Abnormal Psychology

Brief Chapter Outline

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Detailed Chapter Outline

To introduce abnormal psychology, you might want to use some of the film clips that Badura (2002) used to introduce her students to abnormal psychology. Although not all the topics in the following table are included in the textbook, they can still be used to whet students’ appetites for this chapter. The clips that pertain to textual material would certainly introduce the chapter, and the clips that do not pertain to textual material could serve as a basis for covering material not in the text, if you wish to do so.
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The diagnosis and treatment of mental disorders is not a black and white issue within psychological science or in the criminal justice system. An excellent way to introduce these topics (and humanize the discussion) is with a video such as this one featuring Larry, a paranoid-schizophrenic and crack addict living on the streets of NYC. Larry receives a military pension of $3,000 per month, which he spends on drugs. He cannot be incarcerated for petty crimes due to his mental illness and cannot be held for psychiatric treatment without his consent.

This video provides a great example of how psychological disorders can develop from normal, daily life. There’s a brief reference to the history of treatment and the current state of psychotherapy. This video and the one above are excellent resources for introducing the notion of a blurred line between normal and abnormal.

Another resource for introducing the topic is this interactive activity for students. How disorders are diagnosed is explained along with interviews with many practitioners in various therapeutic disciplines explaining how various treatments are applied. The investigation section focuses on the treatment of an individual suffering from anorexia nervosa. Interactive activities assist students in applying knowledge from the investigation section, followed by a review of the material and a quiz to assess comprehension.

Abnormal psychology is the scientific study of mental disorders and their treatment.

I. The Diagnosis and Classification of Mental Disorders

Psychological scientists largely agree on the following criteria for a behavior or thought process to be considered a disorder.

- The behavior is atypical (statistically infrequent in the general population).
- The behavior is maladaptive; that is, it prevents the person from successfully functioning and adapting to life’s demands.
- The behavior is personally distressing.
- The behavior is irrational.

A. The Diagnostic and Statistical Manual

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published in 2013 by the American Psychiatric Association, is the most widely used diagnostic system for psychological disorders. DSM first appeared in 1952, and at that time it described only about 60 disorders. During the last half-century, psychologists have learned a lot about various disorders and how to differentiate them (there are more than 400 known disorders today), so the DSM-5 identifies more disorders. Further, in addition to the print form of the DSM-5, an online version will continue to be incrementally updated as a “living document” (e.g. DSM 5.1, 5.2…). Another major improvement in the latest edition is the effort made to improve the reliability of diagnoses by including current research and other work in the development of diagnostic criteria.

As with previous editions of the DSM, criticisms abound, most notably for the ability of ordinary behavior to meet the criteria for diagnosis of a mental disorder (e.g. “senior” moments and recurrent childhood temper tantrums). In spite of these limitations, the DSM-5 represents the most up-to-date classification system to permit researchers and clinicians to speak a common language when discussing mental disorders. In addition, health insurance companies require a DSM-5 classification before they will pay for therapy. Some disorders share certain symptoms, so the DSM-5 clusters these disorders into major categories, such as anxiety disorders, depressive disorders, and personality disorders. In total, there are 20 categories of disorders; six will be discussed in the text.
B. The Perceptual Bias of Labeling
A problem with classifying mental disorders with labels is that the labels are attached to people, and our perception of these people is biased in terms of the labels. For instance, the word schizophrenic has strong connotations.

Rosenhan (1973) wanted to see if mental hospitals would admit researchers who complained of auditory hallucinations during which they heard the words “thud,” “empty,” and “dull.” He also wanted to learn what would happen after such people were admitted if they behaved normally and said that they no longer heard the voices and were feeling normal again. First, the hospital admitted all of the fake patients with a diagnosis of schizophrenia on the basis of only one symptom. Second, the researchers’ subsequent normal behavior was misinterpreted in terms of their diagnosis. For instance, one researcher’s note-taking (for research purposes) was interpreted as a function of his illness. Ironically, although the doctors didn’t realize the researchers were acting normal, the patients could tell they were not true patients.

II. Six Major Categories of Mental Disorders
Warn students to be wary of the tendency of people to think they have a disorder (or disease, in the case of medical school students) when they read about its symptoms, as students will be doing in this section of the text.

Although all people are anxious or depressed from time to time, symptoms are problematic when they prevent people from functioning normally. When symptoms lead people to behave in an atypical, irrational, maladaptive manner and cause personal distress, the symptoms may indicate a disorder.

Each of the four major research perspectives (biological, behavioral, cognitive, and sociocultural) suggests causes of abnormal behavior and thinking. However, no single perspective adequately explains even one disorder. The biopsychosocial approach to explaining abnormality examines the interaction among biological, behavioral, cognitive, and sociocultural factors.

Table 10.1 lists the six major categories of mental disorders covered in the text, along with examples of specific disorders in each major category.

A. Anxiety Disorders

*Scientific American Introductory Psychology Videos: Anxiety Disorders (6:45)*
This video helps to introduce the topic of anxiety disorders and differentiate between normal anxiety and pathological anxiety. Interviews with prominent brain science researcher Joseph LeDoux are combined with animation and short scenes to assist students in understanding GAD, panic disorder, and phobias. Additionally, the video contains excellent examples that will help students understand the specific differences among these three anxiety disorders and among others presented in the text.

*Worth Video Anthology for Introductory Psychology: Three Anxiety Disorders (4:08)*
This is another excellent resource for introducing the topic of anxiety disorders by presenting examples of phobias, GAD, and panic disorder. Researchers discuss how to differentiate between normal fear and a phobia as well as how phobias and other disorders develop. At its core, anxiety is the basis of all of these disorders.

*Classroom Discussion: Phobias*
As a potential conversation starter, it may be useful to simply poll the class by a show of hands (or using a confidential method) to reveal fears that are the basis of several common phobias, such as spiders, needles/blood, and confinement. (Almost always have at least one student each semester who is deathly afraid of clowns.)

**Anxiety disorders** are disorders in which excessive anxiety leads to personal distress and atypical, maladaptive, and irrational behavior.
1. According to the DSM-5, a **specific phobia** is indicated by a marked and persistent fear of specific objects or situations (such as snakes or heights) that is excessive or unreasonable. The anxiety and fear of the specific stimulus may be rational to an extent, but the anxiety and fear are in excess of what is typical. Prevalence rates in the United States for a specific phobia are estimated to be around 7 to 9 percent. Lifetime prevalence rates are roughly 12 percent, with rates roughly double in women compared to men and in African-Americans and Hispanic-Americans compared to white Americans.

   For example, there was a woman with a specific phobia of birds. She became housebound because of her fear of encountering a bird. At home, when she heard a noise, she interpreted the noise as birds that had broken in to get her. When she did leave the house, she was careful not to drive near any birds, because if she hit a bird, the others would take revenge on her. She knew her fears were irrational, but she could not control their effects on her behavior and thinking.

**Class Activity: Anxiety and Phobias**

Will Canu (2008) presented an experiential learning activity demonstrating normal and phobic anxiety. In addition to discussing phobic disorders, this activity allows for a nice discussion of the characteristics of “normal” versus “abnormal” behavior, the evolutionary purpose of fear, and DSM criteria for diagnosing phobias. For this activity, you will need to gather images that are likely to be anxiety provoking and other images that are unlikely to provoke anxiety. Many examples of such stimuli are readily available via a Google Images search. In his work, Canu used a scorpion, daddy longlegs, snarling wolf, dachshund, tarantula, tiny bug, narrow canyon, narrow room, coiled rattlesnake, garter snake, crowd facing viewer, crowd looking away, intense confrontation scene, and mild confrontation scene. You might not need to show so many stimuli to use this activity. We find 6 or 8 stimuli, half of a threatening nature and half of a nonthreatening nature, are enough to stimulate discussion of (a) the evolutionary function of fear; (b) the classification of normal and abnormal behavior; and (c) the criteria for diagnosing a phobia with the DSM.

   **Caution:** Given that some people will of course have legitimate phobias for certain stimuli (e.g., spiders), it is critical to inform the class of the types of stimuli that you will show them, and to offer services (e.g., contact information for a counseling center) after class should a student be particularly distressed.


Table 10.2 presents a list of relatively common specific phobias. Specific phobias arise from classical conditioning and biological predispositions.

   a. Classical conditioning can lead to a phobia in much the same way that Watson and Rayner conditioned the infant Little Albert to fear white rats by pairing a loud, startling noise (an unconditioned stimulus) with a white rat (a conditioned stimulus).

   b. Because of biological predispositions, certain associations (such as taste and sickness) are easy to learn, while others (such as taste and electric shock) are much more difficult to learn.
2. Social anxiety disorder and agoraphobia are similar to other phobias but are listed as broader types of disorders in the DSM-5. **Social anxiety disorder** is a marked and persistent fear of one or more social performance situations in which there is exposure to unfamiliar people or scrutiny by others. For instance, a person may fear eating in public and thus reject all lunch and dinner invitations. About 7 percent of the U.S. population suffers from social anxiety disorder compared to approximately 2 percent for agoraphobia. **Agoraphobia** is a fear of being in places or situations from which escape might be difficult or embarrassing. Being in a crowd, standing in line, and traveling in a crowded bus or train or in a car in heavy traffic all can bring on an anxiety attack. To avoid such situations, people afflicted by the phobia may not leave the security of their homes. While the explanation for agoraphobia seems behavioral evolutionary, current research suggests that social anxiety disorder is an issue of cognition, fear of inadequacy.

3. **Panic disorder** is a condition in which people experience recurrent panic attacks, which are sudden onsets of intense fear. Some panic attacks occur when people are faced with something they dread, such as giving a speech, but other attacks occur without any apparent reason. Women are twice as likely as men to suffer from panic disorder, with prevalence rates of around 2 to 3 percent. Panic disorder can occur with or without agoraphobia.

   One explanation for panic disorder is biological, an excess or overactive fear response involving norepinephrine and the improper function of brain circuitry including the amygdala. Another explanation is the fear-of-fear hypothesis. Agoraphobia is the result of the fear of having a panic attack in public; thus, agoraphobia is a case of classical conditioning in which the fear and avoidance response is a conditioned response to the initial panic attack.

4. **Generalized anxiety disorder (GAD)** is a disorder in which people have excessive, global anxiety and worry that they cannot control for a period of at least 6 months. The anxiety is not tied to any specific object or situation, as it is in a phobic disorder. GAD may be related to a biochemical dysfunction in the brain that involves gamma-aminobutyric acid (GABA), the major inhibitory neurotransmitter, a transmitter that causes neurons to stop generating impulses. People with generalized anxiety disorder may have problems with the activation of GABA, allowing more and more neurons to get excited.

**B. Obsessive Compulsive and Related Disorders**

   This is a new category in the DSM-5 as OCD was previously classified as an anxiety disorder. In the new edition of the DSM, OCD is grouped with other related disorders that appear compulsive, such as hair-pulling and skin-picking.

1. In **obsessive-compulsive disorder (OCD)**, people experience recurrent obsessions or compulsions that they perceive as excessive or unreasonable and that cause significant distress and disruption in daily life. An obsession is a persistent, intrusive thought, idea, impulse, or image that causes anxiety. A compulsion is a repetitive and rigid behavior that people feel compelled to perform to reduce anxiety.

   Although it is not known for sure what causes OCD, recent research suggests that a neurotransmitter imbalance involving serotonin may be involved. Antidepressant drugs that increase serotonin activity (Prozac and Anafranil, for example) help many obsessive-compulsive patients.

   Two parts of the brain—the orbital region of the frontal cortex (the area just above the eyes) and the caudate nucleus (an area in the basal ganglia)—have significantly higher than normal levels of activity in obsessive-compulsive people. These two areas help filter out irrelevant information and disengage attention, two central aspects of OCD.
A strange case of OCD highlights the importance of the frontal lobe region. A man with OCD became severely depressed and attempted suicide. He shot himself in the head, but he survived and was cured of his disorder. The bullet removed some of his orbital front cortex and the disorder with it.

2. Obsessive-compulsive related disorders. Although numerous, three related disorders are described: hoarding disorder, excoriation (skin-picking) disorder, and trichotillomania (hair-pulling disorder).
   a. Individuals suffering from hoarding disorder have a difficult time parting with possessions and become distressed when forced to throw things away. This inability to part with items results in homes becoming filled with clutter. There’s a high degree of concordance between hoarding disorder and depressive disorders.
   b. Most people who suffer from excoriation disorder focus their picking behavior on one area of their bodies, such as the face or fingers. Similar to hoarding disorder, concordance is roughly 75 percent between excoriation disorder and depressive disorders.
   c. In trichotillomania, individuals pluck hairs in a ritualistic manner, typically one at a time. Often triggered by stress, the disorder is far more prevalent in women than men (10:1).

Worth Video Anthology for Introductory Psychology: Those Who Hoard (7:00)
This video details the daily life of a hoarder who has a house filled with items ranging from mounds of books and clothes to empty milk cartons and other waste containers. The description of the disorder and how hoarders feel when they have to part with material they have collected is humanized by the struggles of people who suffer from this disorder.

Student Video Activities: Trichotillomania: Pulling Out One’s Hair
This video details the life of Liz, a woman suffering from hair-pulling disorder. Liz leads an otherwise normal life but cannot resist engaging in a ritual of removing hair by the root, which she describes as “calming.”

Worth Video Anthology for Introductory Psychology: Obsessive-Compulsive Disorder: A Young Mother’s Struggle (7:15)
This video describes a mother’s obsession that her young son might be kidnapped or contaminated. The mother was diagnosed with OCD before her son was born. The narrator explains that the mother’s natural protective instinct has become extreme. When driving, she is constantly turning around to check on her son. At home, she sets traps to thwart any kidnapping attempt. The mother knows her thoughts are irrational, but cannot control them. When walking in the park, she makes sure her young son is in front of her at all times so that no one can contaminate him in any way. She is constantly avoiding people and turning around to check that an area is safe. To counteract her anxiety about contamination, she engages in compulsive behavior (e.g., thoroughly cleaning her hands multiple times in a precise way before interacting with her son) and cannot stop herself from doing so. The mother is extremely anxious to start therapy because she is concerned about the effect her disorder is having on her son. There is also a follow-up video, Treating OCD: Exposure and Response Prevention, that describes the mother’s experiences with cognitive-behavioral therapy. You might opt to show this second video during coverage of therapy (in the next section of the text); however, you might also choose to show it immediately after discussion of this Obsessive-Compulsive Disorder video. A description of the therapy video follows.

Worth Video Anthology for Introductory Psychology: Treating OCD: Exposure and Response Prevention (7:15)
This video starts with a segment in which a young mother is continually decontaminating her house. The narrator explains that Prozac, which relieves OCD symptoms for some patients, was not sufficient for this woman. The next segment illustrates a portion of a cognitive-behavioral therapy session, taking place at home, in which the mother explains the nervousness she feels when bringing in and handling the mail. The therapy revolves around exposure to activities that create anxiety; however, the patient is not permitted to perform rituals to alleviate the anxiety (response prevention). She is encouraged to spread the “contamination” from the mail to the couch, which she does vigorously, explaining that she is “angry with the OCD.” Next, she takes the important step of holding her son (without first washing her hands) and even putting him on the couch. After nine therapeutic sessions, she can let her son pick things up from the ground as other children do and she responds like a normal mother. It is clear that the therapy has made a distinctly positive change in her life.

Worth Video Anthology for Introductory Psychology: Post-traumatic Stress Disorder: A Vietnam Combat Veteran (3:55)
Although not included in the text, this video enables instructors to expand the discussion of anxiety disorders to PTSD. This video illustrates how a Vietnam War veteran is still plagued by nightmares with intrusive memories of the war and feelings of hopelessness, which are both symptoms associated with PTSD. Despite psychological treatment, he remains hypervigilant and easily startled, avoiding busy streets because of a constant fear of being ambushed. Clearly, it is difficult for him to work or to maintain any semblance of a normal life. The narrator reports that nearly 20 percent of Vietnam veterans returned home from war traumatized.

Another video from the Worth Video Anthology related to this topic is PTSD: Returning from Iraq (8:05). This video discusses the effects of exposure to traumatic life events and how PTSD affects everyday life events. An interview with an Iraq war veteran as well as loved ones provides insight into the devastating effects of this disorder.

Worth Video Anthology for Introductory Psychology: Fear, PTSD, and the Brain (4:00)
This video shows how a psychiatric researcher is studying the brain circuits that underlie a veteran’s fear. The narrator describes how current theory suggests that fear activates two brain circuits: the amygdala, which automatically activates the fear response (e.g., increased heart rate and sweaty palms), and the cerebral cortex, which evaluates the threat and potentially sends a signal to deactivate the fear response. Results of brain activity studies have revealed that the part of the cerebral cortex involved in terminating the fear response is less active in traumatized veterans than it is in other veterans. Thus, the experience of fear continues, with even the slightest threat evoking terror. The psychiatrist comments that traumatized veterans have more vivid memories of the war than they do of very recent events. Additionally, MRI scans suggest that constantly reliving war experiences is associated with having a smaller hippocampus, a brain structure involved in consolidating memories. The video is an impressive reminder of potential long-term effects stemming from a traumatic experience such as war.

C. Depressive Disorders
Depressive disorders involve the presence of sad, empty, or irritable moods that significantly affect an individual’s ability to function.

Worth Video Anthology for Introductory Psychology: Depression (8:35)
An excellent way to introduce this section of the textbook is this series of clips and video diary entries from the life of a 30-year-old man who has been diagnosed with clinical depression, possibly stemming from his mother’s suicide when he was 10. The man speaks about his feelings and how his illness has taken over his life. He considers himself a loser who cannot build or hold on to relationships with people and who can’t deal with things. His former wife, with whom he is still friendly, explains how his depression always lurked in the background of their marriage. She indicates that she never knew what to expect because her former husband would be fine one day and depressed the next. The final scene shows the patient walking in an isolated park, commenting on how his mother had loved the countryside and considering that the majestic beauty of nature should be worth waking up to see.

Class Activity: Almost everyone gets depressed some of the time
Another way to introduce this section of the textbook is to poll the class about feelings of depression. While it’s always good to remind students about available mental health services (and remain vigilant about any concerning signs and symptoms among students enrolled in all classes), it can be effective simply to ask a question such as, “Who in this room has been bummered out at some point in the past semester?” In practice, most students will raise their hands or indicate the same when polled anonymously. This activity serves as a great reminder to students that diagnoses are never clear-cut and that sadness is a normal brain state in most people.

For a person’s disorder to be classified with major depressive disorder, the person must have experienced one or more major depressive episodes. A major depressive episode is characterized by symptoms such as feelings of intense hopelessness, low self-esteem, worthlessness, and extreme fatigue; dramatic changes in eating and sleeping behavior; inability to concentrate; and greatly diminished interest in family, friends, and activities for a period of two weeks or more. The 12-month prevalence for major depressive disorder is 7 percent, but twice as many women as men suffer from major depressive disorder.

1. Recent research suggests that this gender difference for major depressive disorder may be due to biological differences. The sex hormones estrogen and testosterone have different effects on the neurotransmitters involved in mood (serotonin, norepinephrine, and dopamine), leading to a difference in both emotional reactions and symptomology in women and men. The primary emotional symptom for women is sadness; but for men, the primary emotional symptom is anger, often paired with irritability. Thus, female depression will be seen as depression, but male depression may be mistakenly seen as some other emotional problem, such as general frustration. This difference, along with the fact that women are more likely than men to seek help, contributes to the gender difference in prevalence rates for depression.

2. There is also a recent argument that the high prevalence rate for depression is spurious in that it is due to overdiagnosis caused by insufficient diagnostic criteria. Andrews and Thomson (2009, 2010) propose that much of what is diagnosed as depression should not be thought of as a true mental disorder (a brain malfunction), but rather as an evolutionary mental adaptation (stress response mechanism) that focuses the mind to better solve the complex life problems that brought about the troubled state.

It is important to note that feelings of sadness and downward mood following stressful life events (such as a death in the family) are understandable and normal, and given time, they are usually self-correcting. The feelings under these circumstances do not necessarily indicate a major depressive disorder.
3. High concordance among identical twins suffering from depression (approximately 50 percent) is another factor indicating a biological origin to the disorder; however, those same twin studies reveal that nongenetic factors play an equal role compared to genetic factors (i.e., the other 50 percent). The most common treatment for major depressive disorder is the use of antidepressant drugs to treat neurotransmitter imbalances. Other treatments involve the modification of maladaptive behaviors and/or cognitions. This can be related to material from Chapter 8 involving the pessimistic explanatory style in which people explain events in terms of internal (their own fault), stable (here to stay), and global (applies to all aspects of their life) causes.

Student Video Activity
This activity includes a video, Postpartum Psychosis: The Case of Andrea Yates (7:00). Although this video does not deal directly with major depressive disorder but highlights a case of postpartum psychosis—another serious mood disorder that includes symptoms akin to those of depression. The video begins with a clip of a smiling Andrea Yates shortly after she gave birth to her fifth child. It is hard to comprehend how this smiling individual, a nurse who was known as a devoted mother, became a woman who killed her children. In the video, the narrator and her husband jointly explain how, after the birth of her fourth son, Andrea showed signs of depression and tried to commit suicide. She was admitted to a psychiatric hospital and diagnosed with postpartum depression with psychosis. During hospitalization, Andrea demonstrated an obsession with how the children would turn out. She was treated with antidepressant and antipsychotic drugs. Her husband reports she responded well to the medical therapy. Andrea appeared to enjoy being a full-time mother, home schooling the oldest children and choosing not to get help raising the children. As life seemed to return to normal, Andrea and her husband ignored the doctor’s advice not to have another child because there was 50 percent chance that postpartum psychosis would return, which indeed it did, resulting in the deaths of all five children. The narrator explains that although 75 percent of new mothers experience some form of postpartum depression that usually fades away after a few weeks, less than 1 percent of women experience the severe psychosis that afflicted Andrea Yates, leading them to kill themselves or their children.

Lecture Enhancer/Web Activity: Positive Psychology
In earlier stages of his career, Martin Seligman focused his research on such topics as learned helplessness and links between explanatory style and depression. In sharp contrast to his early focus on depression, Seligman later turned his attention to the study of happiness and optimism, in the context of positive psychology. Seligman and Csikszentmihalyi (2000) stated that “The aim of positive psychology is to begin to catalyze a change in the focus of psychology from preoccupation only with repairing the worst things in life to also building the positive qualities” (p. 5).

To acquaint yourself and your students with this emerging subdiscipline, you may opt to register at the Authentic Happiness site at the University of Pennsylvania (http://www.authentichappiness.sas.upenn.edu/). To derive ideas for class discussion or student assignments, you may download articles providing a basic introduction to and overview of positive psychology (http://www.ppc.sas.upenn.edu/publications.htm). Additional teaching resources are available at the Positive Psychology Center (http://www.ppc.sas.upenn.edu/teachingresources.htm).
Other excellent resources on happiness include the 2011 Academy Award-nominated film “Happy,” which explores the universality of happiness (http://www.thehappymovie.com). Furthermore, you may introduce students to the measurement of central constructs in positive psychology by asking them to register at the Authentic Happiness site to complete one or more of the emotion, engagement, meaning of life, or life satisfaction questionnaires online. After a questionnaire is completed, the site displays a graph indicating the respondent’s position relative to others in various groups (Web users, similar age, same gender). Respondents have access to their scores for completed assessments at the Authentic Happiness Testing Center page (http://www.authentichappiness.sas.upenn.edu/testcenter.aspx).


D. **Bipolar Disorder**

In **bipolar disorder**, a person’s mood swings dramatically between depression and mania. The swings are recurrent cycles of depressive and manic episodes.

A **manic episode** is a period of at least a week of abnormally elevated mood in which the person experiences such symptoms as inflated self-esteem with grandiose delusions, a decreased need for sleep, constant talking, distractibility, restlessness, and poor judgment. The text discusses the example of a postal worker who stayed up all night and then went off to work normally in the morning. He returned home later that morning having quit his job, withdrawn the family’s savings, and bought fish aquariums with the money. He bragged about finding a way to keep fish alive forever and ran off to canvass the neighborhood for possible sales.

In bipolar I disorder, the person has both major manic and depressive episodes. In bipolar II disorder, the person has full-blown depressive episodes, but the manic episodes are milder.

The concordance rate for bipolar disorder is 70 percent, so biological causes are the most common explanation. In fact, current research is trying to identify the specific genes that make a person vulnerable to the disorder.

E. **Schizophrenia Spectrum and Other Psychotic Disorders**


This video is an excellent resource to present an updated version of this cluster of associated disorders. The video differentiates between positive and negative symptomology and explains how individuals justify positive symptoms such as visual hallucinations and voices in their heads. The video provides an excellent level of detail on current research on this disorder. Narration is accompanied by interviews and catchy visual animations to highlight the cellular underpinnings of schizophrenia.

*Worth Video Anthology for Introductory Psychology: Schizophrenia: Symptoms (5:57)*
This historical video, though somewhat dated, provides excellent information on schizophrenia. An interview with an individual suffering from schizophrenia is followed by interviews with mental health professionals who describe their observations of the disorder, how individuals suffering from the disorder are treated in an in-patient facility, and their prospects for recovery.

**Worth Video Anthology for Introductory Psychology: A Case Study in Schizophrenia (9:25)**

This video presents ample background information on schizophrenia, including its antecedents, differences in brain functions between “normal” people and those suffering from schizophrenia, positive and negative symptoms, and a history of treatment for this psychotic disorder with an emphasis on antipsychotic medications.

The only psychotic disorder to be discussed in this section is schizophrenia. Schizophrenia is a **psychotic disorder** because it is characterized by a loss of contact with reality. The word *schizophrenia* means “split mind,” as mental functions do indeed become split away from each other and detached from reality.

More people are institutionalized with schizophrenia than with any other psychological disorder, although only about 1 percent of the population suffers from schizophrenia. The onset tends to be in late adolescence or early adulthood. Schizophrenia tends to strike men earlier and more severely than women, though both sexes are equally vulnerable to the disorder. The incidence of schizophrenia is higher in lower socioeconomic groups and for people who are single, separated, or divorced rather than married.

1. The symptoms of schizophrenia can be positive, negative, or disorganized.
   a. **Positive symptoms** of schizophrenia are the active symptoms that reflect excessive distortion of normal thinking or behavior, including **hallucinations** (false sensory perceptions) and **delusions** (false beliefs). Hallucinations and delusions are positive symptoms because they refer to things that have been added to the person’s behavior.

   Hallucinations tend to be auditory, such as hearing voices that are not real. There are different forms of delusions. Individuals with delusions of persecution think others are conspireing against them. Individuals with delusions of grandeur think they are people of great importance, such as Jesus Christ.

   b. **Negative symptoms** refer to things that have been removed; for example, deficits or losses in emotion, speech, energy level, social activity, and even basic drives such as hunger.

   c. **Disorganized symptoms** include disorganized speech, disorganized behavior, and inappropriate emotion. When a person’s speech is disorganized, it can be like a “word salad,” with unconnected words incoherently spoken together.

   d. Schizophrenic behavior may also include catatonia such as remaining motionless for long periods of time or repetitive behaviors like rocking.

   e. The DSM-5 defines **schizophrenia** as the presence, most of the time during a 1-month period, of at least two of the following symptoms—hallucinations, delusions, disorganized speech, disorganized or catatonic behavior, or any negative symptoms (such as loss of emotion). In addition, functioning must be markedly below that prior to onset with signs of a disturbance persisting for at least 6 months, including the 1-month period with two or more symptoms. Clinicians have categorized symptoms of schizophrenia in a variety of different ways, including the following:

   (i) Acute versus chronic, based on how quickly symptoms develop.

   (ii) Type I and II, based on positive (Type I) or negative (Type II) symptomology. Individuals with Type I symptoms respond better to current drug treatments and have a higher likelihood of recovery. Type II may be related to permanent structural modifications to the brain, such as cortical lesions.
This video consists of a portion of a “60 Minutes” interview with John Nash. Nash’s life is the basis for the 2001 Oscar-winning movie A Beautiful Mind, in which his battles with schizophrenia are depicted. Nash’s experiences in this segment offer insights into the workings of the schizophrenic mind and will hopefully promote empathy for people suffering from this disease. Further, the time period highlighted by Nash and his son (i.e. young adulthood) can be pointed out to students as it relates to disease onset.

2. Four hypotheses attempt to explain the causes of schizophrenia. Little is known about the possible genetic relationship. The concordance rate for identical twins is about 50 percent. This is significantly greater than the 17 percent concordance rate for fraternal twins. No particular genes have been identified, and it is possible that different genes might be involved in the different types of schizophrenia.
   a. One hypothesis involves prenatal and early postnatal viral infections. This includes viruses such as herpes and T. gondii, carried in the fecal matter of infected cats.
   b. A second hypothesis involves neurotransmitters. Schizophrenics have elevated levels of dopamine activities in certain areas of their brains. Drugs that increase dopamine increase symptoms (and induce symptoms in nonschizophrenics) and drugs that decrease dopamine activity reduce symptoms.
   c. Other neurotransmitter-based explanations involve psychedelic drugs PCP and Ketamine. Both drugs block glutamate and produce schizophrenic-like symptoms.
   d. Another hypothesis involves various brain abnormalities, especially in people with Type II schizophrenia. There is shrunken cerebral tissue and enlarged fluid-filled areas. The thalamus seems to be smaller and the frontal lobes less active in many schizophrenic brains.
   e. A popular biopsychosocial explanation is the vulnerability–stress model that contends that genetic, prenatal, and postnatal biological factors render people vulnerable to schizophrenia, but environmental stress determines whether it develops. The level of vulnerability interacts with the stressful sociocognitive events in people’s lives to determine the likelihood of schizophrenia. The disorder tends to strike in late adolescence and early adulthood, periods of unusually high stress. The DSM-5 notes that schizophrenia is a heterogeneous disorder with many different causes.

F. Personality Disorders

A personality disorder is characterized by inflexible, longstanding personality traits that lead to behavior that deviates from cultural norms and causes distress or impairment. Personality disorders usually begin in childhood and persist throughout adulthood, with estimates ranging from 9 to 13 percent of American adults having a personality disorder. Although difficult to diagnose, the DSM-5 identifies 10 personality disorders divided into three clusters:

1) One cluster involves highly anxious or fearful behavior and includes avoidant, dependent, and obsessive-compulsive personality disorder.
2) A second cluster involves eccentric and odd behavior and includes paranoid, schizoid, and schizotypal personality disorders.
3) The third cluster involves excessively dramatic, emotional, or erratic behavior and includes antisocial, borderline, histrionic, and narcissistic personality disorder. People with antisocial personality disorder used to be referred to as psychopaths and sociopaths.
PsychSim 5 Tutorial: Losing Touch with Reality
This module focuses exclusively on schizophrenic disorders. It reinforces the logic behind why schizophrenic disorders are disordered behavior. The symptoms of delusions, hallucinations, disorganized speech, disorganized and inappropriate behavior, an absence of normal, expected behaviors or emotional responses, and negative symptoms are explained in detail, with numerous examples. After discussing the types of schizophrenia, students watch video clips of people with schizophrenia and are asked about the symptoms, the type of schizophrenia, and the type of hallucinations displayed. The video clips could be a means of testing student understanding of information in the text. The module concludes with discussion of the causes of schizophrenia, including brain abnormalities, genetic influences, and environmental factors that may trigger the disorder in at-risk individuals.

PsychSim 5 Tutorial: Mystery Client
This module gives students the chance to diagnose five people with disordered behavior. Students read case files and choose between schizophrenic, anxiety, dissociative, mood, and personality disorders. The text only briefly mentions dissociative and personality disorders. The text focuses on six major categories of disorders but does not discuss eating disorders. However, if you opt to extend coverage to include this topic, there are resources available for doing so. Eating disorders, including anorexia nervosa and bulimia nervosa, is an area that is typically of interest among students. Specific information about the diagnostic criteria for and treatment of eating disorders is available on the National Institute of Mental Health Web site: http://www.nimh.nih.gov/health/publications/eating-disorders/summary.shtml. A 26-page pdf file about eating disorders is also available (free download) at that site. Additional basic information about eating disorders and about the diagnosis and treatment of eating disorders is also available at http://www.healthywomen.org/condition/eating-disorders.

Worth Video Anthology for Introductory Psychology: Overcoming Anorexia (3:20)
This video describes the distorted self-perceptions of a 5-foot, 7-inch young man who weighs 105 pounds and suffers from anorexia. Although extremely thin, he does not perceive himself as emaciated. The young man is a scientist and researcher who understands that his thinking is irrational, but he is unable to combat his disorder. Hospitalized, he begins a broad treatment program, involving group therapy, medication, and food, to alleviate his problem. However, when he returns home, he still prefers not to eat. Eventually, after 6 months of therapy, he has gained weight, but is nervous about his continued recovery when he leaves the outpatient treatment program. Although not mentioned in the video, you might remind students that although this case study involved a man, anorexia is more prevalent among women than among men.
III. The Treatment of Mental Disorders

Mental disorders are treated by different types of mental health professionals (see summary in Table 10.3). A **clinical psychologist** needs a doctoral degree in clinical psychology and provides therapy for people with mental disorders. A **counseling psychologist** needs a doctoral degree in psychological or educational counseling and counsels people with milder problems such as academic, job, and relationship problems. A **psychiatrist** needs a medical degree with a residency in mental health and provides therapy for people with mental disorders. A **psychoanalyst** needs any of the above credentials and training at a psychoanalytic institute. A **clinical social worker** needs a master’s or doctoral degree in social work with specialized training in counseling and provides help with social problems, such as family problems.

Mental health professionals rely on two major types of therapy. **Biomedical therapy** involves the use of biological interventions, such as drugs. **Psychotherapy** involves the use of psychological interventions.

A. Biomedical Therapies

Biomedical therapies involve the use of biological interventions, such as drugs, to treat disorders.

The earliest use of biomedical therapy may date to the Stone Age, when trephination was used. A trephine (stone tool) was used to cut away a section of the skull of a person who was afflicted, supposedly to let the evil spirits that were causing the person’s disorder leave the body.

In the early 1800s, the “tranquilizing chair” was used. Patients were strapped into the chair with their heads enclosed inside a box for long periods. The restriction was designed to calm people.

Even modern biomedical therapies are not without controversy. Direct biological interventions have a downside because they involve potential dangers and possible serious side effects. High levels of some drugs can be toxic and potentially fatal if not monitored carefully.

1. The primary type of biomedical therapy is drug therapy.
   a. **Lithium** is not a drug, but rather a naturally occurring metallic element (a mineral salt) that is used to treat bipolar disorder. Around 1950, John Cade, a psychiatrist, injected guinea pigs with a mixture of uric acid, which he thought was the cause of manic behavior, and mixed lithium with it so that the acid more easily liquefied. Instead of becoming manic, the guinea pigs became lethargic. Later tests with humans showed that lithium stabilized the mood of bipolar patients.

   Lithium levels in the blood must be monitored carefully because of possible toxic effects. Because of lithium’s side effects, anticonvulsant drugs are now sometimes prescribed for people with bipolar disorder.
   b. Many drugs have been developed to treat depression. They are known as **antidepressants**.

   • Monoamine oxidase (MAO) inhibitors increase the availability of neurotransmitters, such as serotonin and norepinephrine, in the synaptic gap by preventing their breakdown. MAO inhibitors can have very dangerous side effects, particularly in interactions with several different foods and drinks that lead to high blood pressure and possibly death.

   • Tricyclics are agonists for norepinephrine, serotonin, and dopamine and make these neurotransmitters more available by blocking their reuptake during synaptic gap activity.
• The most common antidepressant drugs are selective serotonin reuptake inhibitors (SSRIs). They selectively block the reuptake of serotonin in the synaptic gap, keeping the serotonin active and increasing its availability. Examples include Prozac, Zoloft, and Paxil. More recent SNRIs such as Cymbalta and Effexor also appear to inhibit norepinephrine reuptake. SSRIs usually have very mild side effects and usually require 3 to 6 weeks before mood improvement is discernible.

The effectiveness of antidepressant drugs is the subject of controversy. Some research suggests a placebo effect, improvement due to expectations of getting better. It may also be the case that positive thinking, in the form of a strong placebo effect, restarts the process of neurogenesis.

Neurogenesis is the growth of new neurons. The neurogenesis theory of depression assumes that neurogenesis in the hippocampus stops during depression, and as neurogenesis resumes, the depression lifts.

Research has shown that SSRIs lead to increased neurogenesis in other animals. It takes about 3 to 6 weeks for new cells to mature, about the same amount of time it takes SSRI patients to improve. This means that, in the case of the SSRIs, the increased serotonin activity may be responsible for restarting neurogenesis and lifting a patient’s mood.

c. Antianxiety drugs are drugs that treat anxiety problems and disorders. Benzodiazepines reduce anxiety by stimulating receptor sites for GABA and also increasing the receptivity of these sites, which increases GABA activity. Examples of benzodiazepines are Valium and Xanax.

d. Antipsychotic drugs are drugs that reduce psychotic symptoms. Early antipsychotic drugs greatly reduced the positive symptoms of schizophrenia, and although they had little impact on the negative symptoms, they greatly reduced the need to institutionalize people with schizophrenia.

Early antipsychotic drugs such as Thorazine and Stelazine produced side effects in motor movement caused by their antagonistic effect on dopamine. New-generation antipsychotic drugs, such as Clozaril and Risperdal, are more selective about the area of the brain in which they reduce dopamine activity. Hence, they do not produce severe movement side effects, such as tardive dyskinesia, in which the person has uncontrollable facial tics, grimaces, and other involuntary movements of the lips, jaw, and tongue.

Recently, Abilify, a new-generation antipsychotic drug, has become available. It is designed to stabilize the dopamine-serotonin system by blocking receptor sites for these two neurotransmitters when their activity levels are too high (agonistic effect) and stimulating receptor sites when their activity is too low (agonistic effect). It appears to have less severe side effects than other antipsychotic drugs and may also help alleviate symptoms of bipolar disorder.

Worth Video Anthology for Introductory Psychology: The Therapeutic Effects of Antipsychotic Drugs (2:20)

This video provides an example of the positive effects of antipsychotic drugs. This short video begins with an individual who is not taking such medication and clearly appears “down” to the point of being barely audible in the video. Then, a month later, the same individual is interviewed again, after having been taking antipsychotic drugs during this time. Physically, he is much more presentable and can talk about his future in ways that appear “normal.”

Worth Video Anthology for Introductory Psychology: Undesired Effects of Conventional Antipsychotic Drugs (1:00)

This video discusses the potential effects of drug therapy, with specific reference made to Thorazine. Both the short- and long-term effects of using antipsychotic drugs are discussed and illustrated.
To lead into discussion of textbook coverage of electroconvulsive therapy (ECT) and psychosurgery, you might opt to show a video that provides historical background about treatment of mental disorders. This video illustrates some of the earliest, largely ineffective, treatments, beginning with three forms of therapy involving water (spraying patients with water, wrapping patients in wet sheets, and giving patients a hot bath). Insulin therapy, a potentially dangerous technique that was used primarily to treat schizophrenia, is described as one type of convulsive therapy that preceded ECT. Another type of early convulsive therapy involved giving patients intravenous injections of the drug Metasol to induce seizures and insulin to induce coma. The video concludes with a description of a lobotomy in which the connections between the cortex and the brain’s frontal lobes were severed.

2. **Electroconvulsive therapy (ECT)** is a biomedical therapy for severe depression that involves electrically inducing a brief brain seizure. Electrodes are placed on one or both sides of the head, and a very brief electrical shock is administered, causing a brain seizure that leads the patient to convulse for a few minutes. Patients are given anesthetics (so that they are not conscious during the procedure) and muscle relaxants to minimize the convulsions.

Psychologists really do not understand why ECT works in treating depression. One explanation is that the electric shock increases the activity of serotonin and norepinephrine, which improves mood. ECT may also increase neurogenesis in people, as it has been demonstrated to do in rats.

ECT does not lead to any type of detectable brain damage or long-term cognitive impairment, but there is memory loss for events before and after the therapy. In spite of a lack of understanding of the mechanism of action, improvement was seen in approximately 80 percent of patients receiving ECT. Patients who have undergone ECT do not see it in such a negative light, and the vast majority reports that they would undergo it again if their depression recurred.

3. However, because of the general public’s negative image of ECT, alternative neurostimulation therapies for the severely depressed are being developed. One promising alternative is transcranial magnetic stimulation (TMS). In contrast to ECT, which transmits electrical impulses, TMS stimulates the brain with magnetic pulses via an electromagnetic coil placed on the patient’s scalp above the left frontal lobe.

4. **Psychosurgery** is the destruction of specific areas in the brain to treat the symptoms of disorders. A lobotomy, the most famous type of psychosurgery, involves cutting the neurological connections between the frontal lobes to lower areas of the brain. Lobotomy was the common means of “treating” schizophrenia in the 1940s and 1950s, before drugs became available. Led by Dr. Walter Freeman, tens of thousands of lobotomies were performed, often in mental institutions rather than hospitals, with ECT administered prior to surgery as a form of anesthesia since the patient was rendered unconscious.

Although frontal lobotomies are no longer performed, psychosurgery still exists. For instance, cingulatomies, in which dime-sized holes are surgically burnt in specific areas of the frontal lobes (the cingulate gyrus), are sometimes performed on severely depressed or obsessive-compulsive patients who have not responded to other types of treatment.

A. **Psychotherapies**
This video is an excellent resource for introducing the various psychotherapies, including psychoanalysis, cognitive, and behavioral therapies. Short clips, animations, and interviews to highlight the various treatments accompany the narration. Terms such as systematic desensitization and virtual reality therapy are defined and their uses are explained.

*Scientific American Introductory Psychology Videos: Psychodynamic and Humanistic Therapies (5:15)*

This is another excellent resource to introduce these two therapeutic approaches. The basic approaches to psychoanalysis are explained and contrasted with other methods of treatment. Narration is again combined with interviews and salient visual examples to help students understand important concepts in each.

Clinicians often use one of four major types of psychotherapy: psychoanalysis, humanistic therapy, behavioral therapy, and cognitive therapy. Psychoanalysis and humanistic therapy are called insight therapies because the belief is that a person will achieve understanding of the causes of his or her behavior and thinking. Behavioral and cognitive therapies are usually referred to as action therapies because the belief is that the actions of the person must change for therapy to be effective.

1. **Psychoanalysis** is a style of psychotherapy originally developed by Sigmund Freud in which the therapist helps the person gain insight into the unconscious sources of his or her problems. A psychoanalyst collects data from a multitude of sources.
   a. **Free association** is a technique in which the patient spontaneously describes, without editing, all thoughts, feelings, or images that come to mind. The assumption is that free association will provide clues to the unconscious conflicts behind a person’s problems. **Resistance** is a patient’s unwillingness to discuss particular topics. When resistance occurs, it may provide clues to unconscious conflicts.
   b. Dream interpretation also provides clues to unconscious conflicts. Dreams have two levels of meaning. The **manifest content** is the surface meaning of the dream; it is what the dreamer reports on awakening. The **latent content** is the underlying, true meaning of the dream and is of primary interest to the psychoanalyst. When people dream, they are not inhibited. Dreams allow people to symbolically experience unconscious conflicts.
   c. **Transference** occurs when patients act toward the therapist as they have done toward important figures in their lives, such as parents. Transference resembles a reenactment of earlier or current conflicts with important figures in patients’ lives. Psychoanalysis requires a lot of time because the therapist must piece together clues with only vague circumstantial evidence. Critics question the validity of the main construct of psychoanalysis—unconscious conflicts and their impact on behavior and thinking.

2. The most influential humanistic therapy is Carl Rogers’s **client-centered therapy**, also called person-centered therapy. Client-centered therapy is a style of psychotherapy in which the therapist uses unconditional positive regard, genuineness, and empathy to help people gain insight into their true self-concepts. To achieve this goal, the therapist is nondirective and does not attempt to steer the dialogue in a certain direction. Instead, clients decide the direction of each session. The therapist’s job is to create the conditions that allow clients to gain insight into their true feelings and self-concept.

   These conditions are the same as those for healthy personality growth discussed in the chapter on personality. The therapist establishes an environment of acceptance by giving clients unconditional positive regard. The therapist demonstrates genuineness by honestly sharing personal thoughts and feelings with clients. To achieve empathetic understanding, the therapist uses active listening to gain a sense of clients’ feelings and then uses mirroring to echo the feelings back to the clients, giving them a clearer image of their true feelings.
PsychSim 5 Tutorial: Computer Therapist

In this module, students can simulate being in client-centered therapy. Students type information into the computer, and the computer responds as if it were a client-centered therapist. Students are urged to discuss their legitimate concerns and are assured that no permanent record of what they type is being made.

3. **Behavioral therapy** is a style of psychotherapy in which the therapist uses the principles of classical and operant conditioning to change a person’s behavior from maladaptive to adaptive. The assumption is that maladaptive behaviors are learned and must be unlearned for therapy to be effective.

   a. In **counterconditioning**, a maladaptive response is replaced by an incompatible adaptive response. **Systematic desensitization** is a counterconditioning procedure in which a fear response to an object or situation is replaced with a relaxation response in a series of progressively increasing fear-arousing steps. For example, a person with a specific phobia of spiders might find planning a picnic to be a situation that evokes slight fear because of the possibility that a spider might be encountered on the picnic. Seeing a picture of a spider might evoke more fear, and being in the same room with a spider would evoke even greater fear. Once this “hierarchy” of fear-provoking situations is established, the patient starts working through the hierarchy and attempts to relax at each step.

   In **virtual reality therapy** the patient is exposed to computer simulations of their fears in a progressively anxiety-provoking manner. Using virtual reality technology, the person experiences seemingly real (but computer-generated) images rather than imagined and actual situations as in systematic desensitization. When a patient is relaxed, the simulated scene becomes more anxiety-provoking until the patient can relax in the simulated presence of the feared object or situation.

   In **flooding**, the patient is immediately exposed to the feared object or situation as a means of counterconditioning.

**Class Activity: Systematic Desensitization**

Tim Lawson and Michael Reardon (1997) provide a simple in-class demonstration of systematic desensitization. We have used this demonstration many times in our classes and find it to be a humorous and effective way not only to teach systematic desensitization, but also to review the elements of classical conditioning. Necessary preparation includes making or finding a picture of a chalkboard eraser and the ability to project it to the entire class. You should also have an actual eraser “locked” in a box or cage. We have placed the actual eraser in a shoebox with the lid on it.

Prior to the demonstration, explain the notion of a hierarchy of fear-provoking situations. Then announce you will work with a student who has a phobia of chalkboard erasers (we tend to preselect a student who typically sits in the back of the room and ask this student if s/he is willing to participate prior to the class meeting in which we do this demonstration; a student with a good sense of humor is always helpful).

Start the demonstration by announcing that there is a student who must sit in the back of the room due to a phobia of erasers. You have already worked with this student to develop the hierarchy of anxiety-provoking situations and he can now remain calm when seeing a picture of an eraser. At this point, put the picture of the eraser on the screen.

Now, to desensitize this student further, use the boxed eraser and bring it toward the student (be sure the student knows to act anxious at first, taking deep breaths to relax). Once the student feels less anxious, take the boxed eraser back to the front of the room, remove the eraser from the box and allow the student to see it. Walk toward the student with the eraser, and once he feels comfortable, he can touch it and/or allow it to stay at his or her desk for the remainder of the class period.
Clearly, systematic desensitization requires more than a single session to treat a real phobia. However, a general notion of systematic desensitization can be demonstrated with this simple and relatively quick in-class demonstration.

In addition to illustrating systematic desensitization, this activity can be used to demonstrate the elements of classical conditioning. Specifically, by presenting the feared object (the eraser, which is the conditioned stimulus) without the unconditioned stimulus that triggered the fear of the conditioned stimulus, and the presence of a different and pleasant unconditioned stimulus (such as breathing deeply to relax), the phobic reaction (the conditioned response) can be assuaged.


Student Video Activity: Overcoming Fear (2:15)
This video describes how exposure therapy is used to overcome a man’s fear of elevators. Supported by others in his group therapy program, he agrees to ride an elevator. His therapist gives him a “survival pack” containing lemonade if his throat closes up. Prior to getting in the elevator, he indicates that he has his prayers memorized. In the elevator, he sings to distract himself, but is trembling after the 25-second ride. The following week, he will be taking more elevator rides.

Worth Video Anthology for Introductory Psychology: Therapy in the Real World: The Use of Real-Life Exposure to Treat Phobias (2:16)
This video shows real-world examples of exposure therapy. You might mention to students that phobic people may experience considerably stronger reactions to exposure therapy (flooding) than does the man in the video.

b. Behavioral therapists also use **operant conditioning** to reinforce desired behaviors and extinguish undesirable behaviors. A token economy is an environment in which desired behaviors are reinforced with tokens (secondary reinforcers, such as stickers) that can be exchanged for rewards such as candy or television privileges. This technique is often used with institutionalized patients and has been fairly effective in helping people with autism, mental retardation, and some kinds of schizophrenia.

4. Cognitive therapy has several variations.
   a. **Basic cognitive therapy** is a style of psychotherapy in which the therapist changes the person’s thinking from maladaptive to adaptive. The assumption is that the person’s thought processes and beliefs are maladaptive and need to change. The therapist identifies the irrational thoughts and unrealistic beliefs that the person holds.

Worth Video Anthology for Introductory Psychology: Rage: One Man’s Story and Treatment (10:05)
This video presents a case study of a man attending anger management sessions to control his rage. The video relates in part to cognitive therapy because Sean, the focus of the case study, learns to change how he thinks. However, the video also contains elements of operant conditioning because Sean is encouraged to reinforce himself when he is able to control angry impulses. A clip of a driving episode in the early part of the video illustrates how readily Sean loses his temper. The episode is filled with bleeps to mask extensive cursing and Sean’s face clearly displays his anger. Sean indicates that he hates himself for losing his temper and agrees to attend therapy. The therapist discusses how parts of Sean’s brain are fighting with each other, suggesting a struggle between conscious awareness of how he should behave and the habitual part of the brain that responds automatically. In other words, the narrator explains that the frontal lobes need a chance to “overrule his raging amygdala.” The therapist suggests that Sean “buy time,” distracting himself in anger-provoking situations, but Sean’s wife sees little change the first week. Sean continues to struggle to put what he learns in therapy into practice. After completing his course, he wears a heart-rate monitor while driving. The narrator explains that if Sean’s heart rate increases but he shows no outward signs of anger, the frontal lobes of his brain are in control, suggesting the therapy has worked. Sean did indeed manage to avoid becoming angry on a route he hates taking. A month after therapy, Sean perceives that his family relationships have improved, as well. Discussion of this video might focus on the idea that expressing anger tends to lead to more anger, rather than providing long-term relief.

b. In Ellis’s rational-emotive therapy, the therapist directly confronts and challenges the patient’s unrealistic thoughts and beliefs to show that they are irrational. Irrational thoughts are marked by words such as must, always, and every.

A rational-emotive therapist shows people that their thinking is irrational and how to think more realistically, using Ellis’s ABC model:

• A = Activating event (e.g., failure to be perfect at everything)
• B = Belief about the event by the person (e.g., feeling like a failure for normal levels of imperfection)
• C = Consequence, the emotional result (e.g., depression)

According to Ellis, A does not cause C; rather, B causes C.

Rational-emotive therapy is very direct and confrontational in getting people to see the errors of their thinking.

c. A therapist using Beck’s cognitive therapy works to develop a warm relationship with each patient and encourages patients to carefully consider the objective evidence for beliefs related to errors in their thinking. For instance, if a student who failed a test thinks he blew his chance to get into medical school, the therapist would have the student examine statistics on the GPAs of students admitted to medical school and note how few students actually have a perfect GPA.

d. Is psychotherapy effective? Spontaneous remission is getting better with the passage of time without receiving any therapy. Thus, the effect of psychotherapy must be significantly greater than the effect of spontaneous remission.

A meta-analysis involves pooling results from a large number of studies into one analysis. A meta-analysis of 475 studies involving different types of psychotherapy revealed that psychotherapy is effective. The average psychotherapy client was better off than about 80 percent of people who did not receive any therapy. No one particular type of psychotherapy was superior to the others (refer to Figure 10.1).
Eye movement desensitization and reprocessing (EDMR) is a controversial therapy that has been used to treat PTSD and panic disorders. This video presents evidence supporting EDMR therapy. The woman in the video experiences panic attacks when she drives, causing her to pull over and wait until an attack passes. Her panic is so intense that it clearly limits her freedom to visit friends, family, and interesting places. To attempt to relieve this anxiety, the woman takes part in EMDR therapy. The objective of the therapy is to get patients to move their eyes from side to side while thinking about an anxiety-provoking event. For example, the patient in the video follows moving lights with her eyes while thinking about a panic attack. After an hour of therapy, the patient seems less disturbed. Subsequently, she was able to drive. No one is quite sure why the therapy works, but it is widely used. One explanation is that EMDR helps patients connect what they know with the emotions they feel. However, some researchers argue that the eye movements are not a necessary part of the EMDR treatment and that it is not any better than other forms of exposure therapy (Devilly, 2002). You might ask students to read this critique, available at http://www.srmhp.org/0102/eye-movement.html.


This video describes a unique approach to treatment of psychiatric disorders, extending text coverage of therapy. Carefully screened patients are placed with foster families, with progress systematically monitored by professional personnel. Patients seem to feel better as they undertake specific responsibilities within the family. Long-term, meaningful relationships develop, although the patients continue to take their psychiatric medications, often in lower dosages. Caretakers receive monetary incentives, but the narrator notes that the incentive cannot explain the warm relationships that develop within the extended families. Family care has become the norm in this Belgian community, with the hospital director overseeing the program. Many of the patients in the program also participate in a work program at the hospital itself. The strong community support seems to eliminate the negative stereotypes associated with people who are mentally ill. This video is apt to provoke discussion about the types of communities in which family care programs could or could not flourish.

Although not connected with a specific form of therapy discussed in the text, this video might be used to emphasize the link between caring, companionship, and well-being. This video describes how a nursing facility was transformed into a thriving home, including a variety of plants and animals. The environment has been called the Eden Alternative. Cats, dogs, birds, and rabbits offer companionship and affection to residents. Children visit to distribute valentines. In effect, caring is substituted for drugs, giving people a feeling of belonging. The animals also improve the attitudes of the staff. The narrator reports that the Eden Alternative is now available in more than 300 nursing homes. Students may find additional information about the Eden Alternative at http://www.pbs.org/thoushalthonor/eden/index.html, which includes links to the Eden Alternative’s official Web site (http://www.edenalt.org/) and to a Jim Lehrer “News Hour” about the Eden Alternative (http://www.pbs.org/newshour/bb/health/jan-june02/eden_2-27.html), containing audio and streaming video files.
**PsychSim 5 Tutorial: Mystery Therapist**
This module defines eight types of therapy (psychoanalysis, systematic desensitization, family therapy, cognitive therapy for depression, drug, ECT, aversive conditioning, and client-centered). Then eight case studies are presented, and students must determine which of the eight therapies is being used with each patient. The module concludes by stressing that most therapists must make use of different therapy types to be effective. This module presents an opportunity to review and expand on information in the text (which does not contain information about family therapy or aversive conditioning).

**Worth Video Anthology for Introductory Psychology: Outpatient Commitment: Forcing Persons into Mental Health Treatment (8:40)**
You might conclude the unit with a debate regarding whether people with mental disorders should be forced to take medication. This video deals with that exact issue. It focuses on an individual with schizophrenia who was shot eight times after he was menacing people in a subway station with a sword and another weapon. Now on medication and a defendant on trial, interviews with the individual are contrasted with interviews with family members. Current legal perspectives and rulings can assist in leading this discussion. A doctor explains that the most important reason mentally ill individuals stop taking medication is that they don’t believe they are ill. The video explains Kendra’s Law, a New York State statute in which court orders can be issued to force people to accept treatment against their will. Details about Kendra’s Law are available at http://www.omh.ny.gov/. An article available at http://nypost.com/2012/12/29/kendra-webdales-infamous-subway-push-killer-says-mental-health-law-needs-to-be-restructured/ addresses the current state of Kendra’s Law.