** Alcoholism is much more likely to occur in societies that forbid children to drink but condone drunkenness in adults (as in Ireland) than in societies that teach children how to drink responsibly and moderately but condemn adult drunkenness (as in Italy, Greece, and France). In cultures with low rates of alcoholism (except for those committed to a religious rule that forbids use of all psychoactive drugs), adults demonstrate correct drinking habits to their children, gradually introducing them to alcohol in safe family settings.

Alcohol is not used as a rite of passage into adulthood. Abstainers are not sneered at, and drunkenness is not considered charming, comical, or manly; it is considered stupid and obnoxious (Peele & Brodsky, 1991; Vaillant, 1983).

The cultural environment may be especially crucial for the development of alcoholism among young people with a genetic vulnerability to alcohol (Schuckit et al., 2008). In one such group of 401 American Indian youths, those who later developed drinking problems lived in a community in which heavy drinking was encouraged and modeled by their parents and peers. But those who felt a cultural and spiritual pride in being Native American, and who were strongly attached to their religious traditions, were less likely to develop drinking problems, even when their parents and peers were encouraging them to drink (Yu & Stiffman, 2007).

Addiction rates can rise or fall rapidly as a culture changes. In colonial America, the average person drank two to three times the amount of liquor consumed today, yet alcoholism was not a serious problem. Drinking was a universally accepted social activity; families drank and ate together. Alcohol was believed to produce pleasant feelings and relaxation, and Puritan ministers endorsed its use (Critchlow, 1986). Then, between 1790 and 1830, when the American frontier was expanding, drinking came to symbolize masculine independence and toughness. The saloon became the place for drinking away from home. As people stopped drinking in moderation with their families, alcoholism rates shot up, as the learning model would predict.

Substance abuse and addiction problems also increase when people move from their culture of

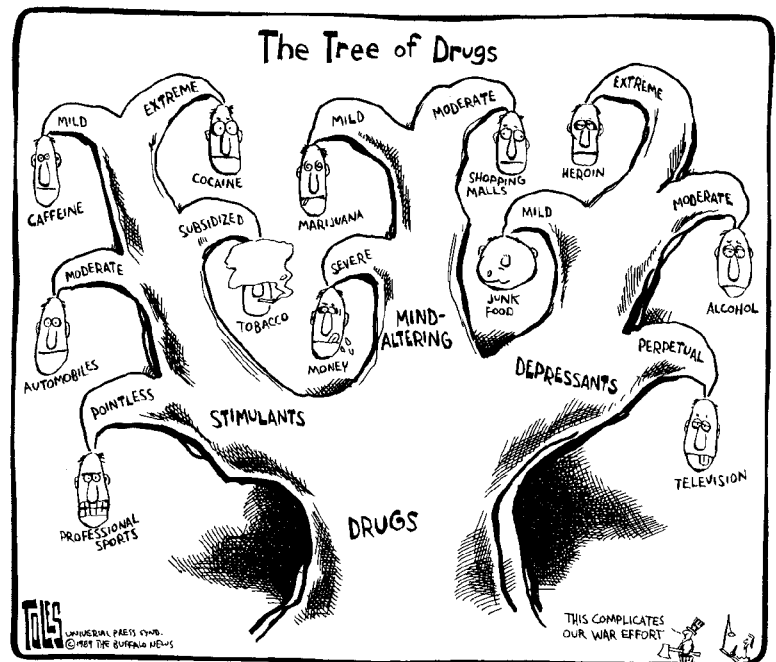


When children learn the rules of social drinking with their families, as at this Jewish family's Passover seder (left), alcoholism rates are much lower than in cultures in which drinking occurs mainly in bars or in privacy. Likewise, when marijuana is used as part of a religious tradition, as it is by members of the Rastafarian church in Jamaica, use of the "wisdom weed" does not lead to addiction or harder drugs.

origin into another that has different drinking rules (Westermeyer, 1995). In most Latino cultures, women tend to drink rarely, if at all; they have few drinking problems until they move into an Anglo environment, when their rates of alcoholism rise (Canino, 1994). Likewise, when norms within a culture change, so may drinking habits and addiction rates. The cultural norm for American college women was once low to moderate drinking; today, college women are more likely to abuse alcohol than they ever used to. One reason is that the culture of many American college campuses encourages drinking games, binge drinking (having at least four to five drinks in a two-hour session), and getting drunk, especially among members of fraternities and sororities (Courtney & Polich, 2009). When everyone around you is downing shots one after another or playing beer pong, it's hard to say, "Gee, I'd really rather just have one drink" (or none).

2 Policies of total abstinence tend to increase rates of addiction rather than reduce them. In the United States, the temperance movement of the early twentieth century held that drinking inevitably leads to drunkenness, and drunkenness to crime. The solution it won for the Prohibition years (1920–1933) was national abstinence. But this victory backfired: Again in accordance with the learning model, Prohibition reduced rates of drinking overall, but it *increased* rates of alcoholism among those who did drink. Because people were denied the opportunity to learn to drink moderately, they drank excessively when given the chance (McCord, 1989). And, of course, when a substance is forbidden, it becomes more attractive to some people. Most schools in America have zero-tolerance policies regarding marijuana and alcohol, but large numbers of students have tried them or use them regularly. In fact, rates of binge drinking have increased the most among underage students, who are legally forbidden to drink until age 21.

3 Not all addicts have withdrawal symptoms when they stop taking a drug. When heavy users of a drug stop taking it, they often suffer such unpleasant symptoms as nausea, abdominal cramps, depression, and sleep problems, depending on the drug. But these symptoms are far from universal. During the Vietnam War, nearly 30 percent of American soldiers were taking heroin in doses far stronger than those available on the streets of U.S. cities. These men believed themselves to be addicted, and experts predicted a drug-withdrawal disaster among the returning veterans. It never materialized; over 90 percent of the men simply gave



up the drug, without significant withdrawal pain, when they came home to new circumstances (Robins, Davis, & Goodwin, 1974). Similarly, the majority of people who are dependent on cigarettes, tranquilizers, or painkillers are able to stop taking these drugs without outside help and without severe withdrawal symptoms (Prochaska, Norcross, & DiClemente, 1994). Many people find this information startling, even unbelievable. That is because people who can quit without help aren't entering programs to help them quit, so they are invisible to the general public and to the medical and therapeutic world. But they have been identified in random-sample community surveys.

One reason that many people are able to quit abusing drugs is that the environment in which a drug is used (the setting) and a person's expectations (mental set) have a powerful influence on the drug's *physiological* effects as well as its psychological ones (see Chapter 5). You might think a lethal dose of, say, amphetamines would be the same wherever the drug was taken. But studies of mice have found that the lethal dose varies depending on the mice's environment—whether they are in a large or small test cage, or whether they are alone or with other mice. Similarly, the physiological response of human addicts to certain drugs also changes, depending on whether the addicts are in a "druggo" environment, such as a crack house, or an unfamiliar one (Crombag & Robinson, 2004; Siegel, 2005). This is the primary reason that addicts need to change environments if they are going to kick their habits. It's

This cartoon, by poking fun at the things people do to make themselves feel better, reminds us that a person can become dependent on many things besides alcohol or other drugs.

Get Involved! Test Your Motives for Drinking

If you drink, why do you do so? Check all of the motives that apply to you:

- | | |
|-------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> to relax | <input type="checkbox"/> to cope with depression |
| <input type="checkbox"/> to escape from worries | <input type="checkbox"/> to get drunk and lose control |
| <input type="checkbox"/> to enhance a good meal | <input type="checkbox"/> to rebel against authority |
| <input type="checkbox"/> to conform to peers | <input type="checkbox"/> to relieve boredom |
| <input type="checkbox"/> to express anger | <input type="checkbox"/> to have sex |
| <input type="checkbox"/> to be sociable | <input type="checkbox"/> other (specify) |

Do your reasons promote abuse or responsible use? How do you respond physically to alcohol? What have you learned about drinking from your family, your friends, and cultural messages? What do your answers tell you about your own vulnerability to addiction?

not just to get away from a peer group that might be encouraging them, but also to literally change and rewire their brain's response to the drug.

4 **Addiction does not depend on properties of the drug alone but also on the reasons for taking it.** For decades, doctors were afraid to treat people with chronic pain by giving them narcotics, fearing they would become addicts. As a result of this belief, millions of people were condemned to live with chronic suffering from back pain, arthritis, nerve disorders, and other conditions. But today we know that the vast majority of pain sufferers use morphine and other opiates not, as addicts do, to escape from the world but rather to function in the world, and they do not become addicted (Portenoy, 1994; Raja, 2008).

Similarly, in the case of alcohol, people who drink simply to be sociable or to relax when they have had a rough day are unlikely to become addicted. *Problem* drinking occurs when people drink to disguise or suppress their anxiety or depression, when they drink alone to drown their sorrows and forget their worries, or when they want an excuse to abandon inhibitions (Cooper et al., 1995; Mohr et al., 2001). College students who feel alienated and uninvolved with their studies are more likely than their happier peers to go out drinking with the conscious intention of getting drunk (Flacks & Thomas, 1998).

Debating the Causes of Addiction

The biological and learning models both contribute to our understanding of drug use and addiction. Yet, among many researchers and public health professionals, these views are quite polarized, especially when it comes to thinking about treatment. The result is either-or thinking on a national scale: Either complete abstinence is the solution, or it is the problem.

Those who advocate the biological model say that alcoholics and problem drinkers must abstain completely, and that young people should not be permitted to drink, even at home with their parents, until they are 21. Those who champion the learning model argue that most problem drinkers can learn to drink moderately if they learn to drink safely and sensibly, acquire better ways of coping with stress, avoid situations that evoke conditioned responses to using drugs, and avoid friends who pressure them to drink excessively. Besides, they ask, how are young people going to learn to drink moderately if they don't first do so at home or in other safe environments? (Denning, Little, & Glickman, 2004; Rosenberg, 1993).

How can we assess these two positions critically? Because alcoholism and problem drinking occur for many reasons, neither model offers the only solution. On the one hand, many people who have been drinking heavily for years may not be able to learn to drink moderately, because, as we saw earlier, physiological changes in their brains



After five years in and out of rehab and facing more prison time, Robert Downey, Jr., got serious about getting help and was able to overcome his addictions.

Thinking Critically
about Theories of
Addiction



and bodies may have turned them from alcohol abusers into addicts. On the other hand, total-abstinence groups like Alcoholics Anonymous (AA) are ineffective for many people. According to its own surveys and those done independently, one-third to one-half of all people who join AA drop out. Many of these dropouts benefit from programs such as Harm Reduction, which teach people how to drink moderately and keep their drinking under control (Witkiewitz & Marlatt, 2006).

So instead of asking, “Can problem drinkers learn to drink moderately?” perhaps we should ask, “What are the factors that make it more or less likely that someone can learn to control problem drinking?” Problem drinkers who are most likely

to become moderate drinkers have a history of less severe dependence on the drug. They lead more stable lives and have jobs and families. In contrast, those who are at greater risk of alcoholism (or other drug abuse) have these risk factors: (1) They have a genetic vulnerability to the drug or have been using it long enough for it to have damaged or changed their brains; (2) they believe that they have no control over their drinking or other drug use; (3) they live in a culture or a peer group that promotes and rewards binge drinking or discourages moderate drug use; and (4) they have come to rely on the drug as a way of avoiding problems, suppressing anger or fear, or coping with stress.

Quick Quiz

If you are addicted to passing exams, answer these questions.

1. What is the most reasonable conclusion about the role of genes in alcoholism? (a) Without a key gene, a person cannot become alcoholic; (b) the presence of a key gene will almost always cause a person to become alcoholic; (c) genes may increase a person's vulnerability to some kinds of alcoholism.
2. Which cultural practice is associated with *low* rates of alcoholism? (a) a gradual introduction to drinking in family settings, (b) infrequent binge drinking, (c) drinking as a rite of passage into adulthood, (d) policies of prohibition
3. In a national survey, 52 percent of American college students said they drink to get drunk and 42 percent said they usually binge when drinking. To reduce this problem, many schools have instituted zero-tolerance programs. According to the research described in this section, are these programs likely to work? Why or why not?

Answers:

1. c 2. a 3. They are not likely to be successful because zero-tolerance programs do not address the reasons that students binge, do not affect the student culture that fosters binge drinking, and do not teach students how to drink moderately.

✓ Study and Review on myspychlab.com



YOU are about to learn...

- why most clinicians and researchers are skeptical about multiple personality disorder.
- why the number of “multiple personality” cases jumped from a handful to many thousands.

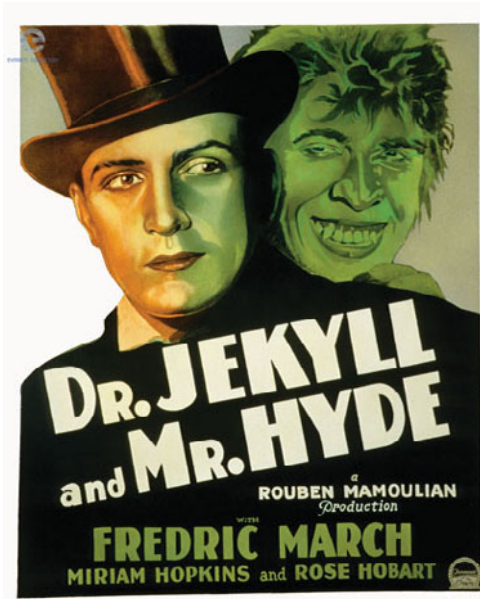
Dissociative Identity Disorder

One of the most controversial diagnoses ever to arise in psychiatry and psychology is **dissociative identity disorder**, formerly and still popularly called *multiple personality disorder* (MPD). This label describes the apparent emergence, within one person,

of two or more distinct identities, each with its own name, memories, and personality traits. Cases of multiple personality portrayed on TV, in books, and in films such as *The Three Faces of Eve* and *Sybil* have captivated the public for years, and they still do. In 2009, Showtime came up with “The United States of Tara,” in which a woman with a *very* tolerant husband and two teenagers keeps breaking into one of her three identities—a sex-and-shopping-mad teenage girl, a gun-loving redneck male, and a 1950s-style homemaker.

Some psychiatrists take MPD seriously, believing that it originates in childhood as a means of coping with sexual abuse or other traumatic experiences (Gleaves, 1996). In their view, the trauma produces a mental “splitting” (*dissociation*):

dissociative identity disorder A controversial disorder marked by the apparent appearance within one person of two or more distinct personalities, each with its own name and traits; formerly known as *multiple personality disorder* (MPD).



In the earliest cases, multiple personalities came only in pairs. In the 1886 story of *Dr. Jekyll and Mr. Hyde*, the kindly Dr. Jekyll turned into the murderous Mr. Hyde. At the height of the MPD epidemic in the 1990s, people were claiming to have dozens of alters, including demons, aliens, and animals.

One personality emerges to handle everyday experiences, and another personality (called an “alter”) to cope with the bad ones. During the 1980s and 1990s, clinicians who believed a client had multiple personalities often used suggestive techniques to “bring out the alters,” such as hypnosis, drugs, and even outright coercion (McHugh, 2008; Rieber, 2006; Spanos, 1996). Psychiatrist Richard Kluft (1987) wrote that efforts to determine the presence of MPD—that is, to get the person to reveal a dissociated personality—may require “between 2 1/2 and 4 hours of continuous interviewing. Interviewees must be prevented from taking breaks to regain composure. . . . In one recent case of singular difficulty, the first sign of dissociation was noted in the

6th hour, and a definitive spontaneous switching of personalities occurred in the 8th hour.”

Mercy! After eight hours of “continuous interviewing” without a single break, how many of us wouldn’t do what the interviewer wanted? Clinicians who conducted such interrogations argued that they were merely *permitting* other personalities to reveal themselves, but their skeptical critics countered that they were actively *creating* other personalities through suggestion and sometimes even intimidation with vulnerable clients who had other psychological problems (Lilienfeld & Lohr, 2003). Researchers have shown that “dissociative amnesia,” the mechanism that supposedly causes traumatized children to repress their ordeal and develop several identities as a result, lacks historical and empirical support (see Chapter 8). Truly traumatic experiences are remembered all too long and all too well (McNally, 2003; Pope et al., 2006).

So what is MPD? The evidence suggests that it is a homegrown culture-bound syndrome. Only a handful of MPD cases had ever been diagnosed anywhere in the world before 1980; yet by the mid-1990s, tens of thousands of cases had been reported, mostly in the United States and Canada. MPD became a lucrative business, benefiting hospitals that opened MPD clinics, therapists who had

a new disorder to treat, and psychiatrists and patients who wrote best-selling books. Then, in the 1990s, as a result of numerous malpractice cases across the country, courts ruled, on the basis of the testimony of scientific experts in psychiatry and psychology, that MPD was being generated by the clinicians who believed in it. The MPD clinics in hospitals closed, psychiatrists became more wary, and the number of cases dropped sharply almost overnight.

No one disputes that some troubled, highly imaginative individuals can produce many different “personalities” when asked. But the *sociocognitive explanation* of MPD holds that this phenomenon is simply an extreme form of the ability we all have to present different aspects of our personalities to others (Lilienfeld et al., 1999). The disorder may seem very real to clinicians and their patients who believe in it, but in the sociocognitive view, it results from pressure and suggestion by clinicians, interacting with acceptance by vulnerable patients who find MPD a plausible explanation for their problems. The

diagnosis of MPD allows some people to account for past sexual or criminal behavior that they now regret or find intolerably embarrassing; they can claim their “other personality did it.” In turn, therapists who believe in MPD reward such patients with attention and praise for revealing more and more personalities—and a culture-bound syndrome is born (Hacking, 1995; Piper & Merskey, 2004).

The rise and fall of MPD provide an important lesson in critical thinking, because unskeptical media coverage of sensational cases, along with all of those movies and TV shows, have played a major role in fostering the rise of MPD diagnoses. When Canadian psychiatrist Harold Merskey (1992) reviewed the published cases of MPD, he was unable to find a single one in which a patient had not been influenced by the therapist’s suggestions or reports about the disorder in the media. Even the famous case of “Sybil,” a huge hit as a book, film, and television special, was a hoax. Sybil never had a traumatic childhood of sexual abuse, she did not have multiple personality disorder, and her symptoms were largely generated by her psychiatrist (Borch-Jacobsen, 2009; Rieber, 2006).

The story of MPD teaches us to think critically about new diagnoses and previously rare disorders that suddenly catch fire in popular culture: to consider other explanations, to examine assumptions and biases, and to demand good evidence.

Thinking Critically
about “Multiple Per-
sonality Disorder”



✱ **Explore**
Dissociative identity
Disorder on
myspsychlab.com

Quick Quiz

Any one of your personalities may answer this question.

A woman named Donna Walker was arrested for trying to convince an Indiana couple that she was their long-missing daughter. She claimed that her “bad girl” personality (Allison) was responsible for this deception and also for her long history of perpetrating hoaxes on police, friends, and the media. Her “good girl” personality (Donna), she said, was a victim of childhood sexual abuse who spent years working as an FBI informant. The FBI verified that Walker had worked for them, although some of her reports were fabricated. One agent said that Walker has as many as seven personalities who come and go. As a critical thinker, what questions would you want to ask about Walker and her multiple-personality defense?

Answer:

Some possible questions to ask: Is there corroborating evidence for Walker's claims? (She said she was sexually abused from ages 4 to 13 by a family member and then by the minister of her church, and that she was sent to a psychiatric hospital at age 13; these claims could be checked.) How much of the rest of her life story can be independently corroborated? Did Walker only claim to have other personalities when she was in a jam with the law or was there evidence of MPD throughout her life? Could she have another mental disorder, such as psychopathy or major depression?

✔ Study and Review on mypsychlab.com



YOU are about to learn...

- the difference between schizophrenia and a “split personality.”
- the five key signs of schizophrenia.
- whether schizophrenia is partly heritable.
- why schizophrenia might begin in the womb yet not emerge until adolescence.

Schizophrenia

In 1911, the Swiss psychiatrist Eugen Bleuler coined the term **schizophrenia** to describe cases in which the personality loses its unity. Contrary to popular belief, people with schizophrenia do not have a “split” or “multiple” personality. Rather, schizophrenia is a fragmented condition in which words are split from meaning, actions from motives, perceptions from reality. It is an example of a **psychosis**, a mental condition that involves distorted perceptions of reality and an inability to function in most aspects of life.

Symptoms of Schizophrenia

Schizophrenia is the cancer of mental illness: elusive, complex, varied in form, unpredictable to treat. The disorder involves the following symptoms:

1 Bizarre delusions. Some people with schizophrenia have delusions of identity, believing that they are Moses, Jesus, or another famous person. Some have paranoid delusions, taking innocent events—a stranger’s cough, a helicopter overhead—as evidence that everyone is plotting

against them. They may insist that their thoughts have been inserted into their heads by someone controlling them or are being broadcast on television. Some believe that everyday objects or animals are really something else, perhaps extraterrestrials in disguise. Some have delusional beliefs; Margaret Mary Ray believed with all her heart that talk-show host David Letterman was in love with her. Caught up in this delusion, she stalked Letterman day and night for a decade, writing him letters and repeatedly breaking into his house.

2 Hallucinations. People with schizophrenia suffer from false sensory experiences that feel intensely real, such as feeling insects crawling on their bodies or seeing snakes coming through walls. But by far the most common hallucination is hearing voices; it is virtually a hallmark of the disease. Some sufferers are so tormented by these voices that they commit suicide to escape them. One man said he heard as many as 50 voices cursing him, urging him to steal other people’s brain cells, or ordering him to kill himself. Once he picked up a ringing telephone and heard them screaming, “You’re guilty!” over and over. They yelled “as loud as humans with megaphones,” he told a reporter. “It was utter despair. I felt scared. They were always around” (Goode, 2003).

3 Disorganized, incoherent speech. People with schizophrenia often speak in an illogical jumble of ideas and symbols, linked by meaningless rhyming words or by remote associations called “word salads.” A patient of Bleuler’s wrote, “Olive oil is an Arabian liquor-sauce which the Afghans, Moors and Moslems use in ostrich farming. The Indian plantain tree is the whiskey of the Parsees

schizophrenia A psychotic disorder marked by delusions, hallucinations, disorganized and incoherent speech, inappropriate behavior, and cognitive impairments.

psychosis An extreme mental disturbance involving distorted perceptions and irrational behavior; it may have psychological or organic causes. (Plural: *psychoses*.)

and Arabs. Barley, rice and sugar cane called artichoke, grow remarkably well in India. The Brahmins live as castes in Baluchistan. The Circasians occupy Manchuria and China. China is the Eldorado of the Pawnees” (Bleuler, 1911/1950).

4 **Grossly disorganized and inappropriate behavior.** Such behavior may range from childlike silliness to unpredictable and violent agitation. The person may wear three overcoats and gloves on a hot day, start collecting garbage, or hoard scraps of food.



Bryan Charnley painted 17 self-portraits, with comments reflecting his battle with schizophrenia. He painted the one above in March 1991, when his mind was clear. In June, he committed suicide.

5 **Impaired cognitive abilities.** People with schizophrenia do much worse than healthy people in almost every cognitive domain, especially verbal learning and recall of words and stories, language, perception, working memory, selective attention, and problem solving (Dominguez et al., 2009; Uhlhaas & Silverstein, 2005). Their speech is often impoverished; they make only brief, empty replies in conversation, because of diminished thought rather than an unwillingness to speak. Many of these cognitive impairments emerge in vulnera-

ble children long before an actual schizophrenic breakdown occurs, and they last after the patient’s psychotic symptoms subside as a result of medication (Heinrichs, 2005).

Other symptoms may appear months or years before hallucinations or delusions do, and they often persist even when more dramatic symptoms are in remission. Many people with schizophrenia lose the motivation and ability to take care of themselves and interact with others; they may stop working or bathing, and become isolated and withdrawn. They seem emotionally flat; their facial expressions are unresponsive and they make poor eye contact. Some completely withdraw into a private world, sitting for hours without moving, a condition called *catatonic stupor*. (Catatonic states can also produce frenzied, purposeless behavior that goes on for hours.)

The cognitive and social deficits in schizophrenia may emerge early, in late childhood or early adolescence (Tarbox & Pogue-Geile, 2008), but the first full-blown psychotic episode typically occurs in late adolescence or early adulthood. In some individuals, the breakdown occurs suddenly; in others, it is more gradual, a slow change in personality. The more breakdowns and relapses the individual has had, the poorer the chances for recovery. Yet, contrary to stereotype, over 40 percent of the people with schizophrenia *do* have one or more periods of recovery (lasting one year or longer) and go on to hold good jobs and have successful relationships,



April 20: “[I am feeling] paranoid. The person upstairs was reading my mind and speaking back to me to keep me in a sort of ego crucifixion.... I felt this was because I was discharging very strong vibrations.”



May 6: “I had no tongue, no real tongue, and could only flatter.... The nail in the mouth expresses this. The people around me cannot understand how I was so stupid and cannot forgive me.... Thus I am a target. The nails in my eyes express that I cannot see whereas other people seem to have extra sensory perception and I am blind in this respect.”




May 18: “My mind seemed to be thought broadcasting [and] it was beyond my will to do anything about it. I summed this up by painting my brain as an enormous mouth.... The trouble seemed to stem from a broken heart so I painted a great mass of gore there.... I feel I am giving off strong personality vibrations, hence the wavy lines emanating from my head.”



FIGURE 11.4

Schizophrenia and the Brain

People with schizophrenia are more likely to have enlarged ventricles (spaces) in the brain than healthy people are. These MRI scans of 28-year-old male identical twins show the difference in the size of ventricles between the healthy twin (left) and the one with schizophrenia (right).

especially if they have strong family support and community programs (Harding, 2005; Hopper et al., 2007; Jobe & Harrow, 2010). What kind of mysterious disease could produce such a variety of symptoms and outcomes?  **Simulate**


Origins of Schizophrenia

Schizophrenia is clearly a brain disease. It involves reduced volumes of gray matter in the prefrontal cortex and temporal lobes; abnormalities in the hippocampus; and abnormalities in neurotransmitters, neural activity, and disrupted communication between neurons in areas involving cognitive functioning, such as memory, decision making, and emotion processing (Karlsgodt, Sun, & Cannon, 2010). Most individuals with schizophrenia also show enlargement of the *ventricles*, spaces in the brain that are filled with cerebrospinal fluid (see Figure 11.4) (Heinrichs, 2005). They are also more likely than healthy individuals to have abnormalities in the thalamus, the traffic-control center that filters sensations and focuses attention (Andreasen et al., 1994; Gur et al., 1998). Many have deficiencies in the auditory cortex and Broca’s and Wernicke’s areas, all involved in speech perception and processing; these might explain the nightmare of voice hallucinations.

Currently, researchers have identified three contributing factors to this disorder:

1 Genetic predispositions. Schizophrenia is highly heritable. A person has a much greater risk of developing the disorder if an identical twin

develops it, even if the twins are reared apart. Children with one schizophrenic parent have a lifetime risk of 7 to 12 percent, and children with two schizophrenic parents have a lifetime risk of 27 to 46 percent, compared to a risk in the general population of only about 1 percent (Gottesman, 1991; Gottesman et al., 2010; Heinrichs, 2005). (See Figure 11.5.) Researchers all over the world are trying to identify the genes that might be involved in specific symptoms, such as hallucinations, sensitivity to sounds,

 **Simulate**
with **Schizophrenia**
Overview on
myspsychlab.com

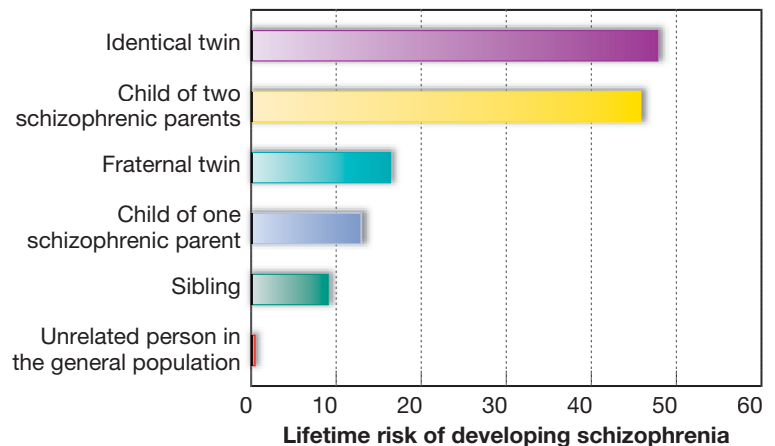


FIGURE 11.5

Genetic Vulnerability to Schizophrenia

This graph, based on combined data from 40 European twin and adoption studies conducted over seven decades, shows that the closer the genetic relationship to a person with schizophrenia, the higher the risk of developing the disorder (based on Gottesman, 1991; see also Gottesman et al., 2010).

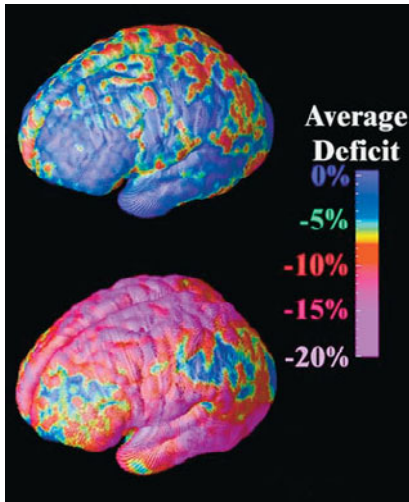


FIGURE 11.6
The Adolescent Brain and Schizophrenia

These dramatic images highlight areas of brain-tissue loss in adolescents with schizophrenia, over a five-year span. The areas of greatest tissue loss (regions that control memory, hearing, motor functions, and attention) are shown in red and magenta. A healthy brain (top) looks almost entirely blue (Thompson et al., 2001).

cognitive impairments, and social withdrawal (Desbonnet, Waddington, & O’Tuathaigh, 2009; Tomppo et al., 2009). However, efforts to find the critical genes in schizophrenia have been difficult because several appear to be involved, and those are linked not only to schizophrenia but also to bipolar disorder, depression, other mental disorders, and even dyslexia (Walker & Tessner, 2008).

2 Prenatal problems or birth complications. Damage to the fetal brain significantly increases the likelihood of schizophrenia later in life. Such damage may occur if the mother suffers from malnutrition; schizophrenia rates rise during times of famine, as happened in China and elsewhere (St. Clair et al., 2005). Damage may also occur if the mother gets the flu virus during the first four months of prenatal development, which triples the risk of schizophrenia (Brown et al., 2004; Mednick, Huttunen, & Machón, 1994). It may occur if there are complications during birth that injure the baby’s brain

or deprive it of oxygen (Cannon et al., 2000). Other nongenetic prenatal factors that increase the child’s risk of schizophrenia, especially if they combine with each other, include maternal diabetes and emotional stress, older paternal age, birth during winter months, and low birth weight (King, St-Hilaire, & Heidkamp, 2010).

3 Biological events during adolescence. In adolescence, the brain undergoes a natural pruning

away of synapses. Normally, this pruning helps make the brain more efficient in handling the new challenges of adulthood. But it appears that schizophrenic brains aggressively prune away too many synapses, which may explain why the first full-blown schizophrenic episode typically occurs in adolescence or early adulthood. Healthy teenagers lose about 1 percent of the brain’s gray matter between ages 13 and 18. But as you can see in Figure 11.6, in a study that tracked the loss of gray matter in the brain over five years, adolescents with schizophrenia showed much more extensive and rapid tissue loss, primarily in the sensory and motor regions (Thompson et al., 2001). “We were stunned to see a spreading wave of tissue loss that began in a small region of the brain,” said Paul Thompson, who headed the study. “It moved across the brain like a forest fire, destroying more tissue as the disease progressed.”

Thus the developmental pathway of schizophrenia is something of a relay. It starts with genetic predispositions, which may combine with prenatal risk factors or birth complications that affect brain development. The resulting vulnerability then awaits the next stage, synaptic pruning within the brain during adolescence (Walker & Tessner, 2008). Then, according to the vulnerability-stress model of schizophrenia, these biological changes usually interact with an environmental stressor to trigger the disease. This model explains why one identical twin may develop schizophrenia but not the other: Both may have a genetic susceptibility, but only one may have been exposed to other risk factors in the womb, birth complications, or stressful life events. These factors may combine in different ways as well, explaining why some schizophrenics recover and others do not.

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Quick Quiz

The following quiz is not a hallucination.

1. What are the five major kinds of symptoms in schizophrenia?
2. What are the three likely stages in the “relay” that produces schizophrenia?

Answers:

1. delusions, hallucinations, disorganized speech, inappropriate behavior, and impaired cognitive abilities 2. genetic predispositions, prenatal risk factors or birth complications, and excessive pruning of synapses in the brain during adolescence

Psychology in the News **REVISITED**

We have come to the end of a long walk along the spectrum of psychological problems: from those that cause temporary difficulty, such as occasional anxiety or “caffeine-induced sleep disorder,” to others that are severely disabling, such as major depression and schizophrenia. Where on this spectrum would you place “sex addiction,” the popular label for the behavior of the many men (and some women) whose sexual behavior has gotten them in trouble?

One of the great questions generated by all diagnoses of mental disorder concerns personal responsibility. In law and in everyday life, many people reach for a psychological reason to exonerate themselves of responsibility for their actions. Romance writer Janet Dailey was once caught having plagiarized whole passages from another writer’s work, and in self-defense she said she was suffering from “a psychological problem that I never even suspected I had.” We wonder if it was in the DSM! But would it matter if it were? What “psychological problem” would absolve a person of responsibility for cheating?

Similarly, many people nowadays claim they are “addicted” to some behavior, whether it is having sex, shopping, or eating chocolate, as an excuse for some habit that is unethical, self-defeating, or fattening. Is their behavior really an addiction in the same way that drug addiction is? As we saw in the opening story, psychologists disagree on the answer. The DSM-V’s proposed new diagnosis of “hypersexual behavior” would apply to people who repeatedly engage in sexual fantasies and behaviors in response to stress, anxiety, or depression; who lack concern for the physical or emotional harm they cause themselves or others; and who claim they are unable to break their craving for sexual activity. But others believe that *any* behavior can fit this description and that most everyday “addictions” are not mental disorders; they are simply a person’s self-justifying way of getting off the hook. Indeed, having many sexual affairs is often considered perfectly normal behavior for rich, powerful celebrities and politicians. It only seems to become a “disorder” when their partner finds out.

Now consider the tragic story of Andrea Yates, a Texas woman who killed her five young children. Yates had suffered from clinical depression and psychotic

episodes for years, and had tried to kill herself twice. Her father, two brothers, and a sister had also suffered from mental illness. Yates was overwhelmed by raising and homeschooling all of her children by herself, with no help from her reportedly domineering husband, who permitted her two hours a week of personal time. Although she suffered a postpartum psychotic episode after the birth of their fourth child and a clinical psychologist warned against her having another baby, her husband refused to consider birth control, although not for religious reasons. Yates was convicted of murder and sentenced to life in prison; the jury rejected her claim that she was so psychotic that she thought she was saving the souls of her children by killing them. Four years later, on appeal, another jury found her not guilty by reason of insanity and she was sent to a mental institution.

Does Andrea Yates deserve our condemnation for her horrible acts of murder or our pity? Before you answer, you might keep this interesting evidence in mind: Many people feel angrier and less sympathetic toward people whose mental illnesses conform to gender stereotypes, such as men who are alcoholic and women who are depressed. They are more sympathetic to people whose illnesses do not conform to the stereotype—alcoholic women and depressed men (Wirth & Bodenhausen, 2009). Apparently, many people think that gender-typical mental disorders are less likely to be “real.”

When thinking about the relationship of mental disorder to personal responsibility, therefore, we face a dilemma, one that requires us to tolerate uncertainty. The law recognizes, rightly, that people who are mentally incompetent, delusional, or disturbed should not be judged by the same standards as mentally healthy individuals. At the same time, society has an obligation to protect its citizens from harm and to reject easy excuses for violations of the law. To balance these two positions, we need to find ways to ensure first, that people who commit crimes or behave reprehensibly face the consequences of their behavior, and second, that people who are suffering from psychological problems have the compassionate support of society in their search for help. After all, psychological problems of one kind or another are challenges that all of us will face at some time in our lives.



Taking Psychology with You

When a Friend Is Suicidal

Suicide can be frightening to those who find themselves fantasizing about it, and it is devastating to the family and friends of those who go through with it. In the United States, suicide is the third leading cause of death among people ages 10 to 24, after accidents and homicides. Every year, more than 1,000 college students commit suicide, and thousands more make an unsuccessful attempt. The group at highest risk of suicide is American Indian men, and the group at lowest risk is African-American women (Goldston et al., 2008).

Women are more likely than men to attempt suicide, primarily as a cry for help, whereas men are four times more likely than women to succeed. Moreover, men's efforts to commit suicide are not always obvious: Some men provoke confrontations with the police, hoping to be shot; some intentionally kill themselves in car accidents; and men are more likely than women to destroy themselves with drugs.

Because of the many widespread myths about suicide, it is important to become informed and know what to do in a crisis:

Take all suicide threats seriously. Some people assume they can't do anything when a friend talks about committing suicide. "He'll just do it at another place, another time," they think. In fact, most suicides occur during an acute crisis. Once the person gets through the crisis, the desire to die fades. Others believe that if a friend is talking about committing suicide, he or she won't really do it. This belief also is false. Few people commit suicide

without signaling their intentions. Most are ambivalent: "I want to kill myself, but I don't want to be dead—at least not forever." Most suicidal people want relief from the terrible pain of feeling that nobody cares and that life is not worth living. Getting these thoughts and fears out in the open is crucial.

Know the danger signs. One team of psychologists who specialize in the study of suicide looked up the "warning signs of suicide" that can be found on the Internet. The search turned up more than 75 supposed indicators, many of them vague or questionable, such as "perfectionism," "loss of security," "neurotransmitters," and "loss of religious faith." In fact, only a few core factors are crucial in predicting a person's risk of trying to commit suicide: The person feels hopeless, feels alienated and profoundly disconnected from other people, and believes that he or she is a burden to loved ones (Joiner, 2005; Mandrusiak et al., 2006; van Orden et al., 2006).

Get involved: Ask questions and get help. If you believe a friend is suicidal, do not be afraid to ask, "Are you thinking of suicide?" This question does not "put the idea" in anyone's mind. If your friend is contemplating the action, he or she will probably be relieved to talk about it, which in turn will reduce feelings of isolation and despair. Don't try to talk your friend out of it by debating whether suicide is right or wrong, and don't put on phony cheerfulness. If your friend's words scare you, say so.

By allowing your friend to unburden his or her grief, you help the person get through the immediate crisis.

Do not leave your friend alone. If necessary, get the person to a clinic or a hospital emergency room, or call a local suicide hotline. Don't worry about doing the wrong thing. In an emergency, the worst thing you can do is nothing at all.

If you are the one who is contemplating suicide, remember that you are not alone and that help is a phone call or an email away. You can call the national hotline number, 1-800-273-TALK, or your school's counseling services. For more information, the Centers for Disease Control and Prevention have a website that provides facts about suicide (www.cdc.gov/safeusa/suicide.htm). Many students fear to get help because they think no one will understand, or they fear they will be made fun of by their friends, or they believe they cannot be helped. Wrong, wrong, wrong.

In her book *Night Falls Fast: Understanding Suicide*, Kay Jamison (1999), a psychologist who suffers from bipolar disorder, explored this difficult subject from the standpoint both of a mental health professional and of a person who has been there. In describing the aftermath of her own suicide attempt, she wrote: "I do know... that I should have been dead but was not—and that I was fortunate enough to be given another chance at life, which many others were not."

Summary

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Defining and Diagnosing Mental Disorders

- When defining *mental disorder*, mental health professionals emphasize the emotional suffering caused by the behavior, whether the behavior is harmful to others or society, and its degree of “harmful dysfunction.”
- *The Diagnostic and Statistical Manual of Mental Disorders (DSM)* is designed to provide objective criteria and categories for diagnosing mental disorder. Critics argue that the diagnosis of mental disorders, unlike those of medical diseases, is inherently a subjective process that can never be entirely objective. They believe the DSM fosters overdiagnosis; overlooks the power of being given a diagnostic label; confuses serious mental disorders with everyday problems in living; and creates an illusion of objectivity.
- Supporters of the DSM believe that when the DSM criteria are used correctly and when empirically validated objective tests are used, reliability in diagnosis improves. The DSM now lists many *culture-bound syndromes* in addition to universal disorders such as depression, panic attacks, anorexia, and schizophrenia.
- In diagnosing psychological disorders, clinicians often use *projective tests* such as the Rorschach inkblot test or, with children, the use of anatomically detailed dolls. These methods have low reliability and validity, creating problems when they are used in the legal arena, as in custody disputes, or in diagnosing disorders. In general, *objective tests (inventories)*, such as the *MMPI*, are more reliable and valid than projective ones.

Anxiety Disorders

- *Generalized anxiety disorder* involves continuous, chronic anxiety and worry. When anxiety results from exposure to uncontrollable or unpredictable danger, it can lead to *posttraumatic stress disorder (PTSD)*, which involves mentally reliving the trauma, emotional detachment, and increased physiological arousal.
- Most people who live through a traumatic experience eventually recover, but a minority develop PTSD. The reasons for their increased vulnerability to traumatic events include genetic vulnerability; a history of psychological problems; a lack of social and cognitive resources; and having a smaller hippocampus than normal.
- *Panic disorder* involves sudden, intense attacks of profound fear. Panic attacks are common in the aftermath of stress or frightening experiences; those who go

on to develop a disorder tend to interpret the attacks as a sign of impending disaster.

- *Phobias* are unrealistic fears of specific situations, activities, or things. Common *social phobias* include fears of speaking in public, eating in a restaurant, or having to perform for an audience. *Agoraphobia*, the fear of being away from a safe place or person, is the most disabling phobia—a “fear of fear.” It often begins with a panic attack, which the person tries to avoid in the future by staying close to “safe” places or people.
- *Obsessive-compulsive disorder (OCD)* involves recurrent, unwished-for thoughts or images (obsessions) and repetitive, ritualized behaviors (compulsions) that a person feels unable to control. Some people with OCD have abnormalities in an area of the prefrontal cortex, which may contribute to their cognitive and behavioral rigidity. Parts of the brain involved in fear and responses to threat are also more active than normal in people with OCD; the “alarm mechanism,” once activated, does not turn off when danger is past. One kind of OCD creates pathological hoarding and may involve deficiencies in other parts of the brain.

Mood Disorders

- Symptoms of *major depression* include distorted thinking patterns, feelings of worthlessness and despair, physical ailments such as fatigue and loss of appetite, and loss of interest in once-pleasurable activities. In severe cases, the feelings of worthlessness or “being a burden” to others can lead to suicide attempts, most of which are not repeated once the acute phase passes. Women are twice as likely as men to suffer from major depression, but depression in men may be underdiagnosed. In *bipolar disorder*, a person experiences episodes of both depression and *mania* (excessive euphoria). It is equally common in both sexes.
- *Vulnerability-stress models* of depression look at interactions between individual vulnerabilities and stressful experiences. The theory that depleted serotonin, perhaps caused by a genetic variant, causes depression has not been supported, but because depression is moderately heritable, the search for specific genes continues. For some vulnerable individuals, repeated losses of important relationships can set off episodes of major depression. Experiences with parental neglect and violence, especially in childhood, increase the risk of developing major depression in adulthood. Cognitive habits also play an important role: believing that the origin of one’s unhappiness is permanent and uncontrollable; feeling hopeless and pessimistic; and brooding or *ruminating* about one’s problems.

Antisocial/Psychopathic Personality Disorder

- Personality disorders are characterized by maladaptive traits that cause distress or an inability to get along with others. One, *borderline personality disorder*, is characterized by impulsiveness, self-mutilating behavior, feelings of emptiness, and a fear of abandonment by others.
- The term *psychopath* describes people who lack conscience and empathy; they do not feel remorse, shame, guilt, or anxiety over wrongdoing, and they can con others with ease. *Antisocial personality disorder (APD)* applies to people with a pattern of aggressive, reckless, impulsive, and often criminal behavior. The DSM-V is likely to combine these overlapping disorders under one label, *antisocial/psychopathic personality disorder*. Abnormalities in the central nervous system and prefrontal cortex are associated with lack of emotional responsiveness and with impulsivity. A genetic predisposition also plays a role in these disorders, but it usually must interact with stressful or violent environments to be expressed.

Drug Abuse and Addiction

- Signs of *substance abuse* include impaired ability to work or get along with others, use of the drug in hazardous situations, recurrent arrests for drug use, and conflicts with others caused by drug use.
- According to the *biological model* of addiction, some people have a genetic vulnerability to the kind of alcoholism that begins in early adolescence and is linked to impulsivity, antisocial behavior, and criminality. Genes also affect sensitivity to alcohol, which varies across ethnic groups as well as among individuals. But heavy drug abuse also changes the brain in ways that make addiction more likely.
- Advocates of the *learning model* of addiction point out that addiction patterns vary according to cultural practices and values; that policies of total abstinence tend to increase addiction rates and abuse because people who want to drink fail to learn how to drink in moderation; that many people can stop taking drugs without experiencing withdrawal symptoms; and that drug abuse depends on the reasons for taking a drug.
- The biological and learning models are polarized on many issues, notably that of abstinence versus moderation. People who are most likely to abuse alcohol and other drugs have a genetic vulnerability or prolonged drug use has damaged their brains; they believe that they have no control over the drug; their culture or peer group promotes drug abuse; and they rely on the drug to cope with problems.

Dissociative Identity Disorder

- In *dissociative identity disorder* (formerly called *multiple personality disorder*, or *MPD*), two or more distinct personalities and identities appear to split off (*dissociate*) within one person. Some clinicians think the disorder is legitimate and originates in childhood trauma. But most clinicians hold a *sociocognitive* explanation—that MPD is an extreme form of the ability to present different aspects of our personalities to others. In this view, the disorder emerges from pressure and suggestion by clinicians who believe in its prevalence, interacting with vulnerable patients who find MPD a plausible explanation for their problems, thereby creating a culture-bound syndrome. Media coverage of sensational alleged cases of MPD greatly contributed to the rise in the number of cases after 1980.

Schizophrenia

- *Schizophrenia* is a psychotic disorder involving delusions, hallucinations, disorganized speech (called “word salads”), inappropriate behavior, and severe cognitive impairments. Other symptoms, such as loss of motivation to take care of oneself and emotional flatness, may appear before a psychotic episode and persist even when the more dramatic symptoms are in remission. Some people with schizophrenia fall into a *catatonic stupor*. Contrary to stereotype, however, many people with schizophrenia recover.
- Schizophrenia is a brain disease that involves certain structural brain abnormalities, such as reduced gray matter, abnormalities in the hippocampus, and enlarged ventricles, as well as abnormalities in neurotransmitters and neuronal connections. In the “relay” that produces the disorder, genetic predispositions interact with prenatal problems (such as the mother’s malnutrition or a prenatal viral infection) or birth complications, and excessive pruning of synapses during adolescence.

Psychology in the News, Revisited

- The diagnosis of mental disorder raises important questions for personal responsibility in the law and everyday life. When people claim to have a mental disorder, psychologists and others struggle to decide whether the claim is an excuse for illegal, unethical, or destructive behavior, or whether these individuals truly have a disorder that reduces their ability to control their behavior.

Key Terms

- mental disorder **371**
Diagnostic and Statistical Manual of Mental Disorders (DSM) **371**
 culture-bound syndromes **373**
 projective tests **374**
 Rorschach inkblot test **374**
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Defining and Diagnosing Mental Disorders

It is very difficult to define **mental disorder**, but most mental health professionals agree that it is any condition that causes a person to suffer, is self-destructive, seriously impairs a person's ability to work or get along with others, or endangers others or the community.

Dilemmas of Diagnosis

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is designed to provide criteria and categories for diagnosing mental disorders.

Problems with the DSM include:

- Dangers of overdiagnosis
- The influence of diagnostic labels themselves
- The confusion of serious mental disorders with everyday problems
- The illusion of objectivity and universality

Advantages of the DSM include:

- Efforts to improve reliability in diagnosis
- Identification of many universal disorders, as well as **culture-bound syndromes**

Measuring Disorders

Projective tests, such as the *Rorschach inkblot test*, have low reliability and validity.

Objective tests (inventories), such as the *Minnesota Multiphasic Personality Inventory (MMPI)*, have high reliability and validity.

Mood Disorders

- **Major depression** involves prolonged grief, hopelessness, and loss of energy, appetite, and interest in activities.
- **Bipolar disorder** involves episodes of both depression and mania (excessive euphoria).

Origins of Depression

Vulnerability-stress models of depression look at interactions between individual vulnerabilities and stressful experiences.

VULNERABILITY-STRESS MODEL OF DEPRESSION

Upsetting events

- Loss of loved one
- Loss of job
- Failure
- Trauma
- Violence

Individual vulnerability

- Genetic predisposition
- History of insecure attachment
- Negative ways of thinking
- Hopelessness
- Brooding rumination
- Low self-esteem

↓
Temporary unhappiness

↓
SEVERE DEPRESSION

Four main factors may contribute to major depression:

1. Genetic factors that may protect against depression or create a predisposition toward it
2. Experiences with violence, childhood physical abuse, and parental neglect
3. Losses of important relationships
4. Cognitive habits, such as believing that unhappiness is permanent and uncontrollable, ruminating about problems, and feeling hopeless

Anxiety Disorders

- **Generalized anxiety disorder** involves continuous chronic anxiety.
- **Posttraumatic stress disorder** involves reliving the trauma in recurrent, intrusive thoughts; a sense of detachment; and increased physiological arousal.
- **Panic disorder** involves sudden, intense attacks of profound fear.
- **Phobias** are unrealistic fears of specific situations, activities, or things, or, in the case of **agoraphobia**, being away from a safe place.
- **Obsessive-compulsive disorder (OCD)** involves recurrent, unwished-for thoughts or images (*obsessions*) and repetitive, ritualized behaviors (*compulsions*).

Drug Abuse and Addiction

Substance Abuse

Signs of substance abuse:

- Impaired ability to work or get along with others
- Use of the drug in hazardous situations
- Conflicts with others caused by drug use

Learning, Culture, and Addiction

The *biological model* holds that some people are genetically predisposed to addiction, or develop addictions as a result of the biological changes in the brain caused by heavy drug abuse.

The *learning model* holds that most kinds of addiction stem from conditions that encourage or discourage drug abuse. Evidence:

1. Addiction patterns vary according to culture.
2. Abuse increases under policies of total abstinence, because people do not learn to drink moderately.
3. Many people stop taking drugs without withdrawal symptoms.
4. Drug abuse depends on the reasons for taking the drug.

Personality disorders are characterized by rigid, self-destructive traits that cause distress or an inability to get along with others, such as with **borderline personality disorder**.

Antisocial/Psychopathic Personality Disorder

- **Psychopathy** is an inability to feel normal social and moral emotions. Psychopaths are incapable of remorse, shame, guilt, and empathy, and lack the ability to fear punishment.
- **Antisocial personality disorder** describes people who repeatedly break the law, are impulsive and violent, and show reckless disregard for their own safety or that of others.
- Debate continues about the extent to which these two disorders overlap. However, certain factors are involved in the central features of psychopathy and of being a lifelong violent offender:
 - Abnormalities in the CNS
 - Impaired frontal-lobe functioning
 - Genetic influences
 - Environmental events

Dissociative Identity Disorder

Dissociative identity disorder, formerly called multiple personality disorder (MPD), involves two or more identities that appear to split off within one person.

- Some clinicians believe MPD is common and originates in childhood trauma; others believe that most cases result from suggestion by clinicians themselves.
- Media coverage has contributed to the rise in MPD diagnoses.
- The sociocognitive explanation of MPD holds that it is simply an extreme form of the ability we all have to present different aspects of our personalities to others.

Schizophrenia

Schizophrenia is a fragmented condition in which words are split from meaning, actions are split from motives, and perceptions are split from reality. It is a form of **psychosis**, a mental condition that involves distortions of reality and inhibits one's ability to function in everyday life.

Symptoms of schizophrenia:

- Bizarre delusions
- Hallucinations, sometimes visual but usually auditory
- Disorganized, incoherent speech ("word salads")
- Disorganized and inappropriate behavior
- Impaired cognitive abilities

Causes of Schizophrenia

Schizophrenia involves abnormalities in the brain, including a decrease in the volume of the temporal lobe or hippocampus, reduced numbers of neurons in the prefrontal cortex, and enlargement of the *ventricles*, spaces in the brain that are filled with cerebrospinal fluid.

Causes of this disease include:

1. Genetic predispositions
2. Prenatal problems or birth complications
3. Adolescent abnormalities in brain development

