

13 Psychological Disorders

Chapter Preview

The U.S. National Institute of Mental Health estimates that 26 percent of adult Americans suffer from a diagnosable mental disorder in a given year. Rates and symptoms vary across the world.

A psychological disorder is a syndrome marked by a clinically significant disturbance in a person's thoughts, feelings, or behaviors. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) provides an authoritative classification scheme. Whether we use a medical model or a biopsychosocial approach affects our understanding of psychological disorders. Although diagnostic labels may facilitate communication and research, they can also bias our perception of people's past and present behavior and unfairly stigmatize these individuals.

Those who suffer from an anxiety disorder may for no reason feel uncontrollably tense (generalized anxiety disorder), may experience sudden episodes of intense dread (panic disorder), or may have a persistent irrational fear (phobia). Two other disorders involve anxiety: obsessive-compulsive disorder, in which the person is troubled by repetitive thoughts and actions; and post-traumatic stress disorder, which involves a reaction to some traumatic event.

Excessive use of psychoactive drugs may result in a substance use disorder. Depressants act by depressing neural functioning. Although their effects are pleasurable, they impair memory and self-awareness and may have other physical consequences. Stimulants act at the synapses by influencing the brain's neurotransmitters. Hallucinogens can distort judgment of time and can alter sensations and perceptions. A number of those who survive a brush with death later recall visionary experiences. Drug effects depend on dosage and the user's personality and expectations.

Mood disorders include major depressive disorder and bipolar disorder. Current research on depression is exploring (1) genetic and biochemical influences and (2) cyclic self-defeating beliefs, learned helplessness, negative attributions, and aversive experiences.

The symptoms of schizophrenia include delusions, hallucinations, disorganized speech, and/or diminished, inappropriate emotional expression. Researchers have linked certain forms of schizophrenia to brain abnormalities. Studies also point to a genetic predisposition that may work in conjunction with environmental factors.

Psychological influences on eating behavior are evident in those who are motivated to be abnormally thin. In dissociative disorders, conscious awareness becomes separated from previous memories, thoughts, and feelings. Those afflicted with a dissociative disorder may even have two or more distinct personalities. Personality disorders are characterized by inflexible and enduring behavior patterns that impair social functioning. The most common is the remorseless and fearless antisocial personality.

Chapter Guide

- ▶ Project: Diagnosing a “Star” (p. 918)
- ▶ Lecture: Using Case Studies to Teach Psychological Disorders (p. 917)
- ▶ Feature Films and TV: Introducing Psychological Disorders (p. 917)

Text Questions/Online Discussion Forum: In Your Everyday Life

At the end of each chapter is at least one “In Your Everyday Life” question that helps students relate the topics to their own lives. We repeat those questions here because they also serve as useful prompts for online or other discussion forums.

1. Can you recall a fear that you have learned? What role, if any, was played by fear conditioning or by observational learning?
2. Psychoactive drugs such as alcohol, heroin, and methamphetamine all bring pleasure followed by discomfort or depression when the substance wears off. Knowing this, what strategies do you think might keep young teens from abusing substances?
3. How has student life affected your moods? What advice would you have for new students?
4. Can you think of a time when being in a sad mood has actually helped you in some ways? Did you reevaluate your situation or make new plans for the future?
5. Now that you know more about schizophrenia, do you think the media accurately portray the behavior of people with this disorder? Why or why not?
6. As his fans already know, comedian and TV personality Howie Mandel suffers from obsessive-compulsive disorder and a severe germ phobia. How do you think being labeled has helped or hurt Mandel?
7. Dissociative identity disorder is rare, but feeling like a “different person” at times is common. Can you recall ever feeling like a “different person” because of the situation you were in? What was that like?

Introductory Exercise: Fact or Falsehood?

The correct answers to Handout 13–1 are as follows: 1. F 2. T 3. F 4. F 5. T 6. T 7. T 8. T 9. F 10. F

What Is a Psychological Disorder?

- ▶ Exercises: Introducing Psychological Disorders (p. 919); Defining Psychological Disorder (p. 920)
- ▶ Lecture/Lecture Break: The Self-Diagnosis Phenomenon (p. 918)
- ▶ Project: Encounters with a “Mentally Ill” Person (p. 920)
- ▶ Lecture: The Commonality of Psychological Disorders (p. 944)

- 13-1. *Discuss how we draw the line between normal behavior and psychological disorder.*

A **psychological disorder** is a syndrome marked by a clinically significant disturbance in a person’s thoughts, feelings, or behaviors. Dysfunctional behaviors are *maladaptive*, and they are often accompanied by distress.

- ▶ Projects/Exercises: Adult ADHD Screening Test (p. 920); Normality and the Sexes (p. 921)

- 13-2. *Discuss the controversy over attention-deficit/hyperactivity disorder.*

Children once regarded as fidgety, distractible, and impulsive are now being diagnosed with **attention-deficit/hyperactivity disorder (ADHD)**. Critics question whether the label is being applied to healthy schoolchildren who, in more natural outdoor environments, would seem perfectly normal. Although the proportion of children treated for the disorder has increased dramatically, the pervasiveness of the diagnosis depends in part on teacher referrals. Others counterargue that

the more frequent diagnoses of ADHD reflect increased awareness of the disorder, particularly in those areas where the rates are highest. ADHD, which is *heritable*, often coexists with a learning disorder or with defiant and temper-prone behavior. It can be treated with Ritalin and Adderall and with psychological therapy.

► Lectures: Tourette Syndrome (p. 921); Culture-Bound Disorders (p. 922)

► Exercise: Multiple Causation (p. 922)

- 13-3. *Discuss how our understanding of psychological disorders is affected by whether we use a medical model or a biopsychosocial approach.*

The **medical model** assumes that psychological disorders are mental illnesses that need to be diagnosed on the basis of their *symptoms* and, in most cases, *cured* through *therapy*, which may include *treatment* in a psychiatric hospital.

Psychologists who reject the “sickness” idea typically contend that all behavior arises from the interaction of our biology, our psychology, and our social-cultural environment (the biopsychosocial approach). But not all disorders are culture-bound. Depression and schizophrenia appear more consistently worldwide.

► Lecture: Mental Health as Flourishing (p. 924)

► Exercise: The Flourishing Scale (p. 925)

► PsychSim 5: Mystery Client (p. 925)

- 13-4. *Describe how and why clinicians classify psychological disorders, and explain why some psychologists criticize the use of diagnostic labels.*

DSM-5 is a current authoritative scheme for classifying psychological disorders. This volume is the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*, fully revised in 2013. Physicians and mental health workers use the detailed “diagnostic criteria and codes” in the DSM-5 to guide medical diagnoses and define who is eligible for treatments, including medication. This new edition has changed some diagnostic labels and added others, some of which are controversial.

► Exercise: The Effects of Labeling (p. 925)

► Feature Film: *In Cold Blood* (p. 925)

Critics point out that labels can create preconceptions that bias our perceptions of people’s past and present behavior and unfairly stigmatize these individuals. Labels can also serve as self-fulfilling prophecies. However, diagnostic labels help not only to describe a psychological disorder but also to enable mental health professionals to communicate about their cases, to comprehend the underlying causes, and to discern effective treatment programs.

Contrary to movie and television depictions, people with psychological disorders are more likely to be victims of violence than perpetrators. Those who do commit violent crimes tend to experience threatening delusions and hallucinations or abuse substances.

Anxiety Disorders, OCD, and PTSD

► Exercise: Penn State Worry Questionnaire (p. 926)

- 13-5. *Identify the main anxiety disorders, and describe how anxiety disorders differ from the ordinary worries and fears we all experience.*

Many everyday experiences—public speaking, preparing to play in a big game, looking down from a high ledge—may elicit anxiety. In contrast, **anxiety disorders** are characterized by distressing, persistent anxiety or maladaptive anxiety-reducing behaviors.

► Exercise: Taylor Manifest Anxiety Scale (p. 926)

Generalized anxiety disorder is an anxiety disorder in which a person is continually tense, apprehensive, and in a state of autonomic nervous system arousal. **Panic disorder** is an anxiety disorder

in which the anxiety suddenly escalates at times into a terrifying *panic attack*, a minutes-long feeling of intense fear in which a person experiences irregular heartbeat, shortness of breath, chest pains, choking, or other frightening sensations.

► Lecture: Discovery Health Channel Phobia Study (p. 927)

► Exercises: Fear Survey (p. 927); Social Phobia (p. 928)

A **phobia** is an anxiety disorder marked by a persistent, irrational fear of a specific object or situation. In contrast to the normal fears we all experience, phobias can be so severe that they are incapacitating. For example, *social anxiety disorder*, an intense fear of being judged by others, is shyness taken to an extreme. The anxious person may avoid speaking up, eating out, or going to parties. If the fear is intense enough, it can lead to *agoraphobia*. Other *specific phobias* focus on animals, insects, heights, blood, or closed spaces.

► Lecture: Obsessive Thoughts (p. 929)

► Exercise: Obsessive-Compulsive Disorder (p. 928)

► Feature Film: *As Good As It Gets* and *OCD* (p. 928)

13-6. Describe OCD.

An **obsessive-compulsive disorder (OCD)** is a disorder characterized by unwanted repetitive thoughts (*obsessions*) and/or actions (*compulsions*). The compulsions may involve excessive hand washing or checking doors, for example. The repetitive thoughts and behaviors become so persistent that they interfere with everyday living and cause the person distress.

13-7. Describe PTSD.

► Lecture: Concentration Camp Survival (p. 930)

► Exercise: The Posttraumatic Cognitions Inventory (PTCI) (p. 930)

Posttraumatic stress disorder (PTSD) is characterized by haunting memories, nightmares, social withdrawal, jumpy anxiety, numbness of feeling, and/or insomnia that last for four weeks or more following a traumatic experience. Many combat veterans, accident and disaster survivors, and sexual assault victims have experienced the symptoms of PTSD. Most people display an impressive *survivor resiliency*. For some, suffering can lead to *posttraumatic growth* (Chapter 14).

► Worth Video Anthology: *Fear, PTSD, and the Brain*

13-8. Describe how learning and biology contribute to the feelings and thoughts found in anxiety disorders, OCD, and PTSD.

The learning perspective views anxiety disorders, OCD, and PTSD as a product of fear conditioning, stimulus generalization, reinforcement of fearful behaviors, and observational learning of others' fears. The biological perspective helps explain why we learn some fears more readily and why some individuals are more vulnerable. It emphasizes the influences of genes, the brain, and natural selection. For example, phobias may focus on fears faced by our ancestors, some of us are genetically predisposed to anxiety, and elevated activity in specific frontal lobe areas appears to be linked to OCD.

Substance Use and Addictive Disorders

► Lectures: Incentive-Sensitization Theory (p. 149); Overcoming Addictions (p. 150)

► Exercises: The Internet Addiction Test (p. 150)

► Exercise/Project: Signs of Drug Abuse (p. 149)

► Exercise/Critical Thinking Break: Drug Effects and the Nervous System (p. 149)

► Project: Understanding Addiction (p. 149)

13-9. Describe substance use disorders, and explain the role that tolerance, withdrawal, and addiction play in these disorders.

Substance use disorders involve continued substance craving and use despite significant life disruption and/or physical risk. **Psychoactive drugs** are chemical substances that alter perceptions and moods. Continued use of a psychoactive drug produces **tolerance**. With continued use of alco-

hol and some other drugs, the user's brain chemistry adapts to offset the drug effect. Cessation of use may produce the undesirable side effects of *withdrawal*. An *addiction* is a compulsive craving of drugs or certain behaviors (such as gambling) despite known harmful consequences.

► PsychSim 5: Your Mind on Drugs (p. 152)

► Exercise/Project: Drug Awareness (p. 152)

Psychoactive drugs operate at the brain's synapses by stimulating, inhibiting, or mimicking the activity of neurotransmitters, the brain's chemical messengers.

► Lectures: Alcohol Consumption Among Students (p. 152)

► Exercise: Alcohol Expectancies (p. 153)

- 13-10. *Describe how depressants, such as alcohol, influence neural activity and behavior.*

Depressants such as alcohol, the *barbiturates*, and the *opiates* act by reducing neural activity and slowing body functions. Each offers its own pleasures, but at the cost of impaired memory and self-awareness or other physical consequences. Alcohol is a *disinhibitor* and thus increases the likelihood that we will act on both helpful and harmful impulses. It also impairs judgment and disrupts memory processes by suppressing REM sleep. Research indicates that when people believe that alcohol affects social behavior in specific ways, and believe that they have been drinking alcohol, they will behave accordingly. In those with *alcohol use disorder*, prolonged and excessive drinking can shrink the brain. *Barbiturates*, or *tranquilizers*, depress nervous system activity. Prescribed to induce sleep or reduce anxiety, in larger doses they can impair memory and judgment. In combination with alcohol, they can be lethal. The *opiates* also depress neural functioning and can cause the brain to stop producing its own opiates, the *endorphins*.

► Lecture: Caffeine—Is It Harmful? (p. 154)

- 13-11. *Describe how the major stimulants affect neural activity and behavior.*

Stimulants, such as caffeine, nicotine, the *amphetamines*, and the even more powerful cocaine, Ecstasy, and *methamphetamines*, excite neural activity and speed up body functions. Methamphetamine is highly addictive; over time, it appears to reduce baseline dopamine levels. *Nicotine* triggers the release of epinephrine and norepinephrine, which in turn diminish appetite and boost alertness and mental efficiency, and dopamine and opioids, which calm anxiety and reduce sensitivity to pain. Cocaine produces a *euphoric* rush and depletes the brain's supply of the neurotransmitters dopamine, serotonin, and norepinephrine. A crash of agitated depression follows as the drug's effects wear off. Regular users become addicted. Cocaine's psychological effects depend in part on dosage and form consumed, but the situation and the user's personality and expectations also play a role. *Ecstasy (MDMA)* is both a stimulant and a mild hallucinogen. By releasing serotonin and blocking its reuptake, it produces high energy, emotional elevation, and connectedness with those around them. Its repeated use may suppress the immune system, damage serotonin-producing neurons, and lead to a permanently depressed mood.

► Lectures: The LSD Experience (p. 155); Near-Death Experiences (p. 156); Is Marijuana Good Medicine? (p. 156)

- 13-12. *Describe the physiological and psychological effects of LSD and marijuana.*

Hallucinogens distort perceptions and evoke sensory images in the absence of sensory input. Common components of the LSD experience are hallucinations and emotions ranging from euphoria to detachment to panic. Some scientists note that such experiences closely parallel reports of the hallucinations produced by loss of oxygen or extreme sensory deprivation. A person's current mood and expectations affect the drug's effects.

The emotions of an LSD trip are similar to the *near-death experience*. These experiences are marked by out-of-body sensations, visions of tunnels and bright lights, and a replay of old memories.

Marijuana's main active ingredient, *THC*, produces a variety of effects, including disinhibition, a euphoric high, feelings of relaxation, relief from pain, and amplified sensitivity to colors, sounds,

tastes, and smells. It may also increase anxiety or depression; impair motor coordination, perceptual skills, and reaction time; and disrupt memory formation. Because THC lingers in the body for a week or more, regular users may achieve a high with smaller amounts of the drug than do occasional users.

► Lectures: Factors in Drug Use (p. 158); The Amethyst Initiative—Should the Drinking Age Be Lowered? (p. 159); Treating Alcohol Dependence [now called alcohol use disorder] (p. 159)

► Project: Debates on Drugs and Society (p. 158)

- 13-13. *Discuss the biological, psychological, and social-cultural factors that help explain why some people abuse mind-altering drugs.*

Substance use by North American youth increased during the 1970s. Then, with increased drug education, substance use declined sharply. After the early 1990s, drugs have again been glamorized in some music and films. Some people are biologically vulnerable to particular drugs. For example, researchers have identified genes that are more common among people and animals predisposed to alcohol use disorder. These genes may produce deficiencies in the brain's natural dopamine reward system. One psychological factor that contributes to drug use is the feeling that one's life is meaningless and directionless. Studies reveal that heavy drug users often have experienced significant stress or failure and are depressed. Substance use can also have social roots, evident in differing rates of drug use across cultural and ethnic groups. Substance addiction rates are very low among the Amish, Mennonites, Mormons, and Orthodox Jews. Peer pressure may lead people, especially teenagers, to experiment with—and become dependent on—drugs. Possible avenues for treatment and prevention involve education, boosting people's self-esteem and purpose in life, and inoculation against peer pressure.

Mood Disorders

► Lecture: Bipolar Disorder (p. 933)

► Exercises: Depression Scales (p. 931); The Automatic Thoughts Questionnaire (p. 932); Depression and Memory (p. 932); Loneliness (p. 932)

- 13-14. *Identify and describe the main mood disorders.*

Mood disorders are psychological disorders characterized by emotional extremes. **Major depressive disorder** occurs when at least five signs of depression (including lethargy, feelings of worthlessness, or diminished interest or pleasure in activities most of the day) last two or more weeks and are not caused by drugs or a medical condition. **Persistent depressive disorder (dysthymia)** occurs when a person experiences a mildly depressed mood more often than not for at least two years and displays two of depression's symptoms. **Bipolar disorder** is a mood disorder in which a person alternates between the hopelessness and lethargy of depression and the overexcited state of **mania** (a hyperactive, wildly optimistic state in which dangerously poor judgment is common). Major depressive disorder is much more common than is bipolar disorder.

► Exercises: The Body Investment Scale and Self-Mutilation (p. 936); Understanding Suicide (p. 936); The Expanded Revised Facts on Suicide Quiz (p. 937)

- 13-15. *Discuss why people attempt suicide, and explore why some people injure themselves.*

Compared with the general population, those who have been depressed are five times more likely to commit suicide. Social suggestion may trigger suicide. The elderly sometimes choose death as an alternative to current or future suffering. In people of all ages, suicide may be a way of switching off unendurable pain. Warning signs include verbal hints, giving possessions away, self-inflicted injuries, or withdrawal and preoccupation with death. Some people, especially adolescents and young adults, engage in **nonsuicidal self-injury** as a way to ask for help and gain attention or to gain relief from intense negative thoughts, for example.

- ▶ Lectures: The Sadder-but-Wiser Effect (p. 934); Cognitive Errors in Depression (p. 934); Commitment to the Common Good (p. 938)
- ▶ Exercise: Attributions for an Overdrawn Checking Account (p. 935)

13-16. *Describe how mood disorders develop, and explain the roles played by biology, thinking, and social behavior.*

Researchers have suggested that any theory of depression must explain the many behavioral and cognitive changes that accompany the disorder, its widespread occurrence, women's greater vulnerability to depression, the tendency for most major depressive episodes to self-terminate, the link between stressful events and the onset of depression, and the disorder's increasing rate and earlier age of onset.

Depression is a whole-body disorder, involving genetic, neural, and biochemical influences, as well as negative thoughts and gloomy moods. Mood disorders run in families, and *linkage analysis* is being used to search for genes that put people at risk. In addition, the brains of depressed people have been found to be less active. The left frontal lobe, which is active during positive emotions, is less active during depressed states. Finally, certain neurotransmitters, including nor-epinephrine and serotonin, seem to be scarce during depression.

The *social-cognitive perspective* suggests that self-defeating beliefs, which arise in part from *learned helplessness*, and a negative explanatory style feed depression. Depressed people explain bad events in terms that are *global*, *stable*, and *internal*. This perspective sees the disorder as a vicious cycle in which (1) negative, stressful events are interpreted through (2) a ruminating, pessimistic explanatory style, creating (3) a hopeless, depressed state that (4) hampers the way a person thinks and acts. This, in turn, fuels (1) negative, stressful experiences such as rejection.

Schizophrenia

- ▶ Lecture: Infantile Autism (p. 940)
- ▶ Exercises: Magical Ideation Scale (p. 939)
- ▶ Project: *The Eden Express* and Schizophrenia (p. 939)
- ▶ PsychSim 5: Losing Touch With Reality (p. 939)

13-17. *Describe the patterns of thinking, perceiving, and feeling that characterize schizophrenia.*

Schizophrenia is a severe disorder characterized by delusions, hallucinations, disorganized speech, and/or diminished, inappropriate emotional expression. Literally, schizophrenia means “split mind,” which refers to a split from reality rather than multiple personality.

Schizophrenia patients who are disorganized and deluded in their talk or prone to inappropriate laughter, tears, or rage are said to have *positive symptoms*. When appropriate behaviors are absent (for example, the schizophrenia patient has a toneless voice, expressionless face, and a mute or rigid body), the person is showing *negative symptoms*.

The thinking of people with schizophrenia may be marked by **delusions**, that is, false beliefs—often of persecution or grandeur. Disorganized thoughts may result from a breakdown in *selective attention*. Sometimes, they also experience *hallucinations*, sensory experiences without sensory stimulation. Hallucinations are usually auditory and often take the form of voices making insulting statements or giving orders. The expressed emotions are often utterly inappropriate, and sometimes patients show no emotion (a *flat effect*).

13-18. *Explain how chronic and acute schizophrenia differ.*

Chronic, or *process*, schizophrenia develops gradually, emerging from a long history of social inadequacy. Recovery is doubtful. *Acute*, or *reactive*, schizophrenia develops rapidly in response to particular life stresses. Recovery is much more likely.

- 13-19. *Describe what we know about the brain chemistry, functions, and structures associated with schizophrenia, and discuss what we have learned about prenatal risk factors.*

Researchers have linked certain forms of schizophrenia with brain abnormalities such as an excess number of receptors for the neurotransmitter *dopamine*. Modern brain-scanning techniques indicate that people with schizophrenia have abnormal brain activity and brain structures. Some patients have abnormally low activity in the frontal lobe and/or they have enlarged, fluid-filled areas and a corresponding shrinkage of cerebral tissue. Persons with schizophrenia also have a smaller-than-normal thalamus.

A possible cause of these abnormalities is a midpregnancy viral infection that impairs fetal brain development. For example, people are at increased risk of schizophrenia if, during the middle of their fetal development, their country experienced a flu epidemic. People born in densely populated areas, where viral diseases spread more readily, also seem to be at greater risk for schizophrenia.

- 13-20. *Discuss whether research indicates a genetic contribution to schizophrenia.*

The nearly 1-in-100 odds of any person developing schizophrenia become about 1 in 10 if a family member has it, and close to 5 in 10 if an identical twin has the disorder. Adoption studies confirm the genetic contribution to schizophrenia. An adopted child's probability of developing the disorder is greater if the biological parents have schizophrenia. A complex disorder such as schizophrenia is surely influenced by multiple genes with small effects. Epigenetic factors, such as maternal stress, influence gene expression.

Other Disorders

► Exercise: Assessing Body Image (p. 942); Motivations-to-Eat Scale (p. 942)

- 13-21. *Describe the three major eating disorders.*

Anorexia nervosa is an eating disorder in which a person (usually an adolescent female) diets to become significantly underweight, yet feels fat, fears being fat, and is obsessed with losing weight.

Bulimia nervosa is an eating disorder characterized by private, binge-purge episodes of overeating, usually of high-calorie foods, followed by vomiting, laxative use, fasting, or excessive exercise.

Binge-eating disorder is marked by significant binge-eating episodes followed by remorse but not by purging, fasting, or excessive exercise.

Challenging family settings and weight-obsessed societal pressures provide fertile ground for the growth of eating disorders. Those most vulnerable to eating disorders are also those (usually women) who most idealize thinness and have the greatest body dissatisfaction. Peer influences, wealth, increased marriage age, and, especially competition for mates are factors. Twin studies suggest that eating disorders may also have a genetic component.

► Lectures: Factitious Disorder (p. 941); Sensory Processing Disorder (p. 941); Psychogenic Versus Organic Amnesia (p. 942)

► Exercise: The Curious Experiences Inventory (p. 941)

- 13-22. *Describe the dissociative disorders, and discuss why they are controversial.*

In **dissociative disorders**, a person appears to experience a sudden loss of memory or change in identity, often in response to an overwhelmingly stressful situation. Conscious awareness is said to *dissociate* or become separated from painful memories, thoughts, and feelings. Dissociation itself is not uncommon. On occasion, many people may have a sense of being unreal, of being separated from their body, or of watching themselves as if in a movie. Facing trauma, detachment may protect a person from being overwhelmed by anxiety.

► Lecture: The Dissociative Disorders Interview Schedule and Dissociative Identity Disorder (p. 942)

Dissociative identity disorder (DID) is a rare disorder in which a person exhibits two or more distinct and alternating personalities, with the original personality typically denying awareness of the other(s). Skeptics question whether DID is a genuine disorder or an extension of our normal capacity for personality shifts. Or is it merely role playing by fantasy-prone individuals? They find it suspicious that the disorder became so popular in the late twentieth century and that outside North America it is much less prevalent. (In Britain, it is rare, and in India and Japan, it is essentially nonexistent.) Some argue that the condition is either contrived by fantasy-prone, emotionally variable people or constructed out of the therapist-patient interaction. Other psychologists disagree and find support for DID as a genuine disorder in the distinct brain and body states associated with differing personalities.

► Lecture: Narcissistic Personality Disorder (p. 943)

► Exercises: Schizotypal Personality Questionnaire (p. 943); Antisocial Personality Disorder (p. 944)

- 13-23. *Identify the characteristics that are typical of personality disorders in general, and describe the biological and psychological factors that are associated with antisocial personality disorder.*

Personality disorders are psychological disorders characterized by inflexible and enduring behavior patterns that impair social functioning. One cluster expresses anxiety (e.g., *avoidant*), a second cluster expresses eccentric behaviors (e.g., *schizoid*), and a third exhibits dramatic or impulsive behaviors (e.g. *histrionic* and *narcissistic*). The most troubling of these disorders is the **antisocial personality disorder**, in which a person (usually a man) exhibits a lack of conscience for wrongdoing, even toward friends and family members. This person may be aggressive and ruthless or a clever con artist. Brain scans of murderers with this disorder have revealed reduced activity in the frontal lobes, an area of the cortex that helps control impulses. A genetic predisposition may interact with environmental influences to produce this disorder.

HANDOUT 13-1

Fact or Falsehood?

- T F** 1. In some cultures, depression and schizophrenia are nonexistent.
- T F** 2. Ritalin and Adderall are stimulants but help calm hyperactivity in children with ADHD.
- T F** 3. About 30 percent of psychologically disordered people are dangerous; that is, they are more likely than other people to commit a crime.
- T F** 4. By age 50, emotions have become stronger and anxiety disorders more common.
- T F** 5. Identical twins who have been raised separately sometimes develop the same phobias.
- T F** 6. In North America, today's young adults are three times as likely as their grandparents to report having experienced depression.
- T F** 7. White Americans commit suicide nearly twice as often as Black Americans do.
- T F** 8. There is strong evidence for a genetic predisposition to schizophrenia.
- T F** 9. Dissociative identity disorder is a type of schizophrenia.
- T F** 10. Most criminals have antisocial personality disorder.