The Longman

Textbook Reader

Revised Edition

http://ablongman.com/englishpages

The Longman Textbook Reader

Compiled by Martha Sledge

LONGMAN

An imprint of Addison Wesley Longman, Inc.

New York · Reading, Massachusetts · Menlo Park, California · Harlow, England
Don Mills, Ontario · Sydney · Mexico City · Madrid · Amsterdam

Senior Acquisitions Editor: Steven Rigolosi
Supplements Editor: Donna Campion
Text Design: Digital Text Construction
Electronic Page Makeup: Digital Text Construction

Grateful acknowledgment is made to the copyright holders on page 211, which is hereby made part of this copyright page.

The Longman Textbook Reader, Compiled by Martha Sledge

ISBN 0-321-11895-2

02—CRS—98765432

Contents

Introduction for Instructors

Reading courses offer college students many opportunities. In addition to helping them increase literal comprehension skills, such courses provide a basis for further college study in a wide variety of disciplines. Students who master the skills taught in their reading courses are well on their way to success in college and in the workplace.

A large part of success in any endeavor involves understanding the expectations of the situation. College students are expected to be independent learners, to take charge of their studies, and to find motivation within. They are expected to attend lectures, take exams, and read their textbooks. Developmental reading texts often stress the importance of attending class and usually offer some tips on how to prepare for and take tests. They also include various excerpts from college texts to prepare students for the material they will encounter in their other college courses.

Unfortunately, such textbook excerpts (which often beautifully illustrate such important concepts as main idea, supporting details, and patterns of organization) tend to be fairly short—no more than a paragraph or two, or three or four pages at most. Such material tends to give ample drill and practice in the all-important reading skills, but often does not match the assignments that students will receive in their other courses, where they will be expected to read one or two complete textbook chapters per week.

In the interests of providing students with longer, chapter-length readings, Addison Wesley Longman is pleased to offer *The Longman Textbook Reader.* Prepared in consultation with Addison Wesley Longman's authors, this paperback volume features five complete chapters from freshman textbooks. These five chapters are:

- **Psychology:** Chapter 15, "Psychological Disorders." From Wade, Carole and Carol Tavris. *Psychology,* 5/e. ©1998 by Longman, an imprint of Addison Wesley Longman.
- **Business:** Chapter 2, "The Cultural Environments Facing Business." From Daniels, John D. and Lee H. Radebaugh. *International Business: Environments and Operations,* 8/e. ©1998 by Addison-Wesley.
- **Computers:** Chapter 8, "Security and Privacy: Computers and the Internet." From Capron, H. L. *Computers: Tools for an Information Age,* 5/e. ©1998 by Addison-Wesley.
- **Biology:** Chapter 31, "Plant Structure and Growth." From Campbell, Neil A., *Biology,* 4/e. ©1996 by Benjamin/Cummings.

- **Communications:** Unit 21, "Friends and Lovers." From DeVito, Joseph A. *The Interpersonal Communication Book*, 8/e ©1998 by Longman, an imprint of Addison Wesley Longman.

These five chapters were chosen to reflect the most common majors of community college students across the country: the allied health professions, business administration, the computer and vocational/technical professions, and the social sciences (including sociology, psychology, and communications). Each chapter contains the complete original text, photos, art, and pedagogical features. In addition, a series of additional exercises, group activities, and critical thinking activities have been prepared specially for this edition.

We hope *The Longman Textbook Reader* will be an asset to you and your students.

STEVEN RIGOLOSI
Senior Editor, Developmental English
Longman Publishers
Steven.Rigolosi@ablongman.com

UNIT I

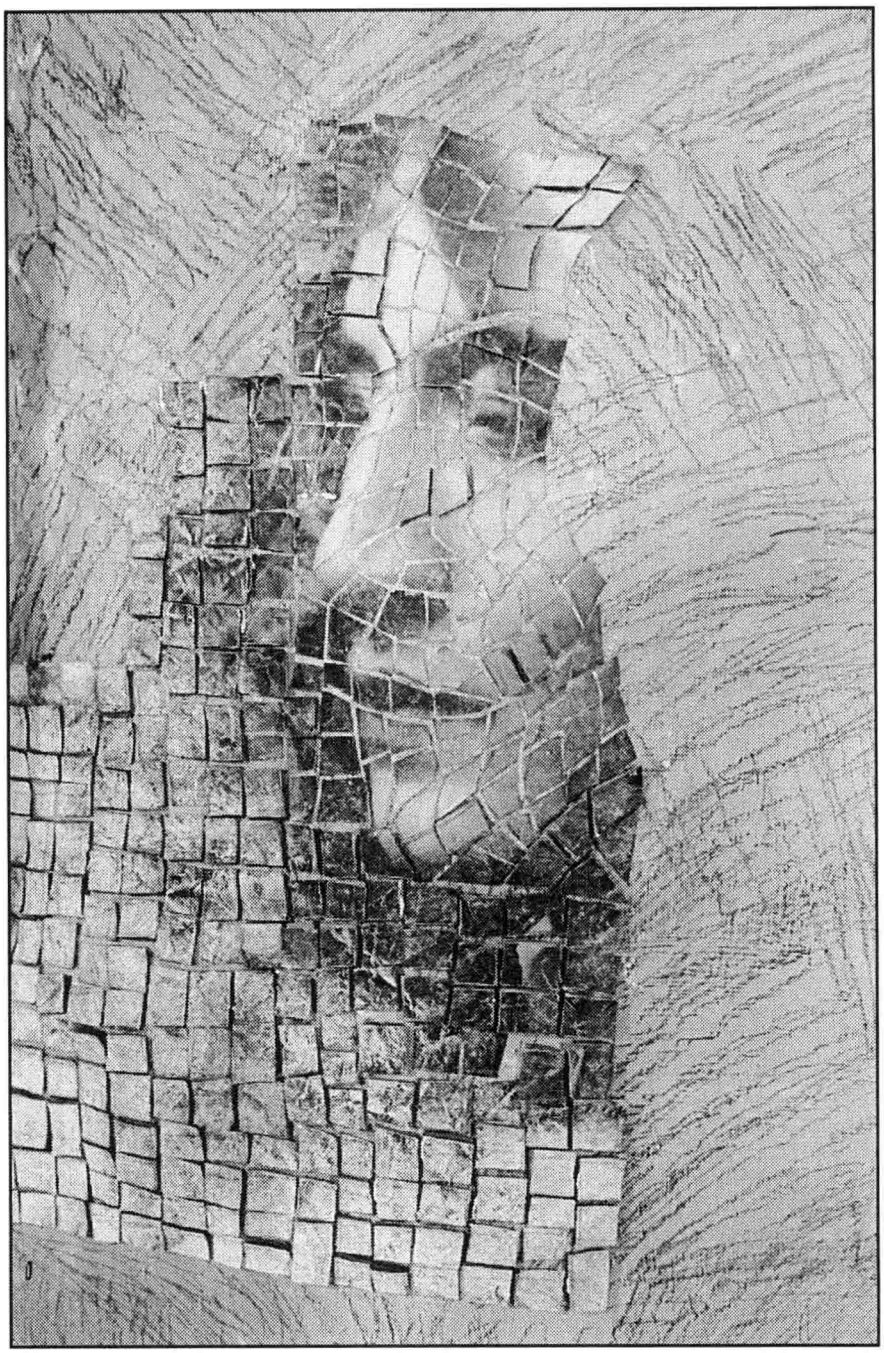
From

Carole Wade
Carol Tavris

Psychology

Fifth Edition

Chapter 15:
Psychological Disorders



Who in the rainbow can draw the line where the violet tint ends
and the orange tint begins? . . . So with sanity and insanity.
In pronounced cases there is no question about them.
But in [less obvious cases, few people are willing]
to draw the exact line of demarcation
. . . though for a fee some professional experts will.

Herman Melville, *Billy Budd*

CHAPTER FIFTEEN

Psychological Disorders

Joan of Arc heard voices that inspired her to martyrdom. Was she sane and saintly—or mad?

YOU DON'T HAVE TO BE A PSYCHOLOGIST to recognize extreme forms of abnormal behavior. A homeless woman stands on a street corner every night between midnight and 3:00 A.M., screaming obscenities and curses; by day, she is calm. A man in a shop tells you confidentially that his shoes have been bugged by the FBI, his phone is wiretapped, and his friends are spying on him for the CIA. An old man has kept every one of his daily newspapers going back to 1945, and, although he has no room in his house for anything else, he panics at the thought of giving them up.

When most people think of "mental illness," they think of odd individuals like these, whose stories fill the newspapers. But most of the psychological problems that trouble people are far less dramatic and would never make the nightly news. They occur when an individual cannot cope effectively with the stresses and problems of life. The person may become so anxious and worried that work is impaired, or become severely depressed for months, or begin to abuse drugs. In most cases, as the quote that opens this chapter says, no "exact line of demarcation" indicates when normal behavior ends and abnormal behavior begins.

You will have noticed by now that we have tried to avoid traps of either–or thinking in this book, whether the subject is right-brain versus left-brain differences or nature versus nurture. It is the same with *normality* and *abnormality*, concepts that include a rainbow of behaviors, with many shadings of color and brightness. A given problem is not a fixed point on the rainbow. A person may go through episodes of inability to function, yet get along fine between those episodes. Problems also vary in intensity; they may be mildly uncomfortable, serious but endurable, or completely incapacitating. Psychologists and psychiatrists diagnose and treat a wide range of "abnormal" behavior.

One of the most common worries that people have is "Am I normal?" It is normal to fear being abnormal. We all occasionally have difficulties that seem too much to handle, that make us feel we can't cope. It is also normal to experience "medical students' syndrome": deciding that you suffer from whatever disorder you are reading about. Precisely because many psychological problems are so common, differing only in shades of intensity on the rainbow, you may start thinking that you have them all. (We are tempted to add that this faulty conclusion is a pigment of the imagination.)

DEFINING DISORDER

Many people tend to confuse the terms *abnormal behavior*—behavior that deviates from the norm—and *mental disorder*, but the two are not the same. A person may behave in ways that are statistically rare without having a mental illness. Some of this behavior is destructive, such as murder; some is charmingly unique, such as collecting ceramic pigs; and some is desirable, such as genius. Conversely, some mental difficulties, such as depression or anxiety, can be statistically common in a society; and some thoughts or behaviors that would usually be called disordered, such as paranoid delusions or sadism, may even be considered desirable qualities in certain cults and organizations, such as the neo-Nazi Aryan Nation.

Moreover, the same symptom may be normal in one context but a sign of a disorder in another. For example, it is normal for people to hallucinate when they have a high fever, are isolated from all external sensation (see Chapter 5), are physically and mentally exhausted or

DEFINE YOUR TERMS

A sect believes that it is being persecuted by nonbelievers, that a secret cabal controls the world, and that World War III is imminent. The group is stockpiling weapons and building bunkers for protection. These beliefs and actions are "normal" to all members of the sect, but would you call them signs of mental disorder? Why or why not?

stressed, are under the influence of various drugs, or are waking from deep sleep or falling into sleep. These conditions can produce "waking dreams" in which people report seeing ghosts, demons, space aliens, or other terrifying images. These normal hallucinations may be bizarre, but they are not signs of disorder; they arise from reactions of the brain to excessive stimulation or deprivation (Siegel, 1992).

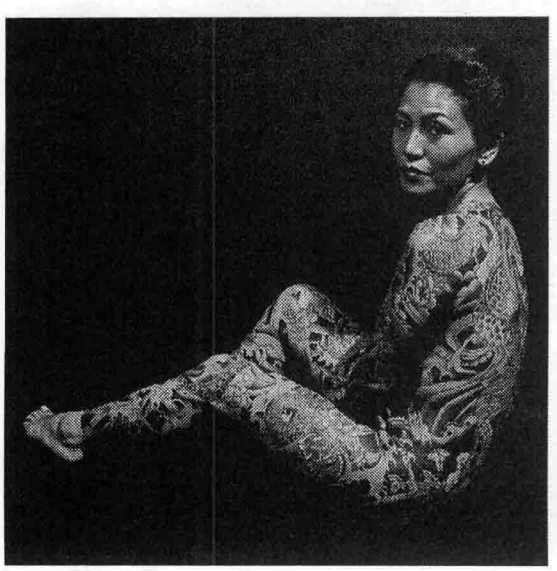
Thus defining mental disorder is not an easy task. It depends in part on who is doing the defining and for what purpose, and it depends on understanding the context of the individual's symptoms and behavior. Here are several criteria in current use:

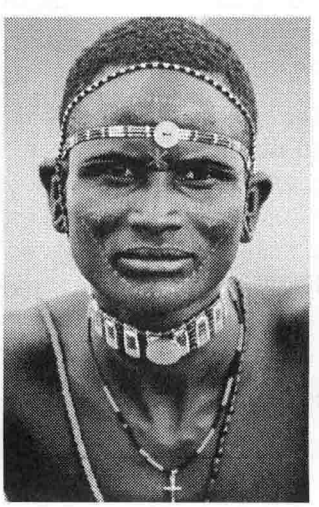
1. *Violation of cultural standards.* One definition of a mental disorder is that it involves a violation of group standards and cultural rules. Every society sets up standards of behavior that its members are expected to follow, and those who break the rules will be considered deviant or abnormal. Some standards are nearly universal, such as wearing clothes. If you run around naked in New Hampshire, most people (and the police) will think something is the matter with you.

But behavior that reflects normal conformity to a standard in one culture might seem to be abnormal in another setting. For example, seeing visions might be interpreted as a sign of schizophrenia in a twentieth-century farmer, but as a sign of healthy religious fervor in a thirteenth-century monk. For most North American cultural groups, hearing the voice or having visions of a deceased relative is thought to be abnormal; but the Chinese, the Hopi, and several other cultures regard such hallucinations as normal. (Actually, hallucinations are fairly common among whites too during bereavement; it is just that they don't tell anyone because they fear being considered "crazy" [Bentall, 1990].)

2. *Maladaptive behavior.* Many psychologists define mental disorder in terms of behavior that is maladaptive for the individual or society. This definition would ap-

People all over the world paint their bodies, but what is normal in one culture often is abnormal or eccentric in another. Hiromi Nakano (left), whose body has been completely tattooed, has taken body painting to an extreme rare in most societies; but the Samburu tribesman of Kenya (center) is painted and adorned in ways typical of his culture. And the tattoos of the American bikers (right) are abnormal to most Americans but perfectly normal in the biking subculture. How are you reacting to these examples of body decoration? Do you think they are beautiful, amusing, disgusting, or creepy?





GET INVOLVED

You don't need to read a text on abnormal psychology to find cases of psychopathology; just open any magazine or newspaper! You will discover stories of violence, suicide, sexual obsession, delusion ("I was abducted by aliens"), and paranoia ("The government is spying on me from black helicopters"). As you look through an issue of your local paper, ask yourself whether the behavior in such stories seems clearly disturbed, normal, or somewhere in between. What are your criteria: cultural violations, maladaptive behavior, emotional distress, or legal judgments of impaired judgment? Can you identify cases in which it is hard to pinpoint where normality ends and disorder begins?

ply to the behavior of a woman who is so afraid of crowds that she cannot leave her house, the behavior of a man who drinks so much that he cannot keep a job, and the behavior of a student who is so anxious about failure that he cannot write term papers or take exams. It also covers the actions of individuals who say they feel fine and deny that anything is wrong but who behave in ways that are disruptive or dangerous to the community, or who are out of touch with reality—the child who sets fires, the compulsive gambler who loses the family savings, or the man who hears voices telling him to kill.

3. *Emotional distress.* A third definition identifies mental disorder in terms of a person's suffering. A person may conform to the rules of his or her community, working and getting along adequately, yet privately feel unreasonably anxious, afraid, angry, depressed, or guilty. By these criteria, according to a nationwide study of 20,000 randomly selected adults, in any given year about 28 percent of all Americans have one or more disorders—such as depression, anxiety, incapacitating fears, and alcohol or other drug problems (Regier et al., 1993; see also Kessler et al., 1994). The benefit of this definition is that it takes the person's own distress as a measure of disorder instead of imposing a single standard for everyone. A behavior that is unendurable or upsetting for one person, such as lack of interest in sex, may be acceptable and thus not distressful to another. One problem with this definition is that some people may be mentally disturbed and harmful to others, yet not feel troubled or conflicted about their behavior.

4. *The legal definition: impaired judgment and lack of self-control.* In law, the definition of mental disorder rests primarily on whether a person is aware of the consequences of his or her actions and can control his or her behavior. If not, the person may be declared insane—that is, incompetent to stand trial. But *insanity* is a legal term only; psychologists and psychiatrists do not use the terms *sanity* or *insanity* in relation to mental disorders.

Each of these definitions is useful, and no one of them is enough. In this chapter we will define **mental disorder** broadly, as any behavior or emotional state that causes an individual great suffering or worry; is self-defeating or self-destructive; or is maladaptive and disrupts either the person's relationships or the larger community. By these criteria, many people will have some mental-health problem in the course of their lives. This is normal.

mental disorder Any behavior or emotional state that causes an individual great suffering or worry; is self-defeating or self-destructive; or is maladaptive and disrupts the person's relationships or the larger community.

DILEMMAS OF DIAGNOSIS

Even armed with a broad definition of mental disorder, psychologists have found that agreeing on a specific diagnosis is easier said than done. As George Albee (1985),

a past president of the American Psychological Association, put it, "Appendicitis, a brain tumor and chicken pox are the same everywhere, regardless of culture or class; mental conditions, it seems, are not." In this section we will examine the difficulties of measuring and diagnosing some of those mental conditions.

MEASURING MENTAL DISORDERS

Clinical and personality psychologists often use psychological tests to help them decide whether a person has a mental disorder. In Chapter 12 we discussed *projective tests*, which are based on the assumption that the test-taker will project his or her unconscious conflicts and motivations onto the stimulus materials. (You may recall the problems with these tests; see pages 478–479.) Most clinicians also rely on *objective tests*, or **inventories,** to diagnose their clients' problems. These tests are standardized questionnaires that require written responses, typically to multiple-choice or true-false items. Usually the test-taker is asked to report how she or he feels or acts in certain circumstances. For example, the Beck Depression Inventory is widely used to measure the severity of depression and distress; the Spielberger State–Trait Anger Inventory and the Taylor Manifest Anxiety Scale assess degrees and expressions of anger and anxiety. Objective tests have better *reliability* (they are more consistent over time) and *validity* (they are more likely to measure what they say they measure) than do projective methods or clinicians' subjective judgments (Anastasi, 1988; Dawes, 1994).

The most famous and widely used objective test of personality is the **Minnesota Multiphasic Personality Inventory (MMPI).** The MMPI was developed in the 1930s by Starke Hathaway and J. Charnley McKinley, who wanted a way to screen people with psychological disorders. They administered 1,000 potential test items to 200 people with various mental disorders and to a control group of 1,500 people who were not in treatment; the two groups differed in their answers to 550 items, and these were retained. The items were then assigned to ten clinical categories, or *scales*, that identified such problems as depression, paranoia, schizophrenia, and introversion. Four *validity scales* indicated whether a test-taker was likely to be lying, careless, defensive, or evasive while answering the items. For example, if a person tried to present an overall favorable but unrealistic image on nearly every item, the person's score on the lie scale would be high.

Since the original MMPI was devised, hundreds of additional scales have been added, and thousands of books and articles have been written on the test (Cronbach, 1990). The inventory has been used in some 50 countries, on everyone from ordinary job applicants to Russian cosmonauts. In 1989, a major revision of the MMPI was released, the MMPI-2, with norms based on a sample that was more representative in terms of region, ethnicity, age, and gender (Butcher et al., 1989).

Despite its popularity, the MMPI has many critics. Some have observed that the test is biased because its standards of normalcy do not reflect cultural differences. Although the sample used for establishing test norms in the MMPI-2 was an improvement, it still underrepresented minorities, the elderly, the poor, and the poorly educated. Some of the scales are still based on inadequate and outdated norms, and some items are affected by the respondent's tendency to give the socially appropriate answer rather than an honest one (Edwards & Edwards, 1991; Helmes & Reddon, 1993). One review concluded that the MMPI is adequate if the test is used for its original purpose—identifying people with emotional disorders (Parker, Hanson, & Hunsley, 1988). Yet in practice, the MMPI is often used in business, industry, and education for inappropriate reasons by persons who are not well trained in testing. Two

inventories Standardized objective questionnaires requiring written responses; they typically include scales on which people are asked to rate themselves.

Minnesota Multiphasic Personality Inventory (MMPI) A widely used objective personality test.

Harriet Tubman (far left) with some of the people she helped to escape from slavery on her "underground railroad." Slaveholders welcomed the idea that Tubman and others who insisted on their freedom had a "mental disorder" called "drapetomania."

psychologists who reviewed the history and validity of both MMPIs concluded that the correct interpretation of these tests requires "substantial experience and sophistication" by the clinician who administers them (Helmes & Reddon, 1993).

The debate about the MMPI reflects a deeper issue: whether mental disorder can be diagnosed objectively at all. The debate about testing is a whisper compared with the noisy controversy about the diagnosis of mental disorder itself.

DIAGNOSIS: ART OR SCIENCE?

In the early years of the nineteenth century, a physician named Samuel Cartwright argued that many slaves were suffering from two forms of mental illness: *drapetomania,* an uncontrollable urge to escape from slavery, and *dysathesia aethiopica,* the symptoms of which included destroying property on the plantation, being disobedient, talking back, refusing to work, and fighting back when beaten. "Sanity for a slave was synonymous with submission," noted Hope Landrine (1988), "and protest and seeking freedom were the equivalent of psychopathology." Thus doctors could assure slaveowners that a mental illness, not the intolerable condition of slavery, made slaves seek freedom.

Today, "drapetomania" sounds foolish and cruel, and most people assume that the bad old days of psychiatric misdiagnosis are past. Yet cultural factors and subjective interpretations still affect the process of diagnosis, a fact that raises many important issues for those who define and treat mental disorders.

In theory, diagnostic categories must meet a set of solid scientific criteria to be included in the "bible" of psychological and psychiatric diagnosis, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which is published by the American Psychiatric Association. The first edition of the DSM, in 1952, was only 128 pages long and contained brief descriptions of organic brain disorders, severe mental disorders, and personality problems. The second edition, the DSM-II, appeared in 1968; it too was short. The third edition, DSM-III, published in 1980, began to include ordinary difficulties such as tobacco dependence, marital conflicts, and sexual problems. The revised third edition, DSM-III-R, in 1987, was 567 pages long and listed more than 200 kinds of mental disorder. The fattest edition yet, the DSM-IV, published in 1994, is nearly 900 pages long and contains more than 300 mental disorders.

The primary aim of the DSM is *descriptive:* to provide clear criteria of diagnostic categories, so that clinicians and researchers can agree on which disorders they are talking about, study them, and treat them. (For a list of its major categories, see Table 15.1.) The DSM makes few assumptions about the causes of the disorders it describes; in many cases, the causes are not known. Where possible, information is provided about typical age of onset, predisposing factors, course of the disorder, prevalence of the disorder, sex ratio of those affected, and cultural issues that might affect diagnosis. The DSM also classifies each disorder on five *axes,* or factors:

1. The primary diagnosis of the problem, such as depression.
2. Ingrained aspects of the client's personality that are likely to affect his or her behavior and ability to be treated, such as narcissism or dependency.
3. General medical conditions that are relevant to the disorder, such as respiratory or digestive problems.
4. Social and environmental problems that can make the disorder worse, such as job and housing troubles or loss of a support group.

TABLE 15.1 *Major Diagnostic Categories in the DSM-IV*

Disorders usually first diagnosed in infancy, childhood, or adolescence include mental retardation, attention-deficit disorders (such as hyperactivity or an inability to concentrate), eating disorders, and developmental problems.

Delirium, dementia, amnesia, and other cognitive disorders are those resulting from brain damage, degenerative diseases such as syphilis or Alzheimer's, toxic substances, or drugs.

Substance-related disorders are problems associated with excessive use of or withdrawal from alcohol, amphetamines, caffeine, cocaine, hallucinogens, nicotine, opiates, or other drugs.

Schizophrenia and other psychotic disorders are disorders characterized by delusions, hallucinations, and severe disturbances in thinking and emotion.

Mood disorders include major depression, bipolar disorder (manic-depression), and dysthymia (chronic depressed mood).

Anxiety disorders include generalized anxiety disorder, phobias, panic attacks with or without agoraphobia, posttraumatic stress disorder, and obsessive thoughts or compulsive rituals.

Somatoform disorders involve individual reports of physical symptoms (e.g., paralysis, heart palpitations, or dizziness) for which no organic cause can be found. This category includes hypochondria, extreme preoccupation with health and the unfounded conviction that one is ill; and conversion disorder, in which a physical symptom (such as a paralyzed arm or blindness) serves a psychological function.

Dissociative disorders include dissociative amnesia, in which important events cannot be remembered after a traumatic event; and dissociative identity disorder (formerly "multiple personality disorder"), characterized by the presence of two or more distinct identities or personality states.

Sexual and gender identity disorders include problems of sexual (gender) identity, such as transsexualism (wanting to be the other gender); problems of sexual performance (such as premature ejaculation, lack of orgasm, or lack of desire); and paraphilias, which involve unusual or bizarre imagery or acts that are necessary for sexual arousal, as in fetishism, sadomasochism, or exhibitionism.

Impulse control disorders involve an inability to resist an impulse to perform some act that is harmful to the individual or to others, as in pathological gambling, stealing (kleptomania), setting fires (pyromania), or having violent rages.

Personality disorders are inflexible and maladaptive patterns that cause distress to the individual or impair the ability to function; they include paranoid, narcissistic, and antisocial personality disorders.

Additional conditions that may be a focus of clinical attention include "problems in living" such as bereavement, academic difficulties, religious or spiritual problems, and acculturation problems.

5. A global assessment of the client's overall level of functioning in work, relationships, and leisure time, including whether the problem is of recent origin or of long duration, and how incapacitating it is.

The DSM has had an extraordinary impact worldwide. It has standardized the categories of what is, and what is not, a mental disorder. Its categories and terminology have become the common language of most clinicians and researchers. Virtually all textbooks in psychiatry and psychology base their discussions of mental disorders