Chapter Fourteen
PSYCHOLOGICAL DISORDERS

Review of Key Ideas

ABNORMAL BEHAVIOR: MYTHS, REALITIES, AND CONTROVERSIES

1. Evaluate the medical model and identify the most commonly used criteria of abnormality.

1-1. A model is a metaphor or theory that is useful in describing some phenomenon. For example, the computer is frequently used as a model of thinking. The *medical model* uses physical illness as a model of psychological disorders. Under the medical model, maladaptive behavior is referred to as mental _____.

1-2. The term "mental illness" is so familiar to all of us that we rarely question its use. Is the analogy with disease useful? Among the model's critics, Thomas Szasz asserts that words such as *sickness*, *illness*, and *disease* are correctly used only in reference to the (body/mind) and that it is more appropriate to view abnormal behavior as a deviation from accepted social _____ than as an illness.

1-3. Still, medical terminolgy (e.g., diagnosis, etiology, prognosis) has proven useful in the treatment of psychological disorders. While there are problems with the medical model, the text takes the position that it may be of value as long as one understands that it is just a(n) _____ and not a true explanation.

1-4. Who is to judge, and how do we judge, what's abnormal? It's a complex question, but the three criteria used most frequently by mental health professionals are *deviance*, *maladaptive behavior*, and *personal distress*.

(a) _____: Does not *conform* to cultural norms or standards.

(b) _____: Behavior that *interferes with* the individual's social or occupational functioning.

(c) _____: Intense *discomfort* produced by depression or anxiety.

1-5. Following are three statements that describe a person with a particular type of disorder. Which criterion of abnormal behavior is illustrated by each statement? Place the letters from the list above in the appropriate blanks.

____ Ralph washes his hands several dozen times a day. His handwashing interferes with his work and prevents him from establishing normal friendships.

____ Even if Ralph's handwashing compulsion did not interfere with his work and social life, his behavior still would be considered strange. That is, most people do not do what he does.

____ It is also the case that Ralph's skin is very raw, and he becomes extremely anxious when he does not have immediate access to a sink.

1-6. What are the conclusions from this section? Mark T or F for the following.

____ The criteria for assessing mental illness are as culture-free as those for judging physical illness.

____ The criteria for assessing mental illness reflect scientific information, but diagnosis of psychological disorders involves value judgments.

____ Cultural trends and political forces may influence judgments of abnormality.

____ The difference between normal and abnormal is not a clear-cut separation but exists along a continuum of frequency and severity.

2. List three stereotypes of people with psychological disorders.

2-1. In the space below, list three stereotypes of people with psychological disorders:

(a) The disorders are _____. (In fact, the vast majorityget better, either spontaneously or with formal treatment.)

(b) People with the disorders are _____ and dangerous. (Most are not, but media attention tends to focus on those who are.)

(c) People with the disorders behave in a bizarre manner and are very _____ from normal people. (For the most part, most people classified with some sort of disorder behave normally most of the time.)

3. Outline the history and structure of the DSM diagnostic system.

3-1. Suppose you are talking to someone about a person you describe as anxious. What do you mean by anxious? Are the two of you talking about the same behaviors? To facilitate communication, especially among clinicians and researchers, the American Psychiatric Association developed a specific classification system, the _____ and Statistical Manual of Mental Disorders, or _____.

3-2. The original DSM-I, published in 1952, was fairly vague. The version published in 1980, the DSM-III, was considered a major advance because the diagnostic criteria were made much more _____. The current version, the DSM-IV published in 1992, describes _____ times as many disorders as the DSM-I. A new version, the _____, is scheduled for publication in 2011.

3-3. Below are descriptions of the five axes of the DSM-IV classification system. Label each with the correct axis number (I through V).

____ Notes concerning the severity of stress experienced by the individual in the past year

____ Estimates of the individual's current level of adaptive functioning (social and occupational)

____ Diagnosis of most types of mental disorders

____ Diagnosis of long-running personality disorders or mental retardation

____ Listing of physical disorders

4. Discuss estimates of the prevalence of psychological disorders.

4-1. What percentage of people will exhibit a mental disorder at some point during their lifetime? In other words, what is the lifetime _____ of mental disorders in our population? If drug-related disorders are included, recent estimates range from 44 to 51%.

4-2. Estimates of prevalence are complicated by several factors (e.g., when do normal difficulties become a disease?), but recent studies do show an increase in lifetime prevalence. High prevalence has economic consequences that include not only the estimated $150 billion annual cost for _____ of the disorders but an estimated loss of more than 1.3 billion days of productive _____.

4-3. The most common disorders are *mood*, *anxiety*, and *substance use* disorders (including alcoholism). List these below in order of prevalence.

_____

_____

_____

ANXIETY DISORDERS

5. Identify five anxiety disorders and describe the symptoms associated with each.

5-1. List the names of the four anxiety syndromes in the space below. (The initial letters of key words are listed at the left.)

GAD: _____

PD: _____

OCD: _____

PDA: _____ and _____

PTSD: _____

5-2. Match the anxiety disorders with the symptoms that follow by placing the appropriate letters (from the previous question) in the blanks.

(a) _____ Sudden, unexpected, and paralyzing attacks of anxiety

(b) _____ Not tied to a specific object or event

(c) _____ Senseless, repetitive rituals

(d) _____ Brooding over decisions

(e) _____ Fear of specific objects or situations

(f) _____ Persistent intrusion of distressing and unwanted thoughts

(g) _____ Free-floating anxiety

(h) _____ Frequently includes fear of going out in public

(i) _____ Nightmare, flashbacks, and anxiety that may follow traumatic events.

6. Discuss the role of biological factors and conditioning in the etiology of anxiety disorders.

6-1. There appears to be a weak inherited predisposition to anxiety disorders. For example, twin studies find higher concordance rates for anxiety among _____ twins than _____ twins. Studies of infant temperament (Kagan) indicate that the approximately 15-20 percent of infants with an _____ temperament (shy, timid, wary) are at higher risk for developing an anxiety disorder later in life.

6-2. Other biological evidence suggests disturbances at the synapse. Drugs taken for anxiety (e.g., tranquilizers) appear to affect _____ (such as GABA and serotonin) that carry signals from one neuron to another.

6-3. Conditioning or learning clearly plays a role as well. For example, a person bitten by a dog may develop a fear of dogs through the process of _____ conditioning and then avoid dogs in the future, a response maintained by _____ conditioning.

6-4. In his concept of _____ Seligman maintains that we are biologically prepared to fear things that were threats in our evolutionary history. More recently, Ohman and Mineka have referred to preparedness as an *evolved* _____ *for fear learning* that produces reactions that are intense, hard to suppress, and condition more rapidly.

6-5. Research supports these writers' contention that our evolutionary history has prepared us to be more readily conditioned to fear:

a. ancient sources of threat, such as snakes.

b. modern sources of threat, such as hot irons.

6-6. Critics note problems with the conditioning model. For example (answer true/false):

____ People with phobias frequently cannot recall the traumatic incident.

____ People who experience extreme traumas do not always develop phobias.

7. Discuss how cognitive factors and stress can contribute to the development of anxiety disorders.

7-1. Cognitive theorists indicate that certain *thinking styles* contribute to anxiety. For example, as indicated in your text, the sentence "The doctor examined little Emma's growth" could refer either to height or to a tumor. People who are high in anxiety will tend to respond with the (tumor/height) interpretation.

7-2. Finally, *stress* is related to anxiety disorders. Studies described in your text indicate that stress is related both to _____ disorder and to the development of social _____.

SOMATOFORM DISORDERS

8. Distinguish among three somatoform disorders.

8-1. For each of the following symptoms, indicate which disorder is described by placing the appropriate letters in the blanks: S for somatization, C for conversion, and H for hypochondriasis.

____ Serious disability that may include paralysis, loss of vision or hearing, loss of feeling, and so on.

____ Many different minor physical ailments accompanied by a long history of medical treatment.

____ Cannot believe the doctor's report that the person is not really ill.

____ Symptoms that appear to be organic in origin but don't match underlying anatomical organization.

____ Diverse complaints that implicate many different organ systems.

____ Usually does not involve disability so much as overinterpreting slight, possible signs of illness.

____ "Glove anesthesia;" seizures without loss of bladder control.

8-2. In the film *Hannah and Her Sisters,* Woody Allen is convinced that certain minor physical changes are a sign of cancer. When tests eventually find no evidence of cancer, he is sure the tests have been done incorrectly. Which of the somatoform disorders does this seem to represent? _____

8-3. Mark the following T or F.

____ Somatoform disorders involve malingering or deliberate faking of an illness.

____ Some cases diagnosed as somatoform disorders are eventually found to have organic causes.

____ Because of diagnostic ambiguities some theorists argue that the category somatoform disorders should be eliminated from the DSM-V.

9. Analyze how personality, cognitive factors, and the sick role contribute to somatoform disorders.

9-1. What causes somatoform disorders? Personality, cognitive style, and learning appear to be more important than genetic inheritance. Individuals who score high on the Big Five trait of _____, as well as those who experienced an insecure _____ style in childhood, are somewhat more likely to develop somatoform disorders.

9-2. Cognition, the way people think about normal bodily processes, also appears to play a role. For example, some people tend to (catastrophize/minimize) minor bodily changes.

9-3. In addition, the "sick role" may provide a convenient excuse for failing to face some of life's problems. Complaints of physical illness also may be reinforced in the sense that they may produce _____ from other people.

DISSOCIATIVE DISORDERS

10. Distinguish among three dissociative disorders.

10-1. Dissociative (amnesia/fugue) refers to loss of memory surrounding a single event or period of time. Dissociative _____ is a more massive forgetting in which people forget their entire past lives and identity.

10-2. Helen wakes up in the hospital after a serious car accident. She knows her name, recognizes her family, and remembers most past events but recalls nothing of the accident or events surrounding the accident. She shows the characteristics of dissociative (amnesia/fugue).

10-3. Dave is found wandering. He doesn't recognize his wife or children and remembers nothing of his past life. Dave remembers how to drive a car and speak a foreign language, but he doesn't know who he is, where he lives, where he works. Dave has the characteristics of dissociative _____.

10-4. Beth has two distinct personalities, one shy and inhibited and the other boisterous and extraverted. Each self is equipped with a different voice, vocabulary, and gestures. Without warning, she will switch from one to the other. Still widely known as _____-personality disorder, this disorder is referred to as _____ _____ disorder (DID) in the DSM-IV.

10-5. ____ (true/false) Dissociative identity disorder is appropriately referred to as schizophrenia.

11. Discuss the etiology of dissociative identity disorder.

11-1. The diagnosis of dissociative identity disorder (DID) is controversial. Although many clinicians believe that the disorder is authentic, Spanos argues that it is the product of media attention and the misguided probings of a small minority of psychotherapists. In other words, Spanos believes that DID (or MPD) (is/is not) a genuine disorder.

11-2. While the majority of people with DID report having been rejected by their parents and physically and sexually _____ in childhood, little is known about possible causes of this controversial diagnosis.

11-3. In a recent survey of American psychiatrists, a majority (i.e., three-fourths) of those polled indicated that there (is/is not) enough scientific evidence to warrant including DID as a valid diagnostic category.

MOOD DISORDERS

12. Describe the two major mood disorders and their relation to suicide.

12-1. The two basic types of mood disorder are *unipolar* and *bipolar*. Bipolar disorder is characterized by _____ and _____ episodes (excitement and elation) and unipolar disorder by only one end of the mood continuum, _____.

12-2. While the terms *manic* and *depressive* describe mood, they refer to a number of other characteristics as well, including those listed below. Place M or D in the appropriate blanks next to the examples that frequently characterize these episodes. (Before you do this, it may be a good idea to review Table 14.1.)

____ Elated, euphoric.

____ Difficulty sleeping, decreased sex drive, decreased appetite.

____ Slow moving, slow thinking, lacks energy, sluggish.

____ Unable to make decisions.

____ Tireless, energetic, increased sex drive.

____ Racing thoughts, impulsive, confident.

____ Negative self-image, self-blame, guilt.

____ Stops engaging in activities previously found enjoyable.

12-3. Mark T or F for the following.

____ A majority of cases of depression emerge after age 40.

____ Milder versions of depression are known by the term dysthymic disorder.

____ Milder versions of bipolar disorder are termed cyclothymic disorder.

____ Manic states may bring an energy and confidence that seem attractive, but they usually escalate to levels that become scary and dangerous .

____ Bipolar disorders are relatively rare, occurring in 1% to 2.5% of the population.

____ Bipolar disorder is much more common in men.

____ Depressive disorder is about twice as common in women as in men.

____ The average age of onset of bipolar disorder is about age 25.

____ Bipolar disorder was formerly known by the name manic-depressive disorder.

12-4. Mark T or F for the following.

____ About 60% of completed suicides are accounted for by people with mood disorders.

____ Studies indicate that the lifetime risk of suicide for people with mood disorders is in the range of about 10-20%.

12-5. Mark T or F for the following.

____ Attempted suicide is much more frequent in women than men.

____ Completed suicide is much more frequent in women than men.

____ Suicides peak in the 15-25 age group.

13. Clarify how genetic, neurochemical, and neuroanatomical factors are related to the development of mood disorders.

13-1. Twin studies implicate genetic factors in the development of mood disorders. Concordance rates for _____ twins are much higher than those for _____ twins, about 65% versus 14%.

13-2. Brain chemistry is involved as well. Correlations have been found between mood disorders and abnormal levels of the _____ in the brain, especially norepinephrine and serotonin.

13-3. There may also be a neuroanatomical basis for depression. One of the brain structures involved in memory consolidation, the _____, tends to be about 8%-10% smaller in depressed subjects.

13-4. Recent studies have found that the brain, and especially the hippocampus, tends to generate new neurons in adulthood, a process termed _____. An interesting new theory maintains that major life stress causes suppression of neurogenesis, and that suppression of neurogenesis is the central cause of _____.

13-5. According to this new theory, drugs that elevate serotonin relieve depression because serotonin promotes (transmission across/growth of) neurons in the hippocampus. Research on this model continues.

14. Explain how cognitive factors can promote depression and describe the Featured Study on negative thinking and depression.

14-1. Martin Seligman authored the learned _____ model of depression. Originally based on an animal conditioning model involving exposure to unavoidable aversive stimuli, Seligman's theory has more recently emphasized (cognitive/behavioral) factors.

14-2. According to Seligman, the way that people explain negative events, their explanatory styles, has a strong relationship to depression, so that people with a _____ explanatory style are particularly prone to depression. For example, people who attribute obstacles to (situational factors/personal flaws) are more likely to experience depression.

14-3. In line with the cognitive explanation of depression, Susan Nolen-Hoeksema has found that people who repetitively focus or _____ about their depression are more likely to remain depressed than people who distract themselves. Women tend to ruminate more than men do, according to Nolen-Hoeksema, which may be one reason why (men/women) have higher rates of depression.

14-4. Other researchers have also found negative thinking to be a factor in depression. In the featured study, for example, scores on a test indicating _____ thinking (among currently non-depressed freshmen) predicted later depressive episodes during a 2.5 year follow-up.

14-5. Does negative thinking cause depression? One can't make a definitive conclusion about causality because the study is correlational, but the fact that the study was _____ rather than retrospective lends support to a causal interpretation.

15. Outline the role of interpersonal factors and stress in the development of mood disorders.

15-1. Depressed people tend to lack _____ skills, which diminishes people's capacities to obtain important _____, including good friends and desirable jobs.

15-2. Why do people tend to reject depressed people?

15-3. Recent evidence finds (almost no/a moderately strong) link between stress and the onset of mood disorders.

SCHIZOPHRENIC DISORDERS

16. Review the general characteristics of schizophrenia.

16-1. Following are general characteristics of the schizophrenic disorders:

(a) Irrational _____, including the false beliefs referred to as _____ (e.g., the idea that one is a famous political figure being pursued by secret agents, when that is not in fact true).

(b) Deterioration of _____ behavior, including social relationships (friends, co-workers), work, and neglect of personal _____.

(c) Distorted _____, hearing or sometimes seeing things that aren't really there, sensory experiences known as _____.

(d) Disturbed _____, with little or no emotional responsiveness, referred to as _____ affect, or else by showing _____ emotional responses, such as laughing at news of a tragic death.

17. Outline the classification of schizophrenic subtypes and the course of schizophrenia.

17-1. Write the names of the four recognized subcategories of schizophrenia next to the descriptions that follow.

(a) _____ type: Particularly severe deterioration, incoherence, complete social withdrawal, aimless babbling and giggling, delusions centering on bodily functions.

(b) _____ type: Muscular rigidity and stupor at one extreme or random motor activity, hyperactivity, and incoherence at the other; now quite rare.

(c) _____ type: Delusions of persecution and grandeur.

(d) _____ type: Clearly schizophrenic but doesn't fit other three categories.

17-2. Critics have asserted that there are no meaningful differences among the four traditional categories and have proposed an alternative classification system with only two categories, one consisting of _____ symptoms and the other of _____ symptoms.

17-3. In Andreasen's system, "positive" and "negative" do not mean pleasant and unpleasant. Positive symptoms *add* something to "normal" behavior (like chaotic speech), and negative symptoms *subtract* something (like social withdrawal). Indicate which of the following are positive and which negative, by placing a P or an N in the appropriate blanks.

____ flattened emotions

____ hallucinations

____ bizarre behavior

____ social withdrawal

____ apathy

____ nonstop babbling

____ doesn't speak

17-4. Theorists hoped that classification of schizophrenia into positive and negative symptoms would provide more meaningful categories in terms of etiology and prognosis. Some differentiation between the two types of symptoms has been found; for example, *positive* symptoms seem to be associated with (better/worse) adjustment prior to the onset of schizophrenia and a (better/worse) prognosis. All in all, however, this system (has/has not) produced a classification that can replace the traditional subtypes.

17-5. Mark the following T (true) or F (false).

____ Schizophrenia tends to emerge in adolescence or early adulthood.

____ Schizophrenia may have either a sudden or gradual onset.

____ About 20% of schizophrenic patients experience a full recovery.

18. Explain how genetic vulnerability and neurochemical factors can contribute to schizophrenia.

18-1. As with mood disorders, twin studies implicate genetic factors in the development of schizophrenia. In a sentence, summarize the general results of these studies.

18-2. As with mood disorders, neurotransmitter substances in the brain are implicated in the etiology of schizophrenia. Although the evidence is markedly clouded, high levels of the neurotransmitter _____ are thought to be involved. Current research is exploring possible interactions between this neurotransmitter and serotonin.

18-3. Recent research has found that _____ use during adolescence may result in schizophrenia in those with a genetic vulnerability to the disorder. This is a controversial, very preliminary finding, but the thinking is that THC, the key chemical in marijuana, may amplify activity of the neurotransmitter _____.

19. Analyze the role of structural abnormalities in the brain and neurodevelopmental processes in the etiology of schizophrenia.

19-1. Differences in brain structure, including enlargement of the fluid-filled cavities in the brain known as _____, have been found to be associated with schizophrenia. The findings are correlational, and it is not known whether schizophrenia is a cause or result of the distorted ventricles.

19-2. Recent brain-imaging studies have also found also found an association between schizophrenia and abnormalities in the _____ cortex. In schizophrenia this structure tends to be of (smaller/larger) size and (reduced/increased) metabolic activity. The findings are intriguing, since the prefrontal cortex contains a major pathway for _____, a neurotransmitter already linked to schizophrenia in other research.

19-3. The neurodevelopmental hypothesis maintains that schizophrenia is caused, in part, by disruption of normal neurological development occurring either _____ or at birth.

19-4. Among possible neurodevelopmental factors are (1) _____ infections (flu) that may occur during pregnancy; (2) prenatal _____ that occurs, for example, during famine; and (3) a history of obstetric _____ complications during pregnancy or delivery. A recent study also found a greater frequency of schizophrenia among the offspring of women who suffer (4) severe _____ during pregnancy.

20. Summarize how family dynamics and stress may be related to the development of schizophrenia.

20-1. The extent to which a patient's relatives are overly critical or protective or are in other ways excessively emotionally involved with the patient is referred to as expressed _____. Patients returning to families that are high in expressed emotion have a relapse rate that is much (higher/lower) than that of families low in expressed emotion.

20-2. Stress is a fact of life, and it is obvious that not everyone who experiences stress develops schizophrenia. Current thinking is that stress may be a precipitating factor for people who are biologically, or for other reasons, already _____ to schizophrenia.

PERSONALITY DISORDERS

21. Discuss the nature of personality disorders and problems with the diagnosis of such disorders.

21-1. The personality disorders, recorded on Axis II, are frequently (less/more) severe versions of disorders on Axis I. Personality disorders consist of relatively extreme and inflexible sets of _____ traits that cause subjective distress or impaired functioning.

21-2. A major problem with the classification of personality disorders is that there is an enormous overlap between the ten _____ disorders on Axis II and the disorders listed on Axis I. There is also considerable _____ among the personality disorders themselves.

21-3. For example, one study found that the majority of patients diagnosed with a histrionic personality disorder (also/did not) fit the descriptions of one or more other personality disorders. This blurring of the lines makes diagnosis difficult.

21-4. In hopes of remedying these problems, some theorists have suggested that rather than using non-overlapping *categories*, personality disorders should be described in terms of *continuous scores* on a set of personality _____. The use of *dimensions* in place of _____ is complicated by a number of factors, and psychologists are not in agreement about the potential utility of the dimensions approach.

22. Describe the antisocial personality disorder and discuss its etiology.

22-1. The *antisocial* personality disorder is more extensively researched than are the other personality disorders and is described in more detail in your text. Check the concepts from the following list that are likely to correctly describe this disorder.

____ sexually promiscuous

____ manipulative

____ feels guilty

____ much more likely to occur in males than females

____ may be a con-artist, thug, or unprincipled business executive

____ genuinely affectionate

____ impulsive

____ lacks an adequate conscience

____ may appear charming

22-2. What types of studies support the idea that biological factors are involved in the etiology of the antisocial personality?

22-3. Eysenck proposed that antisocial personalities have chronically low levels of autonomic arousal, so they are less likely to develop conditioned inhibitions that keep others from violating social norms. What are the research findings related to this idea?

22-4. What family-environmental factors appear related to development of an antisocial personality?

23. Articulate the legal concept of insanity and clarify the grounds for involuntary commitment.

23-1. While the words *insane* and *schizophrenic* may in some cases apply to the same person, the terms do not mean the same thing. The term _____ is a legal term, while _____ is a descriptive term used in psychological diagnosis. For example, an individual troubled by hallucinations and delusions probably fits the category of _____. An individual who is judged by a court not to be responsible for his or her actions would be classified (under the M'naghten rule) as _____.

23-2. The following items concern the insanity defense. Mark True or False.

____ The insanity defense is used in fewer than 1% of homicide cases.

____ Available evidence suggests that in the majority of cases in which is it used, the insanity defense is a successful defense (i.e., wins the case).

23-3. Roughly, how is insanity defined under the M'naghten rule?

23-4. More frequent than judgments of insanity are proceedings related to *involuntary commitment* to a psychiatric facility.

(a) What three criteria are used to determine whether an individual should be committed?

(b) What is required to temporarily commit an individual for one to three days?

(c) What is required for longer-term commitment?

23-5. What American ethical-cultural tradition is ignored in involuntary commitment?

24. Compare the relativistic versus pancultural view of psychological disorders.

24-1. Are psychological disorders universal, or do they vary across cultures? The _____ view is that basic standards of mental health are universal across cultures. The _____ view is that psychological disorders vary as a function of culture.

24-2. ____ (True/False) Panculturalists generally believe that Western diagnostic categories apply to all cultures.

24-3. There are two issues in this debate: (1) Are the psychological _____ observed in the West seen throughout the rest of the world? And (2) are the _____ or characteristics of disorders the same throughout the world? These questions will be considered in the following.

25. Assess the extent of cultural variability in the existence and presentation of mental disorders.

25-1. Are the disorders universal? Most investigators agree that the three most serious categories of disorder, listed below, are universal:

_____

_____

_____

25-2. On the other hand, less severe disturbances (e.g., hypochondria) are (less/more) likely to be universally recognized as disorders.

25-3. In addition, some disorders are unique to particular cultures. For example, some fears described in your text (koro, windigo) are (universal/culture-bound).

25-4. So, are psychological disorders universal? The answer seems to be that: the most _____ disorders are universally recognized, _____ disorders may not be, and some disorders are unique to some cultures.

25-5. If the more severe forms of disorder are universal, are their symptoms the same in all cultures? In general, the more biologically-based the disorder, the (more/less) likely are the symptoms to be invariant.

25-6. However, even the severe disorders express cultural characteristics (e.g., delusions involving satellites wouldn't occur in cultures where satellites are unknown). And depression in non-Western cultures is more likely to express itself in terms of (guilt and self-deprecation/fatigue and pain).

25-7. Are psychological disorders and their symptoms universal, or do they vary across cultures?

a. The standards of normality and abnormality are universal.

b. Disorders are specific to each culture.

c. Some aspects of psychopathology are universal and some vary as a function of culture.

REFLECTING ON THE CHAPTER'S THEMES

26. Identify the four themes highlight in this chapter.

26-1. Below are examples of the highlighted themes. Indicate which theme fits each example by writing the appropriate abbreviations in the blanks: MC for multifactorial causation, HE for the interplay of heredity and environment, SH for sociohistorical context, and C for the influence of culture.

(a) Mood and schizophrenic disorders will occur if one has a genetic vulnerability to the disorder *and* if one experiences a considerable amount of stress. ____

(b) Psychological disorders are caused by neurochemical factors, brain abnormalities, styles of child rearing, life stress, and so on. ____

(c) Anorexia nervosa occurs almost exclusively in affluent Western societies. ____

(d) In part due to changing values, some psychological disorders in the first editions of the DSM were not included in later editions. ____ and ____

PERSONAL APPLICATION • UNDERSTANDING EATING DISORDERS

27. Describe the subtypes, history, and prevalence of eating disorders.

27-1. What are the names of the two major categories of eating disorders? _____ and _____

27-2. The most obvious feature of anorexia nervosa is the drastic weight loss that accompanies the disorder. Other characteristics include an intense _____ of gaining weight and a disturbed _____ _____ (in that they perceive themselves as fat no matter how emaciated they become).

27-3. The two major subtypes of anorexia have in common a dangerous weight loss. In one case weight loss is accompanied by _____ (severely limiting food eaten) and in the other by bingeing and then _____ (vomiting, using laxatives and diuretics) as well as excessive exercise.

27-4. The weight loss that accompanies anorexia nervosa is substantial, typically 25-30% below normal weight. A critical diagnostic criterion for anorexia nervosa in women is amenorrhea, the loss of the _____ cycle.

27-5. There are other consequences as well, including serious gastrointestinal difficulties, heart and circulatory problems, and osteoporosis. These health problems may lead to death, which occurs in approximately ____% of cases. Anorexia nervosa patients (usually/rarely) seek treatment on their own.

27-6. Bulimia nervosa shares many of the characteristics of the binge-eating/purging type of anorexia. Its main differentiating feature is that people with bulimia maintain a (relatively normal/drastically decreased) body weight. They are also much more likely to recognize that they have a problem and more likely to (cooperate with/refuse) treatment.

27-7. A third and less severe category of eating disorder, not in the current DSM, is being considered for inclusion in the DSM-V. Termed _____-_____ disorder, the malady consists of binge eating not accompanied by purging (or fasting or excessive exercise). The binges are frequently triggered by _____ and are likely to result in weight gain.

27-8. Anorexia nervosa and bulimia nervosa were extremely (common/rare) prior to the middle of the 20th century.

27-9. While eating disorders are largely a product of (Western/developing) cultures, with their abundance of food and desire for thinness, they recently they have begun to appear in affluent non-Western countries as well.

27-10. About ____% of individuals with eating disorders are female. Studies report that about 1% of young women develop _____ nervosa and about 2-3% _____ nervosa, although some data suggest that the real numbers may be much higher.

27-11. The age of onset of anorexia nervosa is somewhat (earlier/later) than for bulimia nervosa, typically 14-18 for _____ nervosa and 15 to 21 for _____ nervosa.

28. Outline how genetic factors, personality, culture, family dynamics and disturbed thinking contribute to eating disorders.

28-1. Studies of relatives of people with eating disorders, and data from _____ studies, indicate that there is some degree of genetic predisposition for the disorders.

28-2. There are also personality correlates of the disorders that may reflect an underlying vulnerability. For example, people who are impulsive, overly sensitive, and low in self-esteem are more likely to suffer from (bulimia/anorexia) nervosa. People characterized as neurotic, obsessive, and rigid are more likely to have (bulimia/anorexia) nervosa.

28-3. Cultural values are implicated as well. Over the last half of the 20th century, the prevalence of eating disorders (increased/decreased) as the ideal body weight (increased/decreased). Although one cannot make causal conclusions, it seems likely that cultural milieu is a major factor in eating disorders.

28-4. It is very difficult to sort out cause and effect in case and informal studies, but some theorists contend that parents who are (under-involved/overly involved) in their children's lives unintentionally push their adolescent children to exert autonomy through pathological eating patterns. Other theorists contend that mothers pass along the thinness message by _____ unhealthy dieting practices.

28-5. People with eating disorders are likely to display a rigid, dichotomous, all-or-none pattern of _____ (e.g., If I am not thin, I am worthless; if I eat anything, I am not in control). (But whether disturbed thinking is a cause or a result of the disorders is hard to say. For example, studies of severe food deprivation in volunteer subjects also find disturbed thinking processes.)

CRITICAL THINKING APPLICATION • WORKING WITH PROBABILITIES IN THINKING ABOUT MENTAL ILLNESS

29. Discuss how mental heuristics can distort estimates of cumulative and conjunctive probabilities.

29-1. Basing an estimate of probability on the similarity of an event to a prototype (or mental representation) is a distortion in thinking referred to as the _____ heuristic.

29-2. Over a lifetime, what is the probability that someone will be afflicted with mental illness? Higher than most people think, about one chance in three. People underestimate this probability in part because when they think of mental illness, they think of severe disturbances, such as schizophrenia. When a _____ such as this comes to mind, people tend to ignore information about _____. This bias in our thinking is called the _____.

29-3. In fact, the lifetime mental illness referred to could be schizophrenia, or obsessive-compulsive disorder, or phobia, or substance abuse disorder, or any of an enormous number of other disorders. Each "or" in this instance should involve (adding/subtracting) estimates of the appropriate probabilities, an example of (conjunctive/cumulative) probabilities. The representativeness heuristic, however, results in our estimating probabilities based on similarity to a _____.

29-4. Here is another probability question: Which of the following is more likely (a or b)?

a. having a phobia

b. having a phobia and being obsessive-compulsive

You don't have to know anything about these disorders or their actual probabilities to know that the answer is ____. In this example, you implicitly know that the likelihood of two events occurring together is less than that of either of these events occurring alone. This example illustrates "and" relationships or _____ probabilities.

29-5. Sometimes the answer is not so apparent. Consider this question: John was reported to have been brain damaged at birth. At age 14, John's IQ was measured as 70. Of the following, which is most likely? ____

a. John wins a Nobel prize at age 40.

b. John is given an experimental treatment for retardation; John wins a Nobel prize at age 40.

c. John was mixed up with another baby; John's IQ test was scored incorrectly; John wins a Nobel prize at age 40.

29-6. The answer to the previous question is another example of _____ probabilities. If you, like most people that I have shown this problem, picked some answer other than "a," you made the error known as the _____ fallacy.

29-7. Why do we make the conjunction fallacy? In part, the mistake results, again, from our tendency to be influenced by prototypes, the _____ heuristic. Even though we know that, logically, the likelihood of two events occurring together is less than the probability of either occurring alone, the additional "explanation" makes the combined result seem more reasonable. In fact, it is just another example of _____ probabilities.

29-8. When you first read about mood disorders, or obsessive-compulsive disorder, or generalized anxiety disorder, or hypochondriasis, did you tend to think that each description might fit you or one of your friends? If so, you were probably influenced by the _____ heuristic.

29-9. The availability heuristic involves the ease with which we can bring something to _____. The more readily we can think of some event, the more likely it is to influence our judgment about its frequency or _____.

29-10. Review. If one estimates probability based on a mental image or prototype, one is using the _____. If we think that it is more likely that two events will occur together than that either will occur alone, we have made the error known as the _____ _____. If we base our estimate of probability on the ease with which something comes to mind, we are using the _____.

Review of Key Terms

Agoraphobia
Anorexia nervosa
Antisocial personality disorder
Anxiety disorders
Availability heuristic
Bipolar disorders
Bulimia nervosa
Catatonic schizophrenia
Comorbidity
Concordance rate
Conjunction fallacy
Conversion disorder
Culture-bound disorders
Cyclothymic disorder
Delusions
Diagnosis
Disorganized schizophrenia
Dissociative amnesia
Dissociative disorders
Dissociative fugue
Dissociative identity disorder (DID)
Dysthymic disorder
Eating disorders
Epidemiology
Etiology
Expressed emotion (EE)
Generalized anxiety disorder
Hallucinations
Hypochondriasis
Insanity
Involuntary commitment
Major depressive disorder
Manic-depressive disorder
Medical model
Mood disorders
Multiple-personality disorder
Negative symptoms
Obsessive-compulsive disorder (OCD)
Panic disorder
Paranoid schizophrenia
Personality disorders
Phobic disorder
Positive symptoms
Posttraumatic stress disorder (PTSD)
Prevalence
Prognosis
Representativeness heuristic
Schizophrenic disorders
Somatization disorder
Somatoform disorders
Undifferentiated schizophrenia

_____ **1.** Proposes that it is useful to think of abnormal behavior as a disease.

_____ **2.** Involves distinguishing one illness from another.

3. Refers to the apparent causation and developmental history of an illness.

4. A forecast about the possible course of an illness.

5. An eating disorder characterized by fear of gaining weight, disturbed body image, refusal to maintain normal weight, and dangerous measures to lose weight.

6. The study of the distribution of mental or physical disorders in a population.

7. Refers to the percentage of a population that exhibits a disorder during a specified time period.

8. A class of disorders marked by feelings of excessive apprehension and anxiety.

9. Disorder marked by a chronic high level of anxiety which is not tied to any specific threat.

10. Disorder marked by a persistent and irrational fear of an object or situation that presents no realistic danger.

11. Disorder that involves recurrent attacks of overwhelming anxiety that usually occur suddenly and unexpectedly.

12. Disorder marked by persistent, uncontrollable intrusions of unwanted thoughts and urges to engage in senseless rituals.

13. A fear of going out in public places.

14. One part of a two-category classification system of schizophrenia that includes behavioral excesses such as hallucinations, delusions, and bizarre behavior.

15. A class of disorders involving physical ailments that have no authentic organic basis and are due to psychological factors.

16. Disorder marked by a history of diverse physical complaints that appear to be psychological in origin.

17. Disorder that involves a significant loss of physical function (with no apparent organic basis), usually in a single-organ system.

18. Disorder that involves excessive preoccupation with health concerns and incessant worrying about developing physical illnesses.

19. A class of disorders in which people lose contact with portions of their consciousness or memory, resulting in disruptions in their sense of identity.

20. A sudden loss of memory for important personal information that is too extensive to be due to normal forgetting.

21. The loss of memory of one's entire life along with one's sense of personal identity.

22. Older term, still widely used, that describes the coexistence in one person of two or more personalities.

23. The new term that replaced multiple-personality disorder in the DSM-IV.

24. A class of disorders marked by depressed or elevated mood disturbances that may spill over to disrupt physical, perceptual, social, and thought processes.

25. Severe disturbances in eating behavior, characterized by preoccupation with weight concerns and unhealthy efforts to control weight; includes the syndromes anorexia nervosa and bulimia nervosa.

26. A disorder marked by persistent feelings of sadness and despair and a loss of interest in previous sources of pleasure.

_____ **27.** Disorders marked by the experience of both depressive and manic periods.

_____ **28.** Statistic indicating the percentage of twin pairs or other pairs of relatives who exhibit the same disorder.

_____ **29.** Estimating the probability of an event based on the ease with which relevant instances come to mind.

_____ **30.** A class of disorders marked by disturbances in thought that spill over to affect perceptual, social, and emotional processes.

_____ **31.** False beliefs that are maintained even though they clearly are out of touch with reality.

_____ **32.** Sensory perceptions that occur in the absence of a real, external stimulus or gross distortions of perceptual input.

_____ **33.** Type of schizophrenia dominated by delusions of persecution, along with delusions of grandeur.

_____ **34.** Type of schizophrenia marked by striking motor disturbances, ranging from muscular rigidity to random motor activity.

_____ **35.** Type of schizophrenia marked by a particularly severe deterioration of adaptive behavior.

_____ **36.** Type of schizophrenia marked by idiosyncratic mixtures of schizophrenic symptoms.

_____ **37.** A class of disorders marked by extreme, inflexible personality traits that cause subjective distress or impaired social and occupational functioning.

_____ **38.** Disorder marked by impulsive, callous, manipulative, aggressive, and irresponsible behavior; reflects a failure to accept social norms.

_____ **39.** A legal status indicating that a person cannot be held responsible for his or her actions because of mental illness.

_____ **40.** A part of a two-category classification system of schizophrenia that includes behavioral deficits, such as flattened emotions, social withdrawal, and apathy.

_____ **41.** Legal situation in which people are hospitalized in psychiatric facilities against their will.

_____ **42.** Chronic but relatively mild symptoms of bipolar disturbance.

_____ **43.** Abnormal syndromes found only in a few cultural groups.

_____ **44.** Chronic depression that is insufficient in severity to merit diagnosis of a major depressive episode.

_____ **45.** Estimating the probability of an event based on how similar the event is to a prototype.

_____ **46.** An error in thinking that involves estimating that the odds of two uncertain events happening together are greater than the odds of either event happening alone.

_____ **47.** An eating disorder that involves binge eating followed by unhealthy compensatory efforts such as vomiting, fasting, abuse of laxatives and diuretics, and excessive exercise.

_____ **48.** The coexistence of two or more disorders in the same individual.

_____ **49.** Older term used to refer to bipolar disorder.

_____ **50.** Psychological disturbance due to the experience of a major traumatic event; may appear some time after the event.

_____ **51.** The extent to which a relative of a patient shows highly critical or otherwise overly involved emotional attitudes toward the patient; thought to influence the course of the illness.

Review of Key People

Nancy Andreasen
Susan Nolen-Hoeksema
David Rosenhan
Martin Seligman
Thomas Szasz

_____ **1.** Critic of the medical model; argues that abnormal behavior usually involves a deviation from social norms rather than an illness.

_____ **2.** Did a study on admission of pseudopatients to a mental hospital; concluded that our mental health system is biased toward seeing pathology where it doesn't exist.

_____ **3.** Proposed a classical conditioning explanation of phobias modified by "preparedness;" developed the learned helplessness model; modified learned helplessness to include cognition (pessimistic explanatory style).

_____ **4.** Proposed an alternative approach to subtyping that divides schizophrenic disorders into just two categories, based on the presence of negative versus positive symptoms.

_____ **5.** Found that people who ruminate about their depression, by repetitively focusing on their sad feelings, tend to stay depressed longer that those who distract themselves.

Self-Quiz

1. Which of the following concepts or people asserts that abnormal behavior is best thought of as an illness?
a. the behavioral model
b. the medical model
c. Thomas Szasz
d. Arthur Staats

2. The concordance rate for mood disorders has been found to be about 67% among identical twins and 17% among fraternal twins. These data suggest that the mood disorders
a. are caused primarily by stress.
b. have an onset at an early age.
c. are due primarily to family environment.
d. are caused in part by genetic factors.