CHAPTER 16: MENTAL DISORDERS

QUICK GUIDE TO INSTRUCTOR’S RESOURCES

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CHAPTER OBJECTIVES

After completing Chapter 16, students should be able to:

1. Recognize that mental disorder is a fuzzy concept resting on human judgment, but that the American Psychiatric Association does specify criteria for identifying mental disorders.
2. Discuss DSM as a diagnostic tool and some possible dangers in the use of diagnostic labels.
3. Compare different sociocultural perspectives on disorders such as anorexia nervosa and ADHD and discuss the implications of different cultural perspectives.
4. Describe the three main categories for thinking about causes of mental disorders.
5. Discuss the ways in which sex differences in the prevalence of certain mental disorders are explained.
6. Describe the various types of anxiety disorders, including how each involves the open expression of or defense against symptoms of anxiety.
7. Distinguish between major depression and dysthymia, and discuss the biological, situational, and cognitive bases for depressive disorders.
8. Distinguish between bipolar I disorder and bipolar II disorder.
9. Describe the major symptoms of schizophrenia and discuss the attempts at categorizing schizophrenia.
10. Discuss the biological bases of schizophrenia, citing research on heritability, prenatal or birth trauma, and brain chemistry and structure.
11. Outline the research on the effects of family and culture on the development of schizophrenia.
12. Describe the three clusters of personality disorders.

TEACHING SUGGESTIONS FROM PETER GRAY AND DAVID BJORKLUND

The symptoms of mental disorders are not qualitatively different from the experiences that most of us have had; they differ only in degree.

To reduce this chapter for the shorter course, you can omit any of the main sections after the first two without loss to the chapter’s flow, but our guess is that you will want to keep the sections on mood
disorders and schizophrenia. If you assigned just those plus the opening two sections, you would reduce
the chapter by about 30 percent while preserving extended discussions of prototypical disorders.

Of course, students find mental disorders fascinating. The problem in lecture is not one of generating
interest, but of nudging the interest toward a higher intellectual plane. Throughout the earlier part of the
course, you have probably attempted to convince students that normal, everyday human behavior is
fascinating and needs explaining. This point can be reinforced now in a lecture relating abnormal
behavior to normal behavior and showing that the explanations psychologists offer for the former are not
different from those they offer for the latter. The stated thesis might be, “The symptoms of mental
disorders are not qualitatively different from the experiences that most of us have had; they differ only in
degree.” Some hints for developing the thesis can be found in the chapter’s “Reflections and
Connections.” As a correlate of the thesis you can make the point that just as the symptoms are not
qualitatively different, neither are the causes.

Another lecture might center on the perpetuating causes of mental disorders. The behaviors
generated by many disorders are such that they tend to keep the person in the disordered state. The
depressed person turns away friends, and lack of friends promotes depression. The person with
schizophrenia behaves in ways that induce others to treat him or her as crazy, which may feed into the
person’s self-concept and prolong or exacerbate the schizophrenia. Some of the cross-cultural differences
in the forms and durations of disorders probably have to do with the different ways that people in
different cultures react to the person’s unusual behavior. A lecture on perpetuating causes also provides
a nice transition to the next chapter, on treatment. To a considerable degree, treatments for mental
disorders are attempts to counter the perpetuating causes that keep a disorder going.

FOCUS QUESTIONS

1. How is mental disorder defined by the American Psychiatric Association? What ambiguities lie in that
definition?
2. How does validity differ from reliability? How can the validity of the DSM be improved through
   further research and revisions?
3. What are some negative consequences of labeling a person as having a mental disorder? What is
   recommended as a partial solution to this problem?
4. How does the example of homosexuality illustrate the role of culture in determining what is or is not
   a “disorder”?
5. How is ADHD identified and treated? How do critics of the high rate of diagnosis of ADHD explain
   the high rates?
6. How are Down syndrome and Alzheimer’s disease characterized as brain diseases?
7. How can the causes of mental disorders be categorized into three types—“the three Ps”?
8. What are four possible ways of explaining sex differences in the prevalence of specific mental
   disorders?
9. How can generalized anxiety disorder be understood in terms of hypervigilance, genes, early
   traumatic experiences, and cultural conditions?
10. How might phobias be explained in terms of learning that has been prepared by evolution?
11. Are phobias such as fear of snakes “innate”? Can an evolutionary perspective help us explain some
    phobias?
12. What learned pattern of thought might be a perpetuating cause of panic disorder?
13. How does PTSD differ from other anxiety disorders?
14. What conditions are particularly conducive to development of PTSD?
15. How is an obsessive-compulsive disorder similar to and different from a phobia? What kinds of
    obsessions and compulsions are most common?
16. How might damage to certain areas of the brain result in obsessive-compulsive disorder?
17. What are some similarities and differences between depression and generalized anxiety?
18. According to the hopelessness theory, what pattern of thinking predisposes a person for depression?
   What is some evidence for the theory?
19. How did Kendler demonstrate that the onset of major depression typically requires both genetic predisposition and a severely stressful life event?
20. What early evidence supported the theory that depression results from a deficit in the neurotransmitters norepinephrine and serotonin? Why is that theory now doubted?
21. How might moderate depression, following a loss, be adaptive?
22. How are manic states experienced? What is some evidence linking mild manic (hypomanic) episodes to heightened creativity?
23. What are the five main classes of symptoms of schizophrenia?
24. What early evidence supported the dopamine theory of schizophrenia? Why is the simple form of that theory doubted today?
25. How might an exaggeration of a normal developmental change at adolescence help bring on schizophrenia?
26. How do the varying rates of concordance for schizophrenia among different classes of relatives support the idea that heredity influences one’s susceptibility for the disorder?
27. What sorts of early disruptions to brain development have been implicated as predisposing causes of schizophrenia?
28. What evidence suggests that the family environment may promote schizophrenia, but only in those who are genetically predisposed for the disorder?
29. What cross-cultural difference has been observed in rate of recovery from schizophrenia? What are some possible explanations of that difference?
30. What is a personality disorder? How is it similar to, and different from, more serious disorders such as schizophrenia and obsessive-compulsive disorder?
31. Describe the three clusters of personality disorders. Within each cluster, what means do clinicians use to differentiate the symptoms of one disorder from those of others?

CLASSROOM ACTIVITIES/DEMONSTRATIONS

Defining Abnormality

One way to begin your discussion on abnormal behavior is to ask students about their own definition of mental illness. To engage students in this discussion, Gardner (1976) suggests asking students to come up with and list synonyms for mental illness. Then, ask students to define abnormality/mental illness and normal/mentally healthy behavior. You can then discuss how the definitions are similar to or different from the textbook definitions.


Do Some Depressed People Actively Choose to Maintain a Depressing Self-View?

As an intriguing supplement to Gray and Bjorklund’s discussion of the hopelessness theory of the origins of depression (pp. 639-640), you might want to summarize the research by Swann, Wenzlaff, Krull, and Pelham (1992) about some of the mechanisms through which depression is maintained. In a series of four studies, the authors present evidence that when depressed college students, as compared with the nondepressed, are given a choice, they prefer to interact with people who are inclined to evaluate them unfavorably (as opposed to interacting with individuals who had judged them favorably). Furthermore, depressed college students, as compared with the nondepressed, showed a clear preference for unfavorable feedback over favorable feedback. Swann and his colleagues explained these behaviors in
terms of what they consider to be a widespread phenomenon among all of us—the tendency to seek information that confirms how we already feel about ourselves, which they call self-verification. Although self-verification can be functional in those who possess positive self-concepts and are relatively free of psychological symptoms, such processes are seemingly dysfunctional among the depressed. However, as Swann and colleagues explain, the self-verification tendencies of depressed individuals provide these people with a sense of knowing themselves and of feeling that their environment is predictable.


**Schizophrenia Monologue**

To demonstrate some symptoms of schizophrenia, Osberg (1992) suggests reading the following passage using inappropriate or flat affect. After the reading, ask students to discuss the symptoms presented during your reading.

Okay class, we've finished our discussion of mood disorders. Before I go on I’d like to tell you about some personal experiences I’ve been having lately. You see I’ve [pause] been involved in high abstract [pause] type of contract [pause] which I might try to distract [pause] from your gaze [pause] if it were a new craze [pause] but the sun god has put me into it [pause] the planet of the lost star [pause] is before you know [pause] and so you’d better not try to be as if you were one with him [pause] always fails because one and one makes three [pause] and that is the word for three [pause] which must be like the tiger after his prey [pause] and the zommon is not common [pause] it is a zommon’s zommon. [pause] But really class, [holding your head and pausing] what do you think about what I am thinking about right now? You can hear my thoughts can’t you? I’m thinking I’m crazy and I know you [point to a student] put that thought in my mind. You put that thought there! Or could it be that the dentist did as I thought? She did! I thought she put that radio transmitter into my brain when I had the Novocain! She’s making me think this way and she’s stealing my thoughts!


**ASSIGNMENTS**

**Case Study in “Artificial Sanity”**

Using the case study activity below (Quinn, 2008), students learn about issues of mental illness by analyzing a case study of a death row inmate. After conviction, the inmate was diagnosed with paranoid schizophrenia, which meant that his execution would be “cruel and unusual” given the mental illness laws of the time. Once his symptoms were abated with medication, he was re-given a date of execution. Students are asked to consider: What is mental illness? What models of mental illness are used by the prosecution and defense in this case? Students should back up their answers with the text and specific examples from the case study.


**Case Study from the Novel I Never Promised You a Rose Garden**

An alternative case study is to use a passage from the book *I Never Promised You a Rose Garden*, in which the author Joanne Greenberg describes her experience with mental illness (Grossman, 2008). Students should first work on the case in class in small groups, producing a written response to the passage.
outside of class and individually. In small groups, have one student read the passage and then break to write a few sentences about what the character is feeling and how she is behaving. With group members, have students find specific evidence in the passage of different symptoms of mental illness using six categories (perception, thought, consciousness, behavior, affect, and physical symptoms). Once students have created this list, let them use it to help with the individual written portion in which they speculate on a diagnosis using the list of symptoms and textbook for support.


MEDIA RESOURCES

Videos

“Anxiety Disorders,” Worth Video Anthology for Introductory Psychology (6 minutes, 41 seconds)
This program explores the three types of anxiety disorders: generalized anxiety disorder (GAD), panic disorder, and phobias.
  • What is the relationship between anxiety and fear?
  • Is generalized anxiety disorder (GAD) curable? What kinds of lifestyle changes might benefit a person suffering from GAD?
  • What distinguishes normal anxiety from an anxiety disorder? What criteria does the DSM-5 use to diagnose anxiety as a mental disorder? Discuss the similarities and differences between GAD and social phobias. Can a phobia trigger a panic attack?

“Depression,” Worth Video Anthology for Introductory Psychology (8 minutes, 45 seconds)
The case of a 30-year-old man with clinical depression provides a helpful introduction to the major symptoms of the “common cold” of psychological disorders.
  • What are the major symptoms of depression?
  • What do you believe are the primary causes of Steve’s depression?

“A Case Study in Schizophrenia,” Worth Video Anthology for Introductory Psychology (9 minutes, 25 seconds)
This segment is a case study in schizophrenia. As the segment informs, schizophrenia is a collection of many diseases that manifest themselves differently in different patients. It is an organic, physical brain disease caused by both genetic and environmental factors. The segment cites recent research that has found a correlation between the likelihood of developing schizophrenia later in life and damage to the patient while still a fetus, particularly during the second trimester. There is evidence of schizophrenia even in infancy, with likely schizophrenics having smaller brains and larger brain ventricles than their healthy counterparts.
  • Given the research discussed in this segment, what are some ways that we might prevent or reduce, early in life, the development of schizophrenia in adulthood? Are there certain demographics that might be at higher risk for schizophrenia? Why?
  • How do we determine who is capable of being held accountable in a court of law? Should paranoid schizophrenics be able to plead insanity? Why or why not?
  • The advancements in drug therapy have certainly been beneficial to schizophrenic patients in a number of ways. What are some of the problems or complications of the drug treatment trend?

Interactive Presentation Slides
15.1 “Introduction to Disorders”
Introduces mental disorders including categorization.

15.2 “Anxiety and Mood Disorders”
Covers anxiety and mood disorders including depression.

15.3 “Personality, Dissociative, and Somatoform Disorders”
Covers personality, dissociative, and somatoform disorders.

15.4 “Schizophrenia”
Covers schizophrenia: symptoms, classifications, and causes.

Student Activities/Demonstrations (Web Portal)

Concepts in Action
“Explaining Anxiety Disorders”
Reviews types of anxiety disorders and learning and biological explanations.

“Explaining Mood Disorders”
Covers the biological, social-cognitive, and biopsychosocial explanations of mood disorders.

“Explaining Schizophrenia”
Covers biological and environmental causes of schizophrenia.

PsychSim5
“Losing Touch with Reality”
This activity explores schizophrenia, one of the most severe and bizarre psychological disorders. Students will learn about the types of schizophrenia and the main symptoms, view video clips of individuals with schizophrenia, and be asked to identify the symptoms displayed by each individual.

“Mystery Client”
This activity will be most useful to students after they have read the text material on psychological disorders. In this activity students take the role of a consultant called in to provide a second opinion on several clients with disorders, based only on the information contained in the clients’ files. Students will select the information to be examined for each client, then form a diagnosis according to what they know about the symptoms of the various disorders.

PsychInvestigator
“Mental Illness”
Explores the definition of abnormal behavior and four main perspectives in understanding abnormal behavior. Uses anorexia nervosa as an example.

ONLINE DISCUSSION QUESTIONS

Symptoms
Think of a “star” (e.g., musician, artist, writer, politician) living, dead, or fictional that you believe exhibits symptoms of a mental disorder. What symptoms does your “star” manifest? On this basis, what mental disorder do you think the “star” might suffer from?
Disclaimer: After taking this course, you are in no way qualified to diagnose a mental disorder. In addition, the sources you are using are not appropriate for diagnosing a person with mental illness.

Fears

Some common fears that people have include those produced by certain stimuli (e.g., snakes, spiders, vicious dogs) and social situations (e.g., public speaking). How might these everyday fears be different from a debilitating phobia for the same stimuli and social situations? In what way might the fears be adaptive? In what way are the phobias not adaptive?