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Chapter 11

Psychological Disorders

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Psychological Applications: Some Important Facts about Suicide

My father was an infantry soldier in World War II. In the summer of 1944, during his first battle in Europe, his 200-member company lost two-thirds of its men within a 2-hour period. Later that fall, he and 120,000 other American soldiers were ordered into the Hürtgen Forest, just east of the Belgian-German border. The Battle of the Hürtgen Forest lasted 88 days and was the longest and bloodiest battle on German soil during the war, with at least 33,000 Americans killed and incapacitated. Most of the casualties were from artillery shelling that would either instantly kill soldiers or burst at the tops of trees and send deadly wood splinters into the foxholes where soldiers huddled for safety.

My father's infantry company lost all but 11 soldiers during this long battle, and the two remaining leaders of his company, a lieutenant and a sergeant, were crying and shaking uncontrollably and no longer able to lead their men. That night, my father and the remaining company members moved further toward the German lines and dug fresh foxholes before the shelling started again. As they were preparing to attack

the nearby enemy forces, one of his buddies noticed that my father was bleeding, so he was sent to an Army hospital. Yet within days, on Christmas Eve, the hospital and surrounding area came under German attack with "buzz bombs," which were unguided jet-propelled missiles known for their loud buzzing sound. My father now found himself in the last major German offensive campaign of the war, the Battle of the Bulge, an attack that caught the Americans completely by surprise. Fearing that the entire region would be overrun, the U.S. Army evacuated those in the hospital back to England; my father flew out on the last departing plane. After being treated in England, my father was diagnosed with "combat fatigue" and reassigned as a military policeman, first serving in France, and then in Germany, before being sent home 6 months after the war ended.

Once back in his hometown, my father found a job, met my mother, married, and soon started his family. To outside observers, this now 26-year-old former soldier seemed to have a happy, peaceful, and contented life, far different from the mass death and destruction he experienced 6 years earlier. What they didn't know was that he frequently woke up at night, screaming and sweating, with nightmares of being riddled with enemy bullets or torn apart by exploding bombs, yet never dying. Friends and family members also didn't give much thought about one of his driving habits. When in a car on a country road or open highway, my father would wait for another car to drive by so that he could then follow it; he explained that it was his "pacer car" to protect him and his family from deer that might run onto the road. However, this "pacer car" explanation was hiding the fact that my father was extremely anxious about being physically exposed in an open landscape where danger could strike at any moment; having another car in front of him reduced his fear of being "out in the open."

As a child, I never questioned my father's "pacer car" explanation, and later when I received my own driver's license, I sometimes waited for a "pacer car" on country roads because it seemed sensible. Throughout those years, my mother was the only member of our family who knew about my father's "combat fatigue" effects. When my father returned home from the war, he initially did seek medical help—and an explanation—for his nightmares and anxiety but was simply told that it was due to "an immature nervous system" that would eventually resolve itself. It wasn't until he was 80 years old—60 years after his military service—that my father was accurately diagnosed with *post-traumatic stress disorder* and received proper medical attention to manage his anxiety.

* * * * *

Many of the mental health problems addressed in this chapter are common; it is likely that some of the conditions discussed will remind you of someone you know, including yourself. Even if you think you have not yet met people with serious psychological problems, you are sure to encounter them as your circle of acquaintances grows. Because of this eventuality, it will be helpful to have a basic understanding of the types and causes of psychological problems. The goal of this chapter is to introduce you to the topic of psychological disorders. From this introduction, you will encounter three basic questions. First, how should we define psychological disorders? Next, what are the important theoretical perspectives used to explain these disorders? Finally, how should we classify the major types of psychological disorders?

11.1 How Should We Define and Explain Psychological Disorders?

We do not have to visit a madhouse to find disordered minds; our planet is the mental institution of the universe.

—Johann von Goethe, German philosopher, 1749–1832

In reading the chapter-opening story, you can see how many people who suffer from a psychological disorder sometimes go to great lengths to hide their condition from others. In reading this story you might also wonder how you and others might decide when a pattern of behavior is simply "different" or "quirky" and when it is disordered. How do we explain such behavior?

11.1a The Medical Model Proposes That Psychological Disorders Are Like Diseases

Many psychologists believe that a useful approach in organizing our thinking about mental health problems comes from the field of medicine. The **medical model** proposes that psychological disorders have a biological basis, can be classified into discrete categories, and are analogous to physical diseases. Since the late 18th century, the medical model has reflected the dominant way of thinking about mental disorders (Halfmann, 2012). In comparison to earlier approaches, which were largely based on superstitious beliefs that the mentally ill were possessed by demons or in league with the devil, the medical model represented an enlightened and humane orientation toward mental illness. Due to the medical model, patients were viewed with greater sympathy and less fear, and the scientific method underlying the medical model led to significant improvements in treatment.

Medical model
The viewpoint that psychological disorders have a biological basis and can be classified into discrete categories just like physical diseases

In the late 1800s and early 1900s, Freud and other psychologically oriented therapists challenged the medical model's assumption that biological factors were the cause of all mental illness. Although not agreeing that all mental health problems have a biological basis, contemporary mainstream psychology has adopted the medical model's terminology, using such words as *illness* and *disorder* when referring to troublesome behavior patterns. As in the medical profession, in psychology, a **symptom** is a departure from normal functioning or feeling that indicates the presence of a disorder; **diagnosis** involves distinguishing one disorder from another; **etiology** refers to a disorder's apparent causes and developmental history; and **prognosis** is a prediction about the likely course of a disorder.

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How do we identify and label mental health problems? What symptoms do we look for in diagnosing psychological disorders?

11.1b Psychological Disorders Involve Atypical Behavior That Causes Personal Distress or Social Impairment

One way to differentiate *disordered* from *normal* behavior is in terms of the statistical frequency of disordered behavior in the general population. Behavior that is significantly above or below the average in its frequency of occurrence is *atypical* and thus more likely to be classified as a psychological disorder. However, relying only on the criterion of statistical infrequency can easily lead to false judgments. For instance, the behavioral accomplishments of Nobel Prize winners and Hall of Fame athletes are statistically infrequent, but few would label these individuals as having a psychological disorder. On the other hand, some disorders, such as anxiety and depression, are statistically common in contemporary society. Thus, we cannot rely solely on deviations from the "average" in identifying psychological disorders.

Another way to differentiate between disordered and normal behavior is by determining whether the exhibited behavior violates cultural norms. For example, in mainstream US culture, reporting hallucinations is likely to raise concerns about your sanity. Yet among various American Indian nations or to the Holy Ghost worshipers of Appalachia, hallucinogenic experiences are often perceived as normal and an essential ingredient in spiritual enlightenment.

Symptom
A departure from normal functioning or feeling that indicates the presence of a disorder

Diagnosis
The process of distinguishing one disorder from another

Etiology
The initial cause that led to the development of the disorder

Prognosis
A prediction about the likely course of a disorder

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Do you consider heterosexuality a sign of mental illness? What about homosexuality? Despite the lack of any credible scientific evidence, 50 years ago, people in the US who were exhibiting homosexual desires were considered mentally unstable. This is an example of how cultural prejudices can sometimes override scientific facts, causing widespread harm to specific groups of people in society.

Even within a given culture, shifts in norms can change people's perceptions of what is a mental disorder. For example, homosexuality was labeled a psychological disorder by the American Psychiatric Association up until 1973, not only because it was atypical, but also because it violated prevailing standards of morality. As these examples attest, simply relying on whether something violates cultural norms is not adequate in determining what is disordered.

Info-Bit

Before the Civil War, many enslaved people in Southern states were diagnosed with mental illness because their behavior violated cultural norms (Landrine, 1988). *Drapetomania* was a psychological disorder in which a slave had an uncontrollable urge to escape from bondage, and *dysaesthesia aethiopica* was a disorder in which a slave was disobedient to her or his owners. Although labeling the desire to be free and the resentment of human bondage as disorders seems ludicrous, such labeling illustrates how culture can shape perceptions of mental illness.

There is more to a psychological disorder than being atypical or out of sync with cultural norms. Such behavior is much more likely to be considered disordered if it is judged *maladaptive*—disruptive or harmful—for the person or society. The inability to perform normal activities is an indication of maladaptiveness. Not leaving your house because you fear crowds, repeatedly being fired from jobs due to excessive drinking, or losing your life savings due to compulsive gambling are all examples of maladaptive behavior. Maladaptiveness is generally considered the most important criterion in defining a disorder.

Individuals who disclose that they are experiencing troubling emotions are often considered to have psychological problems. They may be able to perform normal activities, such as caring for family members and holding a job; however, they feel unreasonably fearful, anxious, guilty, angry, or depressed.

One of the advantages of this criterion is that it considers a person's own distress level rather than using the same standard for everyone. The problem with this criterion, however, is that some people who have psychological disorders—and who cause harm to themselves and others—are not troubled by their behavior. Further, some individuals may not be able to tell us how much distress they are experiencing because they are very young or are otherwise unable to communicate.

There's a very fine line between a groove and a rut; a fine line between eccentrics and people who are just plain nuts.

—Christine Lavin, US singer and songwriter, b. 1952

The only difference between me and a madman is that I'm not mad.

—Salvador Dali, Spanish artist, 1904–1989

Cultural factors can also affect how people report personal distress. For example, Asian Americans suffering from a psychological disorder are more likely than non-Asians to report physical symptoms, such as dizziness, rather than emotional symptoms (Lin & Cheung, 1999). This is because in many Asian cultures, it is considered inappropriate to discuss one's personal feelings with others, especially nonfamily members. Many Hispanic Americans feel a similar reluctance to discuss psychological problems (Arredondo & Perez, 2003). Mental health professionals who are unaware of the cultural differences in how people express or present symptoms of mental illness are more likely to misdiagnose psychological disorders as physical ailments.

As you see, one of these criteria alone is usually insufficient to differentiate normal from disordered behavior. Although psychologists sometimes rely on only one criterion in making their diagnoses, they are more confident when more than one of these

indicators is present and valid. Further, when making diagnoses, psychologists try to understand people's symptoms within the larger social context of their lives, in order to distinguish psychological disorders from other problems in living (Hsieh & Kirk, 2005).

In the end, diagnoses of psychological disorders often involve value judgments about what behaviors cross the bounds of normality. All four criteria are useful in arriving at a diagnosis, but they are not completely objective; thus, they can be influenced by the psychologist's value judgments (Whaley, 2004).

Drawing a line that clearly separates normality from abnormality is often difficult because these distinctions represent two ends of a continuum. In this chapter, a **psychological disorder** is defined as a pattern of atypical behavior that results in personal distress or significant impairment in a person's social or occupational functioning. Every year more than 1 in 5 adults in the United States—about 59 million people—suffer from a psychological disorder (Substance Abuse and Mental Health Services Administration, 2023). Over the course of their lives, about half of all people in the US (46%) will suffer from at least one psychological disorder, and more than half of those individuals will be diagnosed with two or more disorders at the same time (Kessler et al., 2005). The occurrence of two or more disorders at the same time is called *comorbidity.*

Psychological disorder
A pattern of atypical behavior that results in personal distress or significant impairment in a person's social or occupational functioning

Worldwide, more than 12% of people—about 970 million children and adults—are living with a psychological disorder, and it is predicted that mental health problems will soon account for 15% of the global burden of disease, just below that caused by heart disorders (Institute for Health Metrics and Evaluation, 2021). Women and men are equally likely to experience psychological disorders during their lifetimes, and the prevalence of mental health problems in most countries is fairly stable over time (de Graaf et al., 2012).

Info-Bit

Contrary to early research indicating that psychological disorders occur more often among African Americans than among White Americans, later research pointed to lower rates of mental illness among African Americans and higher rates among Hispanic Americans (Kessler et al., 2005; Sue & Chu, 2003).

11.1c Psychologists Rely on Different Theories to Explain Mental Illness

There are five primary perspectives in psychology from which to understand mental illness. The most recognizable approach is the *psychodynamic perspective,* which asserts that disordered behavior, like normal behavior, is not freely chosen; rather, unconscious forces that have been largely shaped by childhood experiences control it. The founding father of the psychodynamic perspective, Sigmund Freud, contended that early traumatic events leave the individual with troubling feelings and memories. Because this material is painful, the individual represses it to the unconscious. Once this material is unconscious, the individual does not experience the anxiety that would result if the painful material were faced directly. However, although this painful material is beyond conscious awareness, it continues to influence the person's behavior and is often expressed indirectly through defense mechanisms. This idea of how the unconscious mind shapes people's everyday actions formed the basis for Freud's theory of psychoanalysis (see Chapter 10, Sections 10.2a and 10.2b).

While the psychodynamic perspective assumes that "what you see is not what you get" when you analyze mental illness, the *behavioral perspective* assumes that disordered

behavior is caused by readily identifiable factors in the person's environment and is the product of learning. As you recall from Chapter 6, behaviorists believe that learning occurs through *conditioning*. In classical conditioning, a previously neutral stimulus is paired with a stimulus that automatically elicits a reflexive response, the unconditioned stimulus. Through repeated pairing of the neutral and unconditioned stimuli, the neutral stimulus comes to elicit a response similar to the reflexive response. Classical conditioning can explain the development of several reflexive responses, including those that might lead to a psychological disorder.

The other basic form of conditioning is operant conditioning, which is driven by reinforcement and punishment (see Chapter 6, Section 6.2a). As you recall, behaviors followed by reinforcement will increase in frequency, whereas those followed by punishment will decrease in frequency. Operant conditioning explains why some individuals develop troubling behaviors (for example, a child's misconduct is reinforced), and also why some people fail to develop appropriate behaviors (for example, a child fails to learn appropriate social skills). According to the behavioral perspective, the etiology (initial cause) of disordered behavior is conditioning, whereas the maintaining cause is either the problem behavior itself or the environment that continues to condition the behavior.

Cognition is important in understanding psychological disorders because, as you will soon learn, many disorders involve severe cognitive disturbances. Indeed, the *cognitive perspective* (see Chapter 1, Section 1.2c) holds that ineffective or inaccurate thinking is the root cause of mental illness (Beck, 1991). According to this viewpoint, the person's faulty cognitive style is acquired through learning, perhaps from observing how one's parents interpret their experiences or from interpreting and attempting to understand one's own experiences. This ineffective way of thinking leads the person to experience troubling emotions or behave ineffectively. Cognitive theorists believe that the etiology of a psychological problem is learning and that the maintaining cause is the faulty cognitive style.

Theorists from the *sociocultural perspective* (see Chapter 1, Section 1.2f) propose that mental illness is the product of broad social and cultural forces. For example, within a given culture, the rates of psychological disorders are higher in poor urban settings than in other segments of the population. Further, as unemployment increases, psychiatric hospital admissions and suicides tend to increase similarly (Pines, 1993). Based on these sorts of findings, sociocultural researchers believe that social forces—such as poverty, urbanization, and inequality—may be the primary causes of many mental health problems (Jefferis et al., 2011). During the COVID-19 pandemic, nearly half (45%) of adults in the United States reported that their mental health had been negatively impacted due to worry and stress over the virus (Panchal et al., 2020). As the pandemic wore on, mental health issues increased worldwide as measures taken to slow its spread—such as social distancing, business and school closings, and shelter-in-place orders—further aggravated people's sense of isolation and financial distress.

Cross-culturally, although certain psychological disorders are universally encountered—such as depression and schizophrenia—others are limited to specific societies or cultural areas and have no known physiological causes (Watters, 2010). For example, in certain Mediterranean and Middle Eastern cultures people occasionally suffer from *mal de ojo,* or "the evil eye," in which they experience fitful sleep, unexplained crying, diarrhea, vomiting, and fever. Similarly, only among native Arctic and sub-Arctic people do we find the *piblokto* disorder, which involves an abrupt break with reality, violence, and hyperexcitability, followed by seizures and coma. Mental health experts have not yet determined whether these *culture-bound syndromes* are distinct from the more established psychological disorders or whether they are variations of them (Gureje, 2008), but

their existence demonstrates that a complete understanding of psychological disorders must consider people's sociocultural contexts.

While the previous perspectives primarily focus on the relationship between the mind and the social environment, biological researchers focus on the relationship between the mind and the body. This *biological perspective*—which includes the neuroscience and evolutionary perspectives first introduced in Chapter 1, Sections 1.2d and 1.2e—proposes that psychological disorders are caused by biological conditions, such as genetics, hormone levels, or neurotransmitter activity in the brain (McClenon, 2011). Biological irregularities related to mental illness are also shaped by many other factors, including illness and response to environmental stressors, and they often can be treated through medical intervention and drug therapies (see Chapter 12, Section 12.7).

All are lunatics, but he who can analyze his delusion is called a philosopher.

—Ambrose Bierce, US satirist, 1842–1914

Table 11–1 summarizes the five theoretical approaches to understanding mental illness. Over the years, as researchers have attempted to identify the origins of psychological disorders, they have discovered that adequate one-perspective explanations are rare. As a result, many current explanations of psychological disorders combine the various perspectives into one overall account.

Table 11–1 The Etiology of Psychological Disorders by Theoretical Perspective

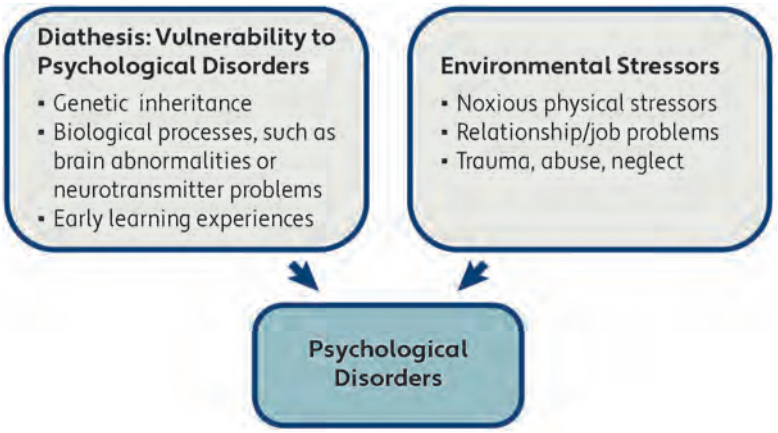
Perspective	Etiology
Psychodynamic	Unconscious conflict from childhood experiences
Behavioral	Conditioning from the environment
Cognitive	Learning ineffective or inaccurate thinking
Sociocultural	Broad social and cultural forces
Biological	Genetics, hormone levels, neurotransmitter activity

One such interdisciplinary approach is the **diathesis-stress model**, illustrated in Figure 11–1. A *diathesis* (pronounced "dye-A-thuh-sis") is an underlying vulnerability or predisposition that may be caused by genetic inheritance, biological processes, or early learning experiences. A person with a diathesis is susceptible to developing a problem later, when experiencing stress. Without the diathesis, stress alone may not be sufficient to produce a disorder (Martin et al., 2010; Thomas-Odenthal et al., 2024). For example, individuals may have inherited neural problems associated with panic disorder. Further, overprotective parents may have taught these individuals to closely monitor their physiological reactions, behaviors also associated with panic disorder. Yet these predispositions may be expressed as a panic disorder only when these individuals are experiencing high levels of life stress. If such stress is infrequent, or if these individuals have learned how to adequately cope with such stressful events, they may never have a panic attack or may have one that is relatively mild. Thus, the diathesis-stress model proposes that the *interaction* of both the predisposition for a disorder (diathesis) and environmental stressors is what causes the psychological disorder. Periodically throughout this chapter, I discuss how the diathesis-stress model can provide additional insight into how the other perspectives might interact in explaining a particular psychological disorder.

Diathesis–stress model
A predisposition to a given disorder (diathesis) that combines with environmental stressors to trigger a psychological disorder

Figure 11-1 The Diathesis-Stress Model

The diathesis-stress model proposes that a predisposition to a psychological disorder (diathesis) interacts with environmental stressors to cause the disorder. According to this model, the diathesis alone or the stressors alone are unlikely to trigger the disorder.



11.1d Using Diagnostic Labels Has Both Risks and Benefits

Regardless of which theoretical perspective is used to understand psychological disorders, diagnostic labels can harm individuals in several ways. First, the label may dehumanize patients by encouraging mental health practitioners to treat them as labels rather than as unique individuals with problems. Further, labeled individuals may experience discrimination if job, housing, or other social opportunities are limited due to negative stereotypes about people with mental illness (see *Exploring Culture & Diversity 11–1*). Such labeling may also cause people to expect those labeled to behave abnormally, and thus to misperceive normal behavior as disordered.

Exploring Culture & Diversity 11–1

How Pervasive Is the Stigma Surrounding Mental Illness?

All available evidence strongly indicates that people identified as having psychological disorders are stigmatized in the United States and in other Western and in Asian cultures, especially when they suffer from disorders often thought to be associated with genetic or biological causes (Huggard & O'Connor, 2025; Kapadia, 2023). A **stigma** is an attribute that serves to discredit a person in the eyes of others. In the United States, a national survey found that people viewed those with psychological disorders as dangerous and as less capable than the average person of handling daily affairs (Pescosolido et al., 1999). The World Psychiatric Association (2019) contends that mental illness stigma is the most important barrier to the quality of life of those suffering from psychological disorders—more so than the illness itself—and a major impediment to mental health reform. Such stigmatization is fostered and strengthened by television shows, movies, and news outlets that regularly portray people with often-unnamed mental illnesses as being dangerous and/or incompetent. Indeed, one study found that the more often people watch television, the less accurate their knowledge is about schizophrenia and obsessive-compulsive disorder (Kimmerle & Cress, 2013). This widespread bias against individuals suffering from psychological disorders extends into our judicial system. Studies of court proceedings in both the United States and Canada find that judges often use and allow others to use language

Stigma
An attribute that serves to discredit a person in the eyes of others

in their courtrooms that stigmatizes mental illness and those who suffer from psychological disorders (Black & Downie, 2013).

Faced with this social stigma and the fear of being negatively evaluated, people with psychological problems often conceal their symptoms and avoid seeking therapy (Wahl, 2012). In many Asian countries, the stigma of mental illness is so severe that it can damage the reputation of the family lineage and thereby significantly reduce the marriage and career prospects of other family members (Ng, 1997). This stigma is also pervasive among Asian Americans in the United States (Vyas et al., 2021). For example, a mental health survey in Los Angeles (Zhang et al., 1998) found that Asian Americans were less than half as likely as White Americans to mention their mental health problems to a friend or relative (12% versus 25%), and only 4% stated that they would seek help from a psychiatrist or psychotherapist (compared to 26% of White Americans). In addition to preventing people from seeking help for their psychological problems, the stigma of mental illness lowers self-esteem while increasing a sense of social isolation and hopelessness.

So what is the truth underlying one of the most common stereotypes of the mentally ill—namely, that they are more violent than the average person? One study monitored the behavior of more than 1,000 individuals during the year after they had been discharged from psychiatric hospitals (Steadman et al., 1998). Results found no significant difference in the incidence of violence between the former patients and a control group of people living in the same neighborhoods with no history of serious mental health problems. Other research indicates that heightened violence is only slightly more likely among people with severe psychological disorders who are currently experiencing extreme psychological symptoms, such as bizarre delusional thoughts and hallucinated voices (Appelbaum, 2019; Link et al., 1992). All other individuals with a psychological disorder who are not experiencing these severe symptoms are no more likely than the average person to be violent. Thus, the research indicates that the cultural stereotype associating mental illness with violence is exaggerated and largely unfounded. However, until such negative stereotypes surrounding psychological disorders are reduced, the stigma of the mental illness label will remain the most formidable obstacle to future progress in mental health (Thornicroft et al., 2022).

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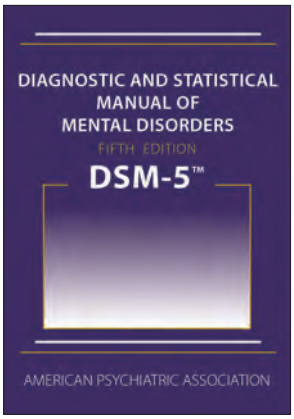
The stigma surrounding psychological disorders causes many people to avoid seeking help. What is one of the most common stereotypes about people with mental illness?

Despite the drawbacks associated with diagnostic labels, mental health professionals continue to use them because they serve several important functions. The first benefit is that a label summarizes the patient's symptoms or problems. Rather than listing each patient's entire set of symptoms, clinicians can communicate a great deal of information about a patient with a single word.

A second benefit is that a diagnostic label conveys information about possible causes of the disorder. For some psychological disorders, research has identified clear causal and maintaining factors, so the diagnostic label carries much useful information that helps the psychologist understand the individual's condition. In other disorders for which the etiology and maintaining causes are still unclear, the diagnostic label may suggest to the psychologist a range of possible causes to consider when working with the patient.

A third benefit is that a diagnostic label conveys information about the patient's prognosis, or expected future course. An important aspect of the prognosis is the patient's likely response to treatment.

Thus, although diagnostic labels may sometimes lead to aversive consequences for people who have psychological disorders, these labels also convey important information about the nature, probable causes, and likely treatments of the problem. Because



The *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* is the classification scheme used by most mental health professionals to diagnose psychological disorders. This classification scheme has been updated several times, with the latest version being its fifth edition.

Diagnostic and Statistical Manual of Mental Disorders (DSM–5)
The manual of psychological disorders published by the American Psychiatric Association and used for descriptive diagnoses

of these benefits, psychologists continue to use diagnostic labels while being mindful of the potential risks.

In arriving at a diagnosis, the vast majority of psychologists, psychiatrists, and other mental health professionals in North America rely upon the American Psychiatric Association's ***Diagnostic and Statistical Manual of Mental Disorders,*** which was first published in 1952 and is now in its fifth edition **(*DSM-5*)**. (Version *DSM-5-TR*, a text revision, was released in 2022.) The *DSM-5* differs from previous diagnostic systems in several ways. First, this classification system is *descriptive* rather than *explanatory,* meaning that it is not based on a particular theory concerning what causes psychological disorders. Rather, it is *atheoretical.* Thus, diagnoses are based more on observable symptoms than on the clinician's judgment about the underlying cause of these symptoms. Second, the *DSM-5* provides clearer directions to clinicians concerning the number, duration, and severity of symptoms that are necessary to assign a diagnosis. By recognizing that two patients with the same disorder may substantially differ from one another, clinicians are much more likely to acknowledge the uniqueness of all patients.

These improvements address many of the criticisms of diagnostic labels, and numerous studies indicate that *DSM-5* diagnoses are, in fact, more reliable than previous diagnostic systems. However, critics still contend that the *DSM-5* incorrectly views many normal behaviors as indicating a psychological disorder. For example, an irrational fear of embarrassment is considered a symptom of social anxiety disorder, while a habitual tendency to violate rules at home or in school is a symptom of conduct disorder. In response, ongoing research seeks to improve the reliability and validity of the *DSM* diagnoses and to address criticisms of specific sections of the diagnostic system. As research identifies new disorders or more reliable ways of diagnosing a disorder, these results are incorporated into new versions of the *DSM.* Version *DSM-5* uses broader categories of disorders than previous versions; it also recognizes the substantial overlap between similar disorders (Elhai et al., 2012). As you can see, and as is evidenced by the most recent *DSM-5-TR* version, the *DSM* will always be a "work in progress," continuously shaped by the insights of ongoing research, which is the hallmark of good science.

Review

- The medical model views psychological disorders like physical diseases.
- The criteria for differentiating disordered behavior from normal behavior include the following:
  1. Behavior is atypical.
  2. Behavior violates cultural norms.
  3. Behavior is maladaptive.
  4. Behavior involves personal distress.
- Psychologists employ multiple perspectives in studying psychological disorders.
- The diathesis-stress model proposes that the predisposition for a psychological disorder (diathesis) interacts with environmental stressors to cause the disorder to emerge.
- Two risks in using diagnostic labels are that (1) mental health professionals may become biased in interpreting normal behavior as disordered in people labeled mentally ill, and (2) labeled individuals may be stigmatized by others and subject to discrimination.

- Using labels does have benefits. For example, diagnostic labels communicate valuable information, including possible causes of the disorder, its likely course, and possible treatment.
- Most clinicians rely on the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* when diagnosing psychological disorders.

11.2 The Major Classes of Disorders Identified by the *DSM–5*

The *DSM-5* describes about 250 different psychological disorders. The remainder of this chapter introduces you to the major classes of psychological disorders. Each class of disorders is defined according to the most severe or most prominent of the patient's symptoms. While reading about these disorders, keep in mind that you may have experienced some of these symptoms yourself at some time. In recognizing yourself, you may begin to worry that you have one (or more) of these disorders. Don't become alarmed. The truth is that many of the described symptoms are common in the general population. On numerous occasions throughout your life, you will experience sadness and euphoria, unrealistic anxiety and fear, and interpersonal problems. Only when these symptoms significantly disrupt your functioning or your sense of well-being are they indicative of a possible psychological disorder. In such instances, you should seek the help of a mental health professional for proper diagnosis and treatment.

11.2a Anxiety Disorders Are Characterized by Distressing, Persistent Anxiety

Everybody experiences anxiety. However, anxiety disorders are distinguished from "normal" anxiety by the severity of the emotional distress and the degree to which the anxiety disrupts daily functioning. **Anxiety disorders**—which are characterized by distressing, persistent fear and anxiety and maladaptive behavior—are the most common psychological disorders (Daitch, 2011). It is estimated that 400,000 adults in the United States may suffer from anxiety disorders, with a lifetime risk of about 42% in the general population (Qingxing et al., 2025). They occur across the life span and commonly co-occur with many other disorders, such as depression and substance abuse. In this section, we discuss six anxiety disorders: panic disorder, specific phobias, social anxiety disorder, generalized anxiety disorder, obsessive-compulsive disorder, and post-traumatic stress disorder.

Anxiety disorders
Disorder characterized by distressing, persistent fear and anxiety and maladaptive behavior

Panic Disorder (and Agoraphobia)

Maya is a 28-year-old hairstylist who has **panic disorder**, which is characterized by episodes of intense anxiety without an apparent reason. When having these attacks, Maya feels dizzy. Her heart races, she sweats and has tremors, and she may even faint. Besides these physiological symptoms, her psychological symptoms may include fear of dying, fear of suffocating, fear of "going crazy," and fear of losing control and doing something drastic, such as killing herself or others.

Panic disorder
An anxiety disorder characterized by episodes of intense fear and dread that usually occur suddenly and unexpectedly

Panic episodes have a clear beginning and end, usually reach a peak within minutes, and last no more than about 10 minutes; they sometimes come and go over a period of an hour or more. As you can imagine, such episodes are extremely frightening; the symptoms of sympathetic nervous system arousal often lead sufferers like Maya to

seek immediate medical attention out of concern that they are having a heart attack or some other serious life-threatening episode. About 3% of the general population worldwide, and about 5% of the US population, experience panic disorder during their lifetimes (Weissman et al., 1997). In general, this anxiety disorder occurs more often in young adults than in older adults, with about twice as many women (5%) suffering from it as men (2%). In the United States, significantly lower rates of panic disorder are reported among Hispanic Americans, African Americans, Black Caribbeans, and Asian Americans compared with European Americans, but the highest rates are found among American Indians. Similarly lower rates of panic disorder are reported in Latin American, African, and Asian countries when compared to European countries.

People often take extreme steps to limit panic episodes (Barlow, 2002; León-Quismondo et al., 2025). For example, Maya is embarrassed about having a panic episode in public, so she limits her social activities. She also avoids locations where she has experienced previous panic episodes, so she has stopped going to shopping malls and restaurants. As you can see, like many people with panic disorder, Maya has significantly restricted her social activities outside her home. Such restriction of activities to limit panic episodes can lead to a related psychological disorder called **agoraphobia**, which involves acute anxiety in situations perceived as difficult or embarrassing to escape. These situations are generally in public settings or wide-open places. As its name implies, agoraphobia was originally classified as a phobia (see next subsection); however, later research found that it is often a complication of panic disorder (Wittchen et al., 2010). One reason agoraphobia was not recognized earlier as developing from panic disorder was that those who experienced it rarely came to clinics for treatment due to their avoidance of outside activities. About one-third of individuals who suffer from panic disorder also suffer from agoraphobia and, as with panic disorder, agoraphobia is twice as likely to occur among women than men. Unlike panic disorder, there do not appear to be differences in the incidence of agoraphobia between ethnic groups.

Agoraphobia
Acute anxiety in situations perceived as difficult or embarrassing to escape, generally public settings or wide-open places

Specific Phobias

Other anxiety disorders are **specific phobias**, which are characterized by strong, irrational fears of specific objects or situations. The *DSM-5* classifies phobias into subtypes based on the object of fear. The most common subtypes in the United States involve fear and avoidance of particular objects and situations, such as heights, animals, enclosed spaces, blood, and automobile or air travel. Specific phobias affect about 7.4% of the world population, but women are diagnosed with this disorder about twice as often as men (Narrow et al., 2002), and they tend to develop phobic symptoms earlier (age 10 for females and age 14 for males). Interestingly, the prevalence, impairment and duration of specific phobias is considerably higher in wealthier countries than in poorer countries, which could be due to cultural differences in the degree to which phobic symptoms are recognized as being related to a mental disorder (Hofmann & Hinton, 2014).

Specific phobias
A group of disorders characterized by strong irrational fears of specific objects or situations

Different types of phobias tend to have different courses. For example, fears of strangers, doctors, storms, and the dark are more common in children than in adults, whereas fears of cancer and the death of a loved one are more common in adults. Most specific phobias develop prior to age 10. Interestingly, phobias have a moderate tendency to run in families, so that individuals with phobias tend to have close relatives with similar kinds of phobias.

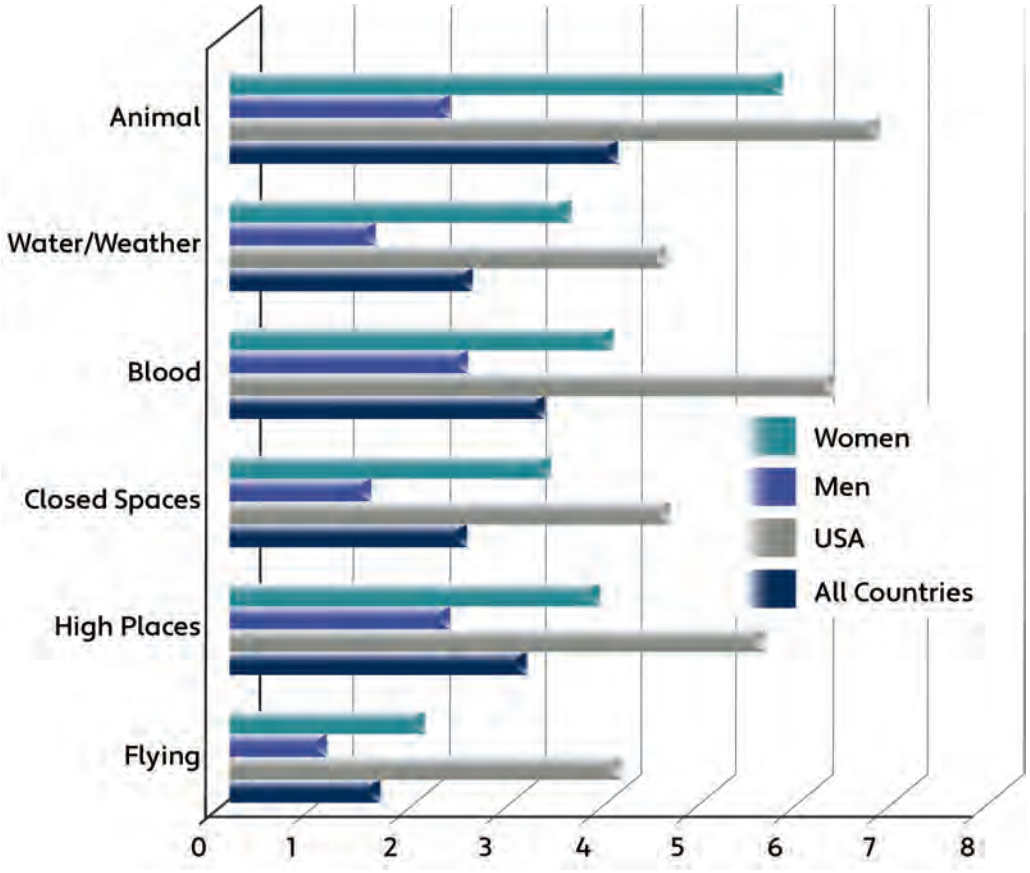
When analyzing phobias, it is important to distinguish them from rational fears that occur in the presence of a realistic threat. For example, it is normal to experience fear when encountering a mugger or when riding in a car that skids off the road. It is also important to distinguish clinical phobias from *subclinical phobias,* which are mild, irrational fears that do not interfere with daily functioning. You may experience fear when

you encounter a huge spider in your basement while washing clothes. If you continue to use the basement for normal activities despite your fear, you have a subclinical phobia. In contrast, if you are so afraid of seeing the spider in your basement that you start taking your clothes to a laundromat, you may have a clinical phobia. Figure 11–2 shows the results of a 2017 cross-national study of the frequency of common specific phobias.

Figure 11-2 Frequency of Specific Phobias Worldwide (Percentage Reporting)

The World Health Organization collected data from 22 low- to high-income countries regarding the presence of specific phobias among their respective populations.

Data source: Wardenaar, K., Lim, C., Al-Hamzawi, A., Alonso, J., Andrade, L., Benjet, C., Bunting, B., de Girolamo, G., Demyttenaere, K., Florescu, E., Gureje, O., Hisateru, T., Hu, C., Huang, Y., Karam, E., Kiejna, A., Lepine, J. P., Navarro-Maeu, F., Oakley Browne, M., . . . De Jonge, P. (2017). The cross-national epidemiology of specific phobia in the World Mental Health Surveys, Table 2. *Psychological Medicine, 47*(10), 1744–1760. Copyright © Cambridge University Press 2017



Social Anxiety Disorder

Social anxiety disorder (also known as *socialphobia*) involves intense fear of being humiliated in the presence of others (LeBeau et al., 2010; Yoon & Joormann, 2012). Physical symptoms often associated with this disorder include excessive blushing, sweating, trembling, difficulty breathing, nausea, stammering, and rapid speech. A person suffering from social anxiety disorder may also experience panic attacks.

Social anxiety disorder
An anxiety disorder involving intense fear of being humiliated in the presence of others

"Adele Feb 24 23," Lady Lotus, CC BY-SA 4.0, via Wikimedia

Singer Adele, who has been diagnosed with social anxiety disorder, has candidly shared her experiences and how she copes with stage fright. Why might social anxiety disorder also be related to depression?

For about half of those suffering from social anxiety disorder, a specific social incident can be identified as triggering the social phobia. For example, during a 1967 concert in New York's Central Park, singer Barbra Streisand suddenly forgot the lyrics to a song, triggering intense anxiety that made it impossible for her to perform in public for nearly another 3 decades. About 7% of the population suffers from social anxiety disorder, with women having only slightly higher rates than men (Wong Sarver et al., 2012). As with panic disorder, higher rates are found among American Indians and lower rates are found among Hispanic Americans, African Americans, and Asian Americans compared to European Americans. In general, Europeans report lower rates (less than 3%) than people in the United States. Social anxiety disorder often occurs alongside major depressive disorder, and suffering individuals may use alcohol or other drugs to reduce their anxiety, which can lead to substance abuse.

Generalized Anxiety Disorder

Generalized anxiety disorder (GAD) is characterized by an almost constant state of excessive anxiety and worry. This anxiety differs from normal anxiety that occurs in response to actual stressful events or situations (Huppert et al., 2008). For example, if you are a full-time college student who works 20 hours a week and maintains an active social life, it is normal to experience stress and anxiety throughout the semester. Further, the anxiety experienced in GAD differs from the anxiety felt in phobic disorder because in GAD, there is no clear object or situation that causes the anxiety. Instead, the anxiety is "free floating." GAD also differs from panic disorder in that the anxiety does not occur in discrete, relatively brief episodes but is almost constant.

Generalized anxiety disorder (GAD)
An anxiety disorder characterized by an almost constant state of excessive anxiety and worry

GAD occurs in about 9% of the general population in their lifetime—about twice as often in women as men, and more often among those over the age of 24, peaking at midlife and then significantly declining. Americans of European descent tend to experience GAD more frequently than Americans of non-European descent. GAD often occurs in association with other problems, including other anxiety disorders and depression (Ritter et al., 2010). The director and actor Woody Allen is perhaps the most famous living person who suffers from generalized anxiety disorder. In his films, Allen often portrays a character who is constantly worrying about something, and he admits that creatively expressing this anxiety on the silver screen helps him cope with this disorder.

Etiology of Anxiety Disorders

Several biological factors appear to influence the development of anxiety disorders. As discussed in Chapter 6, Section 6.1d, our genetic heritage may predispose us to more easily develop phobic reactions toward certain objects and situations, such as snakes and heights, because they once posed real dangers to our ancestors. According to this evolutionary explanation, snakes and heights make many of us unduly anxious and are the source of phobic reactions because the genes that trigger such anxiety are still part of our biological makeup.

Genetics also plays a contributory role in other anxiety disorders. For example, panic disorder is more likely to be shared by identical twins than fraternal twins; agoraphobia occurs at a higher frequency among family members; and family, twin, and adoption studies indicate that obsessive-compulsive disorder (OCD) is at least moderately influenced by genetics (Billett et al., 1998).

The fact that certain drugs can alleviate anxiety symptoms and other drugs can induce those same symptoms further suggests that biology plays a role in anxiety disorders (Hansen et al., 2002). Brain scans reveal that people who have anxiety disorders respond differently to danger signals than those who do not (Gorman, 2002). More recent brain scan studies provide further evidence that some people are simply biologically predisposed to respond more intensely to stressful events than other people, and this stronger stress reaction puts them at greater risk for developing anxiety disorders (Sasaki, Ryo et al., 2024; Shi, K. et al., 2024).

As discussed in Chapter 6, behavioral or conditioning factors have also been implicated in anxiety disorders. For example, as was the case with "Little Albert" (Chapter 6, Section 6.1c), classical conditioning can produce emotional responses to previously neutral stimuli. After these conditioned emotional responses have been initiated, people's avoidance of the feared objects may be reinforced because as they move away from the objects, their anxiety decreases. In other words, classical conditioning may be involved in instilling conditioned emotional responses, and operant conditioning may reinforce—and so, maintain—the person's avoidance responses. This *two-process conditioning model* has been an influential and useful way to understand anxiety disorders. Consistent with this perspective is the finding from one study that 44% of those with social anxiety disorder could identify a traumatic conditioning event in their past that was associated with their anxiety (Stemberger et al., 1995).

Finally, cognitive factors also play an important role in anxiety disorders (Kley et al., 2012). People who have panic disorder often closely monitor their physiological reactions because they want to detect the onset of another panic episode. Because these episodes are so distressing, they often misinterpret and exaggerate the significance of their physiological symptoms, a process known as *magnification*. Unfortunately, their hypervigilance regarding the onset of panic episodes and their tendency to interpret situations as being far more harmful, dangerous, or embarrassing than they actually are contributes to the condition they want to avoid (Beck, 1997). This "fear of fear" is one of the fundamental problems that must be addressed in treating panic disorder.

It is easy to see how biological, behavioral, and cognitive factors interact to cause anxiety disorders. Consider, again, panic disorder. People with panic disorder may have a biological predisposition to this problem, and biological stressors, such as breathing a carbon-dioxide-rich mixture of air, can trigger panic episodes (Rapee, 1995). Through conditioning, panic is associated with certain situations so that eventually these situations alone can trigger panic attacks. Finally, people who have panic disorder become so fearful of panic episodes that they are hypervigilant to signs of a panic attack and thus may frighten themselves into an attack. Given these possible multiple triggers, what is the ultimate cause of panic disorder? Is it biological, behavioral, or cognitive? Most likely, it is some combination of all three.

11.2b Obsessive–Compulsive and Related Disorders Involve Distressing Thoughts and Strong Urges

When the *DSM* was revised in 2015, obsessive-compulsive disorder was removed from the anxiety disorders section and given its own major category. This updated category includes a number of disorders that previously were either not in the *DSM* or that were classified under other diagnoses. This change was prompted by research indicating that there were psychological similarities between a number of disorders involving obsessive thoughts and/or repetitive behaviors.

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Most rituals are not indicators of mental illness. For example, prayer beads are used by members of various religions in counting the repetitions of prayers, chants or devotions. Similarly, kombolói, or "worry beads," are part of a ritual in traditional Greek and Cypriot culture used to relieve stress, keep hands and fingers occupied, and generally pass the time.

Obsessive–Compulsive Disorder

Obsessive-compulsive disorder (OCD) is characterized by repetitive, unwanted, and distressing actions and/or thoughts. *Obsessions* are persistent thoughts or ideas that cause distress or interfere significantly with ongoing activity. For example, some people with OCD may be bothered by thoughts of killing themselves or others even though they have no history of, and are not truly at risk for, suicide or homicide. *Compulsions* are repetitive behaviors or mental acts that people feel compelled to perform in order to prevent or reduce anxiety. Most OCD rituals can be classified as *cleaning* or *checking*. For example, some people with OCD engage in handwashing rituals, cleaning their hands hundreds of times a day, while others feel compelled to repeatedly check the locks on their doors before leaving the house. Still other individuals save things like newspapers and tin cans for years, to the point that it becomes difficult to navigate through their houses (Stewart et al., 2011). In some cases, compulsions serve to control obsessions. For example, a man may have persistent thoughts about sex and might try to control these thoughts, and reduce the anxiety that these thoughts induce, by compulsively reciting a prayer. Unfortunately, this compulsive ritual lowers his anxiety only temporarily, and soon the man must repeat it or add to its length.

Obsessive–compulsive disorder (OCD)
A psychological disorder characterized by repetitive, unwanted, and distressing actions and/or thoughts

Psychologists today recognize that this disorder is more common than had been thought in the past. The lifetime prevalence of OCD is from 2% to 3%, with females having a somewhat higher risk than men (Torres et al., 2004). This disorder tends to develop in adolescence or young adulthood, although it may not be diagnosed until years later. Those with OCD are usually embarrassed about their symptoms and try to hide them from others. It may be years before the symptoms become so intense that they can no longer be hidden.

Daniel Radcliffe in July 2015. Gage Skidmore from Peoria, AZ. CC BY-SA 2.0, via Wikimedia

Actor Daniel Radcliffe, star of the "Harry Potter" film series, suffers from obsessive-compulsive disorder. One of his compulsions was to silently repeat his own words to himself. Radcliffe eventually sought therapy to cope with his compulsions and encourages anyone with OCD to do so.

Body Dysmorphic Disorder

Body dysmorphic disorder (BDD) is characterized by preoccupation with an imagined defect in physical appearance that causes significant distress or interferes with daily functioning (Lambrou et al., 2012). Up to 2% of the population may suffer from BDD, with two-thirds of individuals experiencing this disorder before the age of 18 (Feusner et al., 2008). People suffering from BDD tend to focus on the face and head, but any body part may become the focus of attention. This disorder can occur when an actual physical problem is present, but it is triggered by the person's excessive preoccupation with the defect. Not surprisingly, adolescents with BDD spend more time on social media and engage in significantly more online appearance comparisons than other adolescents (Lavell et al., 2025).

Body dysmorphic disorder (BDD)
An obsessive-compulsive related disorder characterized by preoccupation with an imagined physical defect that causes significant distress or interferes with daily functioning

Until recently, body dysmorphic disorder received relatively little attention from psychologists, largely because those with the disorder often seek out plastic surgeons rather than psychologists for a remedy. In such cases, individuals may undergo multiple plastic surgeries to correct what they believe is a defect in their appearance. Estimates are that about 10% of individuals who seek plastic surgery have BDD (Sarwer & Crerand, 2008). In Chapter 9, Section 9.2e, we discuss in greater detail how culture and gender shape body esteem.

Hoarding Disorder

"Michael Jackson at Cannes," Georges Biard, CC BY-SA 3.0, via Wikimedia

Although Michael Jackson was never formally diagnosed with body dysmorphic disorder, his mother described him as "addicted" to plastic surgery and obsessed since adolescence with his perceived physical flaws.

Hoarding disorder is characterized by persistent difficulty discarding or parting with possessions, regardless of their actual value. Individuals suffering from this disorder have an uncontrollable need to save items and become very distressed when pressured to discard them. Hoarding disorder is not the same as collecting. Collectors look for specific items, such as porcelain figurines or antique clocks, and may organize or display them. People suffering from hoarding disorder often save random items and store them haphazardly. An important factor to keep in mind regarding this disorder is that hoarding both relieves anxiety and produces it. But what determines whether someone is truly suffering from hoarding disorder rather than just being an eccentric pack rat? The main determinant of whether item accumulation is just a personal preference or a disorder is if, and to what extent, the behavior has begun to negatively impact daily living. When this disorder occurs, the large number of items that fill up living or work areas can render them unusable. Hoarding behavior usually has harmful effects both for those who suffer from this disorder and for others, including safety issues due to the clutter and emotional distress, not to mention financial costs. Not surprisingly, hoarding usually causes a great deal of strain in family relationships, as well as conflict with neighbors and local authorities. Some people suffering from this disorder also collect animals, keeping dozens or even hundreds of pets in unsanitary conditions because they can't care for them properly. Unfortunately, people with hoarding disorder often don't see it as a problem, making treatment challenging.

Hoarding disorder
An obsessive-compulsive related disorder characterized by persistent difficulty discarding or parting with possessions, regardless of their actual value

The best available estimates are that approximately 2.5% of people in the US and Europe meet the criteria for this diagnosis, with men being more likely to suffer from hoarding disorder than women (Postlethwaite et al., 2019). Hoarding appears to begin early in life, with the severity of the symptoms increasing as people age. Older adults (55–94 years) are almost 3 times more likely to exhibit hoarding symptoms than younger adults (34–44 years). Once symptoms begin, the course of hoarding is often chronic. It is estimated that about 20% of people with hoarding disorder also suffer from OCD, and half of those who suffer from hoarding disorder also experience major depressive disorder.

Etiology of Obsessive–Compulsive and Related Disorders

Several biological factors appear to influence the development of obsessive-compulsive and related disorders. At the level of neurological functioning, brain imaging studies have found evidence that obsessions are at least partly caused by a malfunctioning neural structure in the basal ganglia, a brain region located below the cerebral cortex (Hansen et al., 2002). Normally, this structure—the caudate nucleus—terminates recurrent thoughts before they become obsessions. But in people with OCD, it does not operate correctly.

Similarly, brain scan studies of individuals with hoarding disorder found that, when deciding whether to throw away their possessions, these individuals had lower activity in the anterior cingulate cortex—a brain region involved in rational cognitive functions such as reward anticipation, decision-making, impulse control, and emotion (Tolin et al., 2012). This lower neural activity would likely cause problems in both identifying the emotional significance of a possession and in making decisions to act regarding the possession. In terms of hereditary influence, an analysis of 14 twin studies indicates there is at least a moderate genetic basis for obsessive-compulsive disorders (Pato et al., 2002; Taylor, 2014).

Obsessive-compulsive behavior may also be learned through operant conditioning. For example, a teenager who is under a great deal of stress at school may discover that he or she can temporarily reduce anxiety by thoroughly cleaning his or her bedroom. If such cleaning behavior temporarily reduces anxiety, through the process of negative reinforcement, it will likely be repeated when the anxiety returns and may eventually become compulsive, trapping the person in a vicious circle of anxiety-reducing rituals (Worden & Tolin, 2014).

11.2c Trauma- and Stressor-Related Disorders Involve Difficulties Caused by Adverse Life Events

Prior to the publication of the *DSM-5* in 2015, trauma- and stressor-related disorders were classified as anxiety disorders. However, now they are considered distinct because many people who are having acute difficulty recovering from traumatic or highly stressful events do not experience anxiety; instead, they have symptoms of anger, aggression, profound dissatisfaction, or an inability to experience pleasure.

Reactive attachment disorder (RAD)
A childhood psychological disorder characterized by a pattern of inhibited, emotionally withdrawn behavior toward adult caregivers

Reactive Attachment Disorder

As discussed in Chapter 3, Section 3.2a, secure attachment develops when a child is repeatedly soothed, comforted, and cared for, and when the caregiver consistently meets the child's needs. In developing secure attachment, the child learns to love and trust others, to become aware of others' feelings and needs, to regulate his or her emotions, and to develop healthy relationships and positive self-esteem. The relative absence of emotional warmth and consistent care during the first few years of life can lead to the development of insecure attachment in children, which can negatively affect their lives as they mature.


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Reactive attachment disorder is an uncommon psychological disorder found in children who have experienced grossly negligent care very early in life.

In extreme cases—when children's basic needs for comfort, affection, and nurturing are not met and, instead, they receive grossly negligent care—they may develop **reactive attachment disorder (RAD)**, which is characterized by a pattern of inhibited, emotionally withdrawn behavior toward adult caregivers. The opening of orphanages in Eastern Europe and in the former Soviet Union following the end of the Cold War in the early 1990s, and the resulting adoption of many young children by US couples, led to the first public awareness of—and later research on—infants and toddlers brought up in very deprived conditions.

Although RAD is most likely to occur in severely understaffed orphanages, children in foster care are also at heightened risk for this attachment disorder due to adverse care and frequent household placements (Zimmermann et al., 2024). The prevalence of RAD is as yet unknown, but it has been found in young children in many cultures around the world. Yet, even in populations of severely neglected children, RAD is uncommon, occurring in less than 2% of such children (Minnis et al., 2018).

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD)
A disorder characterized by flashbacks and recurrent thoughts of life-threatening or other traumatic events

As detailed in the chapter-opening story of my father's wartime experiences, **post-traumatic stress disorder (PTSD)** occurs in some individuals who have experienced or witnessed life-threatening or other traumatic events. Following such trauma, some people experience intense emotional distress, reexperience the event (say, through nightmares or flashbacks), and avoid situations or people that trigger flashbacks. In my

father's case, for the rest of his life he reexperienced his wartime trauma through nightmares and whenever he was alone in open spaces. When these symptoms occur long after the original trauma and significantly interfere with normal daily functioning, the individual is said to have PTSD (Lamprecht & Sack, 2002). It is estimated that almost 16% of US armed service members who are deployed into a war zone develop PTSD (Dursa et al., 2014).

Almost 7% of the US population experience PTSD symptoms during some period in their lifetime, with women being at higher risk than men, most likely because of their greater exposure to traumatic events, such as rape and other forms of interpersonal violence. Compared with European Americans, Hispanic Americans, African Americans, and American Indians have higher rates of PTSD, and Asian Americans have the lowest rates among these ethnic groups. Although highly dramatic events, such as warfare, terrorist attacks, and natural disasters, often lead to this disorder, most PTSD patients have experienced more common types of trauma, such as rape, child abuse, family illness, and witnessing violence (Kazak et al., 2004; Vincent et al., 2023). Trauma related to crime is more likely to trigger PTSD than trauma related to natural disasters; about 28% of people who witness a mass shooting develop PTSD. Risk also varies with the nature and severity of the trauma. For example, the lifetime risk for PTSD following rape is about 35%, while the lifetime risk following automobile accidents ranges from 8% to 41%, depending on the severity of the accident (Stallard et al., 2004). In general, as the severity of the traumatic event increases, the risk for PTSD increases, as does the risk of suicide (Balistreri et al., 2025; Holliday et al., 2020).

AP Photo/David Goldman

Health experts estimate that 28% of people who have witnessed a mass shooting develop post-traumatic stress disorder, which involves emotional distress, nightmares or flashbacks, and avoidance of situations or people that trigger flashbacks.

Etiology of Trauma– and Stressor–Related Disorders

By definition, the most obvious causes of trauma- and stressor-related disorders are environmental stressors—namely, gross neglect very early in life (as in reactive attachment disorder) or exposure to an event involving actual or threatened death, serious injury, or sexual violation (PTSD). However, it is unclear how these life experiences (stress) interact with underlying biological and personality factors (diatheses) to trigger these psychological disorders. As with most mental health problems, these disorders are probably caused by a complex mix of: (1) inherited mental health risks, such as an increased risk of anxiety and depression; (2) life experiences, including the amount and severity of trauma experienced since early childhood; (3) inherited aspects of personality, such as temperament and resilience; and (4) the way the brain regulates chemicals and hormones that the body releases in response to stress. As discussed throughout the text, life experiences change the brain, creating new neural connections and pathways. Traumatic events can create easily activated fear circuits in the amygdala (Herringa et al., 2013; Stevens et al., 2017). Because the amygdala is our brain's filter for threat or danger, if its fear threshold is low, it is much more likely to identify incoming information as dangerous. In turn, this activates other brain areas, such as the hypothalamus, which then activates the fight-or-flight response (see Chapter 13, Section 13.1b), which sends stress hormones coursing through the body to mobilize its resources. Even after the danger has passed, the sympathetic branch of the autonomic nervous system often remains activated, which is ultimately detrimental to health.

11.2d Dissociative Disorders Involve a Loss of Contact with Portions of One's Consciousness or Memory

Dissociative disorders
Psychological disorders characterized by disruptions in consciousness, memory, sense of identity, or perception

Several of the psychological disorders discussed thus far involve symptoms that are familiar to most college students. However, the next category of disorders may be less familiar to you. **Dissociative disorders** are characterized by disruptions in consciousness, memory, sense of identity, or perception (Spiegel et al., 2011). As the label indicates, the primary feature of this class of disorders is *dissociation,* meaning that significant aspects of experience are kept separate—disassociated—in consciousness and memory. Dissociation usually occurs when a situation becomes overwhelmingly stressful, leading the person to psychologically escape by separating his or her consciousness from the painful situational memories, thoughts, and feelings.

Consider what sometimes happens after a natural disaster, such as a flood or hurricane. Some victims are found wandering in a daze, only dimly aware of what is going on around them. Even though they may not have suffered any head injuries, these individuals may not remember their names, addresses, events leading up to the disaster, or other basic information that they would typically know. Although these individuals will likely experience this dazed state only temporarily, in some cases, the symptoms are prolonged; in such instances, the person is diagnosed as having a dissociative disorder. Dissociative disorders generally involve severe symptoms and greater use of mental health treatment compared to other psychiatric disorders; thus, they are very costly to treat and involve a great deal of emotional suffering by those afflicted (Brand et al., 2012).

Dissociative Amnesia

Dissociative amnesia
A dissociative disorder characterized by the inability to recall important personal information, usually of a traumatic or stressful nature

This type of dissociative disorder, sometimes suffered by victims of natural disasters, involves the inability to recall important personal information, usually of a traumatic or stressful nature. Of course, some cases of amnesia are due to organic causes, such as a head injury or a brain tumor. However, when there are no known organic causes and the person's memory loss is isolated to information threatening to the self, it is known as **dissociative amnesia**. Individuals with dissociative amnesia are frequently unaware—or are only partially aware—of their memory problems.

There are two primary forms of dissociative amnesia: (1) *localized amnesia* for a specific event or events, and (2) *generalized amnesia,* which is a complete loss of memory for identity and life history. Many individuals with localized amnesia minimize the importance of their memory loss and may become uncomfortable when encouraged to acknowledge and address it. Generalized amnesia has an acute onset and may be accompanied by the person abruptly leaving home or work and assuming a new identity without realizing that this identity is not the one that she or he had in the past. It may be hard for you to imagine how this can happen, but it does. One such case involved a "Mr. X" who experienced occasional fugue states over a period of several decades. During one episode, Mr. X married a woman—much to the chagrin of the wife he already had and whom he did not remember. In addition to dealing with the consequences of dissociative fugue, Mr. X soon faced legal charges of bigamy.

Localized amnesia is frequently claimed by about one-quarter to one-half of suspects in homicides (Pujol & Kopelman, 2003). Although some of these cases may involve a genuine form of dissociative amnesia, faking is fairly common in such offenders (Zago et al., 2024). Because amnesia is so often claimed but also difficult to accurately assess, the courts are usually very cautious in considering the defendant's amnesia as genuine.

Dissociative Identity Disorder

By far, the dissociative disorder that has received the most attention is **dissociative identity disorder (DID)**, also known as *multiple personality disorder* (Saxena et al. 2023). This condition is characterized by the presence of two or more distinct identities or personalities, which take turns controlling the person's behavior. At least one of the personalities is unaware of what transpired when it was not in control. In some cultures, this disorder is thought to be an experience of possession by an otherworldly spirit or demon. The symptoms of DID are bizarre and extreme. One personality may be that of a 6-year-old child, while another may be that of an infirm grandparent. One personality may be male, while another may be female. Because of the fascinating nature of its symptoms, DID has received a great deal of attention from popular culture, ranging from the 1950s nonfictional book and movie *The Three Faces of Eve* (Thigpen & Cleckley, 1957) to the 1990s fictional novel and film *Fight Club* (Palahniuk, 1996).

Dissociative identity disorder (DID)
A dissociative disorder characterized by the presence of two or more distinct identities or personalities that take turns controlling the person's behavior; also known as multiple personality disorder

Prior to 1980, DID was considered one of the rarest forms of psychological disorder, with only about two cases reported per decade from 1930 to 1960 (McHugh, 1995). Yet, in the 1980s, over 20,000 cases were reported! Skeptics doubted that this increase was due to better diagnosis. Instead, they suggested it was caused both by the media coverage of multiple personalities and by psychotherapists' use of hypnosis and other suggestive techniques that can sometimes elicit DID-like symptoms in patients. According to this argument, psychotherapists may first wonder whether a patient's chaotic and unpredictable behavior is due to DID. Then, during therapy sessions, they ask leading questions that suggest the possibility of DID. Further, they may use hypnosis to try to draw out the multiple personalities. However, one of the unfortunate consequences of hypnosis is that it can lead its subjects to produce "memories" that are not true (see Chapter 5, Section 5.3a). Because these patients are distressed and looking for ways to understand their problems, they may come to accept the multiple personality explanation (Lilienfeld et al., 1999; Pietkiewicz et al. 2021).

AP Photo/*Lexington Herald-Leader*, File

In the 1970s, the book and movie *Sybil* was an international sensation with its depiction of the real-life story of Shirley Ardell Mason, who was diagnosed with 16 different personalities. Mason's story was very influential in focusing the public's attention on dissociative identity disorder. In 2011, evidence came to light suggesting that Mason made up the multiple personalities for attention and excitement (Nathan, 2011).

Research since 1980 has shown that DID is more common than was once believed (Gleaves, 1996). Although it is likely that some cases are manufactured in therapy sessions, most psychologists believe that the research evidence suggests this disorder is rare (about 1.5%), but real (Boysen, 2011; Hawayek, 2024). Women and men are about equally likely to suffer from DID, and more than 90% of people with DID have histories of childhood physical and sexual abuse (Schmidt, 2004).

Etiology of Dissociative Disorders

Many studies examining the etiology of dissociation report that trauma, especially childhood trauma, is closely associated with dissociation (Howell, 2011). Psychodynamic theory suggests that this dissociation is initially used by the child to repress some troubling event. If this event is associated with intense emotion, a corresponding high degree of repression may be required to keep this material in the unconscious. In adulthood, while continuing to repress the memory of the troubling event, the individual also inadvertently represses other memories, including those related to identity. In the case of fugue and DID, individuals develop an alternative identity or identities to avoid facing the stress that would occur upon recognizing that they had lost memory of their identity and other personal information.

Invoking a biological explanation, some psychologists suggest that dissociative disorder patients may have an undetected neurological problem (Bergmann, 2008; Spiegel et al., 2011). For example, neurological studies on people with a history of trauma find they tend to have memory disorders associated with reduced hippocampal and amygdala functioning, and that dissociative symptoms may also be caused by such changes (Chalavi et al., 2015; Spiegel, 1997). That is, because the hippocampus is involved in long-term memory formation and storage, and the amygdala is a major processing center for emotions and emotion-related memories, the amnesia observed in dissociative disorders may be due to these deficits in brain functioning. Research has also shown that individuals with dissociative disorders have high rates of epilepsy and that those with epilepsy have high rates of dissociative disorders (Bob et al., 2002). As intriguing as these biological explanation may be, they cannot account for all cases of dissociative disorder because most DID patients do not have the hallmark abnormal brain wave patterns found among epileptic sufferers or the reduced hippocampal and amygdala functioning. Still, it is possible that at least some individuals with dissociative disorders are suffering from neurological disorders that have not yet been detected.

Another explanation of dissociative disorders comes from the cognitive perspective. This approach holds that individuals learn to dissociate as a way of coping with intense distress. When a child is exposed to prolonged, intense stress (such as torturous abuse), dissociation may be used so frequently that it becomes automatic. Consistent with this idea, several cognitive techniques have been effective in helping to limit pain and emotional distress. For example, distraction (thinking of something other than the stressful stimulus, such as the lyrics to a song), fantasy (imagining oneself as another person, such as James Bond, resisting torture), and imagery (imagining oneself in a peaceful situation other than the current stressful one) all have been shown to reduce subjective pain (Meichenbaum & Turk, 1976). Perhaps a child who experiences repeated abuse learns to cope using these cognitive techniques. Over time, the child's use of these cognitive pain-management techniques becomes automatic, even in the presence of mild stressors. At this point, the individual's dissociation no longer serves the function of protecting her or him from stress but is a problem that interferes with daily functioning in and of itself. Psychophysiological studies of DID patients provide some support for this hypothesis. When subjected to the kind of intense stress that precipitates a dissociated state, DID patients also experience a reduction in nervous system arousal (Williams et al., 2003). These results support the idea that the dissociated state functions as a protective mechanism for the person.

11.2e Depressive and Bipolar Disorders Are Characterized by Emotional Extremes

Prior to *DSM-5,* depressive disorders and bipolar disorders were under one large category of *mood disorders,* but now they are separated from one another. While acknowledging this category change, in this introductory text, the two categories of *depressive disorders* and *bipolar disorders* will be discussed sequentially because they both involve emotional extremes that cause significant disruption in daily functioning (Kupfer et al., 2012).

Depressive Disorders

Have you ever had "the blues"? Most people have had days when they felt sad, lethargic, and uninterested in their usual activities. These symptoms are relatively common; almost 30% of the general population reports experiencing depressed mood for at least 2 weeks at some time in their lives. However, if this depressed mood persists for a long time, it likely qualifies as a depressive disorder.

The most common depressive disorder is **major depressive disorder** (often referred to simply as *depression*), which is characterized by extreme and persistent negative moods and the inability to experience pleasure by participating in activities one previously enjoyed (Kristensen et al., 2012). Depressed individuals often experience physiological problems, such as lack of appetite, weight loss, fatigue, and sleep disorders. In addition, depressed individuals often experience behavioral symptoms, such as slowed thinking and acting (called *psychomotor impairment*), social withdrawal, and decreased rate of activity. Finally, depressed people exhibit cognitive symptoms, including low self-esteem, negative thoughts, thinking about death and/or suicide, and having little hope for the future. When these symptoms are severe, persistent, and interfere with daily functioning, the person is diagnosed as having major depressive disorder. When these symptoms are mild but persistent, lasting for more than 2 years, the individual is diagnosed with **persistent depressive disorder** (previously known as *dysthymia*). The average duration of persistent depressive disorder is about 5–10 years (Subodh et al., 2008).

Major depressive disorder
A mood disorder characterized by extreme and persistent negative moods and the inability to experience pleasure from activities previously enjoyed

Persistent depressive disorder
Chronic low-level depression lasting more than 2 years

Because major depressive disorder is so common—an estimated 21 million US adults (8% of the adult population) have at least one major depressive episode with severe impairment in a given year—it has been termed the "common cold" of mental illness and it costs the US economy approximately $382 billion annually (National Institute of Mental Health, 2023). Further, people who experience major depressive disorder often have multiple recurrences (Solomon et al., 2004). Figure 11–3 lists some well-known individuals who have struggled with this disorder during their lives. Cross-culturally, depression occurs about twice as frequently in women as in men (see Figure 11–4), but significant variations are seen between cultures (Kwon et al., 2013; Umegaki et al., 2024). Depression is also associated with age. For example, in the United States, the risk of having a major depressive episode each year is highest (13.1%) among people between the ages of 18 and 25 years. Although depression does occur in children, the risk among those younger than 10 years is much lower than that among adolescents and adults.

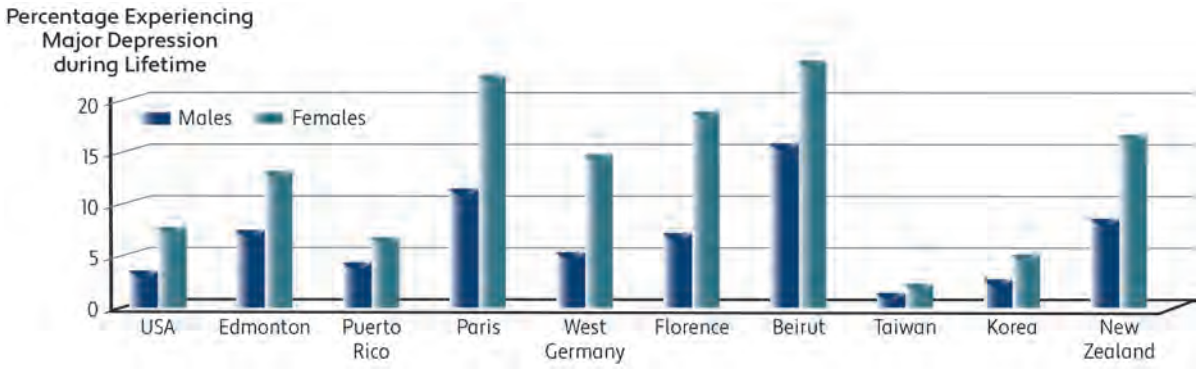
Figure 11-3 Well-Known People Who Have Struggled with Depression

Historical Figures	Contemporary Figures
John Adams, US president	Buzz Aldrin, US astronaut
Agatha Christie, British crime author	Bruce Springsteen, US singer-songwriter
Winston Churchill, British prime minister	Jim Carrey, Canadian actor and comedian
Charles Dickens, British author	Dwayne Johnson, US actor
William James, US psychologist and philosopher	Harrison Ford, US actor
Abraham Lincoln, US president	Katy Perry, US singer-songwriter
Martin Luther, German theologian	Lady Gaga, US singer-songwriter
Sigmund Freud, Austrian psychoanalyst	Ewan McGregor, Scottish actor
Isaac Newton, British physicist	Gwyneth Paltrow, US actor
Sylvia Plath, US writer	J. K. Rowling, British writer
Edgar Allen Poe, US author and poet	Amy Tan, US writer
Leo Tolstoy, Russian writer	Uma Thurman, US actor
Virginia Woolf, British writer	Oprah Winfrey, US talk-show host

Figure 11-4 Gender and Major Depression

Interviews with 38,000 women and men in 10 countries found that women's risk of experiencing major depression is double that of men's. Lifetime risk of depression among adults varies by culture.

Data from "Cross-National Epidemiology of Major Depression and Bipolar Disorder," by M. Weissman, R. Bland, G. Canino, et al, *JAMA*, 1996; 276 (4):293–299.



One of the major challenges of depression is the way it alters a person's way of thinking. Although nondepressed individuals have a normal mix of positive and negative thoughts every day, those suffering from major depressive disorder filter the world predominantly through negative thoughts, which results in a distortion of reality and an extremely negative outlook on life. For depressed individuals, it isn't a matter of the glass being half full or half empty, but instead, the glass is often thought to be virtually empty. In other words, people with depression become trapped in a dangerous cognitive emotional spiral of *negative automatic thoughts,* where depression leads to negative thinking, and negative thinking makes them even more depressed. Check out *Self-Discovery Questionnaire 11–1*, which discusses a strategy to change this sort of negative self-talk into more positive self-talk.

Self-Discovery Questionnaire 11–1

How Can You Change Negative Self-Talk?

Negative automatic thoughts, or negative self-talk, involves any inner dialogue you have with yourself that may be limiting your ability to believe in yourself and your own abilities, and to make positive changes in your life. This inner dialogue may sound a lot like a critical parent or friend from your past and it can be very stressful. The good news is that, with practice, you can learn to recognize negative automatic thoughts and turn them into more constructive, positive thoughts. An important first step in changing negative self-talk is to learn to notice when you're being self-critical so you can short-circuit this thinking. For example, notice when you say things to yourself that you wouldn't say to a good friend or a child. Next, alter some of the wording in your negative self-talk, such as "should," "can't," and "never." Doing so can remove guilt triggers and self-defeating language that can spiral into more negative thoughts. In the exercise below, try turning these examples of negative self-talk into positive thoughts. I've filled in a few to get you started.

Instead of the negative self-talk . . .	Think the more positive . . .
I should exercise every day	I will walk 1 mile today
I can't ace this test	I'm sure I can pass this test
I'm never going to make it today	Today is going to be a good day
It's too complicated	
I can't make this work	
No one likes me	
I can't do this	
No one can rely on me	
I'm not a good person	
I'm a loser	
I'm a failure	
I should eat healthier	
I'll never get any better at this	
I'm too lazy to accomplish this task	
I'm worthless	
Nothing turns out like I want it to	
No one really understands me	
What's wrong with me?	
I wish I could disappear	
I can't see this turning out well	

Adapted from Healthline. (n.d.). *5 Ways to Stop Spiraling Negative Thoughts from Taking Control.* Retrieved from https://www.healthline.com/health/mental-health/stop-automatic-negative-thoughts#1-remove-should-thoughts

Adapted from Mayo Clinic Staff. (2020, January 21). *Positive thinking: Stop negative self-talk to reduce stress.* Retrieved from https://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/positive-thinking/art-20043950

Adapted from "Cognitive self-statements in depression: Development of an Automatic Thoughts Questionnaire" by S. D. Hollon and P. C. Kendall in *Cognitive Therapy and Research, 4,* 1980, pp. 383–395. Copyright © 1980.

One of the major dangers of depression is suicide; about half of all suicide victims kill themselves during a depressive episode (Kokkevi et al., 2012). While the rate of suicide in the general population worldwide is around 14 per 100,000 persons (0.14%), it is 20–30 times higher among people with depressive or bipolar disorders (Miller & Black, 2020). In the United States over 49,000 people die by suicide annually, or about 14.2 per 100,000, making it the 11th leading cause of death in the country. Women are twice as likely as men to attempt suicide. But because men typically use more lethal methods (such as guns instead of pills), men are 4 times more likely to kill themselves (12.3 versus 1.8 per 100,000) (Hedegaard et al., 2021). Although age was once a significant

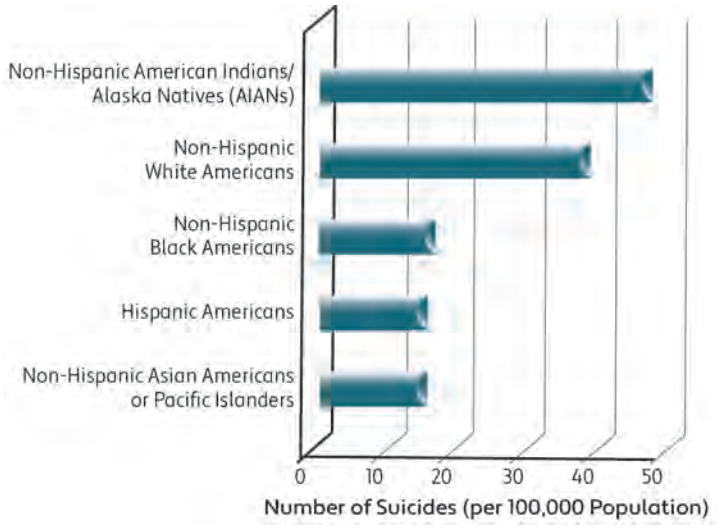
factor in predicting suicide—the elderly were 5 times more likely to die by suicide than young adults 60 years ago—this is no longer the case. According to the Centers for Disease Control and Prevention, from 1999 to 2019, the rate of suicides increased by 33% for all age groups, except age 75 and older (Hedegaard et al., 2021).

Figure 11–5 depicts the suicide rates per 100,000 people in various ethnic groups in the United States. The highest rates of suicide are among the Non-Hispanic American Indians/Alaska Natives (AIANs) (44.8), followed by Non-Hispanic White Americans (36.1), Non-Hispanic Black Americans (14.6), Hispanic Americans (13.8), and Non-Hispanic Asian Americans or Pacific Islanders (13.8). Firearms are the most common method of suicide used by both men and women in the United States, with the risk of suicide being 5 times greater for households with guns (Grossman et al., 2005).

Figure 11–5 Suicide Rates in Various Ethnic Groups

Suicide rates vary widely among ethnic groups in the United States, with rates for Non-Hispanic American Indians/Alaska Natives (AIANs) and Non-Hispanic White Americans being more than twice as high as those for Non-Hispanic Black Americans, Hispanic Americans, and Non-Hispanic Asian Americans or Pacific Islanders. Firearms are by far the most common method of suicide in the United States, with approximately 60% of suicides occurring with a firearm (Centers for Disease Control and Prevention, 2021).

Data source: "Suicide mortality in the United States, 1999–2019 NCHS Data Brief, no 398," by H. Hedegaard, S. C. Curtin, and M. Warner, 2021, Hyattsville, MD: National Center for Health Statistics.



Worldwide, the annual death toll from suicide varies by country and geographic region, with some Asian (e.g., South Korea, Japan, and China) and northern European (e.g., Lithuania, Kazakhstan, and Hungary) countries having annual suicide death rates as high as 25–34 per 100,000 (World Health Organization, 2019). Sociocultural factors, including religion, age, sex, ethnicity, and marital and employment status, are related to suicide risk. For example, countries with suicide rates as low as 4 per 100,000—nations of the Middle East (e.g., Syria, Egypt, Jordan), Central and South America (Guatemala, Paraguay, Venezuela), Greece, and Mexico—have strong religious prohibitions against taking one's own life. The *Psychological Applications* section at the end of this chapter presents additional information about suicide.

Bipolar Disorder

Depression poses serious problems in a person's life, but what about the opposite mood? *Mania* is an excessively elated, active emotional state. People in manic states experience buoyant, exuberant mood and such boundless energy that they do not feel the need for sleep. They often have increased appetites and thus overindulge in food, alcohol, drugs, and sexual activity. Manic individuals speak and move rapidly, often going from activity

to activity with endless optimism and self-confidence. Do you think that such an exaggerated emotional state could be problematic?

At first glance, manic symptoms may not seem very troublesome. They do not appear as severe as depressive symptoms, which often are accompanied by suicidal thoughts and torturous feelings. However, a person in a manic state can engage in very destructive behavior (Kerr-Gaffney et al., 2024; Martini et al., 2023). For example, they may go to a casino and lose the family's life savings in a single session at the roulette wheel, or they may feel so "on top of the world" that they drive their car 100 miles per hour, oblivious to the danger to themselves and others. Manic people may also experience such an increase in physical appetites that they engage in unprotected sex with a dozen people in a day. All these activities can destroy a person's life as decisively as a suicide attempt by a depressed person.

The double tragedy for those who experience such excessively elated, active emotional states is that they will also plunge into the depths of depression. Individuals with high levels of manic symptoms followed by high levels of depressive symptoms that persist for weeks and significantly interfere with daily functioning are diagnosed as having **bipolar disorder** (Glaus et al., 2025). Individuals who experience mild manic and depressive symptoms that persist for at least 2 years are diagnosed with *cyclothymic disorder*.

Bipolar disorder
A mood disorder characterized by swings between the emotional extremes of mania and depression

Bipolar disorder is less common than major depressive disorder, occurring in about 2.8% of the population (Solmi et al., 2022; Thomas, 2004). Unlike major depression, bipolar disorder occurs about equally in men and women and tends to occur earlier in life than major depression. Although bipolar patients usually experience episodes of severe depression as well as bouts of mania, their depressive episodes are more severe than those experienced in major depression, are accompanied by higher suicide risks, and show a distinct pattern of brain activity during sleep. This evidence suggests that bipolar disorder and major depressive disorder are distinct conditions. Further, as depicted in Figure 11–6, brain scans of bipolar patients indicate that manic periods are associated with unusually high levels of brain activity. The symptoms of manic and depressive states are summarized in Table 11–2.

Figure 11-6 Brain Activity in Bipolar Disorder

PET scans of people with bipolar disorder show substantial changes in brain activity when they cycle between mania and depression. Here, the top and bottom sets of brain scans were taken during times when the bipolar patient was depressed, while the middle set of brain scans was taken during a manic period. The red areas indicate a high level of neural activity.

Source: Phelps, M. E., & Maziotta, J. C. (1985). Positron-emission tomography: Human brain function and biochemistry. *Science, 228*, 799–809. Courtesy of Drs. Lewis Baxter and Michael Phelps, UCLA School of Medicine.

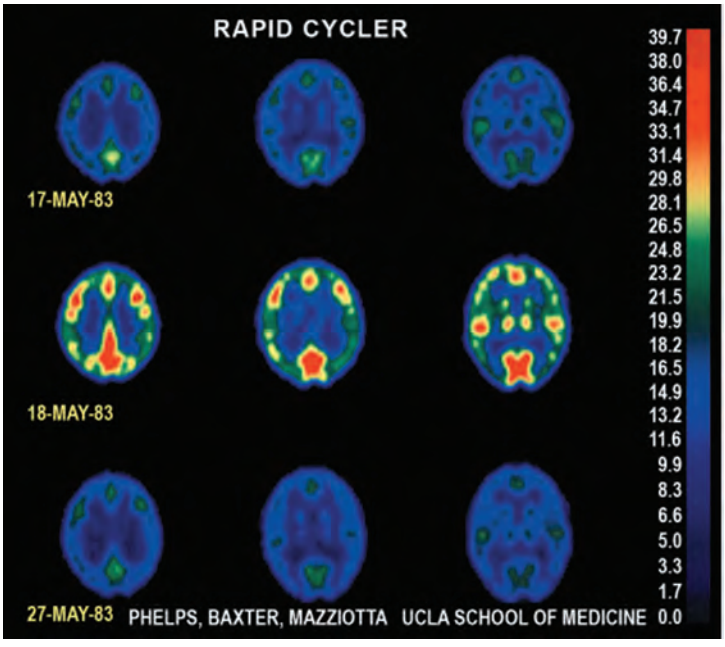


Table 11–2 Symptoms of Manic and Depressive States

Type of Symptom	Depressive State	Manic State
Emotional	▪ Sad mood ▪ Lack of pleasure	▪ Elated mood
Physiological	▪ Fatigue ▪ Sleep difficulty ▪ Decreased appetite ▪ Decreased interest in sex	▪ Increased energy ▪ Lack of need for sleep ▪ Increased appetite ▪ Increased interest in sex
Behavioral	▪ Slowed pace ▪ Decreased activity level	▪ Increased pace ▪ Increased activity level
Cognitive	▪ Low self-esteem ▪ Thoughts of death ▪ Negative view of world	▪ Increased self-esteem ▪ Lack of perception of danger ▪ Positive view of world

Etiology of Depressive and Bipolar Disorders

When seeking to explain depressive and bipolar disorders, it is important to consider the two types of disorders separately. Bipolar disorder clearly has a genetic influence, and most psychologists consider it a biological disorder (Brown, 2012). Why? The risk for bipolar disorder in family members of bipolar disorder patients is more than 30%, which is very high (Sevy et al., 1995). Exactly what is inherited that may predispose an individual to bipolar disorder is as yet unclear; one possible cause, however, is imbalances in neural circuits that use serotonin, norepinephrine, and other neurotransmitters (Pinto et al., 2011). Brain imaging studies have also found evidence that the amygdala—which plays a role in regulating mood and accessing emotional memories—may be enlarged in people who have bipolar disorder (Martini et al., 2023; Strakowski et al., 2002).

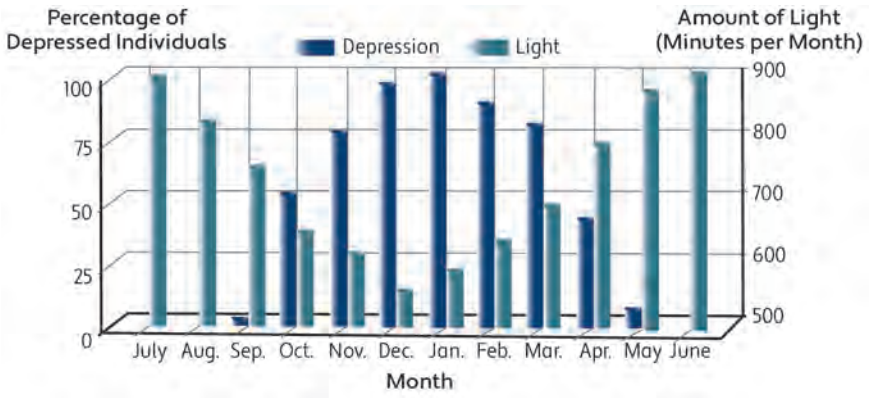
Major depressive disorder, unlike bipolar disorder, can be explained through several approaches (Nantel-Vivier & Pihl, 2008). First, biology does have some influence on this disorder (Lei et al., 2025; Rosso et al., 2005). Family, twin, and adoption studies indicate at least a moderate genetic influence on depression. For example, with identical twins, both individuals are 4 times more likely to experience depression at some time in their lives than are fraternal twins (Kendler et al., 1999). Thus, some individuals may be biologically predisposed to this disorder, and onset of the illness may have little relation to their psychosocial experiences. Such cases tend to be severe and are properly treated using antidepressant medications such as Prozac® and Paxil®.

Seasonal affective disorder (SAD)
A subtype of depression characterized by depressive symptoms during the winter months, when daylight hours are reduced

One subtype of depression that appears to have a biological basis is **seasonal affective disorder (SAD)**. SAD is characterized by symptoms of depression at particular times of the year, especially during the winter months, when daylight hours are reduced (Thompson et al., 2004). Figure 11–7 shows a direct relationship between depression and the length of daylight during the year (Rosenthal et al., 1984). Of course, some cases of winter depression may be due solely to psychosocial influences, such as decreased activity due to poor weather and increased stress brought on by holiday preparations. Yet evidence that SAD is a distinct disorder comes from studies demonstrating that people with SAD have unusually high metabolic rates, as well as physiological differences from other depressed patients (Sher, 2002). One therapy that is quite effective in alleviating SAD is exposure to full-spectrum light for 2 hours a day (Gordijn et al., 2012). This light therapy appears to restore brain levels of the neurotransmitter serotonin to normal, and a low serotonin level is one of the likely biological causes of depression.

Figure 11-7 Depression and Length of Daylight

People who suffer from seasonal affective disorder (SAD) experience periods of depression corresponding to the shorter days of winter.



Although clinical depression often has a biological basis, it is also substantially influenced by environmental stressors. For example, the COVID-19 pandemic crisis contributed to an increase in clinical depression around the world due to such stressors. In fact, the required health measures that were implemented to slow the spread of the virus—such as social distancing, business and school closings, and shelter-in-place orders—aggravated many individuals' sense of isolation and financial distress, which are triggers for clinical depression. Further, while the COVID-19 crisis increased the incidence of depression, it also made it more difficult for those who were experiencing depression to recover from the crisis. Given depression's impact on motivation and problem-solving, as countries began reopening, those who were depressed often had a harder time reengaging in their previous social and career pursuits.

Journey of Discovery

How could you explain seasonal affective disorder and its treatment using light therapy from an evolutionary perspective?

Beyond these explanations, the psychodynamic perspective (Freud, 1909) explains depression as caused by experiencing a "lost loved object" in childhood. As an adult, when the individual experiences subsequent losses, she or he becomes depressed. Rather than express anger outwardly toward whatever environmental circumstances contributed to the loss, the individual experiences "anger turned inward," blaming the self. Although this explanation of depression has received little empirical support, it has remained a popular approach for psychodynamic therapists who treat depressed patients.

As you might expect, cognitive theory suggests that depression is a thinking disorder (Riso et al., 2003). Depressed people have negative views of themselves, the world, and the future, and their irrational thinking causes them to misinterpret their daily experiences so their negative outlook is supported (Beck, 1967). Some cognitive theorists also consider many instances of clinical depression to be largely caused by learned helplessness, which is the passive resignation produced by repeated exposure to aversive events that cannot be avoided (see Chapter 6, Section 6.2g). Studies have found a strong correlation between depression-like symptoms and learned helplessness in laboratory animals (Maier & Watkins, 2005). In contrast, the behavioral perspective holds that depression results from low social reinforcement, which may be due to skill

deficits (such as the inability to solve problems or to interact successfully with others) or to decreased opportunities to interact with others. Consistent with the diathesis-stress model, research indicates that individuals with such predisposing cognitive and behavioral conditions are more likely to become depressed following stressful events in their lives (Peterson, 2010; Teri & Lewinsohn, 1985).

Finally, why does depression occur more frequently among women than men? At one time some psychologists believed that this gender difference was due to biological factors. For example, there are modest relationships between depressed mood in women and biological factors such as the different hormonal structure of the female system and women's use of oral contraceptives. However, subsequent research found little support for these hormonal factors playing a causal role in depression. Instead, a more likely explanation is that social and cultural factors related to gender socialization and cultural sexism are the more likely cause. For example, because women from a young age are more likely than men to be encouraged to attend to their emotions, they are more prone to *rumination*, which is a cognitive process characterized by repetitive, intrusive, and negative thoughts about one's problems, experiences, or emotions (Zou et al., 2025). This type of unproductive thinking is associated with depressive symptoms. Another sociocultural factor thought to be associated with higher levels of depression among women is that women tend to have fewer educational and occupational opportunities than men, and they also receive less money for their work and experience more violence due to their gender, resulting in the world being more "depressing" for them than for men. Some sociocultural theorists also contend that the reported gender difference in depression may be a statistical mistake, reflecting gender differences in seeking help and clinician bias in diagnosis (Bogner & Gallo, 2004). For example, women may seek help for depression more frequently than men, not because they suffer more from this disorder, but because they are more likely than men to seek help for their problems. Further, the mental health profession may have a bias that leads to different diagnoses for women and men, even though they present identical symptoms, with the women labeled as depressed while the men are diagnosed with other conditions.

11.2f Schizophrenia Involves Disturbances in Almost All Areas of Psychological Functioning

Schizophrenia
A psychological disorder characterized by severe impairments in thinking, such as hallucinations, delusions, or loose associations

Schizophrenia is one of the most severe forms of psychological disorder (Falkai & Moller, 2012). This disorder is so severe that it is considered a *psychosis,* meaning that the person is out of touch with reality. People with this disorder may not be aware of what is going on around them and may not be able to interact effectively with the world.

Info-Bit

Prior to 1911, schizophrenia was called dementia praecox because it was thought to be a degenerative disease of the brain (dementia) that began at a young age (praecox). Swiss psychologist Eugen Bleuler (1857–1939) challenged this view, arguing that the disorder was not always degenerative. Bleuler coined the term schizophrenia to refer to what he regarded as the essential characteristic of the disorder—a splitting (schiz) or lack of integration among the person's normal psychological functions.

Schizophrenia is characterized by severe impairments in thinking, including hallucinations, delusions, or loose associations. With *hallucinations,* some schizophrenic patients hear or see things that are not there. For example, they may hear voices that they attribute to aliens or demons. Some people with schizophrenia experience *delusions,* or irrational belief systems. For instance, they may believe that they are Jesus,

a CIA agent, the president of the United States, a robot, their shadow, or some other unusual entity. Often, delusions and hallucinations support and strengthen one another. Individuals with schizophrenia may hear voices; sometimes they attribute the voices to God, leading them to believe that they have been selected for a spiritual mission. They often also experience *loose associations,* meaning that their thoughts are disconnected from one another and from the world around them. Individuals with schizophrenia can be so disorganized in their thinking that they are unable to speak in complete sentences and can only babble. Some people's thoughts jump from topic to topic so rapidly that they cannot speak clearly. These hallucinations, delusions, and loose associations are called *positive symptoms* of schizophrenia because they are symptoms that do not typically occur in other people.

Individuals with schizophrenia also display *negative symptoms,* meaning that they do not exhibit behaviors that most other people do. For example, many individuals are socially withdrawn, unmotivated to engage in common social or recreational activities, and emotionally unresponsive. This emotional unresponsiveness is called *flat* or *blunt affect.* Schizophrenic patients may walk around a hospital ward as though they are zombies, completely uninvolved with what is going on around them.

Finally, *cognitive symptoms* of schizophrenia involve problems with working memory, attention, verbal and visual learning and memory, reasoning and problem-solving, speed of processing, and disordered speech (Abbott et al., 2012). One example of a cognitive symptom is speech that is referred to as *word salad* because spoken sentences may follow grammatical rules but the content makes little sense; words and ideas appear to be tossed around. The following is an illustration of such speech in answer to the question, "Why do you think people believe in God?"

> . . . I don't know why, let's see, balloon travel. He holds it up for you, the balloon. He don't let you fall out, your little legs sticking down through the clouds. He's down to the smokestack, looking through the smoke trying to get the balloon up you know. Way they're flying on top that way, legs sticking out . . . (Chapman & Chapman, 1973, p. 3)

Schizophrenia is diagnosed when symptoms persist for at least 6 months, are not due to some other condition (such as substance use or severe depression), and cause significant impairment in daily functioning. Because people with schizophrenia experience such severe problems in thinking, they often cannot work, manage a home or apartment successfully, or care for their basic needs. Such individuals usually require assistance to care for themselves, either from their family or a treatment center. In the absence of such assistance, many people with schizophrenia end up homeless and living on the streets.

Schizophrenia occurs in about 1% of the world's population, with roughly equal frequency among men and women, and it tends to begin more often in adolescence and young adulthood than in middle and late adulthood. Although the disorder can occur in children, it is rare in those younger than age 10. The psychotic features of schizophrenia typically emerge between the late teens and the mid-30s. The average age at the first psychotic episode is about 21 years for men and 27 years for women. About 20% of people with schizophrenia will attempt suicide on one or more occasions, with about 6% eventually succeeding (Andreasen & Black, 2006).

Etiology of Schizophrenia

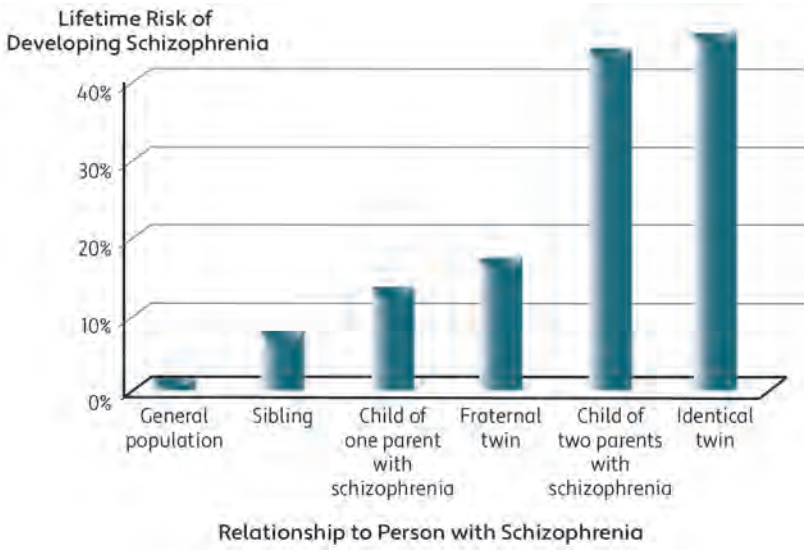
The current consensus is that schizophrenia has a strong genetic basis (Akbarian, 2010). For example, although 1% of the general population develops schizophrenia in their lifetime, from 10% to 15% of first-degree relatives (parents, children, siblings) of

a schizophrenic patient also develop schizophrenia (Willerman & Cohen, 1990). This holds true whether a person is reared in the same household as the schizophrenic person or in an adoptive home with no schizophrenic family members. Perhaps most convincing is the evidence from twin studies. Among fraternal-twin pairs in which one member displays schizophrenia, the other member has about a 15% risk of also developing the disorder, about the same as for non-twin siblings. However, among identical twins, the risk jumps to about 50% (Shorter & Miller, 2015; Tsuang, 2000). Figure 11–8 depicts these findings.

Figure 11-8 Risk of Developing Schizophrenia

The lifetime risk of developing schizophrenia increases with genetic closeness to relatives with schizophrenia.

Sources: "Epigenetics of schizophrenia," by S. Akbarian, 2010, in N. R. Swerdlow (Ed.), *Behavioral neurobiology of schizophrenia and its treatment* (pp. 611–628), New York, NY: Springer; "Epigenetic mechanisms in schizophrenia," 2015, by K. R. Shorter and B. H. Miller, *Progress in Biophysics and Molecular Biology, 118*(1–2), 1–7; "Schizophrenia: Genes and environment," by M. Tsuang, 2000, *Biological Psychiatry, 47*(3), 210–220; *Psychopathology,* by L. Willerman and D. B. Cohen, 1990, New York, NY: McGraw-Hill Education.



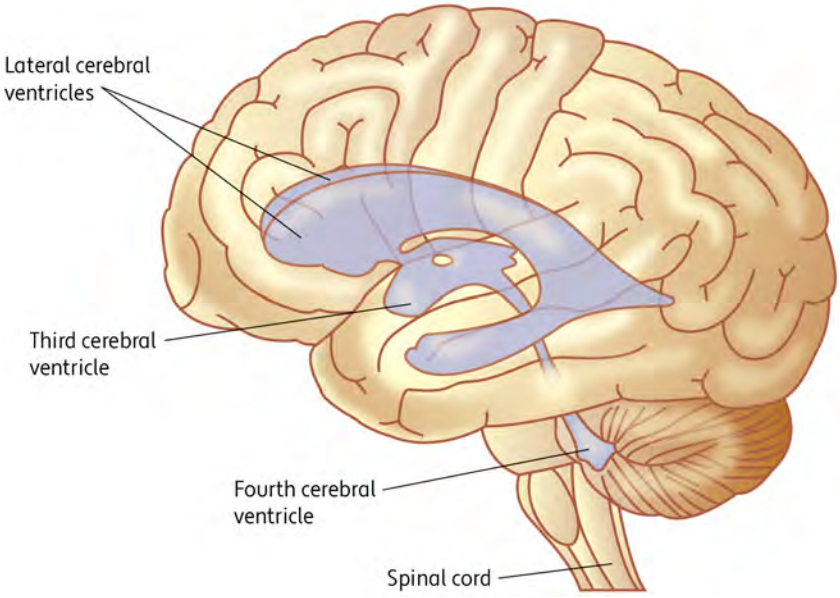
What biological condition is inherited that may predispose for the development of schizophrenia? Most antipsychotic medications that control the symptoms of schizophrenia have the effect of decreasing the amount and/or activity of dopamine, a neurotransmitter that facilitates movement and influences thought and emotion (see Chapter 2, Section 2.1d). Amphetamines and other medications that increase the amount or activity of dopamine can induce symptoms that mimic those of schizophrenia (Green, 1998). Further, autopsies of individuals who suffered from schizophrenia often reveal an unusually high number of dopamine receptors in the brain (Seeman et al., 1993). Thus, compelling evidence indicates that increased dopamine activity is related to schizophrenia. According to this *dopamine hypothesis,* schizophrenic symptoms, such as seeing and hearing things that are not there and have racing thoughts that cannot be controlled is due to dopamine pathways in the brain being overactive (Gründer & Cumming, 2016).

Another biological explanation for schizophrenia is that it is caused by abnormalities in brain structure (Brown & Thompson, 2010; Brunner et al., 2025). As illustrated in Figure 11–9, brain scans of some schizophrenic patients show enlarged ventricles (brain cavities filled with cerebrospinal fluid) in the cerebral cortex and a corresponding shrinkage in temporal lobes and frontal lobes, as well as abnormal blood flow in certain brain areas (Arasappa et al., 2013; Wright et al., 2000). What might have triggered this shrinkage of the cerebral cortex? Because schizophrenia often develops at about

the same time that rapid changes are occurring in the adolescent brain (see Chapter 3, Section 3.5b), some neuroscientists suggest that this disorder is caused by excessive pruning of neurons and their interconnections (Sekar et al., 2016). Evidence supporting this theory comes from MRI studies indicating that while average adolescents lose about 15% of their neural mass during this important stage of brain maturation, those who develop schizophrenia lose as much as 25% (Gogtay et al., 2004). Related to these findings are studies suggesting that some of the hormones flooding the brain during puberty may activate previously dormant "vulnerability genes" that cause the type of abnormal brain development associated with schizophrenia (Walker & Bollini, 2002). Thus, the development of schizophrenia may be at least partially caused by an overzealous process of brain sculpting during the teen years.

Figure 11-9 Brain Abnormalities in Schizophrenia

The hollow cavities in the brain (ventricles) are filled with cerebrospinal fluid. Brain scans suggest that people suffering from schizophrenia may have enlarged ventricles, as shown here, which is consistent with additional findings that people with schizophrenia have fewer brain neurons than do normal individuals. This shrinkage of the brain may be caused by the excessive destruction of neurons and their interconnections that occurs during adolescent brain maturation.



Brain sculpting earlier in life—during fetal development—is also a possible contributing factor in the later development of schizophrenia. As previously discussed in Chapter 3, Section 3.1c, a fetus's brain produces about 250,000 new neurons per minute. With such rapid brain growth in the womb, any kind of disease or toxic substance experienced by the mother can have a profound impact on the fetus's developing brain. Several studies have found evidence that increased risk of schizophrenia is related to prenatal exposure to such infections and diseases as influenza, rubella, and herpes (Brown, 2006). One theory is that maternal infections and diseases adversely affect genes that regulate how neurons in the frontal lobes of the cerebral cortex communicate with one another, causing the disordered brain activity typical of schizophrenia (Bassett et al., 2008).

Regarding behavioral explanations for schizophrenia, during the 1950s some theorists proposed that the disorder might directly result from disturbed family interactions that teach children to communicate in a confusing fashion (Mednick, 1958). By the 1970s, this "disturbed family" explanation had been discarded due to lack of empirical support.

Although family or social factors do not cause schizophrenia, the diathesis-stress model suggests that environmental factors such as acute poverty and poor parenting may interact with biological factors in triggering the onset of the disorder. Such environmental factors may influence the course of the disorder by increasing the stress level of individuals who are biologically predisposed for schizophrenia (Walker & Diforio, 1998). By contrast, individuals who face similar environmental stressors but do not have the necessary biological vulnerability (the diathesis) will not develop schizophrenia.

Currently, the diathesis-stress model, which considers the interaction of both biological and environmental factors, provides the best explanation of this highly complex psychological disorder. This disorder does have a strong genetic component, but what is inherited is not the disorder itself but a state of vulnerability manifested as neuropsychological impairment (Byrne et al., 2003).

11.2g Personality Disorders Involve Significant Impairments in Personality Functioning

Personality disorders
A category of disorders characterized by general styles of living that are ineffective and that can lead to problems

A final category of psychological problems is composed of the personality disorders. **Personality disorders** differ from the other psychological disorders considered so far in that personality disorders are not associated with specific symptoms that cause distress or interfere with daily functioning (Samuel et al., 2012). Instead, they are characterized by general styles of living that are ineffective and lead to problems for the person and for others. Personality disorders develop by adolescence or young adulthood and typically persist for a long time. They are associated with personality traits that are extreme and inflexible, and that ultimately lead the person to have problems in daily functioning. Often, individuals with personality disorder do not consider their personality to be a problem but instead blame others for their problems. Figure 11–10 lists and briefly describes the 10 primary personality disorders identified in *DSM-5.* As you can see, *DSM-5* groups the personality disorders into three clusters based on the following shared behavior patterns: Cluster A, odd or eccentric; Cluster B, dramatic or erratic; and Cluster C, anxious or fearful. To illustrate this category of disorders, let us examine a bit more extensively three of these disorders.

Two of the more common personality disorders are borderline personality and narcissistic personality. *Borderline personality disorder* is characterized by unstable personal relationships, self-concept, and emotions. Because individuals suffering from this disorder tend to see things in terms of extremes, such as things being either all good or all bad, their perceptions of events and other people often change quickly. A person who is looked up to one day may be looked down on the next day. *Narcissistic personality disorder* is characterized by an extremely positive, self-centered, and arrogant self-concept with little empathy for others. Individuals suffering from this disorder crave constant admiration from others. Their overblown sense of self-importance and egocentric focus make them feel entitled to special privileges without any kind of reciprocation (Kacel et al., 2017). Throughout history, narcissists have emerged in times of crisis to inspire people and to shape the future, but their self-centeredness, arrogance, and utter disregard for others often leads to disastrous consequences. As with the other personality disorders, individuals with these two disorders are extremely difficult to live with on an everyday basis.

Figure 11-10 Personality Disorders and Their Symptoms

Cluster A (Odd or Eccentric)	
Cluster and Type	**Typical Symptoms**
Paranoid	Intense distrust and suspicion of others; assumes all are hostile
Schizoid	Detachment from social and sexual relationships; restricted range of emotions in social settings
Schizotypal	Acute discomfort with, and reduced capacity for, social relationships; odd perceptions and eccentricities
Cluster B (Dramatic or Erratic)	
Cluster and Type	**Typical Symptoms**
Histrionic	Excessive emotionality, preoccupation with being the center of attention, emotional shallowness
Narcissistic	Grandiose perceptions of self-importance, need for admiration, lack of empathy, arrogance
Borderline	Instability of interpersonal relationships, self-concept, and emotion; impulsivity; angry outbursts
Antisocial	Disregard for, and violation of, the rights of others; deceitfulness; consistent irresponsibility
Cluster C (Anxious or Fearful)	
Cluster and Type	**Typical Symptoms**
Avoidant	Social inhibition, feelings of inadequacy, hypersensitivity to negative evaluation
Dependent	Helplessness, excessive need to be taken care of, submissiveness and clinginess; fear of separation
Obsessive-compulsive	Preoccupation with orderliness, perfectionism, and control *(Note: Obsessive-compulsive personality disorder is different from obsessive-compulsive disorder.)*

Antisocial Personality Disorder

Antisocial personality disorder
A personality disorder characterized by a persistent pattern of disregard for, and violation of, the rights of others

By far, the personality disorder that has received the most attention is the **antisocial personality disorder**, which is quite similar to *psychopathy,* a diagnostic category that is not used in the *DSM-5* (Bateman & Fonagy, 2012). Individuals with antisocial personality disorder exhibit a persistent pattern of disregard for, and violation of, the rights of others, occurring since age 15. They repeatedly exhibit antisocial behavior across all realms of life, often lying, cheating, stealing, and manipulating others to get what they want (Ermer & Kiehl, 2010). When other people catch them in their deceit, they fail to take responsibility and do not exhibit remorse. In addition to their lack of remorse and empathy toward others, they often engage in risky and irresponsible actions.

Although this description sounds nasty, people with antisocial personality disorder are, surprisingly, often charming and likable. They have learned how to manipulate people to get what they want and can lie without hesitation or guilt. Although only about 3% of the population has antisocial personality disorder—with men outnumbering women 3 to 1—some studies suggest that more than half of male prison inmates have this disorder (Arboleda-Florez, 2007). At present, there is no effective treatment for antisocial personality disorder, mainly because individuals who demonstrate true psychopathic tendencies tend to view themselves as normal and not needing treatment.

AP Photo/Heiko Junge, Pool

Determining whether individuals who commit crimes are suffering from a psychological disorder has important implications for their prosecution and sentencing. On July 22, 2011, Anders Behring Breivik killed eight people with a bomb in Oslo, Norway, before carrying out a mass shooting at a Norwegian youth camp where he killed another 69 people, mostly teenagers. Although Breivik's callous lack of empathy and remorse on that day and during his trial is typical of people with antisocial personality disorder, he was judged to be mentally competent.

Etiology of Personality Disorders

As with other mental health disorders, the causes of personality disorders aren't fully understood, yet a good deal of research points to a likely genetic component, perhaps related to abnormal brain development or chronic underarousal of both the autonomic and central nervous systems (Sundram et al., 2012). Regarding borderline personality disorder, some studies of twins and families suggest that this disorder may be inherited or strongly associated with other mental health disorders among family members. Other studies suggest that changes in certain areas of the brain involved in emotion regulation, impulsivity, and aggression may contribute to the onset of this disorder. Regarding narcissistic personality disorder, genetic and biological factors, as well as environment and early life experiences, are all thought to play a role in the development of this condition.

Regarding the possible causes of antisocial personality disorder, one study of 14,000 adoptions found that adopted-away sons of fathers with a criminal background are themselves at increased risk for experiencing legal problems as adults, even when reared by noncriminal adoptive fathers (Mednick et al., 1987). Further, this study found that the more habitual the criminal history of the father, the more likely that the adopted-away son will engage in criminal behavior. Similarly, large-scale twin studies indicate that identical twins resemble one another with respect to various types of antisocial behavior more than do fraternal twins (Kendler et al., 2012; Lykken, 1995). At the brain activity level, research suggests that individuals with antisocial personality disorder tend to have a smaller amygdala than normal individuals (Marsh et al., 2011). As discussed in Chapter 2, Section 2.3b, this brain area is associated with fear and emotional learning. Additional research finds that individuals with antisocial personality disorder have higher pain thresholds and do not experience fear or anxiety nearly to the same degree as the average person (Lykken, 1995). This research suggests that individuals with antisocial personality disorder have a lower overall level of nervous system arousal, which may partly explain why they engage in sensation-seeking behavior and do not learn from punishment. The current thinking is that both biological and environmental factors interact to cause antisocial personality disorder (Choy & Raine, 2024; Hiatt & Dishion, 2008). For instance, there may be a biological predisposition, such as a neurological influence on impulse control. Children with this predisposition who are reared in chaotic households may not learn to control their impulses and so behave in ways to maximize their benefit, even if this means violating social rules. On the other hand, children with this predisposition who are reared in more stable homes are more likely to acquire self-control techniques so they do not act to satisfy their immediate impulses.

Every normal man must be tempted at times to spit upon his hands, hoist the black flag, and begin slitting throats.

—H. L. Mencken, US political commentator, 1880–1956

Good people do not need laws to tell them to act responsibly, while bad people will find a way around the laws.

—Plato, Greek philosopher, 427–347 BCE

Review

- The *DSM-5* lists major classes of psychological disorders.
- Anxiety disorders involve distressing, persistent anxiety and related behavioral disturbances.
- Obsessive-compulsive and related disorders involve distressing thoughts and strong urges.
- Trauma- and stressor-related disorders involve difficulties caused by adverse life events.
- Dissociative disorders involve loss of contact with portions of one's consciousness or memory.
- Depressive and bipolar disorders involve emotional extremes.
- Schizophrenia involves disturbances in almost all psychological functioning.
- Personality disorders involve significant impairments in personality functioning.
- For individuals with personality disorders, their general styles of living are ineffective and lead to problems.

Psychological Applications

Some Important Facts about Suicide

There are many misconceptions about suicide. In this section, let me address five commonly asked questions concerning this important issue and provide information that may prove helpful to you now or in the future (Neuner et al., 2008).

- Does suicide run in families? Not exactly. People who have major mood disorders, such as severe depression and bipolar disorder, are at increased risk for suicide. It is possible to find families that have histories of suicide across generations, but the genetic influence appears to be related to the mood disorder rather than to suicide itself.
- Is it true that people who talk about suicide never actually carry through with the act? No! This is a dangerous misconception. One of the best predictors of suicide risk is a stated suicide threat. In fact, some form of warning precedes 80% of all suicides. Psychologists therefore take every threat of suicide seriously, at least until they can conduct a thorough evaluation of risk in the individual case. Some threats may be veiled. For example, a person may give away her prized possessions or talk about "getting away to end my problems." Observers should be sensitive to such hints of suicidal thinking and should ask direct questions about the person's intentions.
- Does every person who attempts suicide truly want to die? No! Suicide attempts are often impulsive, prompted by fleeting emotional crises, and some of these attempts are designed more to get attention and help than to die. For example, a person who takes a half-bottle of baby aspirin or who scratches his or her wrist with nail clippers may not truly have intended to die. Such nonlethal attempts are called "suicidal gestures" and are considered cries for help. However, psychologists must be careful when working with clients who have histories of suicidal gestures because such clients are often not thinking in a rational manner. The fact that a person has made several suicidal gestures in the past does not mean that she or he will not make a more lethal attempt in the future (Cooper et al., 2005). Also, some people who make suicidal gestures make a mistake and inadvertently kill themselves, even though that may not have been their true intention.
- Why do men have a higher suicide rate than women? Even though women attempt suicide more often than men, men have a higher suicide rate. The explanation for this gender difference is complex. Men attempt suicide by using guns, hanging, and leaping from high places more frequently than do women (Rosenberg et al., 1999; Studdert et al., 2020). Thus, men tend to use methods that are more lethal and less reversible than do women, who more frequently use pills (see Chapter 14, Section 14.4b). Although you can kill yourself with pills, they take time to work; thus, people have more time to change their minds or be found and saved. Now, why do men and women use these different methods? Perhaps men have more familiarity with and accessibility to firearms than do women, which leads men to select this more lethal method. Or perhaps men are less willing than women to call for help, so men are less likely to make a suicidal gesture.
- What should I do if a friend is talking about suicide? It is important that you take the threat seriously because providing those at high risk with help and social support can prevent many suicide attempts. However, it is also important to recognize that you are

not a mental health professional; thus, you are not equipped to evaluate suicide risk or provide psychotherapy. As a friend, you can listen and provide appropriate comfort and support; however, it is important to encourage your friend to seek professional help. You can convey the information that depression is not a sign of weakness or craziness but instead is recognized as a mental illness. You can convey the information that depression is well understood by the mental health profession and that there are effective treatments for it. However, it will be up to the mental health professional—not you—to provide this treatment. If your friend does not take your advice, perhaps you can find someone important in your friend's life—a family doctor, a member of the clergy, a family member—who can convince your friend to see a mental health professional. As a last resort, a suicidal individual may be committed against his or her will to a psychiatric hospital for treatment. Commitment procedures vary across states, and they usually require the request of a relative and the opinion of one or more physicians that the individual is dangerous to himself or herself, or dangerous to others, and unable to make decisions in his or her best interest. Although commitment may seem a drastic step, it is far better to commit someone to treatment than lose them through suicide.

Chapter Review

Suggested Websites

National Institute of Mental Health (NIMH)

http://www.nimh.nih.gov/

This website, intended for both the general public and mental health professionals, includes information on various psychological disorders.

HealthCentral

https://www.healthcentral.com/category/mental-health

This website provides information about mental health symptoms, tools, and treatment.

Schizophrenia.com

http://www.schizophrenia.com/

This website provides not only information on schizophrenia but also discussion and support groups.

Key Terms

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Review Questions

1. The diagnosis of psychological disorders relies on specific criteria that distinguish normal from abnormal behavior. Which of the following is one of the most important of these criteria?
   a. an uncontrollable urge for freedom
   b. behavior that is disruptive or harmful to the individual or others
   c. behavior that is infrequent in the "normal" population
   d. extremely odd or eccentric behavior
   e. personal distress
2. A variety of theories attempt to explain the etiology of psychological disorders. How does the cognitive approach primarily explain mental illness?
   a. as behavior that has been conditioned through reinforcement and punishment
   b. as resulting from a diathesis-stress model of vulnerability interacting with environmental stressors
   c. as associated with broad sociocultural forces
   d. as a product of unconscious forces shaped by childhood experiences
   e. as a learned pattern of faulty thinking or maladaptive interpretations
3. The use of diagnostic labels carries both risks and benefits to the patient, including all except which of the following?
   a. the ability to convey information about possible causes of the disorder
   b. the ability to summarize the patient's symptoms or problems
   c. dehumanization of patients by treating them as "labels" rather than individuals
   d. the ability to convey information about the patient's prognosis
   e. the ability to stigmatize patients so they have greater credibility in the eyes of others
4. What is the term for an attribute that serves to discredit a person in the eyes of others?
   a. stereotype
   b. stigma
   c. schema
   d. schemata
   e. socialization
5. Negative attributions surrounding mental illness can result in which of the following?
   a. avoiding seeking treatment
   b. lowered self-esteem
   c. hopelessness
   d. social isolation
   e. All of the above
6. What has research on the association between violence and mental illness found?
   a. that there are no differences at all between the mentally ill and the general population
   b. that there are significant differences between the mentally ill and the general population
   c. that, except for extreme cases of severe psychopathology, there are no differences between the mentally ill and the general population
   d. that violence levels among the mentally ill and the general population are disturbingly high
   e. that evidence has been inconclusive
7. Why is the *Diagnostic and Statistical Manual of Mental Disorders* considered, primarily, a work in progress?
   a. Ongoing research seeks to continually improve the reliability and validity of *DSM-5* diagnoses.
   b. The manual is currently undergoing its first classification revision.
   c. There is a lack of agreement among insurance companies concerning how the *DSM-5* classifies mental illness.
   d. The etiological descriptions provided by the *DSM-5* are considered tentative.
   e. The criteria specified for diagnosing mental disorders are vague and unclear.
8. Panic disorder is characterized primarily by which one of the following symptoms?
   a. extended periods of excessive fear lasting for several days at a time
   b. avoidance of places where previous attacks have not occurred
   c. brief attacks of intense anxiety that occur for no apparent reason
   d. strong, irrational fears of specific objects or situations
   e. subclinical phobias that do not interfere with normal functioning

9. Obsessive-compulsive disorder is unique in that two relatively distinct types of symptoms are experienced. They are which of the following?
   a. obsessions, which are unwanted, repetitive thoughts, and compulsions, which are repetitive behaviors that may disrupt daily functioning
   b. obsessions, which are desired, repetitive urges to hoard, and compulsions, which are fears of overeating
   c. obsessions, such as repeated hand washing, and compulsions, such as fear of contamination
   d. obsessions, which are urges to perform some type of repetitive or ritualistic behavior, and compulsions, which are repetitive, intrusive thoughts
   e. obsessions and compulsions, which are rarely recognized as abnormal by the individual
10. Despite the similarities in many of the symptoms of anxiety disorders, a variety of theories have been proposed to explain their causes, including which of the following?
   a. conditioning explanations for the initial onset of generalized anxiety disorder
   b. hypnotic suggestions as a cause of PTSD
   c. "fear of fear" explanations for generalized anxiety disorder
   d. sociological causes of social anxiety disorder
   e. genetic or evolutionary causes of phobias
11. Depressive and bipolar disorders may involve all except which of the following symptoms?
   a. a prolonged feeling of sadness and lethargy
   b. a change in sleep patterns
   c. repetitive lying or dishonesty
   d. difficulties concentrating
   e. thoughts of suicide
12. Which of the following is true of bipolar disorder?
   a. It affects only about 9% of the population.
   b. It is probably caused by the same etiological factors as depression.
   c. It follows the same symptom and behavior pattern in all individuals with the disorder.
   d. It involves manic behavior, which may be destructive in its consequences.
   e. It involves only mild symptoms of mania and depression, but over extended periods.
13. Etiological explanations for depression and bipolar disorder tend to be quite different, although there is some degree of overlap. Bipolar disorder is typically explained by which one of the following?
   a. misinterpretations of daily experiences
   b. a genetic or biological disturbance leading to imbalances in neural circuits
   c. low social reinforcement
   d. childhood loss, with subsequent anger turned against oneself
   e. negative views of oneself, the world, and the future
14. Of all the psychological diagnoses, dissociative identity disorder is probably the most fascinating because the symptoms tend to be so unusual. For example, some characteristic symptoms include which of the following?
   a. the presence of two or more distinct identities or personalities that take turns controlling the person's behavior
   b. the gradual assumption of a new identity, with no awareness by the individual involved, and no return to the previous identity
   c. a gradual loss of memories threatening to the self, known as dissociative amnesia
   d. a permanent "dazed" state following a trauma or tragedy
   e. both male and female personalities, in dissociative identity disorder
15. Which of the following is true of schizophrenia?
   a. It is classified as a psychosis.
   b. It tends to begin in later adulthood.
   c. It involves positive symptoms.
   d. It occurs in about 10% of the world's population.
   e. Both *a* and *c*

16. What has research investigating the etiology of schizophrenia shown?
    a. very high family risk beyond that for identical and fraternal twins
    b. that dopamine-enhancing drugs may cause schizophrenic-like symptoms, suggesting an overactive dopamine system
    c. an enlargement of the cerebral cortex and corresponding shrinkage of cerebral ventricles
    d. that disturbed family communication is directly responsible for some types of schizophrenia
    e. increased risk in families with an overbearing mother
17. How do personality disorders differ from other psychological disorders?
    a. They appear to be caused by the interaction of genetic factors, such as temperament or impulse control, and environmental influences, such as family functioning.
    b. They are almost always attributable to a single cause.
    c. They are associated with maladaptive personality traits and result in longstanding problems with living rather than extreme distress or dysfunction.
    d. Individuals with personality disorders are universally unlikable.
    e. Personality disorders involve affective, cognitive, and behavioral systems of functioning.
18. Which of the following is a common misconception about suicide?
    a. Women attempt suicide more often than men, but men have a higher suicide rate.
    b. Some suicide attempts are designed more to get attention and help than to die.
    c. People who have major mood disorders are at increased risk of suicide.
    d. People who talk about suicide never follow through with the act.
    e. Some suicide threats may be veiled; for example, a person may give away her prized possessions or talk about getting away to end her problems.

Answers: 1.b 2.e 3.e 4.b 5.e 6.c 7.a 8.c 9.a 10.e 11.c 12.d 13.b 14.a 15.e 16.b 17.c 18.d