ROBERT C. CARSON • JAMES N. BUTCHER • SUSAN MINEKA

ABNORMAL PSYCHOLOGY AND MODERN LIFE

TENTH EDITION

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ROBERT C. CARSON
Duke University
JAMES N. BUTCHER
University of Minnesota
SUSAN MINEKA
Northwestern University

HarperCollins*CollegePublishers*

Acquisitions Editor: Catherine Woods
Developmental Editor: Betty Gatewood
Project Coordination, Text and Cover Design: York Production Services
Photo Researcher (interior): Roberta Knauf
Photo Researcher (cover): Nina Page
Electronic Production Manager: Mike Kemper
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Electronic Page Makeup: York Production Services
Printer and Binder: R.R. Donnelley & Sons Company
Cover Printer: New England Book Components, Inc.
Cover Illustration: Gorky, Arshile (Vosdanig Manoog Adoian). *Agony. 1947.* Oil on canvas, 40 x 50 ½" (101.5 x 128.3 cm). The Museum of Modern Art, New York. A. Conger Goodyear Fund. Photograph © 1995 The Museum of Modern Art, New York.

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Abnormal Psychology and Modern Life, Tenth Edition

Library of Congress Cataloging-in-Publication Data
Carson, Robert C., 1930–
Abnormal psychology and modern life / Robert C. Carson, James N. Butcher, Susan Mineka.—10th ed.
p. cm.
Includes bibliographical references and index.
ISBN 0-673-99241-1
ISBN 0-673-98161-4 (paper)
1. Psychiatry. 2. Psychology, Pathological. I. Butcher, James Neal, 1933–. II. Mineka, Susan.
RC454.C275 1995
616.89—dc20 95-18510
CIP

95 96 97 98 9 8 7 6 5 4 3 2 1

PREFACE

In preparing the new tenth edition of *Abnormal Psychology and Modern Life,* we enthusiastically welcome a new co-author, Professor Susan Mineka of Northwestern University, who adds a significant increment of breadth in our attempt to make accessible to students the latest and best of available research in the ever-expanding field of abnormal psychology. Dr. Mineka, herself a noted researcher and former editor of the *Journal of Abnormal Psychology,* has brought new expertise, broad knowledge of the research literature, and great energy to her work on this edition. We think readers familiar with former editions of this work will appreciate that the results speak for themselves.

The discipline of abnormal psychology has undergone many dramatic changes since this text first appeared, under the inspired authorship of James Coleman, in the early 1950s. However, our goals for this tenth edition remain unchanged from that first successful effort: to provide the reader with a comprehensive, searching, and engaging overview of the field. Over the course of nine editions, *Abnormal Psychology and Modern Life* has given generations of psychology students a thorough and rigorous grounding in abnormal psychology. In each edition, the authors have sought continually to incorporate current research and to examine critically its contribution to advancing knowledge, while retaining a focus on rich clinical description. In this tenth edition, as in the past, we have balanced the enormous challenge of including the latest developments in a constantly changing field with a judicious reevaluation and streamlining of the wide variety of topics covered by our text. We believe that the tenth edition is as thorough, timely, and dynamic as the ground-breaking first edition was in its time.

Highlights of the New Edition

Presenting in concise and pedagogically mindful fashion the wealth of exciting new research in abnormal psychology has challenged us to reevaluate each chapter from the ninth edition and, in a few cases, to completely rework chapter content. We've made a number of organizational changes in the book to accommodate the new material we've included. Among the changes in the new edition are the following:

- The new edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) has appeared since the publication of the ninth edition of this book. Accordingly, we have integrated the DSM-IV taxonomy and diagnostic criteria into our discussion of the various types of disorder, noting changes in terminology as appropriate.
- We have updated all major topics with relevant new research where it was available. In so doing, we have sometimes found it necessary to present a complex and detailed picture. Sometimes the addition of new research, particularly from biologically oriented investigators, will pose a challenge to students unfamiliar with the methods and terminology involved. Within the context of our aims, this is largely unavoidable; the field itself is challenging, and we believe that occasional complexity is to be preferred to oversimplification. We also believe that complexity does not in and of itself preclude clarity, nor excuse unintelligible writing, and we have tried hard to present complicated systems in a manner that facilitates understanding and mastery. We have not hesitated, for example, to lay out the complex developmental pathway thought to underlie a progression from early, mild neuropsychological deficit through early-onset conduct disorder to adult antisocial personality disorder.
- In response to consistent reviewer recommendations, we have combined the ninth edition chapters on causal factors and theoretical viewpoints into a single integrated chapter.
- The anxiety disorders are now covered in a chapter of their own.

- Somatoform and dissociative disorders are also covered in a chapter of their own.
- Autism has been moved into the chapter on childhood disorders.
- Mental retardation and learning disorders have been moved into a chapter covering brain disorders and other cognitive impairments.
- We have done a considerable amount of overall trimming and reduction to essentials, largely by purging discussions of older studies and of peripheral issues.
- The use of illustrative case material has always been an important and integral component of this textbook. We have added substantial amounts of new case material at critical points in various chapters, and additional examples are provided to illustrate the procedural aspects of treatments found to be especially effective in various disorders.

Significant Changes in this Edition

The tenth edition represents an extensive reorganization and revision of the text. Some of the more important specific changes include the following.

- In our new Chapter 3, "Causal Factors and Viewpoints in Abnormal Psychology," the coverage of nonspecific causal or "risk" factors in psychopathology has been thoroughly updated to reflect a number of important findings from the expanding field of developmental psychopathology. For example, there is enhanced coverage of the concepts of vulnerability and resilience. In addition, the importance of the development of schemas and self-schemas in childhood and the role they play in vulnerability to psychopathology is emphasized.
- Our new Chapter 5, "Panic, Anxiety, and Their Disorders," has been very substantially updated and expanded. This chapter now surveys the very latest thinking on research and treatment of anxiety disorders, including the role of biological and cognitive factors in causing and maintaining these conditions. Many new case studies are also presented.
- Our new Chapter 6, "Mood Disorders and Suicide," has been heavily revised to reflect the wealth of new research in this field. We review recent biological research, including work on disturbed biological rhythms, and we also highlight important new research on psychosocial factors in the context of several prominent and competing vulnerability-stress causal models. We discuss bipolar disorders separately from unipolar disorders, reflecting an increasing tendency, supported by research, in favor of emphasizing a distinction between the two.
- Somatoform and dissociative disorders now have their own chapter, Chapter 7, which has allowed us to expand our coverage of the fascinating issues raised by these types of phenomena, including purported basic linkages they may share. We also discuss the debate over whether "multiple personalities" really exist, and we review the controversy over what have been called "created memories."
- In Chapter 9, "Personality Disorders," we have expanded coverage about recent controversies regarding dimensional versus categorical approaches to understanding these types of exaggerations of normal personality traits. The new cognitive approaches to understanding personality disorders and their treatment are also discussed. We have also expanded our coverage of the causal factors in psychopathy and antisocial personality disorder, including, as noted above, a developmental pathway involving childhood conduct disorder.
- In Chapter 11, "Sexual Variants, Abuse, and Dysfunctions," we have added coverage of the issue of sexual abuse of children and the reliability of their memories. We also discuss historical and cross-cultural issues that affect society's views on what are normal and psychopathological variants of sexual behavior. Also examined are the methodological issues surrounding the question of childhood sexual abuse as a cause of adult psychopathology.
- We have updated our coverage of the schizophrenic disorders (Chapter 12), incorporating much new research deriving from the high level of investigative activity in this domain. For example, a recently published and exceptionally searching study of discordance for schizophrenia in identical twins is carefully examined for what it can yield in enhanced understanding of the sources of psychotic functioning.
- Chapter 15, "Clinical Assessment," now includes discussion of the new and rapidly expanding area of forensic assessment, where psychological testing is employed in the resolution of questions involving an interface between the law and psychological states or characteristics of litigants in both civil and criminal proceedings.

- In Chapter 16, "Biologically Based Therapies," we have expanded and updated our coverage of drug treatment, including the controversy concerning the new and widely used antidepressant Prozac. Also included is a contemporary review of two traditional somatic therapies, electroconvulsive therapy (ECT), and psychosurgery.
- Chapter 18, "Contemporary Issues in Abnormal Psychology," features a considerably expanded and updated treatment of the insanity defense in criminal law and undertakes a detailed examination of the often perplexing legal theories determining courtroom practices in this very controversial area.

Organization of the Text

Throughout the previous nine editions, the organization of *Abnormal Psychology and Modern Life* has to a large extent set the organizational standard for the study of abnormal psychology. Although some chapters have been rearranged, as described above, the basic organization of the tenth edition remains familiar.

- Part One, "Perspective on Abnormal Behavior," sets forth a framework for understanding abnormal behavior, beginning with discussions of classification and scientific research in abnormal psychology (Chapter 1). A brief historical overview traces the changing views of mental disorder from ancient to modern times and includes a discussion of the difficulties of interpreting historical events over time (Chapter 2). This leads to a discussion of causal factors and viewpoints (Chapter 3). Throughout, the reader will be aware of the diversity of the field and the interaction of biological, psychosocial, and sociocultural factors. The ideal of achieving a biopsychosocial integrative approach to understanding the causes of the different disorders is emphasized.
- Part Two, "Patterns of Abnormal (Maladaptive) Behavior," can be considered the core of the text. Here the clinical pictures, causal factors, and treatment and outcomes of maladaptive behavior patterns are examined individually. This section begins with an examination of stress and adjustment disorders, followed by chapters on panic- and anxiety-based disorders, mood disorders, somatoform and dissociative disorders, psychological factors and physical illness, personality disorders, substance-use disorders, sexual variants and dysfunctions, schizophrenic and delusional disorders, brain insult and other cognitive impairments, and disorders of childhood and adolescence. As already noted, these chapters have been extensively revised and updated throughout.
- Finally, Part Three is a more comprehensive look at the clinical assessment, treatment, and prevention of disorders. It includes chapters on assessment, biological therapies, psychosocial therapies, and contemporary social issues pertaining to abnormalities of behavior.

Pedagogical Aids

Many features have been incorporated into this book to aid students in their understanding of abnormal psychology.

- A **chapter outline** introduces each chapter and provides an overview of what is to come. **Chapter summaries** at the end of each chapter also provide an overview, and can be read as an introduction to the chapter or as a review after reading the chapter.
- **Key terms** appear in boldface type when first introduced and defined in the text. For each chapter, these terms are also listed after the summary. At the end of the text, the terms are included and defined in a glossary.
- **Highlight boxes** expand on or summarize important text content.
- The essential features of **DSM-IV** are printed for ready reference on the endpapers of the book.
- **Case studies** of individuals with various disorders appear throughout the book. These cases provide real-life examples of the clinical pictures of many disorders covered in the text. Some are brief excerpts; others are detailed analyses. These cases serve not only to make what the student is reading about more real but also to remind students of the human factor that is so intimately a part of the subject matter of this text. Cases are set off from the text in tinted areas. They also sometimes appear in Highlight boxes. Numerous new case examples are provided for the anxiety disorders, sexual disorders, and personality disorders.
- **Patient art** appears in the chapter openers, with a brief biographical sketch of the artist.

Photos, too, are used throughout to enhance the concepts of the text visually. In some cases, these photos are of people who have been diagnosed as having the disorder in question. The art and the photos will serve not only to instruct but to humanize the study of abnormal behavior.

- At the end of the book is a **glossary** that contains definitions of key terms that appear in boldface type in the text and other terms that appear in the text.
- A **subject index** and a **name index** at the end of the book provide ready reference to any topic or person discussed in the book. The boldface page numbers in the subject index indicate where key terms are first discussed in depth.
- A list of **references** appears at the end of the text; it gives complete information on the citations that appear in the text proper.

Ancillaries

Here is an overview of the ancillaries that accompany this text.

For the Student

A *Study Guide* by Don Fowles (University of Iowa) includes learning objectives, study questions, quizzes, and key terms. New to the tenth edition of the study guide is a feature to prompt critical thinking on the part of the student.

SuperShell II Computerized Study Guide by Suzanne de Beaumont is an interactive text-related program for IBM and compatible machines. It features multiple-choice, true-false, and short-answer questions as well as chapter outlines and a complete text glossary.

For the Instructor

An *Instructor's Manual* by Frank Prerost (Wesleyan Illinois University) gives overviews, learning objectives, lists of key terms, abstracts with discussion questions, suggested readings, discussion and lecture ideas, suggested films, and ideas for activities and projects.

Videos from "The World of Abnormal Psychology," a telecourse produced by the Annenberg/CPB Project in conjunction with Toby Levine Communications, Alvin H. Perlmutter, and HarperCollins Publishers, are available to qualified adopters. Contact your HarperCollins sales representative for more information. The videos are accompanied by literature on how to incorporate the videos into classroom lectures.

A *Test Bank* by Gerald Metalsky (Lawrence University) and Rebecca Laird contains over 100 multiple-choice questions per chapter as well as 15 essay questions and 20 short-answer questions per chapter.

TestMaster, the computerized version of the test bank, is also available for IBM PC and Macintosh machines and compatibles. The program allows you to customize your own tests on a built-in word processor that lets you delete, add, and revise questions as necessary.

Acknowledgments

We want here to single out for a special note of praise and appreciation our developmental editor, Betty Gatewood. For one of us, this was a first attempt at writing a textbook, and Betty showed enormous patience and wisdom in passing on the skills necessary to write at the appropriate level. For all of us, her editorial experience was evident in the great editorial wisdom that she showed in helping us with each chapter. This editorial wisdom, combined with her great organizational skills, personal warmth, and enthusiasm for the project, were central to whatever success the current edition enjoys.

We are greatly indebted to Dr. J. Michael Bailey of Northwestern University for his enormous help in revising and updating the coverage of material regarding sexual variants and abuse in Chapter 11. As a researcher in this important and controversial area, his advice on what to include in such a chapter and how to cover it in an interesting and sensitive fashion was invaluable. Dr. Steve Finn of the Center for Therapeutic Assessment (Austin, Texas) also provided important advice on how to address some of the sensitive topics raised in this chapter.

Numerous reviewers also contributed comments on the previous edition as well as on the manuscript for the current edition. These include: Norman Anderson, Duke University Medical Center; John Bates, Indiana University; Alfred Baumeister, Vanderbilt University; Ira Bernstein, University of Texas—Arlington; Bruce Bongar, Pacific Graduate School of Psychology; Linda Bosmajian, Hood College; Kenneth Bowers, University of Waterloo; Wolfgang Bringmann, University of Southern Alabama; Alan Butler, University of Maine; James Calhoun, University of Georgia; Caryn Carlson, University of Texas at Austin; Alan Carr, University College Dublin; Kathleen Carroll, Yale School of Medicine; Lee Anna Clark, University of Iowa;

David Cole, University of Notre Dame; Bruce Compas, University of Vermont; Eric Cooley, Western Oregon State; Robert Deluty, University of Maryland Baltimore County; Joan Doolittle, Anne Arundel Community College; John Exner, Rorschach Workshops; Gary Ford, Stephen F. Austin State University; Don Fowles, University of Iowa; Sol Garfield, Washington University; Carlton Gass, Veterans Administration Medical Center–Miami, Florida; Paul Goldin, Metropolitan State of Denver; Ethan Gorenstein, Columbia University; Lisa Green, Baldwin-Wallace College; Susan Hardin, University of Akron; Marc Henley, Delaware County Community College; Karen Horner, Ohio State University; William Iacono, University of Minnesota; Ira Iscoe, University of Texas at Austin; Fred Johnson, University of the District of Columbia; Gary Johnson, Normandale Community College; John Junginger, State University of New York at Binghamton; John Kihlstrom, Yale University; Marlyne Kilbey, Wayne State University; David Kosson, Chicago Medical School; Dennis Kreinbrook, Westmoreland County Community College; Gerard Lenthall, Keene State College; Gloria Leon, University of Minnesota; Arnold LeUnes, Texas A&M University; Richard Lewine, Emory University; Patrick Logue, Duke University Medical Center; Lester Luborsky, University of Pennsylvania; Edwin Megargee, Florida State University; Linda Montgomery, University of Texas of the Permian Basin; Eileen Palace, University of Minnesota; John Poppleston, Akron University; Charles Prokop, Florida Institute of Technology; Paul Retzlaff, University of Northern Colorado; Clive Robins, Duke University Medical Center; Kenneth Sher, University of Missouri; Gregory Smith, University of Kentucky; Kathleen Stafford, Court Diagnostic Clinic; Brian Stagner, Texas A&M University; Louis Stamps, University of Wisconsin–La Crosse; Veronica Stebbing, University College Dublin; Patricia Sutker, Veterans Medical Center–New Orleans; Alexander Troster, University of Kansas Medical Center; Samuel Turner, Medical University of South Carolina; Linda Van Egeren, Department of Veterans Affairs Medical Center–Minneapolis; Charles Wenar, Ohio State University; Fred Whitford, Montana State University; Jennifer Wilson, Duke University Medical Center; Richard Zinbarg, University of Oregon.

Within the HarperCollins organization, Art Pomponio, Marcus Boggs, Susan Driscoll, Lisa Pinto, and Priscilla McGeehon performed important management roles in shepherding this large and complex project through the contemporary publishing maze. Catherine Woods was continuously ready at a moment's notice to provide backup resources and unfailing support to the authors through the inevitable but often unpredictable crises encountered in the planning, writing, and production of the revision. Diane Wansing, Supplements Editor, Mark Paluch, Marketing Manager, Erica Smith, Editorial Assistant, and Diane Kraut, who coordinated our permissions, also made significant contributions in their respective areas of expertise.

We are extremely pleased with the high quality of our text supplements for this edition, and we sincerely thank those involved. They are: Don Fowles (Study Guide), Frank Prerost (Instructor's Manual), Jerry Metalsky and Rebecca Laird (Test Bank), Suzanne de Beaumont (Supershell), and Toby Levine (Video/Telecourse materials).

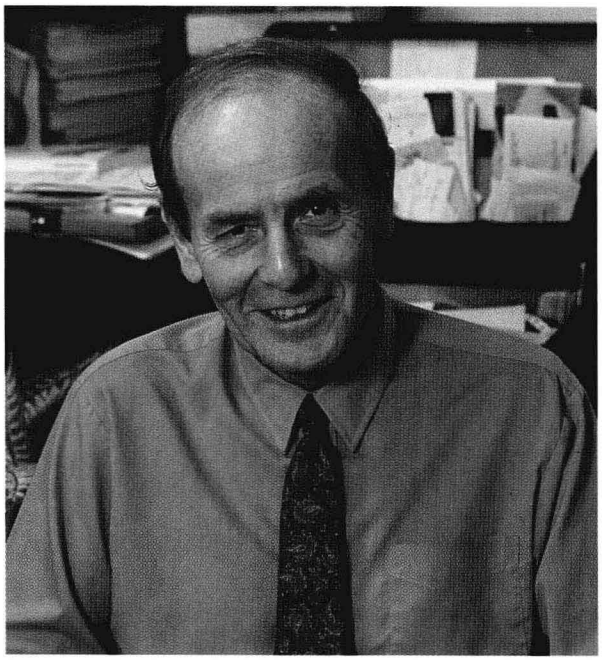
Finally, we thank the staff of York Production Services, particularly Kevin Bradley, for their superbly performed role of transforming our often decidedly imperfect "copy" into what we perceive as a textbook of uncommon accuracy and attractiveness.

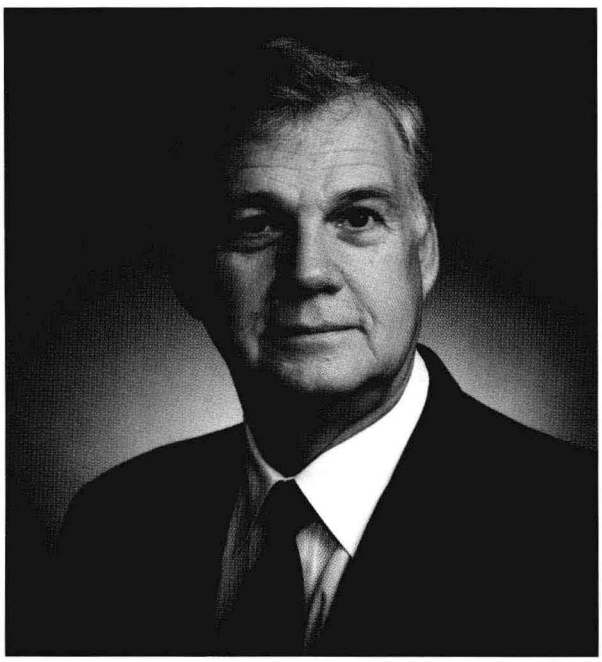
We suspect that only other authors of textbooks fully comprehend the disruptions and deprivations of family life entailed in a project of this magnitude. For their patience and forebearance in undergoing once again these frustrations, we acknowledge with gratitude these special contributions of Tracey Potts Carson, Kelly Carson, Carolyn Williams, and Holly Butcher.

Robert C. Carson
James N. Butcher
Susan Mineka

About the Authors

Robert Carson, a native New Englander, received his undergraduate degree in psychology at Brown University. His graduate training, culminating in the PhD in clinical psychology, occurred at Northwestern University. He has been a member of both the Medical and Arts and Sciences faculties at Duke University since 1960. In the course of that tenure he served as Head of Duke Medical Center's Division of Medical Psychology and, in the Department of Psychology, as Director of its doctoral clinical program and as Chair. He has taught psychology to undergraduates virtually uninterruptedly since his senior year at Brown, and in 1993-94 was named a Distinguished Teacher in Duke University's Trinity College. Also, partly in recognition of his teaching contributions, he was appointed a G. Stanley Hall Lecturer by the American Psychological Association for 1989. Dr. Carson's scholarly interests are focused on the interpersonal dimensions of psychopathology, although he claims to work hard at remaining a generalist and avoiding excessive specialization.





James N. Butcher was born in West Virginia. He enlisted in the Army at 17 years of age and served in the airborne infantry for three years, including a one-year tour in Korea during the Korean War. After military service, he attended Guilford College, graduating in 1960 with a BA in psychology. He received an MA in experimental psychology in 1962 and a PhD in clinical psychology from the University of North Carolina at Chapel Hill. He was awarded Doctor Honoris Causa from the Free University of Brussels, Belgium, in 1990.

He is currently Professor of Psychology in the Department of Psychology at the University of Minnesota and was Associate Director and Director of the Clinical Psychology Program at Minnesota for 19 years. He was a member of the University of Minnesota Press' MMPI Consultive Committee that undertook the revision of the MMPI in 1989. He is currently the editor of Psychological Assessment, a journal of the Amercian

Psychological Association, and serves as consulting editor or reviewer for numerous other journals in psychology and psychiatry. Dr. Butcher has been actively involved in developing and organizing disaster response programs for dealing with human problems following airline disasters. He organized a model crisis intervention disaster response for the Minneapolis-St. Paul Airport, and organized and supervised the psychological services offered following two major airline disasters: Northwest Flight 255 in Detroit, Michigan, and Aloha Airlines on Maui.

He is a fellow of the American Psychological Association and the Society for Personality Assessment. He has published 34 books and more than 150 articles in the fields of abnormal psychology, cross-cultural psychology, and personality assessment.

Susan Mineka, born and raised in Ithaca, New York, received her undergraduate degree magna cum laude in psychology at Cornell University. She received a PhD in experimental psychology from the University of Pennsylvania in 1974, and later completed a formal clinical retraining program from 1981-1984. She taught at the University of Wisconsin-Madison and at the University of Texas at Austin before moving to Northwestern University in 1987. She has taught a wide range of undergraduate and graduate courses, including introductory psychology, learning, motivation, abnormal psychology, and cognitive-behavior therapy. Her current research interests include cognitive and behavioral approaches to understanding the etiology, maintenance, and treatment of anxiety and mood disorders. She has served as editor of the Journal of Abnormal Psychology (1990-1994), as President of the Society for the Science of Clinical Psychology (1994-1995), and is currently President-Elect of the Midwestern Psychological Association (1995-1996). She also served on the American Psychological Association's Board of Scientific Affairs (1992-1994, Chair 1994) and on the Executive Board of the Society for Research in Psychopathology (1992-1994).

A Visual Guide To:

Abnormal Psychology and Modern Life

Tenth Edition

Robert C. Carson
Duke University

James N. Butcher
University of Minnesota

Susan Mineka
Northwestern University

ISBN 0-673-99241-1

The tenth edition of *Abnormal Psychology and Modern Life* continues to offer the most authoritative survey of abnormal psychology, providing students with a thorough and rigorous study of the field. The classic elements of the text remain—it is serious, comprehensive, and includes unbiased, balanced discussions of psychodynamic, behavioral, cognitive-behavioral, humanistic, and interpersonal views of mental disorders and their treatments. A new co-author, Dr. Susan Mineka, a noted researcher on anxiety disorders and former editor of the *Journal of Abnormal Psychology,* played a significant role in reorganizing the text, devoting distinct chapters to casual factors and viewpoints (3), anxiety disorders (5), mood disorders (6), personality disorders (9), and sexual variants, abuse, and dysfunctions (11). In addition, the tenth edition contains a parallel look at anxiety and mood disorders, updated material on psychopathy and antisocial personality disorders, and a reworked chapter on personality disorders. The text continues to offer numerous case studies and provides students with a thought-provoking sampling of key debates in "Unresolved Issues" sections. Throughout, discussions of the various disorders and the corresponding terminology have been revised according to DSM-IV.

NEW CO-AUTHOR, DR. SUSAN MINEKA

This renowned researcher on anxiety disorders and former editor of the *Journal of Abnormal Psychology* lends her expertise and broad knowledge of the research literature, most notably in the distinct treatments of causal factors and viewpoints (chapter 3), anxiety disorders (chapter 5), mood disorders and suicide (chapter 6), personality disorders (chapter 9), and sexual variants, abuse, and dysfunctions (chapter 11).

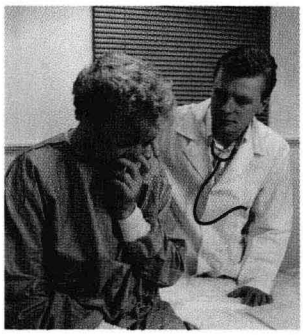
DSM-IV INCORPORATED THROUGHOUT

DSM-IV has been integrated into the discussion of all disorders to familiarize students with the current standard diagnostic criteria and taxonomy. Changes in terminology are clearly noted throughout.

DSM Classification of Mental Disorders

We have already introduced the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). We return to it here because, in addition to defining what is to be considered a mental disorder, this manual specifies what subtypes of mental disorder are currently officially recognized and provides for each a set of defining criteria. These criteria consist for the most part of symptoms and signs. By "symptoms" is usually meant the patient's subjective description, his or her complaints about what is wrong; "signs," on the other hand, refer to objective observations the diagnostician may make either directly or indirectly (e.g., the results of pertinent tests administered by a psychological examiner). For a given diagnosis to be made, the diagnostician ***must*** observe the particular criteria—the symptoms and signs asserted to define that diagnosis—to be met.

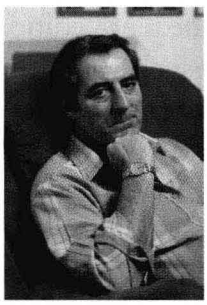
As we have seen, the DSM is currently in its fourth edition (**DSM-IV**), this version having been published in May 1994. The first edition of the manual appeared in 1951, with successive editions appearing in 1968 (II), 1980 (III), 1987 (III-R, a revision of DSM-III), and the current one in 1994. The number of officially recognized mental disorders has increased enormously from DSM-I to DSM-IV, mostly for reasons that will shortly become apparent, [illegible] a worldwide men- [illegible] of the



Many clinical situations require a rapid determination of the main characteristics of the presenting problem as well as assessment of any risk (e.g., suicide) involved. Diagnostic guidelines aid clinicians in making such judgments.

NEW EXAMINATION OF CAUSAL FACTORS

This vastly updated chapter thoroughly explores nonspecific developmental psychopathological causal factors as well as the latest, most significant findings in this expanding field.



This set of identical twins from Bouchard's University of Minnesota study of the relative roles of genetics and environment provides some striking support for the prominence of genetic influences on personality traits and attitudes (Bouchard et al., 1990). Jim Springer (left) and Jim Lewis (right) were separated four weeks after their birth in 1940. They grew up 45 miles apart in Ohio. After they were reunited in 1979, they discovered they had some eerie similarities: Both chain-smoked Salems, both drove the same model blue Chevrolet, both chewed their fingernails, and both had dogs named Toy. Further, they had both vacationed in the same neighborhood in Florida. When tested for such personality traits as sociability and self-control, they responded almost identically.

manifest its effect on the phenotype until much later in life. In many other cases, the genotype may shape the environmental experiences a child has, thus affecting the phenotype in yet another way. For example, a child who may be genetically predisposed to aggressive behavior may be rejected by his or her peers in early grades because of aggressive behavior. Such rejection may lead the child to go on to associate with similarly aggressive and delinquent peers in later grades, leading to a increased likelihood of developing a full-blown pattern of delinquency in adolescence.

Researchers have found three ways in which an individual's genotype may shape his or her environment (Hetherington & Parke, 1993; Scarr, 1992). First, the genotype may have what has been termed a passive effect on the environment resulting from the genetic similarity of parents and children. Such genetic similarity is likely to result in the parents automatically creating an environment compatible with the child's predisposition. For example, highly intelligent parents may provide a highly stimulating environment for their child, thus creating an environment that will interact in a positive way with the child's genetic endowment for high intelligence. Second, the child's genotype may evoke particular kinds of reactions from the social and physical environment. For example, active, happy babies evoke more positive responses from others than do passive, unresponsive infants (Lytron, 1980). Finally, the child's genotype may play a more active role in shaping the environment. In this case the child seeks out or builds an environment which is congenial. Extraverted children may seek the company of others, for example, thereby enhancing their own tendencies to be sociable (Baumrind, 1991; Hetherington & Parke, 1993).

The few instances in which relatively straightforward predictions of mental disorders can be made on the basis of known laws of inheritance invariably involve gross neurological impairment. In such cases, abnormal behavior arises in part as a consequence of a central nervous system malfunction, such as occurs in Huntington's disease; such conditions will be discussed in Chapter 13.

It appears likely that many of the most interesting (if still largely obscure) genetic influences in normal and abnormal behavior typically operate polygenically, that is, through the action of many genes together in some sort of additive or interactive fashion (e.g., Plomin, 1990; Torgersen, 1993). A genetically vulnerable person has inherited a large number of these genes that collectively represent faulty heredity. These faulty genes, in turn, may lead to structural abnormalities in the central nervous system, to errors in the regulation of brain chemistry, or to excesses or deficiencies in the reactivity of the autonomic nervous system, which is involved in mediating many of our emotional responses. These various processes serve to predispose the person to later difficulties.

Methods for Studying Genetic Influences. Although advances have been made in identifying faulty genetic endowment (including locating genes responsible for certain physical anomalies), we are not yet able to isolate specific defects on the genes themselves. Therefore most of the information we have

FULL CHAPTER TREATMENT OF ANXIETY DISORDERS

Packed with new case studies to support lively discussion of the latest research, this substantially expanded and updated chapter provides an even-handed survey of viewpoints on the role of biological and cognitive factors as causal and maintaining factors for each disorder.

of these patients refuse to take the drug or stop taking the drug because of the side effects (Barlow, 1988; Mavissakalian & Perel, 1989; Wolfe & Maser, 1994).

Psychopharmacological treatment of social phobia has also received some attention in the past decade. Although there have been some promising results with the use of beta-blockers such as Inderal, which help control peripheral autonomic arousal symptoms (Barlow, 1988), it appears that monoamine oxidase inhibitors are significantly more effective (Liebowitz et al., 1992).

Recently the drug Anafranil (clomipramine) has been approved for use in the United States as an effective biological treatment for obsessive-compulsive disorder (e.g., Benkelfat et al., 1989; DeVeaugh-Geiss, 1991). It appears to reduce the intensity of this disorder's symptoms, with OCD patients showing a mean improvement of 40–45 percent (relative to 4–5 percent on placebo). Some patients may show greater improvement than this, but approximately 40 percent do not show significant improvement (Greist, 1990; McCarthy & Foa, 1990). In addition, some of the newer antidepressants that also affect serotonin activity, such as Prozac, have also been shown to be useful in the treatment of OCD (DeVeaugh-Geiss, 1991; Riggs & Foa, 1993).

A major disadvantage of all drug treatments for anxiety disorders is that relapse rates range from moderate to very high following discontinuation of the drug (see Clum et al., 1993, for panic disorder). Thus many patients who do not seek alternative forms of psychotherapy that have more long-lasting benefits may have to stay on these drugs indefinitely given that most of the anxiety disorders tend to be chronic conditions if left untreated. This problem can often be overcome through combining drug and psychosocial treatments, with the goal being to withdraw patients from the drug after they have gained the skills from psychotherapy necessary to deal with their panic or anxiety symptoms directly.

UPDATED CHAPTER ON MOOD DISORDERS

This heavily revised chapter amply reflects the recent surge in biological and psychosocial causal factor research. Following the lead of current research, the authors address bipolar disorders separately from "regular" depression along with detailed examinations of depression-anxiety comorbidity and depression in women.

Stress as a Causal Factor. Psychosocial stressors are known to be involved in the onset of a variety of disorders, ranging from some of the anxiety disorders to schizophrenia, but nowhere has their role been more carefully studied than in the case of unipolar depression. Indeed, many investigators have been impressed with the high incidence of stressful life events that apparently serve as precipitating factors for unipolar depression, and Harder and colleagues (1989) did not even find a difference between more and less severely depressed patients in regard to the magnitude of prior life stressors. Based on clinical observations, Beck (1967) provided a broad classification of the most frequently encountered precipitating circumstances in depression: (a) situations that tend to lower self-esteem; (b) the thwarting of an important goal or the posing of an insoluble dilemma; (c) a physical disease or abnormality that activates ideas of deterioration or death; (d) single stressors of overwhelming magnitude; (e) several stressors occurring in a series; and (f) insidious stressors unrecognized as such by an affected person. Paykel (1982b) comprehensively reviewed the research literature available at that time on life events occurring before episodes of mood disorder and arrived at conclusions generally in agreement with Beck's. In particular, and perhaps not surprisingly, he concluded that separations from people important in one's life (through death, for example) are strongly associated with depression, although such losses tend to precede other disorders as well. Another serious stressor that has been the focus of study only fairly recently is caregiving to a spouse with a debilitating disease such as Alzheimer's (formerly known as senility), which is known to be associated with the onset of both major depression and generalized anxiety disorder for the caregiver (e.g., Russo et al., 1995).

Research on stress and the onset of depression is complicated by the fact that depressed people have a distinctly negative view of themselves and the world around them (Beck, 1967), and so at least to some extent their perceptions of stress may *result* from the cognitive symptoms of their disorder rather than causing their disorder (Monroe & Simons, 1991). That is, because of their pessimistic outlook, they may evaluate events as stressful that an independent evaluator (or a nondepressed friend) would not. This is why both George Brown and Bruce Dohrenwend—two leading stress researchers—have developed more complex and sophisticated measures of stress that involve either the use of independent evaluators or of questionnaires with specific narrowly defined stressors with objectively determined weights. Therefore, both measures do not rely on the depressed person's appraisal of an event as stressful. But because relatively few studies have used these more sophisticated strategies, much of the research literature on the association of depression and life stress as assessed by self-report is difficult to evaluate.

In several studies using these sophisticated measurements of life stress, Brown and Harris (1978, 1986, 1989) have concluded that depression often follows from one or more severely stressful events, usually involving some loss or exit from one's social sphere. (Interestingly, events signifying danger or threat were found more likely to precede the onset

Physical illness and physical disability are stressors that may precipitate major depres-

FULL-CHAPTER TREATMENT OF SOMATOFORM AND DISSOCIATIVE DISORDERS

Now featured is expanded coverage of the controversy and debates surrounding multiple personalities and "created memories." Fascinating case material is employed to illustrate and clarify various viewpoints.

if cooperative, may be a valuable consultant for the therapist.

Dual and multiple personalities have received a great deal of attention and publicity in fiction, television, and motion pictures. Actually, however, they were rare in clinical practice until relatively recently. Until approximately the last quarter-century, in fact, only slightly more than 100 cases could be found in the psychological and psychiatric literature worldwide. Their occurrence seems to have increased dramatically in recent years. No wholly complete or satisfactory explanation exists for such a change in the occurrence base rate. Some of the increase, however, is almost certainly artifactual, the product of increased acceptance of the diagnosis by clinicians, who traditionally have been somewhat skeptical of the astonishing behavior these patients often display—such as undergoing sudden and dramatic shifts in personal identity before one's eyes. More females than males are diagnosed as having the disorder, with the ratio being about nine to one (Ross, 1989).

A more substantive and disturbing reason for the apparent increase in cases of DID is offered by Ross (1989), who attributes it in part to an increasingly "sick" society in which child abuse, especially sexual abuse by adults, has become rampant. If Ross's suggestion about the deterioration of society is arguable, his observation that DID is commonly accompanied by reports of childhood abuse is not. While it is surprising that this connection was not generally recognized until about 1980, there is now no reasonable doubt about its reality. Serious questions remain, as we shall see, about the magnitude of this association, about the trustworthiness of memories of abuse, and indeed about the clinical validity of DID diagnoses. Since childhood sexual abuse is a far more common occurrence for females than for males (Trickett & Putnam, 1993), there may be a relationship here with the gender discrepancy in incidence/prevalence.

As already suggested, the question of malingering has dogged the diagnosis of DID for at least a century. These doubts are reinforced by the suspicion that clinicians, by virtue of undue fascination with the clinical phenomena and unwise use of hypnosis, are themselves responsible for eliciting this disorder in highly suggestible patients (Spanos & Burgess, 1994). The latter criticism has a ring of truth, but it fails to account convincingly for all of the observations reported—such as the elaborate pretreatment personal histories with which alternate personalities are commonly endowed. Cynicism about the con-
cept of DID has also been encouraged by the fre-
quency with which it is used by defendants and their attorneys to escape punishment for crimes ("My other personality did it"). This defense was used, unsuccessfully, in the famous case of the "Hillside Strangler," Kenneth Bianchi (Orne, Dinges, & Orne, 1984).

It is also true, as Spanos, Weekes, and Bertrand (1985) have demonstrated, that normal college students can be induced by suggestion to exhibit some of the phenomena seen in DID, including the adoption of a second personality. Such role-playing demonstrations are interesting, but they do not answer, nor even convincingly address, the question of the reality of DID. That college student subjects might be able to give a convincing portrayal of a person with a broken leg would not, after all, establish the nonexistence of broken legs.

Our own view of the controversy surrounding DID is that it is too often formulated in terms of an absolute dichotomy: It is viewed either as a completely genuine disorder affecting a helpless and passive victim, or as a completely dissembled fabrication orchestated by an unscrupulous person seeking unfair advantages. There is of course a wide range of possibilities between these two extreme positions. Our increasing knowledge, earlier alluded to, concerning widespread evidence of separate (dissociated) memory subsystems and nonconscious active mental processing, indicates that much highly organized mental activity is ***normally*** carried on in the "background," outside of awareness. This is analogous in some ways to computer multitasking, where the same machine may simultaneously carry on several complex activities other than the one in which its keyboard operator is currently fully engaged. Accordingly, questions about whether a given behavior is consciously or unconsciously motivated, genuine or feigned, intended or unintended, deliberate or spontaneous, and so on, are as a general rule oversimplified. So far as we can tell, the human mind does not operate in these dichotomous ways, and undue preoccupation with unanswerable questions can distract us from the task of understanding the adaptational processes in which the patient is engaged.

Is DID "real?" Our answer here is perhaps already implied in the foregoing. Addressing the question directly, Horevitz (1994), following a thorough review of the evidence, was unable to offer an unequivocal answer. The deceptive simplicity of the question is belied by a number of serious evidential and methodological issues. Do we, the authors, believe that elements of theatrical pretense are never a part of dissociative identity disorder? Not by any means, but neither are we prepared to dismiss DID as simply unqualified fakery.

Much less is known about sexual deviations, abuse, and dysfunctions than is known about many of the other disorders we have considered thus far in this book, such as anxiety and depression. The major clinical psychology and psychiatry journals have relatively few articles related to sexual dysfunctions and deviations, and there are also many fewer sex researchers than depression and anxiety researchers. One major reason is the sex taboo. Although sex is an important concern for most people, many have difficulty talking about it openly. This makes it difficult to obtain knowledge about even the most basic facts, such as the frequency of various sexual practices, feelings, and attitudes. This is especially true when the relevant behaviors are socially ostracized, such as homosexuality. It is difficult both to ask people about such behaviors and to trust their answers.

A second reason why sex research has progressed less rapidly is that many issues related to sexuality—including homosexuality, teenage sexuality, abortion, and childhood sexual abuse—are among our most divisive and controversial. In fact, sex research is itself controversial. Two large-scale sex surveys were halted because of political opposition even after being officially approved and deemed scientifically meritorious (Udry, 1993). Fortunately, one of these was funded privately, although on a much smaller scale, and it is now considered the definitive study for the 1990s (Michael et al., 1994). Senator Jesse Helms and others had argued that sex researchers tended to approve of premarital sex and homosexuality, and that this would likely bias the results of the surveys. Perhaps in part because of the controversial nature of sex research, it is not well funded. For example, although sex offenders are widely feared and millions of dollars are spent keeping convicted sex offenders behind bars every year, the National Institute of Mental Health spent only $1.2 million on sex offender research in 1993, compared with $125.3 million on depression (Goode, 1994).

Recent evidence has suggested that the use of anatomically correct dolls to question young children about where they may have been touched in alleged incidents of sexual abuse does not improve the accuracy of their

Despite these significant barriers, we do know some things about sexual variants and dysfunctions. Clinical investigations have provided rich descriptions of many sexual variants. Etiological research on sexual dysfunctions and deviations, although in its infancy, has shown promise for some disorders, and we discuss these developments.

Before we turn to specific disorders, we examine sociocultural influences on sexual behavior and attitudes in general. We take this excursion first in order to provide some perspective about cross-cultural variability in standards of sexual conduct, and to encourage special caution in classifying sexual practices as "abnormal" or "deviant."

SOCIOCULTURAL INFLUENCES ON SEXUAL PRACTICES AND STANDARDS

Although some aspects of sexuality and mating are cross-culturally universal (Buss, 1989), others are quite variable. For example, all known cultures have taboos against sex between close relatives, but attitudes toward premarital sex vary considerably (Frayser, 1985). Ideas about acceptable sexual behavior also change over time. Sexual standards have changed tremendously in our own culture, especially over the past century. Less than 100 years ago, for example, sexual modesty was such that women's arms and legs were always hidden in public. Nowadays, actors are shown nude in movies and sometimes even on television.

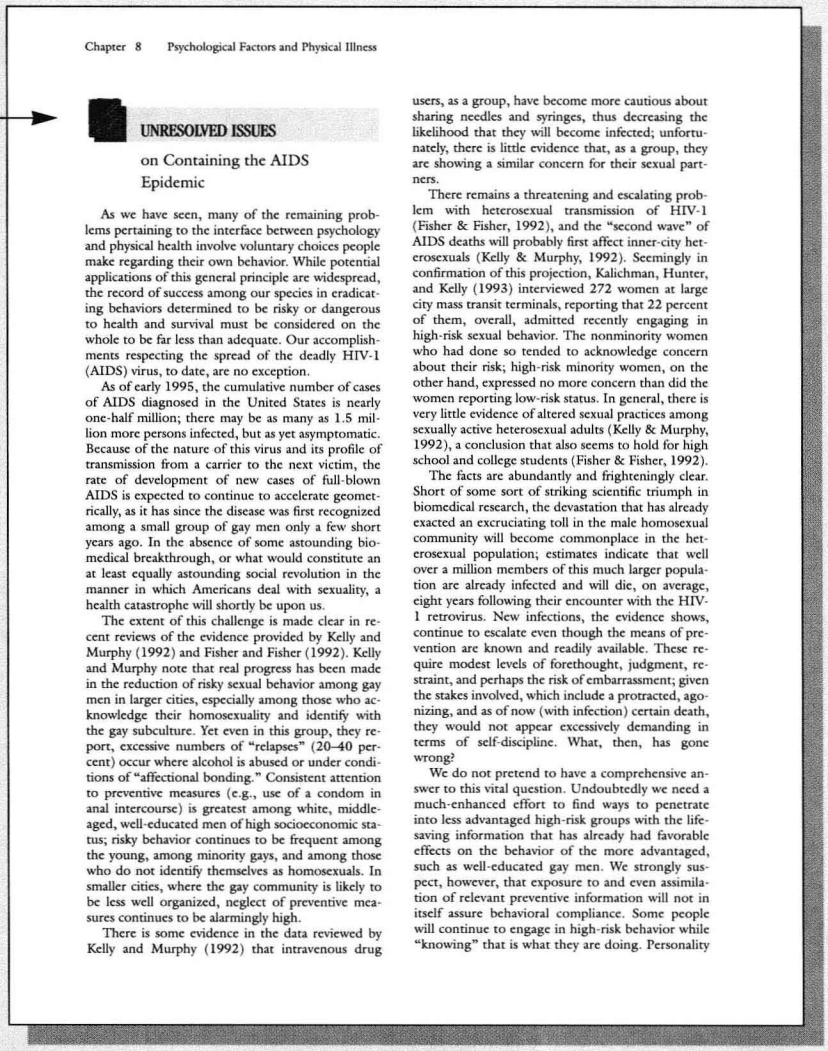
Despite the substantial variability in sexual attitudes and behavior in different times and places, people typically behave as if the sexual standards of their time and place were obviously correct, and they are intolerant of sexual nonconformity. Sexual nonconformists are often considered evil or sick. We do not mean to suggest that such judgments are always arbitrary. There has probably never existed a society in which Jeffrey Dahmer, who was sexually aroused by killing men, having sex with them, storing their corpses, and sometimes eating them,

EXPANDED COVERAGE OF SEXUAL DISORDERS

This significantly revised chapter now addresses the sexual abuse of children and the reliability of their memories, as well as historical and cross-cultural issues that affect societal views of normal and psychopathological variants of sexual behavior.

"UNRESOLVED ISSUES" SECTIONS

Provide students with a thought-provoking sampling of key debates at the end of each chapter.



Chapter 8 Psychological Factors and Physical Illness

UNRESOLVED ISSUES

on Containing the AIDS Epidemic

As we have seen, many of the remaining problems pertaining to the interface between psychology and physical health involve voluntary choices people make regarding their own behavior. While potential applications of this general principle are widespread, the record of success among our species in eradicating behaviors determined to be risky or dangerous to health and survival must be considered on the whole to be far less than adequate. Our accomplishments respecting the spread of the deadly HIV-1 (AIDS) virus, to date, are no exception.

As of early 1995, the cumulative number of cases of AIDS diagnosed in the United States is nearly one-half million; there may be as many as 1.5 million more persons infected, but as yet asymptomatic. Because of the nature of this virus and its profile of transmission from a carrier to the next victim, the rate of development of new cases of full-blown AIDS is expected to continue to accelerate geometrically, as it has since the disease was first recognized among a small group of gay men only a few short years ago. In the absence of some astounding biomedical breakthrough, or what would constitute an at least equally astounding social revolution in the manner in which Americans deal with sexuality, a health catastrophe will shortly be upon us.

The extent of this challenge is made clear in recent reviews of the evidence provided by Kelly and Murphy (1992) and Fisher and Fisher (1992). Kelly and Murphy note that real progress has been made in the reduction of risky sexual behavior among gay men in larger cities, especially among those who acknowledge their homosexuality and identify with the gay subculture. Yet even in this group, they report, excessive numbers of "relapses" (20–40 percent) occur where alcohol is abused or under conditions of "affectional bonding." Consistent attention to preventive measures (e.g., use of a condom in anal intercourse) is greatest among white, middle-aged, well-educated men of high socioeconomic status; risky behavior continues to be frequent among the young, among minority gays, and among those who do not identify themselves as homosexuals. In smaller cities, where the gay community is likely to be less well organized, neglect of preventive measures continues to be alarmingly high.

There is some evidence in the data reviewed by Kelly and Murphy (1992) that intravenous drug users, as a group, have become more cautious about sharing needles and syringes, thus decreasing the likelihood that they will become infected; unfortunately, there is little evidence that, as a group, they are showing a similar concern for their sexual partners.

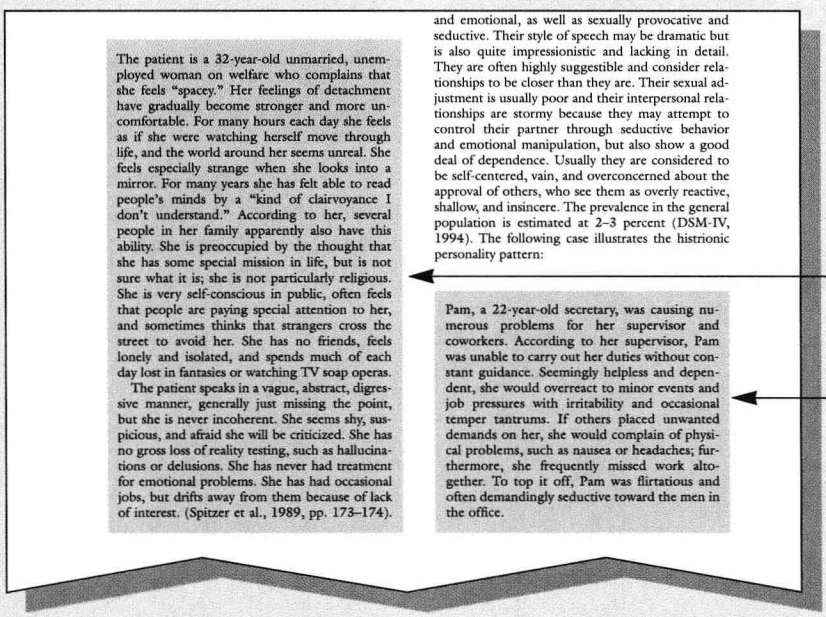
There remains a threatening and escalating problem with heterosexual transmission of HIV-1 (Fisher & Fisher, 1992), and the "second wave" of AIDS deaths will probably first affect inner-city heterosexuals (Kelly & Murphy, 1992). Seemingly in confirmation of this projection, Kalichman, Hunter, and Kelly (1993) interviewed 272 women at large city mass transit terminals, reporting that 22 percent of them, overall, admitted recently engaging in high-risk sexual behavior. The nonminority women who had done so tended to acknowledge concern about their risk; high-risk minority women, on the other hand, expressed no more concern than did the women reporting low-risk status. In general, there is very little evidence of altered sexual practices among sexually active heterosexual adults (Kelly & Murphy, 1992), a conclusion that also seems to hold for high school and college students (Fisher & Fisher, 1992).

The facts are abundantly and frighteningly clear. Short of some sort of striking scientific triumph in biomedical research, the devastation that has already exacted an excruciating toll in the male homosexual community will become commonplace in the heterosexual population; estimates indicate that well over a million members of this much larger population are already infected and will die, on average, eight years following their encounter with the HIV-1 retrovirus. New infections, the evidence shows, continue to escalate even though the means of prevention are known and readily available. These require modest levels of forethought, judgment, restraint, and perhaps the risk of embarrassment; given the stakes involved, which include a protracted, agonizing, and as of now (with infection) certain death, they would not appear excessively demanding in terms of self-discipline. What, then, has gone wrong?

We do not pretend to have a comprehensive answer to this vital question. Undoubtedly we need a much-enhanced effort to find ways to penetrate into less advantaged high-risk groups with the life-saving information that has already had favorable effects on the behavior of the more advantaged, such as well-educated gay men. We strongly suspect, however, that exposure to and even assimilation of relevant preventive information will not in itself assure behavioral compliance. Some people will continue to engage in high-risk behavior while "knowing" that is what they are doing. Personality

CASE STUDIES THROUGHOUT

These fascinating real-life examples illustrate the clinical pictures of many disorders discussed within the text and emphasize the human side of psychological disorders and treatments.



The patient is a 32-year-old unmarried, unemployed woman on welfare who complains that she feels "spacey." Her feelings of detachment have gradually become stronger and more uncomfortable. For many hours each day she feels as if she were watching herself move through life, and the world around her seems unreal. She feels especially strange when she looks into a mirror. For many years she has felt able to read people's minds by a "kind of clairvoyance I don't understand." According to her, several people in her family apparently also have this ability. She is preoccupied by the thought that she has some special mission in life, but is not sure what it is; she is not particularly religious. She is very self-conscious in public, often feels that people are paying special attention to her, and sometimes thinks that strangers cross the street to avoid her. She has no friends, feels lonely and isolated, and spends much of each day lost in fantasies or watching TV soap operas.

The patient speaks in a vague, abstract, digressive manner, generally just missing the point, but she is never incoherent. She seems shy, suspicious, and afraid she will be criticized. She has no gross loss of reality testing, such as hallucinations or delusions. She has never had treatment for emotional problems. She has had occasional jobs, but drifts away from them because of lack of interest. (Spitzer et al., 1989, pp. 173–174).

and emotional, as well as sexually provocative and seductive. Their style of speech may be dramatic but is also quite impressionistic and lacking in detail. They are often highly suggestible and consider relationships to be closer than they are. Their sexual adjustment is usually poor and their interpersonal relationships are stormy because they may attempt to control their partner through seductive behavior and emotional manipulation, but also show a good deal of dependence. Usually they are considered to be self-centered, vain, and overconcerned about the approval of others, who see them as overly reactive, shallow, and insincere. The prevalence in the general population is estimated at 2–3 percent (DSM-IV, 1994). The following case illustrates the histrionic personality pattern:

Pam, a 22-year-old secretary, was causing numerous problems for her supervisor and coworkers. According to her supervisor, Pam was unable to carry out her duties without constant guidance. Seemingly helpless and dependent, she would overreact to minor events and job pressures with irritability and occasional temper tantrums. If others placed unwanted demands on her, she would complain of physical problems, such as nausea or headaches; furthermore, she frequently missed work altogether. To top it off, Pam was flirtatious and often demandingly seductive toward the men in the office.

HIGHLIGHT BOXES

These easily recognizable sections expand upon or summarize important items within the text.

Biological Factors in Addiction to Psychoactive Drugs

How do substances such as alcohol, cocaine, or opium come to have such powerful effects on some people—an overpowering hold that sometimes occurs in some people after only a few uses of some drugs? Although the exact mechanisms are not fully agreed on by experts in the field, two important factors are apparently involved. One factor involves the person's biological makeup or constitution, which includes both genetic inheritance and the environmental influences (learning factors) that enter into the need to seek mind-altering substances to an increasing degree. The other important factor in the equation is the ability of some drugs to activate areas of the brain that produce intrinsic pleasure and immediate, powerful reward. Let's examine each of these elements in more detail.

Constitutional Factors

Research has begun to accumulate that genetic factors contribute substantially to the development of alcohol preference. Research with animals, for example, has shown that strains of animals can be bred to have very high preference for alcohol (McBride et al., 1992). Moreover, genetic factors are likely to be involved in increased susceptibility or sensitivity to the effects of drugs. For example, low doses of alcohol or other addictive substances might be more stimulating to some people as a result of inherited differences in the ***mesocorticolimbic dopamine pathway*** or ***system*** often referred to as the MCLP (Liebman and Cooper, 1989). It seems increasingly likely that inherited factors affect an individual's response to psychoactive drugs.

Nevertheless, genetics alone are not the whole story. The genetic mechanism or model for the generally agreed upon observation that alcoholism is familial is insufficient to explain the behavior fully (Schuckit & Irwin, 1990). That is, genetic transmission in the case of alcoholism does not follow the hereditary pattern found in other genetic disorders.

When we talk about familial or constitutional differences we are not strictly limiting our explanation to genetic inheritance. Rather, learning factors appear to play an important part in the development of constitutional reaction tendencies. Having a genetic predisposition or biological vulnerability to alcoholism, of course, is not a sufficient cause of the disorder. The person must be exposed to the substance to a sufficient degree for the addictive behavior to appear. In the case of alcohol, almost everyone in America becomes exposed to the drug to some degree through such means as peer pressure, parental example, and advertising. The development of alcoholism involves living in an environment that promotes initial as well as continuing use of the substance. People become conditioned to stimuli and tend to respond in particular ways as a result of learning. Learning appears to play an important part in the development of substance abuse and antisocial personality disorders (see Chapter 9). There clearly are numerous reinforcements for using alcohol in our social environments and everyday lives. Furthermore, the use of alcohol in a social context is often a sufficient reason for many people to continue using the drug. However, research has also shown that psychoactive drugs such as alcohol contain ***intrinsic*** rewarding properties that provide pleasure in and of itself—apart from the social context or its operation to diminish worry or frustration. The drug stimulates pleasure centers in the brain.

Drug Action

Let's examine the role that drugs themselves play in the process of addiction. Drugs differ in terms of their biochemical properties as well as how rapidly they enter the brain. There are several routes of administration—oral, nasal, and intravenous. Alcohol is usually drunk, the slowest route, while cocaine is often self-administered by injection or taken nasally. Central to the neurochemical process underlying addiction is the role the drug plays in activating the

CHAPTER

7

SOMATOFORM AND DISSOCIATIVE DISORDERS

Gaston Duf, Pôlinchinêlle Rôise Vilôse. *As a child, Duf (b. 1920) was frequently terrorized by his father, often seeking the protection of his mother. When his parents belatedly married (when Duf was 18), he reacted violently. After two suicide attempts, he was institutionalized in 1940. He began his artistic career while in the asylum, painting strange, powerful animals and comically proportioned human figures.*

PATIENT ART

Chapter-opening clinical photographs and artwork serve to both instruct and humanize the study of abnormal behavior.

CHAPTER OUTLINES AND INTRODUCTIONS

A chapter outline and introduction begins each chapter, providing an overview of what is to come.

With the schizophrenias, we move into a realm of disorder that represents in many ways the ultimate in psychological breakdown. These disorders include some of the most extreme of human behaviors, the ultimate in **"psychosis,"** a term referring to pervasive loss of contact with reality. The hallmark of **the schizophrenias** is thus a more or less sharp break with the world in which most less disturbed people live, a world that is rooted in a basic consensus about what is true and real in our shared experience. The typical schizophrenic person is thus someone who has lost or become detached from a set of anchoring points fundamental to adequate integration and communication with the surrounding human environment. To those around the schizophrenic he or she appears incomprehensible, perhaps even frightening.

If we look more closely, trying to identify the component processes underlying this detachment from reality, we observe in schizophrenics many psychological abnormalities. These include peculiarities in action, thinking, perception, feeling, sense of self, and manner of relating to others, with the features displayed varying from one patient to another. As is implied here, the group is a heterogeneous one, and this heterogeneity extends well beyond differences in current behavior. As we shall see, it includes as well marked variations in associated background features, in the course of the disorder in different people, and in the variety of outcomes they experience.

In the face of this heterogeneity, many clinicians and researchers have concluded that "schizophrenia" will probably someday be recognized as consisting of several separate and distinct conditions. We share that expectation, which explains our choice of the plural form in the title of this chapter.

As that title also indicates, we will in addition consider in this chapter the condition the DSM-IV calls *delusional disorder,* whose main features were formerly included under the classic rubric *paranoia,* or *"true" paranoia* (to distinguish it from the paranoid subtype of schizophrenia, described below). Patients with delusional disorders, like many schizophrenics, nurture, give voice to, and sometimes take actions based on, beliefs that are considered completely false and absurd by those around them. Unlike schizophrenics, however, persons with delusional disorders may otherwise behave quite normally. Their behavior does not show the gross disorganization and fragmentation characteristic of schizophrenia, and general behavioral deterioration

SUMMARY

Traditionally, diagnosing behavior problems of children and adolescents has been a rather confused practice, in part because children have sometimes been viewed as "miniature" adults. It was not until the second half of the twentieth century that a diagnostic classification system focused clearly on the special problems of children.

Two broad approaches to the classification of childhood and adolescent behavior problems have been undertaken: a categorical approach, reflected most extensively in the DSM-IV, and a dimensional approach. Both classification approaches involve organized classes of observed behaviors. In the categorical approach, symptoms of behavior problems are grouped together as syndromes based on clinical observations. In the dimensional approach, a broad range of observed behaviors are submitted to multivariate statistical techniques; the symptoms that group together make up the diagnostic classes referred to as "dimensions."

In this chapter, the DSM-IV classification system is followed in order to provide clinical descriptions of a wide range of childhood behavior problems. Attention-deficit hyperactivity disorder is one of the more frequent behavior problems of childhood. In this disorder, the child shows impulsive, overactive behavior that interferes with his or her ability to accomplish tasks. There is some controversy over the explicit criteria used to distinguish hyperactive children from "normal" children or from children who exhibit other behavior disorders, such as conduct disorders. This lack of clarity in defining hyperactivity increases the difficulty of determining causal factors for the disorder. The major approaches to treating hyperactive children have been medication and behavior therapy. Using medications, such as amphetamines, with children is somewhat controversial. Behavior therapy, particularly cognitive-behavioral methods, has shown a great deal of promise in modifying the behavior of hyperactive children.

Another common behavior problem among children is that of conduct disorder. In this disorder, a child engages in persistent aggressive or antisocial acts. In cases where the child's misdeeds involve illegal activities, the terms ***delinquent*** or ***juvenile delinquent*** may be applied. A number of potential causes of conduct disorder or delinquent behavior have been determined, ranging from biological factors to personal pathology to social conditions. Treatment of conduct disorders and delinquent behavior is often frustrating and difficult; treatment is likely to be ineffective unless some means can be found for modifying a child's environment.

Another group of disorders, the childhood anxiety disorders, are quite different from the conduct disorders. Children who suffer from these disorders typically do not cause difficulty for others through their aggressive conduct. Rather they are fearful, shy, withdrawn, insecure, and have difficulty adapting to outside demands. The anxiety disorders may be characterized by extreme anxiety, withdrawal, or avoidance behavior. A likely cause for these disorders is early family relationships that generate anxiety and prevent the child from developing more adaptive coping skills. Behavior therapy approaches—such as assertiveness training and desensitization may be helpful in treating this kind of disorder.

Several other disorders of childhood involve behavior problems centering on a single outstanding symptom rather than pervasive maladaptive patterns. The symptoms may involve enuresis, encopresis, sleepwalking, or tics. In these disorders, treatment is generally more successful than in the other disorders just described.

Finally, this chapter addressed one of the most severe and inexplicable childhood disorders—autism. In this disorder, extreme maladaptive behavior occurs during the early years and prevents affected children from developing psychologically. Autistic children, for example, seem to remain aloof from others, never responding to or seemingly not caring about what goes on around them. Many never learn to speak. These disorders likely have a biological basis, although definite proof of such a basis has proven elusive. Neither medical nor psychological treatment has been notably successful in fully normalizing the behavior of autistic children, but newer instructional and behavior-modification techniques have sometimes scored significant gains in improving their ability to function. In general, at present the long-term prognosis in autism appears discouraging.

A number of potential causal factors were considered for the disorders of childhood and adolescence. Although genetic predisposition appears to be important in several disorders, parental psychopathology, family disruption, and stressful circumstances, such as parental death or desertion and child abuse, can have an important causal influence. Recent research has underscored the importance of multiple risk factors in the development of psychopathology.

There are special problems, and special opportunities, involved in treating childhood disorders. The need for preventive and treatment programs for children is always growing, and in recent years the

CHAPTER SUMMARIES AND KEY TERMS

Found at the end of each chapter, these summaries provide an overview and can be read as either an introduction to the chapter or as a review. In addition, key terms appear in boldface type when first introduced and defined in the text. For each chapter, these terms are also listed after the summary. At the end of the text, the terms are included and defined in a glossary.