Abnormal Psychology

CHAPTER 12

KEY TERMS

Insane
DSM
Multiaxial approach
Anxiety disorders
Specific phobia
Agoraphobia
Social phobia
Generalized anxiety disorder
Panic disorder
Obsessive-compulsive disorder
Post-traumatic stress disorder
Somatoform disorders
Hypochondriasis
Conversion disorder
Dissociative disorders
Psychogenic amnesia
Fugue
Dissociative identity disorder
Mood or affective disorders
Major depressive disorder
Seasonal affective disorder
Dysthymic disorder
Bipolar disorder
Cognitive triad
Learned helplessness
Schizophrenic disorders
Delusions of persecution
Delusions of grandeur
Hallucinations
Disorganized schizophrenia
Paranoid schizophrenia
Catatonic schizophrenia
Waxy flexibility
Undifferentiated schizophrenia
Dopamine hypothesis
Tardive dyskinesia
Diathesis-stress model
Double bind
Personality disorders
Antisocial personality disorder
Dependent personality disorder
Paranoid personality disorder
Narcissistic personality disorder
Histrionic personality disorder
Obsessive-compulsive personality disorder
Paraphilia or psychosexual disorder
Anorexia nervosa
Bulimia
Autism
Attention deficit/hyperactivity disorder
Rosenhan study

OVERVIEW

Abnormal psychology is the study of people who suffer from psychological disorders. These disorders may be manifested in a person's behavior and/or thoughts. Abnormal psychology encompasses the study of relatively common problems such as depression, substance abuse, and learning difficulties, as well as the study of fairly rare, and particularly severe, disorders such as bipolar disorder and schizophrenia.

DEFINING ABNORMALITY

In order to identify psychological abnormality, we must first define it. This task is surprisingly difficult. Common characteristics of abnormality include:

1. It is maladaptive (harmful) and/or disturbing to the individual. For instance, someone who has agoraphobia, fear of open spaces, and is thus unable to leave his or her home experiences something maladaptive and disturbing.
2. It is disturbing to others. Zoophilia, being sexually aroused by animals, for example, disturbs others.
3. It is unusual, not shared by many members of the population. In the United States, having visions is atypical, while in some other cultures it occurs more commonly.
4. It is irrational; it does not make sense to the average person. Feeling depressed when your family first moves away from all your friends is not seen as irrational, while prolonged depression due to virtually any situation is.

Note that people may be diagnosed with a psychological disorder even if they are not experiencing all, or even most, of the above symptoms. Another important point is that the term *insane*, often used by laypeople to describe psychological disorders in general, is not a medical term. Rather, insanity is a legal term. The reason behind the legal definition of insanity is to differentiate between those people who can be held entirely responsible for their crimes (the sane) and those people who, because of a psychological disorder, cannot be held fully responsible for their actions. When defendants plead not guilty by reason of insanity (NGRI), they are asking that the court acquit them due to psychological factors.

An obvious question is how psychologists determine whether or not someone has a psychological disorder. To do so, psychologists use a book called the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). Periodically, this book is revised. The latest version is the *DSM-IV-TR*. The *DSM-IV-TR*, as its name suggests, provides a way for psychologists to diagnose their patients. The *DSM-IV-TR* contains the symptoms of everything currently considered to be a psychological disorder. The book's revisions have resulted in astronomical growth in the number and kinds of disorders included since the original *DSM*. However, sometimes behaviors classified as disorders in earlier editions, for instance homosexuality, have been removed from the definition of abnormality.

The DSM employs a multiaxial approach to diagnosis, based on the belief that many factors affect a person's mental health. Typically, when a psychologist first meets with a client, the psychologist assesses the client on the following five axes:

Axis I — *Clinical disorders*—The first axis diagnosis is generally what we think of as the client's major diagnosis. The bulk of this chapter will describe a number of such disorders including major depressive disorder, generalized anxiety disorder, and paranoid schizophrenia.

Axis II — *Personality and developmental disorders*—Personality and developmental disorders are also described later in this chapter. Personality disorders are

maladaptive, long-term ways a person has of interacting with the world. Examples include antisocial, paranoid, and dependent personality disorders. Most developmental disorders emerge during childhood and have to do with an aspect of development that is not proceeding typically. Mental retardation, attention deficit/hyperactivity disorder, and autism are examples of developmental disorders.

Axis III — *Medical conditions*—It is increasingly clear that physical and mental health are related. Psychologists therefore note any physical ailments (for example, cancer, a brain injury, diabetes) that could impact a person's psychological well-being.

Axis IV — *Psychosocial conditions*—Psychosocial conditions are environmental factors that may affect a person's mental health. Experiences such as divorce, the loss of a job, or starting a new school can be stressful for people. Similarly, people's life circumstances, be it poverty or a dysfunctional family, can also make them more vulnerable to psychological difficulties.

Axis V — *Global assessment of functioning*—To classify someone's overall level of functioning, psychologists use the global assessment of functioning scale (GAF). The GAF yields a score from 1 to 100; higher numbers are indicative of higher levels of functioning.

The *DSM-IV-TR* does not include any discussion of the causes (also called etiology) or treatments of the various disorders, because adherents to each of the psychological perspectives disagree. Psychoanalytic theorists locate the cause of psychological disturbances in unconscious conflicts often caused by traumatic events that occurred during the psychosexual stages (see Chapter 9). Behaviorists assert that psychological problems result from the person's history of reinforcement. Cognitive theorists locate the source of psychological disorders in maladaptive ways of thinking. Humanistic psychologists view the root of such disorders in a person's feelings, self-esteem, and self-concept. One of the most recent perspectives, the sociocultural perspective, holds that social ills such as racism, sexism, and poverty lie at the heart of psychological disorders. Finally, the biomedical model sees psychological disorders as caused by biological factors such as hormonal or neurotransmitter imbalances or differences in brain structure. Biomedical psychologists believe that many psychological disorders are associated with genetic abnormalities that may lead to the physiological abnormalities described above. However, the differences do not have to occur at the genetic level.

Most clinical psychologists do not subscribe strictly to one perspective or another. Rather, most psychologists are *eclectic,* which means that they accept and use ideas from a number of different perspectives (see Table 12.1).

CATEGORIES OF DISORDERS

The *DSM-IV-TR* lists hundreds of different psychological disorders, most of which lie beyond the scope of your introductory course. We will deal with six major kinds of disorders: anxiety disorders, somatoform disorders, dissociative disorders, mood or affective disorders, schizophrenic disorders, and personality disorders. We will also touch briefly on a few other types of disorders in order to communicate a sense

TABLE 12.1

Different Perspectives on the Causes of Psychological Disorders

Perspective	Cause of Disorder
Psychoanalytic/psychodynamic	Internal, unconscious conflicts
Humanistic	Failure to strive toward one's potential or being out of touch with one's feelings
Behavioral	Reinforcement history, the environment
Cognitive	Irrational, dysfunctional thoughts or ways of thinking
Sociocultural	Dysfunctional society
Biomedical	Organic problems, biochemical imbalances, genetic predispositions

of the breadth of the field. After a short explanation of each type of disorder, we will briefly discuss how psychologists from a few of the various perspectives might view the cause of some of the disorders within the category. Keep in mind that many psychologists do not strictly adhere to any one perspective.

Anxiety Disorders

Anxiety disorders, as their name suggests, share a common symptom of anxiety. We will discuss five anxiety disorders: phobias, generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, and posttraumatic stress disorder.

A simple or *specific phobia* is an intense unwarranted fear of a situation or object such as *claustrophobia* (fear of enclosed spaces) or *arachnophobia* (fear of spiders). Two other common types of phobias are *agoraphobia* and *social phobias.* Agoraphobia is a fear of open, public spaces. People with severe agoraphobia may be afraid to venture out of their homes at all. A social phobia is a fear of a situation in which one could embarrass oneself in public, such as when eating in a restaurant or giving a lecture. Phobias are classified as anxiety disorders because contact with the feared object or situation results in anxiety.

A person who suffers from *generalized anxiety disorder*, often referred to as GAD, experiences constant, low-level anxiety. Such a person constantly feels nervous and out of sorts. On the other hand, someone with *panic disorder* suffers from acute episodes of intense anxiety without any apparent provocation. Panic attacks tend to increase in frequency, and people often suffer additional anxiety due to anticipating the attacks.

Obsessive-compulsive disorder, known as OCD, is when persistent, unwanted thoughts (obsessions) cause someone to feel the need (compulsion) to engage in a particular action. For instance, a common obsession concerns cleanliness. A man experiencing this obsession might be plagued with constant worries that his environment is dirty and full of germs. These thoughts might drive him to wash his

hands and shower repeatedly, even to the extent that he is able to do virtually nothing else. Obsessions result in anxiety, and this anxiety is reduced when the person performs the compulsive behavior.

Post-traumatic stress disorder usually involves flashbacks or nightmares following a person's involvement in or observation of an extremely troubling event such as a war or natural disaster. Memories of the event cause anxiety.

Theories About the Cause of Anxiety Disorders

We will follow the discussion of the psychological disorders with a brief description of how adherents from several perspectives view the etiology of such disorders. Since many introductory psychology texts do not deal with the etiology of specific disorders at all, we will be selective and focus on the information most likely to appear on the Advanced Placement examination.

Psychoanalytic theorists see psychological disorders as caused by unresolved, unconscious conflicts. Anxiety is viewed as the result of conflicts between the desires of the id, ego, and superego. For instance, a young woman's repressed sexual attraction to her father may cause a conflict between her id, which desires the father, and her superego, which forbids such a relationship. Anxiety disorders could be the outward manifestation of this internal conflict.

Behaviorists believe all behaviors are learned. Therefore, they assert that anxiety disorders are learned. Consider acrophobia, the fear of heights, as an example. Behaviorists would say that someone who has acrophobia learned the fear response. This learning could happen through classical conditioning, operant conditioning, or some type of cognitive learning. (See the chapter "Learning" for more information about basic learning principles.) Suppose three-year-old Pablo went with his family to visit the Space Needle in Seattle. While on the observation deck, Pablo got separated from his family and was found hours later crying hysterically at the gift shop. Ever since, Pablo has been terrified of heights. In this example, behaviorists would say that Pablo learned through classical conditioning to associate heights with the fear that resulted from losing his family.

Cognitive theorists believe that disorders result from dysfunctional ways of thinking. Therefore, they would attribute an anxiety disorder to an unhealthy and irrational way of thinking and/or specific irrational thoughts. For instance, someone with GAD may have an unrealistically high standard for his or her own behavior. Since the person believes, irrationally, that she or he must always excel at everything she or he does, the person feels constant anxiety stemming from the impossibility of meeting this goal.

Somatoform Disorders

Somatoform disorders occur when a person manifests a psychological problem through a physiological symptom. In other words, such a person experiences a physical problem in the absence of any physical cause. Two somatoform disorders are hypochondriasis and conversion disorder. A person suffering from *hypochondriasis* has frequent physical complaints for which medical doctors are unable to locate the cause. In addition, such a person may believe that minor problems such as headaches or occasional shortness of breath are indicative of severe physical illness

even after she or he is assured by doctors that no evidence of such physiological problems exists.

People who have *conversion disorder* will report the existence of a severe physical problem such as paralysis or blindness, and they will, in fact, be unable to move their arms or see. However, again, no biological reason for this problem can be identified.

Theories About the Cause of Somatoform Disorders

Psychodynamic theorists would assert that somatoform disorders are merely outward manifestations of unresolved unconscious conflicts. Behaviorists would say that people with somatoform disorders are being reinforced for their behavior. For instance, someone experiencing blindness due to conversion disorder may avoid unpleasant tasks like working or someone with hypochondriasis may receive a great deal of attention.

Dissociative Disorders

Dissociative disorders involve a disruption in conscious processes. Psychogenic amnesia, fugue, and dissociative identity disorder (DID) are classified as dissociative disorders. *Psychogenic amnesia* is when a person cannot remember things and no physiological basis for the disruption in memory can be identified. Biologically induced amnesia is called *organic amnesia.* People who have *fugue* not only experience psychogenic amnesia but also find themselves in an unfamiliar environment. For example, one day Albert wakes up with no memory of who or where he is and no one else in the environment can answer that either. Albert has left friends and family, as well as his memory, behind.

Dissociative identity disorder (DID), formerly known as multiple personality disorder, is when a person has several personalities rather than one integrated personality. Someone with DID can have any number of personalities. The different personalities can represent many different ages and both sexes. Often, two of the personalities will be the opposite of each other. People with DID commonly have a history of sexual abuse or some other terrible childhood trauma.

Theories About the Cause of Dissociative Disorders

Psychoanalytic theorists believe that dissociative disorders result when an extremely traumatic event has been so thoroughly repressed that a split in consciousness results. Behaviorists posit that people who have experienced trauma simply find not thinking about it to be rewarding, thus producing amnesia or, in extreme cases, DID.

Interestingly, cases of DID are rare outside of the United States, where the number increased dramatically in the last century as cases became more publicized. Coupled with the growing belief on the part of many psychologists that people do not engage in repression, these facts have led many to question whether DID is a legitimate psychological disorder. Critics suggest that some people diagnosed with DID may have been led to role-play the disorder inadvertently as a result of their

therapists' questions (for example, "Is there a part of you that feels differently?") and media portrayals.

Mood or Affective Disorders

Someone with a mood or affective disorder experiences extreme or inappropriate emotions. *Major depressive disorder,* also known as unipolar depression, is the most common mood disorder and is often referred to as the common cold of all psychological disorders. While we all feel unhappy now and again, most of us do not suffer from major depressive disorder. The *DSM-IV-TR* outlines the symptoms that must be present for such a diagnosis. One key factor is the length of the depressive episode. People who are clinically depressed remain unhappy for more than two weeks in the absence of a clear reason. Other common symptoms of depression include loss of appetite, fatigue, change in sleeping patterns, lack of interest in normally enjoyable activities, and feelings of worthlessness. Some people experience depression but only during certain times of the year, usually winter, when there is less sunlight. *Seasonal affective disorder* (SAD) is the resulting diagnosis. SAD is often treated with light therapy.

Unlike unipolar depression, *bipolar disorder,* formerly known as *manic depression,* usually involves both depressed and manic episodes. The depressed episodes involve all of the symptoms just discussed. People experience manic episodes in different ways but they usually involve feelings of high energy. While some sufferers will feel a heightened sense of confidence and power, others simply feel anxious and irritable. Even though some people feel an inflated sense of well-being during the manic period, they usually engage in excessively risky and poorly thought out behavior that ultimately has negative consequences for them. A small number of people appear to experience *mania* without depression.

Another mood disorder is *dysthymic disorder.* The symptoms are similar to those of major depressive disorder but generally are less intense. A diagnosis of dysthymic disorder in an adult requires a period of depressed mood lasting at least two years.

Theories About the Cause of Mood Disorders

Psychoanalysts commonly view depression as the product of anger directed inward, loss during the early psychosexual stages, or an overly punitive superego. Learning theorists view the mood disorder as bringing about some kind of reinforcement such as attention or sympathy.

Aaron Beck, a cognitive theorist, believes that depression results from unreasonably negative ideas that people have about themselves, their world, and their futures. Beck calls these three components the *cognitive triad.* Another way that cognitive psychologists look at the cause of depression is by exploring the kind of attributions that people make about their experiences. An attribution is an explanation of cause. For instance, if Jonas fails a math test, he may attribute his failure to lack of studying, stupidity, his teacher, or a host of other causes. Pessimistic attributional styles seem more likely to promote depression. Jonas may attribute his failure to an

internal (I am bad at math) or an external (the class is difficult) cause. He may attribute his failure to a global (I am bad at all subjects) or a specific (I have trouble with trigonometry) cause. Finally, Jonas may attribute his failure to a stable (I will always be bad at math) or to an unstable (I had a bad day) cause. People who tend to make internal, global, and stable attributions for bad events are more likely to be depressed. Often, these same people tend to make external, specific, and unstable attributions when good things happen to them.

Many theories about the cause of depression combine a cognitive and a behavioral component. An example of these social cognitive or cognitive-behavioral theories is Martin Seligman's idea of *learned helplessness*. Seligman conducted an experiment in which dogs received electric shocks. One group of dogs was able to terminate the shock by pressing a button with their noses while the helpless group had no way to stop the shocks. In a second phase of the experiment, both groups of dogs were put in a situation in which they could easily escape electric shocks by moving to another part of the experimental chamber. While the dogs that were able to stop the shock in the first phase of the experiment quickly learned to move to the area where they would not be shocked, the other group of dogs just hunkered down and endured the shocks. Seligman suggested that due to their lack of ability to control their fate in the first phase of the experiment, these dogs had learned to act helpless.

Seligman further posited that humans, too, might suffer from learned helplessness. Depression has been found to correlate positively with feelings of learned helplessness. Learned helplessness is when one's prior experiences have caused that person to view himself or herself as unable to control aspects of the future that are controllable. This belief, then, may result in passivity and depression. When undesirable things occur, that individual feels unable to improve the situation and therefore becomes depressed.

A growing body of evidence suggests that a biological component to affective disorders exists. Low levels of serotonin, a neurotransmitter, have been linked with unipolar depression. People who suffer from bipolar disorder have more receptors for acetylcholine, also a neurotransmitter, in their brains and skin. Other researchers have suggested that low levels of norepinephrine are associated with depression. Both unipolar depression and bipolar disorder often respond to somatic therapies (see the chapter "Treatment of Psychological Disorders"). This suggests that these disorders are caused, at least partially, by biological factors. In addition, both major depression and bipolar disorder seem to run in families, a finding that can also be interpreted as indicative of a genetic component to their etiology.

Schizophrenic Disorders

Schizophrenia is probably the most severe and debilitating of the psychological disorders. It tends to strike people as they enter young adulthood. The fundamental symptom of schizophrenia is disordered, distorted thinking often demonstrated through delusions and/or hallucinations. *Delusions* are beliefs that have no basis in reality. If I believed that I was going to win a Nobel prize in literature for writing this book, I would be experiencing a delusion. Common delusions include:

- Delusions of persecution—the belief that people are out to get you.
- Delusions of grandeur—the belief that you enjoy greater power and influence than you do, that you are the president of the United States or a Nobel prize-winning author.

Hallucinations are perceptions in the absence of any sensory stimulation. If I keep thinking I see newspaper headlines, "Weseley Wins Nobel," and hordes of autograph seekers outside my window, then I am suffering from hallucinations.

HINT

People often confuse schizophrenia with DID. Schizophrenics DO NOT have split personalities. Schism does mean break, but the break referred to in the term schizophrenia is a break from reality and not a break within a person's consciousness.

Four kinds of schizophrenia are disorganized schizophrenia, paranoid schizophrenia, catatonic schizophrenia, and undifferentiated schizophrenia. Each of these will be described briefly.

Disorganized schizophrenics evidence some odd uses of language. They may make up their own words (*neologisms*) or string together series of nonsense words that rhyme (*clang associations*). In addition, people with disorganized schizophrenia often evidence *inappropriate affect.* For instance, they might laugh in response to hearing someone has died. Alternatively, they may consistently have essentially no emotional response at all (*flat affect*).

The key symptom in *paranoid schizophrenia* is delusions of persecution. A man suffering from delusions of persecution would believe that others are trying to hurt him or out to get him.

People who suffer from *catatonic schizophrenia* engage in odd movements. They may remain motionless in strange postures for hours at a time, move jerkily and quickly for no apparent reason, or alternate between the two. When motionless, catatonic schizophrenics usually evidence *waxy flexibility.* That is, they allow their body to be moved into any alternative shape and will then hold that new pose. Catatonic schizophrenia is an increasingly rare form of schizophrenia in the United States.

Finally, people are diagnosed with *undifferentiated schizophrenia* if they exhibit disordered thinking but no symptoms of one of the other types of schizophrenia.

Schizophrenic symptoms are often divided into two types: positive and negative. *Positive symptoms* refer to excesses in behavior, thought, or mood such as neologisms and hallucinations whereas *negative symptoms* correspond to deficits such as flat affect or catatonia.

Theories About the Cause of Schizophrenic Disorders

One of the most popular ideas about the cause of schizophrenia is biological and is called the *dopamine hypothesis.* The basic idea behind the dopamine hypothesis is that high levels of dopamine seem to be associated with schizophrenia. The evidence for this link includes the findings detailed below:

- Antipsychotic drugs used to treat schizophrenia result in lower dopamine levels and a decrease in the disordered thought and behavior that is the hallmark of schizophrenia. However, extensive use of these drugs may also

cause negative side effects: muscle tremors and stiffness, a problem known as *tardive dyskinesia.*

- Parkinson's disease, characterized by muscle stiffness and tremors not unlike tardive dyskinesia, is treated with a drug called L-dopa that acts to increase dopamine levels. When given in excess, L-dopa causes schizophrenic-like distortions in thought.

More evidence suggests a biological basis for schizophrenia as well. Enlarged brain ventricles are associated with schizophrenia, as are brain asymmetries. Furthermore, a genetic predisposition seems to exist for schizophrenia. People who are related to schizophrenics suffer from the disorder at an increased rate, and the closer the relationship, the higher the incidence of the disorder. The incidence of schizophrenia in the general population is 1 in 100, but it rises to nearly 1 in 2 among identical twins whose co-twins are schizophrenic. As is the case with most disorders, a number of genes have been identified that seem to play a role in predisposing people to schizophrenia. Some research has suggested that negative symptoms are linked to genetic factors while positive symptoms tend to be related to abnormalities in dopamine levels.

Not surprisingly, not all psychologists agree that schizophrenia has a biological basis. Some people believe that certain kinds of environments may cause or increase the likelihood of developing schizophrenia. One commonly suggested cognitive-behavioral cause is the existence of *double binds.* A double bind is when a person is given contradictory messages. If when growing up, Sally is continually cautioned by her parents against acting promiscuously while they give her revealing, provocative outfits as gifts, Sally would be experiencing a double bind. People who live in environments full of such conflicting messages may develop distorted ways of thinking due to the impossibility of rationally resolving their experiences.

HINT

Do not confuse double binds, a hypothesized cause of schizophrenia, with double blinds, a way of eliminating experimenter bias.

Another theorized cause of schizophrenia comes from the *diathesis-stress model.* The diathesis-stress model is often applied to schizophrenia but can be more widely applied to many psychological and physical disorders. According to this model, environmental stressors can provide the circumstances under which a biological predisposition for illness can express itself. This theory helps explain why even people with identical genetic makeups (i.e., monozygotic twins) do not always suffer from the same disorders.

Personality Disorders

Personality disorders are well-established, maladaptive ways of behaving that negatively affect people's ability to function. The most important personality disorder with which you should be familiar is *antisocial personality disorder.* People with antisocial personality disorder have little regard for other people's feelings. They view the world as a hostile place where people need to look out for themselves. Not surprisingly, criminals seem to manifest a high incidence of antisocial personality disorder.

The characteristics of many other personality disorders are deducible from the names of the disorders. For instance, people with *dependent personality disorder* rely too much on the attention and help of others, and those with *paranoid personality*

disorder feel persecuted. Similarly, but based on words more difficult to define, *narcissistic personality disorder* involves seeing oneself as the center of the universe (*narcissism* means self-love), and *histrionic personality disorder* connotes overly dramatic behavior (histrionics). Keep in mind that a personality disorder is a more minor form of disorder than the others we have discussed. Therefore, people with paranoid personality disorder may believe they are being persecuted, but they will not experience the distortion of thought and delusions that paranoid schizophrenics do. Likewise, people with *obsessive-compulsive personality disorder* may be overly concerned with certain thoughts and performing certain behaviors, but they will not be debilitated to the same extent that someone with obsessive-compulsive disorder would.

HINT

Although your vocabulary will generally help you figure out what psychological terms mean, sometimes it will mislead you. For instance, many students incorrectly assume that people who suffer from antisocial personality disorder are merely unfriendly. In reality, as explained above, people with antisocial personality disorder are insensitive to others and thus often act in ways that bring pain to others.

Other Examples of Psychological Disorders

The *DSM-IV-TR* describes a wide variety of disorders. Although this chapter certainly cannot be comprehensive, some additional problems will be briefly discussed.

Paraphilias or *psychosexual disorders* are marked by the sexual attraction to an object, person, or activity not usually seen as sexual. For instance, attraction to children is called *pedophilia*, to animals is called *zoophilia*, and to objects, such as shoes, is called *fetishism*. Someone who becomes sexually aroused by watching others engage in some kind of sexual behavior is a *voyeur*, someone who is aroused by having pain inflicted upon them is a *masochist*, and someone who is aroused by inflicting pain on someone else is a *sadist*. Interestingly, most paraphilias occur more commonly in men than in women, however masochism is an exception.

Eating disorders are another kind of psychological problem classified in the *DSM-IV-TR*. Although we most often hear about *anorexia nervosa* and *bulimia*, obesity is also classified in the *DSM-IV-TR*. The basic symptoms that result in a diagnosis of anorexia nervosa are loss of 15 percent or more of the average body weight for one's age and size, an intense fear of fat and food, and a distorted body image. Anorexia nervosa, which predominates in girls and young women, is essentially a form of self-starvation. Bulimia shares similar features with anorexia nervosa such as a fear of food and fat and a distorted body image. However, bulimics do not lose so much of their body weight. Bulimia commonly involves a binge-purge cycle in which sufferers eat large quantities of food and then attempt to purge the food from their bodies by throwing up or using laxatives.

Another category of psychological disorders involves the use of substances such as alcohol and drugs. Use of such substances does not automatically mean one would be classified as having a disorder. *Substance use disorder* is a diagnosis made when the use of such substances regularly and negatively affects a person's life. *Substance dependence* is another term for addiction. A person whose life is disturbed by the use of chemical substances and who is unable to cut down his or her use of the substances suffers from substance dependence.

One final example of the kinds of disorders in the *DSM-IV-TR* is developmental disorders. Some developmental disorders deal with deviations from typical social development. *Autism* is one such disorder. From very early on, autistic children seek out less social and emotional contact than do other children. Autistic children are slow to develop language skills and less likely to seek out parental support when distressed.

Other developmental disorders involve difficulties in terms of developing skills. *Attention deficit/hyperactivity disorder* (ADHD) is one example. A child with ADHD may have difficulty paying attention or sitting still. This disorder occurs much more commonly in boys. Critics suggest that the kind of behavior typical of young boys (regardless of whether its cause is biological, environmental, or a combination of the two) results in an overdiagnosis of this problem.

Some developmental disorders emerge later in life. One example is Alzheimer's disease, which typically manifests after 65 years of age. The main symptom of Alzheimer's is a deterioration of cognitive abilities, often seen most dramatically in memory.

A Cautionary Note

The *DSM-IV-TR* provides psychologists with an invaluable tool by enabling them to diagnose their clients. However, keep in mind that diagnostic labels are not always correct and have a tendency to outlast their usefulness.

THE ROSENHAN STUDY: THE INFLUENCE OF LABELS

In 1978, David Rosenhan conducted a study in which he and a number of associates sought admission to a number of mental hospitals. All claimed that they had been hearing voices; that was the sole symptom they reported. All were admitted to the institutions as suffering from schizophrenia. At that time, they ceased reporting any unusual symptoms and behaved as they usually did. None of the researchers were exposed as imposters, and all ultimately left the institutions with the diagnosis of schizophrenia in remission. While in the institutions, the researchers' every behavior was interpreted as a sign of their disorder. The Rosenhan study, while flawed and widely critiqued, raises several important issues:

1. Should people who were once diagnosed with a psychological problem carry that diagnosis for the rest of their lives?
2. To what extent are disorders the product of a particular environment, and to what extent do they inhere in the individual?
3. What is the level of institutional care available if the imposters could go undetected for a period of days and, in some cases, weeks?

Now that we have discussed various psychological disorders, the next chapter will discuss treatment methods.