Unit XII - Answer Key
Abnormal Behavior

Module 65 - Introduction to Psychological Disorders

While You Read

65-1

1. disturbance: Clinically significant means that the disturbance is great enough to cause disruption in normal functioning. What is clinically significant has changed over time as evidenced by the removal of homosexuality from the DSM.

Answers will vary for the four breakdowns of the definition but should show understanding of the difference between cognition (thoughts and beliefs), emotion, and behavior. Some disorders will demonstrate challenges in all of these areas, while others may only impact a single category.

2. Unless the fear of spiders is a significant disturbance in a person's life, it can be considered a "normal fear." Routinely dusting books on a shelf can be maladaptive and interfere with normal day-to-day life if the dusting becomes more important than getting to work on time or eating, for instance. In order to have a disorder, the issue must interfere with living out a normal life. On the other hand, if someone`s fear of spiders impacted their day-to-day life because they checked every room for spiders before entering a room or thought about spiders even when there was no danger of encountering a spider, it may reach the level of a phobia which is considered a disorder.

3. As society changes, the behaviors and thoughts we classify as disordered change as well. The definition of "normal" is directly impacted by the changes in society over time. Homosexuality was thought to be an abnormal behavior for a period of time in Western

society as it was classified by the American Psychiatric Association as a disorder. It no longer is considered as such, although the accompanying stigma and stress that remains even today can sometimes increase the risk of mental health problems, such as depression, in homosexuals.

65-2

1. The medical model states that psychological disorders have physical causes that can be diagnosed, treated, and, in most cases, cured, often through treatment in a hospital. This model has drastically changed how patients are treated in that they are no longer subjected to brutal treatments, believed to be possessed by the devil, or thought to be animals. Instead, patients are diagnosed by their symptoms and treated through therapy which in extreme cases may involve time in a psychiatric hospital.
2. The biopsychosocial model states that all behavior arises from the interaction of nature and nurture and proposes that the body and mind are interconnected. It explains psychological disorders through the person's environment, the person's current interpretation of events, and the person's bad habits and poor social skills, in addition to the potential biological or genetic predisposition of the disorder.
3. The diathesis-stress model purports that behavior is the result of the interaction of genes and environmental factors. If an individual has a predisposition for schizophrenia because one of their parents was schizophrenic, they may not display the illness unless environmental factors trigger that display of schizophrenic behaviors. Epigenetics examines the environmental influences on genes without a change to DNA. In some environments, a gene may be expressed and in other situations, it may be dormant.

65-3

1. Classification aims not only to describe a disorder, but also to predict its future course, imply appropriate treatment, and stimulate research into its causes. The DSM-5 was created to include detailed "diagnostic criteria and codes" to guide diagnoses and define who is eligible for treatments, including medication.

2. (1) "Asperger's syndrome" and "autism" are no longer included; they have been combined into "autism spectrum disorder."

(2) "Mental retardation" has become "intellectual disability."

(3) New categories include "hoarding disorder" and "binge-eating disorder."

3. In disorders such as adult posttraumatic stress disorder and child autism spectrum disorder inter-rater reliability was roughly 70%, however for generalized anxiety disorder and antisocial personality disorder the concordance rate was only 20%. While the first statistic is quite high, the second makes one question the accuracy of the diagnosis received.

4. The DSM is criticized for bringing almost any kind of behavior within the compass of psychiatry. The disadvantage is to extend the pathologizing of everyday life but the advantage is that some behaviors are genuine disorders that would benefit from treatment. As table 65.1 indicates, nearly anyone who has trouble sleeping could potentially be diagnosed with insomnia based on the symptoms presented. If, however, people are not diagnosed, they may blame themselves for their perceived inadequacies. Identifying an existing disorder may motivate the individual to seek help ad overcome or at least find a way to cope with their condition.

5. The National Institute of Mental Health (NIMH) aims to use genetics, neuroscience and

behavioral science together in order to study psychological disorders and better understand the underlying factors that contribute to these disorders.

6. Rosenhan knows that labels matter. In his study, when his graduate students received the label "patient," it completely changed how others viewed and treated them. Similarly, when one received as label of a mental illness, others may stereotype them based on their label or interact with them differently because of misperceptions they may have about individuals with mental disorders. This may lead to stereotype threat or confirmation bias.

7. The pseudo patients were not actually ill, this may have taken time away for the patients who actually needed treatment. The deception of faking an illness is a challenge to the findings in this research study and perhaps not a reflection of the label the pseudo patients received as they were displaying signs of schizophrenia when they first reported to the hospitals.

8. In videotaped interviews, those believing the interviewee was a psychiatric or cancer patient perceived them as "different from most people." But if told the interviewee was simply that, a job applicant, they perceived the person as normal.

Getting a job or finding a place to rent can be a challenge for those known to be just released from prison or a mental hospital.

9. What role do Hollywood movies play in further stigmatizing mental disorders?

Hollywood portrayals of disorders further stigmatize mental disorders because Hollywood's goals are not to inform necessarily, but to entertain. Often, the most sensational characteristics of a disorder are exaggerated on the movie screen to produce emotion in the viewer. People with disorders are portrayed as objects of humor or ridicule, as homicidal maniacs, or freaks.

65-4

1.

a. In neuroimaging studies, ADHD has associations with abnormal brain activity patterns (Barkley et al., 2002).

b. More frequent diagnoses today are a reflection of increased awareness of the disorder.

c. The World Federation for Mental Health in 2005 declared that there is strong agreement among the international scientific community that ADHD is a real neurobiological disorder whose existence should no longer be debated.

2.

a. Children are not designed to sit for hours in chairs inside.

b. Older students are seeking out medication for ADHD as "good grade pills".

c. What are the long-term effects of drug treatment?

3. According to the definition, the disorder is diagnosed if one or more of the three key symptoms occurs by age 7 and like all disorders, there has to be significant disruption in social or occupational functioning. A highly energetic child who can still master her school work and function socially should not receive a diagnosis of ADHD.65-5

4. While there have been cases of mass shootings perpetrated by those who are mentally ill, most people who harm others are not mentally ill and most mentally ill people are of no danger to others. In fact, mentally ill individuals are far more likely to hurt themselves than others. Because in a few instances, these have been cases that have received much media coverage, the public tends to see violence and mental illness as highly correlated.

5. The insanity plea can be misused to allow a perpetrator of a violent crime to avoid a jail sentence. It can be used effectively if the perpetrator was seriously ill and hospitalization

could treat the illness. Some individuals believe that by sending the individual to treatment, they are somehow not punished for the crime they have committed.

65-6

1. The country with the greatest prevalence of disorders is the United States according to Figure 65.2, and the disorders most frequently reported, aside from the generic "any mental disorder" category, are depressive and bipolar disorder followed by phobias of a specific situation or object.

   Potential explanations will vary. Answers may include that there are more psychologists in the U.S. to diagnose these illnesses, stigmas against these illnesses are beginning to change to make people more comfortable discussing them or friends and family members may have similar illnesses allowing those in the U.S.to identify the symptoms.
2. It is interesting to note that many of the collectivist cultures are much lower on the prevalence graph. Perhaps the group goals of those cultures impact the prevalence of disorders.

   Individualist cultures emphasize the goals of the individual and perhaps that allows for much more introspection and observation, comparison of self to others, and thus labeling and identifying of differences or disorders.

   There are other ways this question can be answered. The strong answer will refer to the characteristics of the two cultures as they relate to the prevalence of specific disorders or disorders in general.
3. It may be that the stress of poverty causes those at risk to develop illness (diathesis-stress model) or it could be that illness causes one to lose out of job and educational opportunities

that could potentially direct them into a cycle of poverty.

The incidence of serious psychological disorders has been doubly high among those below the poverty line.

4. Answers will vary but should include factors such as parental mental illness, intellectual disabilities, or low birth weight for risk factors and exercise, literacy and high self-esteem for protective factors.

After You Read

Module 65 Review

1. Janine's depression likely has a physical cause that can be diagnosed, treated, and, in most cases, cured, perhaps through medication and if severe, hospitalization.
2. Janine's depression may be caused by the interaction of biological factors such as genes or brain structure, social factors such as societal expectations or the roles she is expected to play, and psychological factors such as stress or bad memories.
3. **c.** In neuroimaging studies, ADHD has associations with abnormal brain activity.
4. **e** the number of disorders contained in the DSM-5 contains less items than any of the earlier editions.
5. **b.** David Rosenhan.
6. Answer should include reference to the West African Wodaabe tribe compared with the young American male if students are discussing the picture on text page 651. Additional examples will vary. In Japanese culture back pain is often a sign of depression but not in the United States. Clinicians in the U.K. are more likely to diagnose someone as depressed, whereas clinicians in the U.S. are more likely to diagnose the same symptoms as schizophrenia.

Module 66 - Anxiety Disorders, Obsessive-Compulsive Disorder, and Posttraumatic Stress Disorder

While You Read

66-1

1. An anxiety disorder is maladaptive. It is characterized by distressing, persistent activity, or maladaptive behaviors that reduce anxiety. Many of us feel anxiety about daily events such as tests, deadlines, and relationships but it is passing and does not impair our ability to live a normal life. An anxiety disorder differs in that it disrupts occupational and social functioning.
2. The common symptoms of generalized anxiety disorder are persistence for six months or more of continuous worry, jitteriness, agitation, sleep deprivation, difficulty concentrating, trembling, perspiration, fidgeting, and an anxiety whose cause can't be easily identified.
3. Because the source of the anxiety cannot be identified, it is very difficult to deal with or avoid its cause. This is different than a common phobia, because in those cases an individual knows what the object or situation that causes them anxiety, but in free-floating anxiety panic attacks can seem to "come out of the blue".
4. Panic disorder is characterized by unpredictable, minutes-long episodes of intense dread in which a person experiences terror and accompanying chest pain, choking, or other frightening sensations.

   Panic disorder differs from generalized anxiety disorder in the prevalence of worry and cognitive involvement. Individuals who experience a panic disorder often avoid places where they believe a panic attack is likely to occur.
5. Smokers are at greater risk (more than double) for panic disorder, because nicotine is a stimulant.

6. The symptoms of phobias are persistent, irrational fear and avoidance of a specific object, activity, or situation. People are often incapacitated by their efforts to avoid the feared situation, or think about the feared objects or situation even when there is no danger. Specific phobias can be focused on animals, insects, heights, blood, enclosed spaces, or high places, for example.
7. Individuals with panic disorders tend to avoid situations in which they believe a panic attack is likely, which may mean that they stay close to home more often. Agoraphobia occurs when an individual feels a loss of control or a fear of a place where they believe they will have difficulty escaping. While there are many different boundaries those with agoraphobia set for themselves, often, they are confined to their own homes and will not go out without a trusted companion.
8. The most common specific phobia is the fear of heights (acrophobia). A strong fear becomes a phobia if it provokes a compelling but irrational desire to avoid the dreaded object or situation.
9. Answers will vary but may include that in many cases of phobias people simply try to avoid the object or situation they fear. For those with agoraphobia, especially in cases where a person cannot leave their own home, the limited ability to live a normal life moves the individual to seek treatment.

66-2

1. Obsessive thoughts and compulsive behaviors cross the line into disorder when they persistently interfere with everyday living and cause distress.
2. OCD is more common among teens and young adults. About 2 percent of people suffer from

OCD.

3. Knowing that the anxiety-fueled obsessive thoughts can only be put to rest with the compulsive rituals increases the suffering as the person really doesn't want to be performing these behaviors but seems to have no choice if they wish to quiet the thoughts and resume occupational and social functioning. This may lead to co-morbidity (the overlapping of more than one disorder) between OCD and depression for some individuals who cannot stop their compulsive behaviors.
4. Hoarding disorder. The inability to discard personal possessions

   Trichotillomania: Constant hair pulling, usually of the eyebrows, eyelashes or head

   Excoriation disorder: Constant and repeated skin pulling

66-3

1. PTSD originated in the military with what once was called shellshock or battle fatigue. The diagnosis of PTSD is now applied to anyone who experiences haunting memories, nightmares, social withdrawal, jumpy anxiety, numbness of feeling, and/or insomnia after a traumatic experience. First responders to tragic events and victims of sexual assault are at higher risk for developing PTSD
2. Research indicates that the greater one's emotional distress during a trauma, the higher the risk for posttraumatic symptoms. Also, a sensitive limbic system seems to increase vulnerability to PTSD by flooding the body with stress hormones again and again as images of the traumatic experience erupt into consciousness.
3. They believe that what is sometimes characterized at PTSD may be normal stress related to bad memories or dreams and that asking a person to reflect on the bad memory or reliving

the bad memory through a stress response may actually increase the trauma.

66-4

1. Because both classical and operant conditioning develop through associative learning, the link between conditioned fear and general anxiety helps explain why anxious or traumatized people are hyper attentive to possible threats.

Stimulus generalization occurs when a person attacked by a fierce dog later develops a fear of all dogs. Reinforcement helps maintain our phobias and compulsions after they arise. For example, if a person experiences anxiety because they believe their hands are sticky, they may feel a compulsion to wash their hands. The anxiety is removed making it more likely they will wash their hands again in this situation in the future (negative reinforcement).

2. By observing others' fears we learn fear. If a parent has a fear of snakes or spiders, we watch them react to the stimulus and learn to react in the same way. Monkeys raised in the wild nearly all fear snakes because they have watched other moneys who fear snakes, however, those raised in captivity do not because they do not watch others fear snakes.

3. Natural selection is the idea that certain traits are more likely to be present in the population if they lead to success in reproduction or survival. Our phobias, such as those of height or spiders, might have been evolutionarily adaptive in that they kept us away from cliffs where we could fall, or away from the few poisonous spiders that would have bitten us.

Genes impact the development of phobias and anxiety because some people are more anxious than others; when a traumatic event is paired with a sensitive, high-strung individual, a phobia may result.

4. Serotonin which influences sleep, mood and attending to threats and glutamate which

heightens activity in the brain`s alarm system. Norepinephrine also plays a role in mood and depression.

5. The anterior cingulate cortex, a brain region that monitors our actions and checks for errors, seems especially likely to be hyperactive in those with OCD. Fear-learning experiences that traumatize the brain can also create fear circuits within the amygdala.
6. 9-month old babies respond more to thunder or hisses (ancient threats) than they do to a bomb exploding or breaking glass (modern threats). We may fear snakes even without a negative experience, while we may not fear balloons even with a negative experience.

After You Read

Module 66 Review

1. **a.** panic disorder.
2. **c.** a specific phobia.
3. **e.** agoraphobia.
4.
   a. Making light of a disorder that causes suffering in those who have it is insensitive.

   b. People who suffer from OCD are not perfectionists in the sense of having organized materials. They have obsessive thoughts that couple with routinized actions and impact social and occupational functioning. Likely Rachel could still attend classes even if her pens were not in color order. Someone with OCD might miss work or other important social obligations as a result of the disorder.
5. **a.** obsessive-compulsive disorder.
6. **b.** learning perspective.

7. **b.** anterior cingulate cortex

8. Freud assumed that anxiety developed from unconscious childhood conflicts, whereas today psychologists believe anxiety develops from myriad biopsychosocial influences.

Module 67 – Depressive Disorders, Bipolar Disorder, Suicide, and Self Injury

While You Read

67-1

1. Sadness is like a car's low-fuel light—a signal that warns us to stop and take appropriate measures. Depression is like a psychic hibernation: it slows us down, defuses aggression, helps us let go of unattainable goals and restrains risk taking. Even mild sadness can improve people's recall, make them more discerning, and help them make complex decisions.
2. At least five signs of depression lasting two or more weeks: Depressed mood most of the day; markedly diminished interest or pleasure in activities; significant weight/appetite loss or gain when not dieting; insomnia or sleeping too much; physical agitation or lethargy; fatigue or loss of energy; feeling worthless, or excessive or inappropriate guilt; problems in thinking, concentrating, or making decisions; recurrent thoughts of death and suicide. For those experiencing a persistent depressive disorder, the symptoms are milder but last for a longer period of time.
3. In a survey of 21 countries, 4.6 percent of those interviewed reported experiencing moderate to severe depressive symptoms.
4. How do reported depressive symptoms typically change over the course of a year and what is the challenge to this typically held belief?

   More individuals report crying more frequently in December than May, however evidence does not seem to support the idea that people who live in cloudier or more northerly experience depression at higher rates.
5. Mania is characterized by hyperactivity, euphoria and wildly optimistic states. If depression is living in slow motion, mania is fast forward in which a person may be euphoric, overly

talkative, energetic and wildly optimistic. During a manic episode, the individual may need less sleep, show few sexual inhibitions and experiences flight of ideas.

6. Between 1994 and 2003, the U.S. National Center for Health Statistics surveys revealed a 40-fold increase in the diagnosing of bipolar disorder in those 19 and under—from 20,000 to 800,000. Two-thirds of the cases were boys.

7. Disruptive mood regulation disorder

67-2

1. Wording of answers and discussions will vary, but will likely include the following:

- **a.** Behavioral and cognitive changes accompany depression.
- **b.** Depression is widespread.
- **c.** Women's risk of major depression is nearly double men's.
- **d.** Most major depressive episodes self-terminate.
- **e.** Stressful events related to work, marriage, and close relationships often precede depression.
- **f.** With each generation, depression is striking earlier and affecting more people.

2. Mood disorders run in families. The risk of major depressive disorder and bipolar disorder increases if you have a parent or sibling with the disorder. If one identical twin is diagnosed with major depressive disorder, the chances are about 1 in 2 that at some time the other twin will be, too. Some studies estimate the heritability of major depression at 40 percent. If one identical twin has bipolar disorder, the chances of the other twin also having bipolar disorder at about 7 in 10. It has however been difficult to link depression with a single gene as it is likely that many genes work together and interact with other external factors to determine if

the disorder will be displayed.

3. Many studies have found diminished brain activity during slowed-down depressive states and more activity during periods of mania. The left frontal lobe and an adjacent brain reward center are active during positive emotions, but less active during depressed states. Decreased axonal white matter or enlarged fluid-filled ventricles are found in the brains of people with bipolar disorder.
4. Norepinephrine is scarce during depression and overabundant during mania. Serotonin is also scarce during a depressive episode, one New Zealand study of young adults found that the recipe for depression combined two necessary ingredients—life stress plus a variation on the serotonin-controlling gene.
5. Drugs that relieve depression tend to increase norepinephrine or serotonin by either blocking reuptake or their chemical breakdown.
6. Depressed people view life through the dark glasses of low self-esteem. Their intensely negative assumptions about themselves, their situation, and their future lead them to magnify bad experiences and minimize good ones. Self-defeating beliefs and a negative explanatory style feed depression's vicious cycle.
7. Rumination is staying focused on a problem but can also be compulsive fretting and overthinking the problem and its causes. Excessive rumination can divert us from thinking about other tasks and produces a negative mood and interfere with daily functioning.
8. Those who offer stable, global, and internal attributions for life's negative events tend to be more pessimistic and more at risk for depression.

   Examples will vary but should reflect at least one of the three components of pessimistic thinking. For example, after Peter fails an exam, he thinks he is not very smart (stable), that

he cannot be successful in the course because he is not working hard enough (internal) and that this failure are just a preview of more academic failure to come (global).

9. Answers will vary.

10. Pessimistic, overgeneralized and self-blaming attributions may lead to learned helplessness as the individual comes to believe they cannot do anything to improve their situation.

11. Bad moods feed on themselves. When we feel down, we think negatively and remember bad experiences.

67-3

1.

a. national differences

Britain's, Italy's, and Spain's suicide rates are little more than half those of Canada, Australia, and the United States. Austria and Finland's are about double. Within Europe, people in the most suicide- prone country have been 16 times more likely to kill themselves than those in the least.

b. racial differences

Within the United States, Whites kill themselves twice as often as Blacks.

c. gender differences

Women are much more likely than men to attempt suicide. Men are 2 to 4 times more likely to actually end their lives. Men use more lethal methods, such a firing a bullet into the head, the method of choice in 6 out of 10 suicides.

d. age differences and trends

In late adulthood, rates increase, peaking in middle age and beyond. In the last half of the

twentieth century, the global rate of annual suicide deaths nearly doubled.

e. other group differences

Suicide rates are much higher among the rich, the nonreligious, and those who are single, widowed, or divorced. When facing an unsupportive environment, including family or peer rejection, gay and lesbian youth are at increased risk of attempting suicide.

f. day of the week differences

25 percent of suicides occur on Wednesdays.

2. The risk of suicide is five times greater for those who have been depressed. Among people with alcohol use disorder, 3 percent die by suicide.

3. People engage in NSSI to gain relief from intense negative thoughts through the distraction of pain, to ask for help and gain attention, to relieve guilt by self-punishment, to get others to change their negative behavior, or to fit in with a peer group.

4. Older adults may not want to deal with the pain of a permanent illness or they do not want to be a burden to their families.

5.

1. listen and empathize
2. Connect the person with a psychologist or counselor
3. Protect the individual by seeking help from a trusted adult.

6. NSSI does not typically lead to suicide; they are suicide gesturers, not suicide attempters. However, if they do not get help, their non-suicidal behavior may escalate to suicidal ideation and attempted suicide.

After You Read

Module 67 Review

1. **b.** major depressive disorder.
2. **d.** rumination.
3. **d.** norepinephrine; reduced; overabundant
4. **c.** the frontal lobes and hippocampus.
5. Sample answers: overtalkative, overactive, elated, easily irritated, little need for sleep, fewer sexual inhibitions, loud speech which is flighty and hard to interrupt, reckless spending, or unsafe sex.
6. Depressed people tend to make stable, global, and internal attributions of their failures. Believing that "I'll never get over this," "I can't seem to do anything right," and "It is all my fault," is a negative explanatory style and is seen more in depressed people.

Module 68 - Schizophrenia

While You Read

68-1

1. "Shizo" means split and "phrenia" means mind, this does not mean splitting into more than one personality, it means that the mind has split from reality. Psychotic disorders are a group of disorders characterized by irrationality, distorted perception and loss of contact with reality.
2. Positive symptoms are the presence of inappropriate behaviors, including hallucinations, talking in disorganized and deluded ways, and exhibiting inappropriate emotion. Negative symptoms are the absence of appropriate behaviors, so the opposite: toneless voices, expressionless faces, or mute and rigid bodies.
3. Positive symptoms: In the case of schizophrenia, refer to added behaviors not normally present. In the same sense, positive punishment refers to adding a punisher to the situation and positive reinforcement refers to adding a reinforcer to the situation.

   Negative symptoms: In the case of schizophrenia, refer to something missing from normal behavior. In the same sense, negative punishment refers to taking away something positive in order to influence behavior and negative reinforcement refers to taking away something negative in order to influence behavior.
4. A hallucination is a false sensory experience, such as seeing something in the absence of an appropriate visual stimulus (for example, seeing a ghost when there is nothing there). A delusion is a false belief, often of persecution or grandeur (for example, truly believing the FBI is closely monitoring your every move) that has no basis is truth. Those who are schizophrenic believe that these hallucinations and delusions are real and see them in a

similar way as others view their day-to-day life.

5. One symptom of schizophrenia is delusions, which are fragmented, bizarre, and distorted thoughts or beliefs, sometimes of persecution or grandeur. Within sentences, jumbled ideas may create what is known as a word salad.
6. Disorganized thoughts may result from a breakdown in selective attention. Normally, we have a remarkable capacity to give our undivided attention to one set of sensory stimuli while filtering out others; those with schizophrenia cannot do this. Minute, irrelevant stimuli attract their attention constantly.
7. Someone with schizophrenia may laugh at the wrong times or cry when others are laughing or become angry for no reason. Flat affect refers to an emotionless state with no facial expressions.
8. Motor behavior may also be inappropriate. Some people with schizophrenia perform senseless, compulsive acts such as continually rocking or rubbing an arm. Others may exhibit catatonia; they may remain motionless for hours and then become agitated.
9. 1 out of 7 will fully recover, while over 40% will have extended periods of a "normal life" with social support and medication.

68-2

1. Schizophrenia typically strikes in early adulthood and afflicts 1 in 100 people. Men face the disorders, earlier, with more severity and in higher number than women. Most individuals will begin to display symptoms of the disorder in their late teens or early twenties.
2. Acute schizophrenia appears suddenly, seemingly as a reaction to stress. This has a greater recovery rate because the positive symptoms such as hallucinations seem to respond to

medical treatment.

Chronic schizophrenia develops slowly over time, often emerging from a long history of social inadequacy and poor school performance. Social withdrawal which is a negative symptom is often associated with chronic schizophrenia and does not seem to respond well to medication, which often makes treatment difficult.

68-3

1. After examining schizophrenia patient's brains after death, researchers found an excess of receptors for dopamine—a six-fold excess for the D4 dopamine receptor. This may create positive symptoms of schizophrenia such as hallucinations and delusions.
2. Some with schizophrenia have low brain activity in the frontal lobes and also display a noticeable decline in the brain waves that reflect synchronized neural firing in the frontal lobes. One PET scan study showed that when hallucinating, the brain became active in the thalamus and the amygdala. Many studies have also found enlarged fluid-filled areas (ventricles) and a shrinking of cerebral tissue. The corpus collosum, hippocampus thalamus and cortex have also been found to be smaller in post-mortem analysis of the brain of schizophrenic individuals.
3. PET scans have shown that when patients with schizophrenia were experiencing a hallucination, their brain became active in several regions, including the thalamus and the amygdala.

68-4

1. When a flu epidemic occurs during the middle of fetal development, there is an increased risk

of schizophrenia. In densely populated areas where viral diseases spread more rapidly, there is a greater risk of schizophrenia. Those born after the fall-winter flu season, in winter and spring months, have an increased risk of the disease.

68-5

1. The odds of developing schizophrenia increase if a sibling or parent has the disorder. The chance increases to 1 in 2 if an identical twin has the disease (this increases to roughly 6 in 10 for those twins that shared prenatal placenta and drops to 1 in 10 (nearly the same similarity as siblings) if they did not share the same prenatal placenta. Identical twins with the same genes who are raised in separate environments can be examined to determine the genetic influence. The co-twin of an identical twin with schizophrenia retains that 1 in 2 chance even when twins are reared apart. Adoption studies confirm the genetic link is real. These studies however are unethical to conduct and can only be examined if the twins were separated at birth.

2. A genetic predisposition means that the genetic foundation exists to develop the disease if environmental triggers present themselves. A predisposition to schizophrenia does NOT mean one will develop schizophrenia, but it generally places them at a higher risk for developing the disorder.

3. Epigenetic factors determine if and when genes will be expressed. A stressful environment may make it more likely that a gene will "turned on", if someone has a genetic predisposition for schizophrenia.

4.

- a mother whose schizophrenia was severe and long-lasting

- birth complications
- separation from parents
- short attention span and poor muscle coordination
- disruptive or withdrawn behavior
- emotional unpredictability
- poor peer relations and solo play

After You Read

Module 68 Review

1. **c.** "split mind."

2. **e.** heavy birth weight

3. **b.** It affects approximately 1% of the population worldwide.

4. Sample answers: fragmented, bizarre thinking; delusions; word salad; paranoid tendencies; hallucinations; inappropriate emotions

5.

P **a.** auditory hallucinations

N **b.** voice lacking in tone

N **c.** expressionless face

P **d.** inappropriate laughter

N **e.** rigid body

P **f.** disorganized speech

6. Hermann is at a greater risk than an individual in the normal population because he has a

genetic disposition for the illness. However, because only about 50% of cases have both identical twins who exhibit the illness, we cannot be certain if Hermann will develop schizophrenia.

Module 69 - Other Disorders

While You Read

69-1

1. The symptoms are wide and varied but may include, exhaustion, pain, anxiety, weakness or headaches. Somatic symptom disorders all share the common characteristic of reporting physical complaints, however, clinicians are unable to identify a physiological explanation for their illness.
2. In China, for instance, psychological explanations of anxiety and depression are socially less acceptable than in many Western countries, and people less often express the emotional aspects of distress.
3. Conversion disorder is characterized by very specific genuine physical symptoms such as numbness in a certain body part or unexplained paralysis for which no physiological basis can be found. An illness anxiety disorder occurs when a person interprets normal physical sensations (such as stomach cramp or headache) as symptoms of a larger and potentially destructive disease.

69-2

1. Dissociation is not rare; many feel a sense of being unreal, being separated from their body. Sometimes when we drive long distances or read a page in a book we may mentally separate and not recall how we arrived at a certain street or finished a section of the book. A dissociative disorder will cause disruption of normal social and occupational functioning. In these cases, a person appears to experience a sudden loss of memory or change in identity, often in response to an overwhelmingly stressful situation.

2. Their conscious awareness dissociates or becomes separated from painful memories, thoughts, and feelings. A fugue state can leave an individual with no memory of what happened to them while in the fugue state which often involves travel to a distant location with no clear memory of doing so.
3. Dissociative identity disorder is characterized by the existence of two or more distinct and alternating personalities. The alter or alters are generally quite distinct from the core personality who often tends to be quite shy and reserved.
4. Dissociative identity disorder is a break from self into multiple different selves who are often unware of each other, while schizophrenia is a break from reality where the individual cannot tell what is real from what is a hallucination or delusion brought about by their illness.
5. One argument is that between 1930 and 1960 the number of DID diagnoses was about 2 per decade, then in the 1980s when the DSM contained the first formal code for this disorder, the number of reported cases rose to more than 20,000. The average number of personalities rose from 3 to 12 per patient. Additionally, outside North America, the disorder is much less prevalent, even rare and nonexistent. Some see it as a fad or a cultural phenomenon created by therapists or the popularity of the disorder as portrayed in movies and books. Also, some like Nicholas Spanos believe that DID may be an exaggeration of the roles we all play in our lives or it could be attributed to a fantasy prone personality in which people get lost in their roles they play in day-to-day life. The increased diagnosis of DID may also be attributed to the suggestibility from therapists that an individual may be suffering from DID.
6. They have found support for this view in the distinct brain and body states associated with differing personalities--handedness sometimes switches with personality. Patients with DID exhibited shifting visual acuity and eye-muscle balance as they switched personalities, which

control group members trying to simulate DID did not. Patients have also showed heightened activity in brain areas associated with the control and inhibition of traumatic memories and quicker detection to threats. DID may also like Freud suggested with defense mechanisms be a way to cope with painful memories by holding them at a distance from one`s core personality.

69-3

1.

Behaviors or Emotions Expressed in This Cluster	**Example of Personality Disorder**
Anxiety	Avoidant personality disorder
Eccentric or odd behaviors	Schizoid personality disorder
Dramatic or impulsive behaviors	Narcissistic personality disorder

2. A person exhibits a lack of conscience for wrongdoing, even toward friends and family members. The person may be aggressive and ruthless or a clever con artist. This individual expresses a lack of conscience or ability to empathize in all aspects of life and is often extremely manipulative in an effort to get what they want.

3. Molecular geneticists have identified some specific genes that are more common in those with antisocial personality disorder. Studies have shown that levels of stress hormones and low arousal in response to threats. These individuals often show little autonomic system arousal.

4. PET scans show increased activity in an area of the cortex that helps control impulses in 41

murderers as compared to people of the same age and sex. It was also found that the murderers had 11 percent less frontal lobe tissue than normal.

5. Environmental factors such as child abuse, poverty or family instability can be triggers for the development of antisocial personality disorder. However; channeled in more productive directions, the fearlessness that is characteristic of the disorder could lead to heroism, adventurism, or high-level athleticism.

69-4

1. Symptoms: dropping significantly below normal weight but still feeling fat, fear being fat, exercising excessively, and remaining obsessed with losing weight. People with anorexia nervosa are 15 percent or more underweight.

   Prevalence: About 0.6 percent of the population meet the criteria for anorexia.

2. Symptoms: alternating binge-eating (usually high-calorie foods) with purging (by vomiting or laxative use), excessive exercise, or fasting.

   Prevalence: About 1 percent of the population meet the criteria for bulimia.

3. Symptoms: significant binge eating followed by disgust, distress, or guilt, but without the purging or fasting marked by bulimia nervosa. Many individuals with binge-eating disorder tend to be overweight.

   Prevalence: About 2.8 percent of the population meet the criteria for this disorder.

4. Mothers of girls with eating disorders tend to focus on their own weight and their daughters' weight and appearance.

   Families of bulimia patients have a higher-than-usual incidence of childhood obesity and negative self-evaluation.

Families of anorexia patients tend to be competitive, high-achieving, and protective.

5. Twins are more likely to share an eating disorder if they are identical rather than fraternal.

6. Answer will vary.

After You Read

Module 69 Review

1. **c.** anorexia nervosa.

2. **b.** a somatic symptom disorder.

3. **d.** dissociative identity disorder.

4. **b.** antisocial personality disorder.

5. **a.** illness anxiety disorder.

✓ Check Yourself

1.

Potential diagnosis: Major depressive disorder

How would the biopsychosocial approach offer an explanation? Genetic factors: Did a parent suffer from depression? Do any of her siblings suffer from disorders? Psychological influences: learned helplessness (she cannot do anything right), stress of grades Social factors: expectations of friends and family, she may be under a great deal of stress at the moment.

How would the learning perspective offer an explanation? Darya may have learned

depressive behaviors by observing a parent who suffers, or she may feel rewarded by the attention she receives when she is upset.

How would the social-cognitive perspective view this disorder? Rumination: compulsive worry and overthinking her problem Negative explanatory style: stable—no end to the fall; global—cannot do anything right; internal—blames herself

How will diagnosing/labeling this individual with a specific disorder impact perceptions of this person's behavior? Friends may view Darya differently if they know she suffers from depression. Comments she makes will be viewed as depressive comments; a simple behavior such as wanting to take a nap will be viewed as excessive sleep. They may not want to associate with someone who has a mental illness because of the stigma that still surrounds mental illnesses.

Additional symptoms or behaviors to watch for: Additional symptoms or behaviors to watch for include significant weight loss or gain and recurrent thoughts of death or suicide. In addition, behaviors such as further withdrawal or loss on interest in activities that were formerly enjoyable for the individual.

How could Darya change her explanatory style to alleviate the depressive symptoms? She should embrace a more temporary, specific, and external explanatory style that leads to more successful coping.

2. Celeste is suffering from generalized anxiety disorder, which is characterized by continuous worry for six months or more; often jittery, agitated, and sleep-deprived; twitching eyelids; free-floating anxiety, unable to identify a cause. Two-thirds of sufferers are women.
3. Jarrod is suffering from schizophrenia. Onset is usually in a young person maturing into adulthood, and it is characterized by auditory hallucinations, word salad, and disorganized thoughts.
4. Walter is suffering from a conversion disorder, which is anxiety converted to a physical symptom, one specific physical symptom with no physiological/organic cause.
5. Sal has antisocial personality disorder; characteristics include lack of conscience before age 15, inability to keep a job, irresponsible as a spouse, assaultive or otherwise criminal.