Chapter 15
Psychological Disorders

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*Multimedia Suggestions*


Interactive Presentation Slides for Introductory Psychology: 15.2 Anxiety and Mood Disorders

Worth Video Series:

- Video Anthology for Introductory Psychology: Psychological Disorders – Obsessive-Compulsive Disorder: A Young Mother’s Struggle
- Video Anthology for Introductory Psychology: Therapy – Treating OCD: Exposure and Response Prevention
- Video Anthology for Introductory Psychology: Psychological Disorders – Those Who Hoard
- Video Anthology for Introductory Psychology: Psychological Disorders – Trichotillomania: Pulling Out One’s Hair
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IV. POSTTRAUMATIC STRESS DISORDER: TROUBLES AFTER A TRAUMA

Worth Video Series:

- Video Anthology for Introductory Psychology: Psychological Disorders – Post-traumatic Stress Disorder: A Vietnam Combat Veteran
- Video Anthology for Introductory Psychology: Psychological Disorders – Fear, PTSD, and The Brain
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*The Devil and Daniel Johnston* (2005, 110 min, rated PG-13) (p. 15-23)

Interactive Presentation Slides for Introductory Psychology: 15.2 Anxiety and Mood Disorders

Worth Video Series:

Video Anthology for Introductory Psychology: Psychological Disorders – Depression

Video Anthology for Introductory Psychology: Introduction to Psychology – Postpartum Psychosis: The Case of Andrea Yates

Video Anthology for Introductory Psychology: Brain, Biology, and Mind – Self-Stimulation in Rats

Video Anthology for Introductory Psychology: Psychological Disorders – Mood Disorders

*Scientific American Introductory Psychology Videos: Anxiety and Mood Disorders*

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Multimedia Suggestions

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* Clean, Shaven (1995, 80 min, not rated) (p. 15-33)

* Titicut Follies (1967, 84 min, not rated) (p. 15-33)

Interactive Presentation Slides for Introductory Psychology: 15.4 Schizophrenia

PsychSim 5 Tutorials: Losing Touch with Reality

Worth Video Series:

* Video Anthology for Introductory Psychology: Psychological Disorders – Schizophrenia: Symptoms


* Video Anthology for Introductory Psychology: Psychological Disorders – The Schizophrenic Brain

* Video Anthology for Introductory Psychology: Psychological Disorders – Schizophrenia: New Definitions, New Therapies

* Scientific American Introductory Psychology Videos OR Video Anthology for Introductory Psychology: Therapy – Schizophrenia

VII. DISORDERS OF CHILDHOOD AND ADOLESCENCE

Worth Video Series:

* Video Anthology for Introductory Psychology: Developing Through the Life Span – The Two Faces of Autism

* Video Anthology for Introductory Psychology: Developing Through the Life Span – Childhood Disorder: Autism

* Video Anthology for Introductory Psychology: Psychological Disorders – ADHD and the Family
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  * American Psycho (2000, 101 min, rated R) (p. 15-40)
  * Henry: Portrait of a Serial Killer (1990, 83 min, not rated) (p. 15-40)
  * Monster (2003, 109 min, rated R) (p. 15-40)

Interactive Presentation Slides for Introductory Psychology: 15.3 Personality, Dissociative, and Somatoform Disorders

Worth Video Series: Video Anthology for Introductory Psychology: Psychological Disorders – The Mind of the Psychopath

IX. SELF-HARM BEHAVIORS: WHEN THE MIND TURNS AGAINST ITSELF

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Multimedia Suggestions

Feature Films: The Bridge (2007, 94 min, rated R) (p. 15-43)

Worth Video Series: Video Anthology for Introductory Psychology: Psychological Disorders – Suicide: Case of the “3-Star” Chef

OTHER FILM SOURCES (p. 15-43)

HANDOUTS

  * HANDOUT 15.1: Phobias—Letter “A”
  * HANDOUT 15.2: Obsessive-Compulsive Test
Chapter Objectives

After studying this chapter, students should be able to:

1. Describe some of the problems associated with defining abnormality, and discuss why a medical model of psychological abnormalities was eventually adopted.

2. Describe how the Diagnostic and Statistical Manual (DSM–5) is used to diagnose and classify mental disorders; include in your description three key elements that must be present for a cluster of symptoms to qualify as a potential mental disorder.

3. Explain how the biopsychosocial perspective contributes to our overall understanding of the classification and causes of psychological disorders; describe the diathesis–stress model and discuss how the Research Domain Criteria Project (RDoC) is attempting to integrate the multiple causal factors that underlie different disorders.

4. Describe the central features of anxiety disorders, and describe the main differences between generalized anxiety disorder, phobic disorders, and panic disorder.

5. Contrast specific phobias with social phobia, and comment on how preparedness theory might apply to phobic disorders.

6. Describe the characteristics of obsessive compulsive disorder (OCD) and discuss why OCD is no longer classified with the other anxiety disorders in the DSM–5.

7. Describe the characteristics of posttraumatic stress disorder (PTSD) and discuss how research on hippocampal volume in PTSD is consistent with a diathesis–stress model.

8. Compare some varieties of depression, such as major depressive disorder, dysthymia, double depression, seasonal affective disorder, and postpartum depression.

9. Summarize the research evidence that implicates biological factors in depression.

10. Summarize the research evidence that implicates psychological factors in depression.

11. Differentiate bipolar disorder from depression, and discuss biological and psychological factors implicated in bipolar disorder.

12. Define schizophrenia and describe five symptoms of schizophrenia, providing an example of each.

13. Discuss research evidence for the role of biological factors in schizophrenia, describing evidence from genetics, prenatal factors, biochemical factors, neuroanatomy, and psychological factors.

14. Define autism spectrum disorder and describe some symptoms of this disorder.

15. Differentiate between attention deficit/hyperactivity disorder (ADHD) and conduct disorder.
16. Describe the central features of personality disorders, and describe the main differences between the three clusters of personality disorders.

17. Describe the features of antisocial personality disorder.


I. Defining Mental Disorders: What Is Abnormal?

(Chapter Objectives 1–3)

The study of abnormal behavior not only enhances our understanding of the causes and treatments of mental disorders but also offers insight about normal psychological functioning. These scientific studies of psychological problems depend on reliable identification and classification of mental disorders. Abnormal psychology follows a medical model in which symptoms are understood to indicate an underlying disorder. Psychologists and psychiatrists use the Diagnostic and Statistical Manual of Mental Disorders (DSM), currently in its 5th edition, to diagnose disorders. The classification system includes a global assessment of functioning and several categories of disorders. A mental disorder is defined as occurring when someone experiences disturbances of thought, emotion, or behaviors that produce distress or impairment and arise from internal sources. Mental disorders are best understood from a perspective that considers a combination of influences, including environmental, psychological, and biological factors, and most psychologists adopt a biopsychosocial perspective, recognizing that behavior arises out of an interaction of these different factors. Comorbidity of disorders is common; that is, people frequently have more than one diagnosable disorder. The diathesis–stress model proposes that a person may possess a predisposition for a mental disorder that remains unexpressed until it is triggered by stress. It is an oversimplification to assume that the intervention that cures a disorder reflects the cause of the disorder. When a person is given a diagnosis, the label can be difficult to overcome because of the social stigma that often accompanies the given diagnosis.

Lecture Suggestion 15.1

Guest Lecturer: Mental Health Professional

Chances are good that you have easy access to a mental health professional in your community. A member of your psychology faculty, for example, might also have a small private practice, and certainly there are people at your university’s counseling center who work with mental health issues on a daily basis. Your local Yellow Pages most likely has several listings for psychiatric social workers, counseling psychologists, clinical psychologists, or people who work at drug and alcohol rehabilitation centers. A bit of cold calling on your part can line up an experienced guest speaker or maybe even a panel of experts.

Although the background, training, and work experiences of your guests will differ, one common element you might ask them to focus on is “what is abnormal?” This question needs a fair amount of attention, given that your audience of students probably
thinks that abnormality is only defined by bizarre behavior, sensational actions, or extremely rare events. Hearing a member of the counseling center, for example, describing how dealing with basic life challenges (feeling homesick, depressed, anxious) might lead a person to seek some kind of treatment, or hearing a psychiatric social worker talk about life on an inpatient ward, will no doubt expand your students’ awareness of what disorders are. Your panel can also talk about other issues germane to this chapter—diagnosis, symptoms, treatment, etiology—but sharing a little knowledge about how they determine if a behavior is disordered or not is a good starting point.

Lecture Suggestion 15.2

First-Person Accounts of Abnormality

John Norcross and his colleagues suggest that incorporating autobiographical accounts of mental illness into a discussion of psychological disorders is a good way to get an inside view of various conditions. There is no lack of published accounts by people who have suffered from mental disorders (see the sources, below), and many of these stories have been best-sellers. In fact, some of these life stories have inspired major motion pictures (which is also a good way to illustrate concepts of abnormality).

Depending on your circumstances, you can rely on autobiographical accounts as you see fit. For example, sometimes finding just the right passage and reading it aloud at the start of class does wonders to set the tone for the day. Hearing about someone’s descent into madness, described in poignant, personal tones, can bring home to students the humanness of mental illness. Similarly, allowing students to read an autobiography for extra credit points can provide them with a richer understanding of that person and her or his circumstances. Simply using the existence of such autobiographies as a point of discussion is worthwhile. Students will have heard of many of the celebrities, athletes, and other well-known people who have grappled with psychological disorders.

Sources:

http://psychology.ucdavis.edu/faculty_sites/sommerr/htmAuto/Annot.htm


Lecture Suggestion 15.3

Trouble in Mind?

Over 35 years ago, David Mechanic discussed “medical student syndrome,” or the tendency for beginning medical students to believe, without a biological foundation, that they have contracted an illness. Simply reading about a disease—no matter how remote the possibility of contracting it—is sometimes sufficient to plant the notion that a person has acquired the disease. So, although malaria may be virtually unheard of in the Western hemisphere, a medical student reading about the symptoms of malaria may come to believe that she or he has contracted the disease.

A similar phenomenon has been entertained in psychology. Call it “abnormal psychology student syndrome” if you’d like, but the implication remains that when beginning undergraduates learn about the symptoms of psychological disorders, they may come to believe that they have those disorders. Never mind that folie à deux is fairly rare (at least compared with depression, let’s say); it happens to somebody, doesn’t it?

A recent longitudinal study can help put all our minds at ease. Lisa Curtin and her colleagues administered a battery of symptom checklists and mental health questionnaires to students in psychology and business courses at the start and at the end of a semester. There were slight differences between psychology and business students at the beginning of the semester; students enrolled in an abnormal psychology course reported greater concern with the mental health of their loved ones. However, by the end of the semester, there were no demonstrable differences between groups of students. Rather than producing evidence of “abnormal psychology student syndrome,” the study suggests that students in such courses leave relatively unscathed in self-imagined distress symptoms.

Sources:


**Classroom Exercise 15.1**

Identifying Preconceptions

Students often think of individuals with psychological disorders as strangers very different from themselves and stories in the media help reinforce that sense of difference. The fact of the matter is that when you are discussing psychopathology with your class, it is quite likely that you will have several students who have struggled with some of these issues themselves. The point of this exercise is to help students identify their unconscious biases and stereotypes about people with psychological disorders. Simply ask your students what first comes to mind when they hear the phrase “psychological disorder,” and write their responses on the board. Depending on your class, you may get a list of disorders (e.g., depression, OCD, PTSD, schizophrenia), a list of names (e.g., Hannibal Lecter, Norman Bates, Charles Manson, Michael Jackson), or a variety of responses ranging from “chemical imbalances” to “looney bins.” Once you have a sufficient number of responses, review them with the class and then ask half of the class to stand up, for example, everyone whose last names begin with the letters A–L. At this point, you tell your students that almost 50% of the population will have a psychological disorder at some point in their lives and the people standing represent that proportion of the class. You can then point out to them that psychological disorders are personal, that individuals in your classroom will be struggling or have struggled with many of the disorders that you will be discussing in the next several classes. If they haven’t struggled with the disorders personally, then someone close to them probably has, and it is important to remember as you cover these topics that it isn’t “somebody else” who has these disorders, it is us.

**Classroom Exercise 15.2**

Shrinking Stars

Brad Johnson suggests a way to get students to think about clinical diagnosis and symptoms of psychological disorders.

- Ask students to choose a celebrity—an actor, musician, athlete, politician, or other well-known person—whose behaviors might show signs of mental illness. For the purposes of this brief report the celebrity need not have been professionally diagnosed with a disorder (although we’ll get to that in a minute). Rather, it’s sufficient that the person appear to have a disorder, on the basis of media reports and other information. For example, Michael Jackson may not have been professionally diagnosed with body dysmorphic disorder, yet from all appearances (so to speak), one could reasonably conclude that such a diagnosis could be made.
The point of this exercise is not to sell the tabloids some hot new story. In fact, Johnson cautions that students should be clear they are not professionals, they have not worked with the individual in therapy, they have not completed the credentials to make a diagnosis, and so on. There are ethical principles to uphold all the way around: No one wants to violate APA standards of practice, and no one wants to impugn the reputation of the Hollywood glitterati who have so enriched our lives. The focus here should be on getting your students to think about disorders and diagnosis, and to do so by capitalizing on their interest in well-known people.

Some celebrities who might be amenable to this consideration include:

Kurt Cobain—depression
Walt Disney—bipolar disorder
Pee Wee Herman—sexual paraphilias
Elvis Presley—depression
Lindsay Lohan—substance abuse
R. Kelly—pedophilia
Kirsten Dunst—depression
Lady Gaga—depression
Portia de Rossi—eating disorder
Robin Williams—ADHD
Mike Tyson—impulse control disorder
Ludwig van Beethoven—depression
Margot Kidder—bipolar disorder
Anne Heche—psychotic behavior
Michael Jackson—body dysmorphic disorder

Other celebrities who’ve publicly discussed their professional diagnoses include:

Ben Stiller—bipolar disorder
Harrison Ford—OCD
David Beckham—OCD
Jamie-Lynn Sigler—eating disorder
Dick Clark—depression
Linda Hamilton—bipolar disorder
Drew Barrymore—depression
Sheryl Crow—depression
Earl Campbell—anxiety disorder
Elton John—eating disorder
Ernest Hemingway—depression
Brian Wilson—depression
Jessica Alba—OCD
Jennifer Love Hewitt—OCD
John Belushi—substance abuse
Justin Furstenfeld—substance abuse
Johnny Depp—anxiety disorder
Oprah Winfrey—anxiety disorder
Leonardo DiCaprio—OCD
Fred Durst—OCD
Mike Wallace—depression
Tipper Gore—depression
Naomi Campbell—anxiety disorder
Howard Stern—anxiety disorder
Ricky Williams—social anxiety
Donny Osmond—social anxiety
Sting—depression
Tom Waits—depression
Ted Turner—bipolar disorder
Greg Louganis—depression

Source:


**Multimedia Suggestions**

**Movies and Mental Illness** Hollywood loves a good story, and some of the most compelling stories come from people on the fringes of society. Psychopaths, drug addicts, and lunatics put “bottoms in the seats,” so to speak. But beyond the sensationalism of lurid tales of degenerate behavior, there have been many movies made focusing on the more mundane aspects of mental illness. In fact, so many movies have been made with disorders as a theme that it is nearly impossible to list them all here; the suggestions in this chapter are just a few that come to mind. Fortunately, there are many fine resources available for tracking down feature films that have abnormal psychology as a theme. Give these sources a look as a starting point for visually enhancing your lecture material.
Sources:


http://teachpsych.org/resources/Documents/otrp/resources/wedding09.pdf


**Feature Film: Crumb (1994, 119 min, rated R)** Terry Zwigoff (*Ghost World, Bad Santa*) enjoyed unprecedented access to reclusive underground artist Robert Crumb to make this documentary over a period of many years. The result is an often intriguing, sometimes disturbing look at a man who’s probably the most mentally healthy member of his family. Crumb’s brother Maxon is a sort of mystic who begs on the street and scams the local 7-11, then retires to his apartment to sit on a bed of nails. Brother Charles is a recluse who rarely leaves his squalid bedroom to venture into the outside world. Robert himself reports being sexually attracted to Bugs Bunny at the age of five and to currently engaging in compulsive masturbation. There’s much more to these stories, but you wouldn’t want the endings spoiled.

See the Preface for product information on the following items:

**Interactive Presentation Slides for Introductory Psychology:** 15.1 Introduction to Disorders

**PsychInvestigator** Mental Illness

**PsychSim 5 Tutorials** Mystery Client

**Worth Video Series** Video Anthology for Introductory Psychology: Psychological Disorders – ADHD and the Family

**II. Anxiety Disorders: When Fears Take Over**

(Chapter Objectives 4–5)

**Anxiety disorders** involve irrational fears and worries that undermine well-being and result in dysfunction. The anxiety may be chronic, as in **generalized anxiety disorder** (GAD), or it may be tied to a specific object or situation, as in the **phobic disorders**. Phobias typically involve stimuli that humans are evolutionarily prepared to find threatening. People who experience **panic disorder** experience a sudden and intense attack of anxiety that is terrifying. Those who experience frequent panic attacks can gradually become agoraphobic and stay home for long periods of time for fear of public humiliation. Overall, the anxiety disorders show a moderate level of heritability.
Lecture Suggestion 15.4

What Are You So Afraid Of?

Franklin Delano Roosevelt famously said, “We have nothing to fear but fear itself.” Perhaps he was talking about “fearophobia,” or the fear of feeling afraid.

The list of things people shun, avoid, fear, or otherwise run from is quite lengthy. A little knowledge of Greek and an active imagination can produce lists like the one found at The Phobia List (http://www.phobialist.com). It’s claimed that each of the phobia names listed has been found in one or more reference books. Handout 15.1 lists some of the more unusual ones for the letter “A.”

As you discuss anxiety disorders in general and phobias in particular, spice up your presentations with a few references to fear of tapeworms (taeniophobia), fear of puppets (pupaphobia), or fear of beards (pogonophobia). Take caution, though. If you’re a little too zealous in your presentation, students may develop sophophobia: fear of learning.

Source:
http://www.phobialist.com

Multimedia Suggestions

Feature Film: Running with Scissors (2006, 116 min, rated R) Augusten Burroughs wrote a fine book about his life that was made into a movie about a lot of people’s lives. Nonetheless, this account of growing up in strange circumstances provides a wealth of material to share with your students. Burroughs was the son of an alcoholic father and a mentally unstable mother, who decided it was in his best interest to live with the family of her therapist. That household turned out to be not much better. Alec Baldwin, Annette Bening, Gwyneth Paltrow, Brian Cox, Evan Rachel Wood, Joseph Fiennes, and Jill Clayburgh make up the all-star cast.

See the preface for product information on the following items.

Interactive Presentation Slides for Introductory Psychology: 15.2 Anxiety and Mood Disorders

Worth Video Series

Video Anthology for Introductory Psychology: Learning – Overcoming Fear

Video Anthology for Introductory Psychology: Psychological Disorders – Experiencing Anxiety

Video Anthology for Introductory Psychology: Psychological Disorders – Three Anxiety Disorders
III. Obsessive-Compulsive Disorder: Trapped in a Loop

(Chapter Objective 6)

People with obsessive-compulsive disorder (OCD) experience recurring, anxiety-provoking thoughts, or obsessions, that compel them to engage in ritualistic, irrational behaviors, or compulsions. With the publication of the DSM–5, OCD is now classified in a separate category from the anxiety disorders. Although anxiety plays a role in obsessive compulsive behaviors, research suggests that different brain regions are in OCD as compared to the other anxiety disorders.

Lecture Suggestion 15.5

Body Modification

The following letter appeared in the Dear Abby advice column on February 25, 2005:

Dear Abby:
I am 13 years old, and I suffer from a condition where a person has a strong, persistent desire to have one or more limbs amputated. This happens every day, and I don’t understand it, but I want to have my leg amputated.

I have researched prosthetics on the Internet and have found that life as an amputee is not that different. But I’m afraid if I tell my parents they will think I’m crazy. What should I do? Please answer this. It is ripping me apart.

—Wannabe Amputee in Berkeley

Dear Wannabe: The compulsion you have described is, I don’t have to tell you, an unusual one. Please find the courage to tell your parents what is on your mind. Your parents may want to explore this issue with a psychotherapist. Do not be afraid to do so; it does not mean you are “crazy.” However, it would be extremely helpful for you to understand what is driving this “need.”

Sage advice indeed.

Body dysmorphic disorder is usually included with the anxiety disorders as it incorporates obsessions, compulsions, anxiety-producing thoughts, and irrational behaviors. For most people with this disorder, the focus is on a minor defect that is exaggerated in importance—seeing one’s slightly crooked nose as hideously deformed and in need of rhinoplasty, for example.

The case of Wannabe Amputee suggests an extreme reaction to a body part. For starters, most sites of dysmorphic discontent are the skin, hair, or nose; leg dissatisfaction is fairly infrequent. There are stronger tones of body integrity identity disorder (BIID), which is primarily characterized by the desire to amputate one’s limbs. Formerly seen as a sexual paraphilia, BIID is probably more appropriately classified among the anxiety
disorders, although it shares features with gender identity disorder. There have been speculations that it may be organic in nature, involving a disruption in the parietal lobe. Not a lot of research has been done on this disorder, and there currently is no approved and/or effective course of treatment. The disorder itself was recognized only about 30 years ago, when sex researcher John Money observed two cases of elective amputeeism as a paraphilia. More recently, researcher Michael First and others have focused on the central role of identity as defining this disorder.

It remains to be seen where theory and research in BIID will lead.

Sources:


http://www.biid.org/

http://www.uexpress.com/dearabby/?uc_full_date=20050225

**Lecture Suggestion 15.6**

**Impulse Control Disorders**

Impulse control disorders, which are a subset of self-control disorders (such as eating disorders, criminal acts, and aggressive outbursts), are characterized by an inability to refrain from acting on impulses that are harmful to the actor or to others, a compelling pressure to act experienced just before the behavior takes place, and a sense of pleasure or gratification upon completing the behavior. The following disorders fall in this category:

- **Kleptomania**. Kleptomaniacs are more interested in the act of stealing than in what they steal. Despite popular belief that this disorder is prevalent, it is most often seen clinically in the context of other disorders. This suggests that kleptomania may be a symptom of some other disorder, one that is perhaps biologically based. Evidence
supporting this conclusion is that Prozac, which increases serotonin activity, has been found to be helpful in treating kleptomania.

- **Pathological gambling.** “Lotto fever” (as it is sometimes called), obsessing about hitting it big at the track, entering every neighborhood football pool, and playing quarter slots for hours on end in any casino may be signs of an impulse control disorder. The potential fruits of this pathological and debilitating disorder become the focus of existence for these gamblers, and it places stress on family and loved ones due to financial, psychological, and interpersonal distress. The prevalence of suicide attempts, as well as drinking, smoking, and eating disorders, among spouses of pathological gamblers has been estimated to be inordinately high. To compound matters, this gambling fever usually exists alongside other disorders, such as narcissistic, antisocial, or aggressive personality disorders, low tolerance for boredom, and proneness to addiction. Treatment usually follows a behaviorist approach, relying on aversive therapy or imaginal desensitization.

- **Trichotillomania.** An irresistible urge to pull out one’s hair is the focus of this rare disorder. People with trichotillomania form extreme obsessions with hair, acquiring bald patches, losing eyelashes, armpit, or pubic hair, and in extreme cases swallowing the hair after pulling it out, which leads to myriad other harmful consequences. This disorder may be linked to obsessive-compulsive disorder, although trichotillomanics tend to suffer from other disorders, such as mood, anxiety, eating, or substance abuse disorders. Behavioral treatments seem effective in reducing the frequency of hair pulling.

- **Pyromania.** This compelling and intense desire to prepare, start, or watch fires is a relatively rare disorder; even among fire starters, only 2% to 3% would be considered pyromaniacs. Often getting its start in childhood, this disorder has been seen in conjunction with other disorders, but only weakly linked to sexual paraphilias to date. David Berkowitz, the Son of Sam serial killer, set more than 2,000 fires in New York City during the 1970s.

- **Intermittent explosive disorder.** The difficulty of this disorder, which is characterized by sudden, brief bouts of extreme rage, lies in extreme difficulty suppressing this common inclination. Biological origins of intermittent explosive disorder seem most likely. Serotonin, insulin, and norepinephrine deficits have all been implicated, and a link to epilepsy is being explored.

- **Sexual impulsivity.** People who are sexually impulsive engage in frequent and indiscriminate sexual activity and often come from family backgrounds where excessive guilt, sexual abuse, or restrictive attitudes toward sex predominated. One pathological reaction to this environment would be sexual aversion; sexual impulsivity may be a reaction at the opposite extreme.
Classroom Exercise 15.3

The Obsessive-Compulsive Test

Have you ever had an image of the guy in the Burger King costume playing Ping-Pong with a bear stuck in your mind? Unlike most of us who experience occasional obsessive thoughts, in obsessive-compulsive disorder, thoughts and their related behaviors are often uncontrollable and generate high levels of anxiety.

Have students complete the test, reproduced in Handout 15.2 that was developed by Rick Gardner to measure obsessive-compulsive thoughts and behaviors. Next, instruct the students to add the total value of the circled numbers. Gardner’s proposed scoring and interpretation of results are as follows:

- **25–45** Not obsessive-compulsive
- **46–55** Mildly obsessive-compulsive—adaptive and generally beneficial
- **56–70** Moderately obsessive-compulsive—although still adaptive, short periods of high tension are experienced
- **71–100** Severely obsessive-compulsive—although adaptive, insecurity and hard-driving style may result, with extended periods of high tension

The level of development of this test is unknown, so you should emphasize that this exercise is simply meant to help students understand obsessive-compulsive behavior and is not meant as a diagnostic tool.

Source:


Multimedia Suggestions

**Feature Film:** Matchstick Men (2003, 116 min, rated PG-13) Nicholas Cage is Roy, a small-time grifter who suffers from obsessive-compulsive disorder.

See the preface for product information on the following items.

**Interactive Presentation Slides for Introductory Psychology:** 15.2 Anxiety and Mood Disorders

**Worth Video Series**

Video Anthology for Introductory Psychology: Psychological Disorders – Obsessive-Compulsive Disorder: A Young Mother’s Struggle

Video Anthology for Introductory Psychology: Therapy – Treating OCD: Exposure and Response Prevention
IV. Posttraumatic Stress Disorder: Troubles after a Trauma

(Chapter Objective 7)

Posttraumatic stress disorder (PTSD) is an extreme and prolonged response to severe trauma characterized by symptoms of hyperarousal; recurrent and intrusive thoughts or images related to the trauma; and an avoidance thoughts, places, and experiences that are related to the trauma. Individuals exposed to the violence of war are at an increased risk for developing PTSD, but not everyone exposed to trauma goes on to develop the disorder. Recent research suggests that individuals with smaller brain volumes in the hippocampus may be at more risk for developing the disorder when they are exposed to some form of trauma.

Worth Video Series:

Video Anthology for Introductory Psychology: Psychological Disorders – Posttraumatic Stress Disorder: A Vietnam Combat Veteran

Video Anthology for Introductory Psychology: Psychological Disorders – Fear, PTSD, and The Brain

Video Anthology for Introductory Psychology: Psychological Disorders – PTSD: Returning from Iraq

V. Depressive and Bipolar Disorders: At the Mercy of Emotions

(Chapter Objectives 8–11)

Mood disorders are mental disorders in which a disturbance in mood is the predominant feature. Major depressive disorder, or unipolar depression, is characterized by a severely depressed mood lasting at least two weeks, with symptoms that include excessive self-criticism, guilt, difficulty concentrating, suicidal thoughts, sleep and appetite disturbances, and lethargy. Women are twice as likely to be diagnosed with depression as are men. Dysthymia is a less severe form of depression that persists for at least two years. Depression shows a moderate level of heritability and is likely to involve neurotransmitter imbalances. Patterns of negative thinking may also contribute to
depression, such as the tendency to explain personal failures by attributing them to internal, stable, and global causes. Depression-prone individuals may behave in ways that lead to social rejection that serves to confirm a sense of low self-worth.

**Bipolar disorder** is an unstable emotional condition involving extreme mood swings of depression and mania. The manic phase is characterized by periods of abnormally elevated or irritable mood, lasting at least one week. Bipolar disorder has a high rate of heritability. Stress and family problems may also contribute to the onset and maintenance of the disorder. Some believe that norepinephrine and serotonin imbalances contribute to the disorder, but that does not explain why lithium is effective as a drug treatment.

**Lecture Suggestion 15.7**

You’re Not Alone

There’s a popular conception that many students enter the study of psychology because they or someone they care about has concerns about psychological issues. Students studying abnormal psychology, by extension, are perceived as being personally concerned with psychological disorders. Perhaps they’ve been dealing with a psychological disturbance.

Patricia Connor-Greene decided to bring a little empiricism to these notions by surveying the students in her abnormal psychology courses. The students were asked in an open-ended format to anonymously indicate whether they personally knew someone who had received a formal diagnosis of and treatment for a psychiatric disorder. The 56 respondents provided the following information (these are cases in which 10 or more students reported knowing at least one person with the disorder):

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>69.6</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>48.2</td>
</tr>
<tr>
<td>Anorexia nervosa</td>
<td>33.9</td>
</tr>
<tr>
<td>Substance abuse (other than alcohol)</td>
<td>30.4</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>30.4</td>
</tr>
<tr>
<td>Alzheimer’s disease</td>
<td>28.6</td>
</tr>
<tr>
<td>Bulimia nervosa</td>
<td>26.8</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>19.6</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>17.9</td>
</tr>
</tbody>
</table>
You might share this information with your students in several ways. First, you could conduct a similar survey yourself. It wouldn’t be difficult to ask students to report the same kinds of information requested by Connor-Greene, provided that anonymity and confidentiality were assured. Compiling the results of such a survey would no doubt reveal to students that, when they think they’re alone in having a loved one with a psychological disorder, they’re really not. In Connor-Greene’s data, almost 70% of the students had personal experience with someone suffering from depression.

Second, point out that the relative distribution of experience with these types of disorders matches the relative distribution of the disorders themselves in the population. Mood and substance abuse disorders are generally more prevalent than psychoses, which is why more people have had personal experience with depression than schizophrenia. You can use these observations as a lead-in to a discussion of the various diagnostic categories in the DSM, the prevalence of disorders in the United States, or cross-cultural comparisons of mental illness.

Third, you can use this information as the basis for discussing the disorders themselves and also treatment options. In fact, you could share these data in the present context, but trot them back out again in a week or so when you move to the therapy chapter. Given that depression is a disorder that affects a lot of people, what treatment options are available? What strategies are used for treating substance abuse, and do they differ depending on the type of substance? How is schizophrenia managed? How are disorders of organic origin managed? By linking your later discussion of treatment to your earlier discussion of disorders themselves, you can bring a little more continuity to your classroom presentations.

Source:


Lecture Suggestion 15.8

“U-S-A! U-S-A! We’re Number 1! Woot Woot Woot!”

Here’s a dubious distinction: The United States is the global leader for mental illness.

In 2001, Ronald Kessler, of the Department of Health Care Policy at the Harvard Medical School, led the National Comorbidity Survey Replication, a survey of nearly 10,000 respondents that followed up the original National Comorbidity Survey of the early 1990s. As you might imagine, the survey produced an incredible volume of material, but some of the more notable findings are these:

- A quarter of all Americans met the criteria for having a mental illness during the year prior to data collection.
- A quarter of that group could be classified as having a serious disorder that impeded daily functioning.
The prevalence of mental illness in the United States has remained roughly flat in the decade between the original National Comorbidity Survey and the replication, which is encouraging.

However, fewer than half of those in need receive treatment, and even that can come after a decade of delays, during which time comorbid problems can develop.

Inadequate health care, inattention to symptoms, and the stigma of mental illness are contributing factors to the lack of care.

Approximately one-third of people in need of care seek it from nonprofessional sources, such as an Internet support group or member of the clergy.

Nearly half of people with one psychological disorder met the criteria for two or more disorders.

Sources:

http://www.hcp.med.harvard.edu/ncs/
http://www.hcp.med.harvard.edu/faculty/core/ronald-c-kessler-phd

Multimedia Suggestions

**Feature Film: Melancholia (2011, 130 min, rated R)** Kristen Dunst took best actress honors at Cannes for her performance in Lars von Trier’s apocalyptic drama. Von Trier has stated that his own experience with depression was the inspiration for this film. Justine (Dunst) should be happy as she celebrates her wedding at the family estate, but family conflicts and her own issues result in an unhappy evening leading to her husband’s departure at the end of the party. Justine stays at the estate with her sister (Charlotte Gainsborough) and brother-in-law (Kiefer Sutherland) and falls into a near-catatonic depression. The appearance of a previously hidden planet, Melancholia, and the planet’s collision course with Earth casts a pall over the family, but Justine is calm and serene as everyone else is overcome with despair.

**Feature Film: The Devil and Daniel Johnston (2005, 110 min, rated PG-13)** Daniel Johnston has been acclaimed as a brilliant singer-songwriter, a designation that’s merited largely by his angular, personal, obtuse albums and by his endorsement by artists such as Kurt Cobain, Jad Fair, and Sonic Youth. But Daniel Johnston is also a deeply troubled man. From the time of his arrival in the mid-1980s Austin, Texas, music scene, to his current semi-self-imposed exile in Waller, Texas, Daniel has battled a range of demons. This film comes highly recommended.

See the Preface for product information on the following items:
**Interactive Presentation Slides for Introductory Psychology:** 15.2 Anxiety and Mood Disorders

**Worth Video Series**

- Video Anthology for Introductory Psychology: Psychological Disorders – Depression
- Video Anthology for Introductory Psychology: Introduction to Psychology – Postpartum Psychosis: The Case of Andrea Yates
- Video Anthology for Introductory Psychology: Psychological Disorders – Self-Stimulation in Rats
- Video Anthology for Introductory Psychology: Psychological Disorders – Mood Disorders

*Scientific American Introductory Psychology Videos:* Anxiety and Mood Disorders

**VI. Schizophrenia and Other Psychotic Disorders: Losing the Grasp on Reality**

(Chapter Objectives 12–13)

Schizophrenia is a profound disorder involving hallucinations, delusions, disorganized speech and behavior and thoughts, and emotional and social withdrawal. The motivational and social deficits are called negative symptoms. Five sub-types of schizophrenia have been identified: paranoid, catatonic, disorganized, undifferentiated, and residual. Although schizophrenia affects approximately 1% of the population, it accounts for a disproportionate number of psychiatric hospitalizations. Drugs that reduce the availability of dopamine sometimes reduce the positive symptoms of schizophrenia. Neuroimaging studies have shown that a progressive loss of gray matter is a common feature of the progression of the disease. There is an increased risk of developing schizophrenia or experiencing a relapse if the family of an individual has poor communication patterns and relationships.

**Lecture Suggestion 15.9**

Art and Mental Illness

The link between creativity and madness has piqued the imagination of scholars, artists, writers, and the public alike. Another aspect of this link that is gaining in popularity, outsider art—or art produced by people on the fringes of society—has become the hot ticket among critics and collectors within recent years.

Outsider art is broadly applied to art made by transients, the criminally insane, and the mentally ill. Art that can be found primarily in thrift stores, art produced in isolation and discovered only upon the artist’s death, art that at one time would have qualified as a “primitive” style (e.g., the work of Grandma Moses), as well as work that typically conveys a singular, often idiosyncratic view of mundane subjects where the “outside”
boundary of outsider art lies, is often determined by a buyer and seller. Take, for example, the work of Rev. Howard Finster (who painted the cover of the Talking Heads album *Little Creatures*), anything done on velvet (from Elvis to large-eyed weeping children to clowns), or better known examples such as Munch’s *The Scream*, Louis Wain’s famous paintings of cats (which grew more bizarre as his schizophrenia progressed), or much of the work of Van Gogh.

At one time, however, outsider art referred exclusively to the works of the mentally ill or the criminally insane. *Art brut*, or art of the insane, actually has enjoyed popularity for a number of decades in underground circles. The paintings of convicted serial killer John Wayne Gacy, for example, were quietly acquired by various collectors before his execution. (After his death a single collector acquired all he could for the express purpose of publicly destroying them.) There have also been exhibitions of such work in several respected galleries, as well as a collection housed at the Musée de l’Art Brut in Lausanne, Switzerland.

It is nonetheless fascinating to study art brut because it gives a glimpse into the psychological state of the person producing it, be that the turmoil experienced by a moderately depressed person or the suffering of someone with anxiety disorder. In some cases, however, the unusual art generated doesn’t seem to map onto a tidy diagnosis. At the artists’ wing of Landers Clinic in Gugging, Austria, for example, a select handful of painters and a sole poet have produced artwork that has been acquired by worldwide collectors for handsome prices (all profits are maintained in trust funds for the artists). According to the ward’s director, Johann Feilacher, these patients are talented artists, regardless of their sicknesses. In this sense art brut becomes the work of artists who happen to be mentally ill, rather than a mentally ill person’s artistic products.

The many meanings of art brut to discuss in this lecture should provide lively and stimulating discussions. You might address the link between creativity and madness, explore the definition of what constitutes art brut, or discuss the therapeutic and diagnostic value of having patients express themselves in this way. If possible, share with your students some of this work. A convenient source of art produced by the mentally ill is *Schizophrenia Bulletin*. Each issue of this journal features cover artwork and brief commentary by a schizophrenic patient. You might also visit http://www.artbrut.com, http://www.artbrut.ch/, or http://www.rawvision.com/articles/art-brut-psychiatry.

Sources:


Lecture Suggestion 15.10

Thought Disorders and Delusions

Presented below are some of the more common delusions (false beliefs that are inconsistent with the thinker’s background or level of intelligence) and thought disorders (disrupted patterns of cognition, language, or logic) found in many forms of mental illness, especially schizophrenia.

Delusions

- **Persecution** is the belief that another person or group is trying to harm the individual or his or her loved ones. An example is believing that Wal-Mart is maintaining a file on your shopping activities and is plotting to destroy your lifestyle.

- **Grandeur** is a delusion that can be either specific or somewhat vague and involve an exaggerated view of one’s own importance. For example, believing that you are Madonna is a rather focused delusion, whereas believing that you are someone who has been preordained to have an important role in music is more diffuse.

- **Somatic** beliefs involve a preoccupation with one’s body, especially that some disease or disorder is present. Mistakenly believing that chemicals from soap products are aging your body parts is a somatic delusion. (Compare this with Ekbom’s psychosis, discussed in “Uncommon Psychiatric Syndromes.”)

- **Nihilism** is the delusion that everyone is nonexistent—the world, others, and/or oneself. An ongoing, spooky sense of unreality, or believing that one is “living in a dream,” often accompanies this delusion.

- **Reference** delusions are beliefs that one is being targeted by others or by certain events. Believing that the storyline of *Desperate Housewives* has been taken (literally) from your own life is an example.

- **Thought broadcasting** is the notion that one’s thoughts are being broadcast to everyone in the vicinity. For example, you might believe that your thoughts about your coworkers can be heard throughout your work building.

- **Thought insertion** is the conviction that outside thoughts are being inserted into one’s mind by forces known or unknown. David Berkowitz, the Son of Sam, reportedly believed that his thoughts were being implanted in his mind by his neighbor’s dog.

Thought Disorders

- **Incoherence** is the thought disturbance that is probably best known among the public. Incoherent speech is incomprehensible or lacking in meaning and structure, such as saying, “The sheep on the roof twelve is New Jersey” when asked one’s name.
Flight of ideas speech is intelligible, marked by a fast pace and rapid acceleration, and often characterized with abrupt changes of topic. Flight of ideas has the quality of a speaker ready to burst forth with a spew of sentences.

Loosening of associations is a cognitive disruption characterized by an illogical, unfocused, or vague train of thought. For example, when asked how one is feeling, the person might reply “Healthy, wealthy, and wise. Three wise men run the bank, you know; they have the wealth of nations.”

Neologisms are the inventions of new words or distortion of existing ones, often to match some self-perceived meaning. Describing the “wretchedivism” of your “tetramatic” lifestyle would be an example.

Clanging is a thought disorder characterized by the sounds of words, rather than their meaning, which determine the content of one’s speech. For example, you might respond “The note in the till, by the goat eating swill, sank the boat on the hill” when asked how you arrived at the psychiatric clinic.

Circumstantiality is speech filled with unnecessary, tedious, and inconsequential detail, leading to rambling descriptions of events or responses to questions. For example, “Although this morning when I woke up I felt as though today I would think of an example of this, but it didn’t turn out to be a productive day of writing. While I was eating my breakfast, as a matter of fact, I knew today would be a bust, especially when I was pouring my milk, which is always nonfat. Emily and I try to cut down on our fat intake wherever possible. I think the milk came from Costco, but I can’t remember.”

Perseveration is not clanging, but clinging to the same idea, word, phrase, or sound repeatedly. “I must stop writing. I must stop writing. I have to finish this. I must stop writing. I have to finish this writing. I must stop” would be an example.

Word salad is a jumble of random words that have no meaning, though because they may be arranged in phrases, they sound as if they are conveying meaning. The words may or may not be grammatically correct. For example, “Sheep furiously color greens truths speaking.”

Lecture Suggestion 15.11

Catching Madness in the Act

When David Silbersweig and Emily Stern, of the Cornell Medical Center in New York, developed a technique for capturing PET scans of very short durations that provided a useful tool for neuroimaging, they didn’t realize that their application of the technique is the aspect of their work that would prove most intriguing. What they achieved, in collaboration with colleagues in London, was the ability to use PET technology to capture an image of the schizophrenic brain in the process of hallucinating.
All of the six volunteers who agreed to participate in the PET scan experiment experienced hallucinations. In the PET scanner, patients pressed a button to indicate the onset of hearing hallucinatory voices and pressed it again when the experience stopped. One patient heard voices that bellowed “How horrible!” or “Don’t act stupid!”; another was tormented by images of rolling, decapitated heads that shouted out orders to him. The PET scans revealed that the structures active during this period were deep inside the brain—the hippocampus, thalamus, and striatum seemed abuzz with activity, and these structures usually integrate emotion, memory, and perception, suggesting that a miswired neural circuitry may be implicated in schizophrenia. And none of the brain structures that should have activated were. For example, there was no significant activity in the prefrontal cortex, suggesting that the reality-monitoring functions of the prefrontal lobe were not at work. Furthermore, when a control group heard actual voices, PET scans revealed that the auditory cortex was activated, whereas none of the deep structures were.

Although the application and, to some extent, the exact interpretation of these results is not clear, they suggest that some central features of schizophrenia may involve more than simply a chemical disruption; indeed, five of the six patients in the study obtained no relief from standard medication. Further research may reveal whether aberrant brain circuitry is present and where it might be; in fact, some research has used fMRI to investigate active hallucinations. For now, researchers at least have a tool for shedding light on a very private and very frightening event.

Sources:


**Lecture Suggestion 15.12**

Uncommon Psychiatric Syndromes

David Enoch and Hiram Ball have published a handbook of psychiatric disorders that are at the outposts of mental disturbance. Many of these disorders are worth presenting to your students to illustrate the extremes of psychopathology, although some of them are increasingly discussed in textbooks and the popular press (e.g., Tourette’s syndrome) and others border on anthropological and social analyses (e.g., possession and exorcism).

**Capgras Syndrome**

This syndrome, described by Capgras and Reboul Lachaux in 1923, is manifested when a patient believes that a person close to her or him has been replaced by an exact double. It is typically the dominant feature found amid other functional psychoses (such as schizophrenia or affective disorders). Often, the patient acknowledges the striking resemblance to a loved one but insists the person is a duplicate. The syndrome is also seen in concert with some organic disorders, where it is characterized by more confusion about the misidentification.

Capgras syndrome is classified as one of many delusional misidentification syndromes. An example of this general classification is found in the *illusion of Fregoli* (named for a famous stage actor and presented by Courbon and Fail in 1927), in which the patient is convinced that his or her persecutors are changing faces, so that the person’s spouse, doctor, coworker, or mail carrier are alternately presented as the same one person. Other examples include the description by Courbon of the *illusion of intermetamorphosis* in which a patient believes that those in his or her surroundings are changing from one to another where Bob becomes Mitch, Mitch becomes Roger, and Roger becomes Bob; the 1978 description by Christadoulou of the *subjective doubles syndrome*, involving a patient’s conviction that others have been transformed into the patient; and the 1903 description of *reduplicative paramnesia* by Pick, who regarded this syndrome as
neurological in origin, involving the perception that a physical location has been duplicated.

**Ekbom’s Syndrome**

This syndrome, also known as *delusional parasitosis*, refers to patients who suffer delusions of infestation. Those afflicted believe that lice, maggots, insects, or other small vermin are living on them, in their skin, or in some cases in their bodies.

The manifestations of this rare syndrome was made reference to during the late 1800s, but first described most thoroughly by Ekbom in 1937. By most accounts the syndrome is very rare; one study estimated that 3 cases were seen in 1,869 psychiatric admissions over 18½ years. Among those suffering from it, however, it appears to be intractable once established.

**Munchausen Syndrome**

Munchausen syndrome by proxy involves a caregiver’s persistent fabrication of medical symptoms and signs in the person cared for (typically a mother/child relationship), leading to illness, endangerment, and unnecessary invasive or hazardous treatments. It has received increasing attention by practitioners and researchers as a form of child endangerment. In Munchausen syndrome, similar behavior is found in a single individual. The patient is usually admitted to a hospital presenting some acute illness that has a dramatic but plausible origin. It is subsequently discovered that the history is riddled with falsehoods and that the patient has similarly deceived the staff of several other hospitals. Patients often discharge themselves against medical advice, often after arguing about a course of treatment or after some medical intervention has been initiated.

What both of these manifestations have in common are the presence of physical symptoms that are self-induced (or other-induced, in the case of by proxy) and pathological lying reminiscent of Baron Munchausen, a renowned teller of tall tales. Some illustrative cases include a young nurse who swallowed a dinner fork on six separate occasions to necessitate gastrostomy each time; she eventually died as a result of this practice (acute abdominal disturbances).

- Patients have pricked their fingers and contaminated the wounds with urine, or used an animal spleen to simulate a blood clot in the mouth (hemorrhagic disturbances).

- Some patients have undergone craniotomy or pre-frontal leucotomy as a result of their presentations (neurological disturbances).

- Some patients have inserted needles into their chests; others have ingested infected sputum from other patients (respiratory disturbances).

- Patients repeatedly swallow safety pins or needles; some self-inflict stab wounds or purposely irritate scabs and blisters to prevent healing and promote infection (other disturbances).
Folie à deux

Folie à deux ("insanity of two"), a shared paranoid disorder, is listed by the DSM as characterized by the development of persecutory delusions as a result of a close relationship with another person who already has such a disorder. In 1877, seven cases were described by Lasègue and Falret, making their report the first full account of the disorder. Although they concentrated on “psychosis by association” in sisters, folie à deux describes the case when any two (or more; folie à trois, folie à quatre, folie à famille, have been described) persons in close association with one another develop delusional ideation. Treating this disorder involves separating the two delusional participants, which, in many cases, produces marked recovery in the delusional subject. Variants include folie imposée (the patient with the primary psychosis is dominant in the relationship), folie simultanée (delusions occur simultaneously but independently in the two parties), and folie communiquée (the second party initially develops delusions similar to those of the first, and then develops a unique delusional system independently).

Source:


Classroom Exercise 15.4

Diagnosing the Instructor

Your students can see the behaviors of people with a variety of psychological disorders by watching the various feature films, educational films, and online videos mentioned in this chapter. However, you might also like to illustrate disordered behavior in “real time” with a bit of acting on your part.

- Consider borrowing scripts from Tom Tomcho and colleagues or devising some of your own. Tomcho and his colleagues suggest a classroom activity that allows students to gain insight into clinical interviewing and the diagnostic process. They developed scripts for clients exhibiting signs of either anxiety disorder, mood disorder, or psychotic disorder (these scripts can be found in their research article). The scripts were written to rule in and rule out certain diagnoses—the anxiety script, for example, was intended to depict generalized anxiety disorder but not other anxiety disorders—and their appropriateness was validated by clinical psychology faculty.

- In any event, you should play the role of the interviewer and an assistant (e.g., a graduate student, your teaching assistant, or a member of the class) should play the role of the pseudo-client.

- The scripts can certainly be read, but a little rehearsal to make them sound more spontaneous is probably a better idea.

- Before you conduct the interview at the front of the classroom, distribute to the remainder of the students a list of specific disorders relevant to the diagnostic
category at hand. If you’re enacting psychotic disorders, for example, you might prepare a handout that lists common features of the different subtypes of schizophrenia or schizoaffective disorder; if you’re enacting mood disorders, distribute a handout that lists features of major depression, bipolar disorder, and so on.

- Your students’ task should be to listen carefully to the interview and then provide a diagnosis.

- If you’d like, you can make this an open discussion topic, or you can ask students to first indicate their diagnoses privately (by checking a box next to the appropriate disorder, or by listing the symptoms and features of the interview that led them to one decision or another) before discussing the scenario with the rest of the class. Group discussion should reveal both the factors that led to a particular diagnosis and the factors that led away from competing diagnoses.

Option: A similar “real time” demonstration is suggested by Tim Osberg.

- Before you discuss schizophrenia, enter into a “disordered monologue” that illustrates some of the verbal features of schizophrenic behavior. Osberg provides a sample script in his original report, but you can probably develop one yourself.

- Be sure to include language features such as loose associations, neologisms, perseveration, clanging, and features of disordered thought, such as thought insertion, thought broadcasting, and delusions of being controlled.

- This demonstration will have more impact if it comes from out of the blue; pause in the middle of what you’re currently discussing and launch into a monologue rife with incoherencies and verbal tangents. Osberg cautions that the portrayal should be accurate but sensitive to the feelings of students who might know someone with schizophrenia.

Your goal is to convey some of the qualities of schizophrenic thought and speech in a realistic manner, as a means of generating discussion about the schizophrenias and psychotic behavior in general.

Sources:


Multimedia Suggestions

*Feature Film: Spider (2002, 98 min, rated R)*

Dennis Clegg is in his thirties and lives in a halfway house for the mentally ill in London. Dennis, nicknamed “Spider” by his mother, has been institutionalized with acute schizophrenia for some 20 years. As the story progresses, we vicariously experience his increasingly fragile grip on reality.

*Feature Film: A Beautiful Mind (2001, 135 min, rated PG-13)* This is the Academy Award–winning biopic of mathematician John Nash and his lifelong struggles with mental health. Nash enrolled as a graduate student at Princeton in 1948 and devoted himself to finding a completely original mathematical theorem. John becomes a professor at MIT where he meets and later marries a graduate student, Alicia. Over time, John begins to lose his grip on reality, eventually being diagnosed with schizophrenia, then institutionalized. As the depths of his imaginary world are revealed, Nash withdraws from society and it’s not until the 1970s that he makes his first foray back into the world of academics, gradually returning to research and teaching. In 1994, he was awarded the Nobel Prize in Economics.

*Feature Film: Clean, Shaven (1995, 80 min, not rated)* Peter Greene stars in this disturbing look at the world through the eyes of a schizophrenic. Writer/director Lodge Kerrigan masterfully captures the disorientation, confusion, and paranoia of the protagonist’s world as he searches fitfully for his daughter. Along the way we share his frustrations at completing simple tasks, such as making a sandwich or pouring sugar in his coffee. We also witness his self-mutilation as he tries to pry a misperceived transmitter/receiver set from his scalp and thumb. A fine film for generating discussions about schizophrenia.

*Feature Film: Titicut Follies (1967, 84 min, not rated)* *Titicut Follies* has the singular distinction of being the only American film banned from presentation for reasons other than obscenity or national security. Frederick Wiseman directed this disturbing look at life in the Massachusetts Correctional Institution at Bridgewater, a prison hospital for the criminally insane. Scenes of mistreatment of inmates, indifference by staff, and gruesome treatments make it clear why the Commonwealth of Massachusetts sued the filmmakers and why the film was banned from 1967 until 1992, when it was finally allowed to be shown on PBS. Currently there are several outlets for purchasing the movie, such as http://www.zipporah.com/.

See the Preface for product information on the following items:

*Interactive Presentation Slides for Introductory Psychology: 15.4 Schizophrenia*

*PsychSim 5 Tutorials* Losing Touch with Reality
VII. Disorders of Childhood and Adolescence

While many psychological disorders can begin during childhood or adolescence, there are some disorders that, by definition, must begin during childhood or adolescence. **Autism spectrum disorder (ASD)** is one of the more well-known childhood disorders. ASD develops in early childhood and is characterized by deficits in communication and restricted or repetitive interests, activities, or behaviors. With the release of *DSM–5*, the diagnostic categories of autistic disorder, Asperger’s disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified were all subsumed under the diagnosis of ASD. This has made it hard to get an accurate estimate of prevalence rates in the population, but some estimates are that the disorder is seen in 60 out of every 10,000 children. Boys are four times more likely than girls to be diagnosed with ASD.

Another childhood disorder, **attention deficit/hyperactivity disorder (ADHD)**, is seen in about 10% of boys and 4% of girls. ADHD involves chronic, longstanding difficulties with maintaining attention and/or hyperactivity or impulsiveness that cause significant impairments in functioning. Research suggests that there is a strong genetic component to this disorder, and brain imaging studies have found that ADHD is associated with smaller brain volumes and decreased function in the frontal lobe. Another common childhood disorder, **conduct disorder**, is characterized by a persistent pattern of deviant behavior involving aggression, lying, theft, destruction of property, or serious rule violations. Conduct disorder is seen in approximately 12% of boys and 7% of girls, and a host of biological, psychological, and environmental factors have been implicated in this disorder.

See the Preface for product information on the following items:
VIII. Personality Disorders: Going to Extremes

(Personal Objectives 16–17)

Personality disorders are deeply ingrained, inflexible patterns of thinking, feeling, or relating to others, or controlling impulses that cause distress or impaired functioning. There are three clusters of personality disorders: odd/eccentric, dramatic/erratic, and anxious/inhibited. The classification, and even existence, of these disorders is controversial because they may just be extreme versions of normal personality and they are often comorbid with other disorders. People with personality disorders often lack insight into their own disorders, making self-report difficult or useless, but peer nomination procedures are relatively successful. Antisocial personality disorder (APD) is associated with a lack of moral emotions. Individuals with APD are often manipulative, dangerous, and reckless, often hurting others and sometimes hurting themselves. A disproportionate number of prison inmates have antisocial personality disorder.

Lecture Suggestion 15.13

Limbic Kindling

According to Anneliese Pontius, retired from Harvard Medical School, the following is not-improbable fiction:

He kept to himself mostly. He acknowledged his neighbors, but wasn’t much for conversation. Routine was his master; early to work, a stop at the store for the evening’s groceries, a little television, then off to bed most days of the year, day in and day out. Never said much, most people didn’t really know him, couldn’t really say much about him. Until the day he strangled three of his coworkers with his bare hands. When the police asked his neighbors what type of person he was, they could only reply “He was a quiet fellow . . .”

Pontius, after gathering evidence over several decades, proposes that what she calls limbic psychotic trigger reactions is a type of previously unrecognized mental illness. According to Pontius, some people fly into a violent rage after sudden brain seizures are triggered by some harmless sight or sound. In her description of many cases, quiet, unassuming loners were reported to suddenly erupt into violence, only to just as suddenly
recoil in horror at their actions and be gripped by remorse. In one case, for example, a devout, middle-aged monk unexpectedly robbed a bank, went to a topless nightclub, assaulted the performers, and then just as unexpectedly turned himself in to the authorities. In another case, a man walking along a pier flew into an unprovoked rage, murdered an innocent person who was fishing, then immediately felt revulsion at his actions.

These offenders often experience hallucinations, waves of hot or cold sensations, or auras of flashing colored lights just before their violent acts. The events seem to be triggered by words or scenes that cause painful, long-suppressed memories to surface, even though the acts themselves are typically devoid of emotion (counter to the “crime of passion” notion that usually accompanies such outbursts). Pontius estimates that perhaps 1% of all murders result from limbic psychotic trigger reactions, and she continues to compile data on this controversial theory.

Sources:


Psychopathy in Motion

There have been a lot of well-publicized cases of serial killing and multiple murders, especially in the United States.

You might capitalize on this intrinsic interest by pointing out that most serial killers (although certainly not all) are diagnosed with antisocial personality disorder. The content of their crimes—murder, certainly, and often rape, burglary, or arson as well—fit with the general patterns of psychopathy. To illustrate aspects of their crimes and the aftermath (i.e., sentencing, victims’ suffering, parole hearing), a quick trip to YouTube or other online video source should suffice.

Listed below are some starting points for your consideration. Keep in mind that there are more sources available, and that some of these clips may contain mature themes and language.

Charles Manson Convicted of orchestrating the Tate/LoBianco murders in the 1960s

Sirhan Sirhan Convicted of assassinating Robert Kennedy

Ted Bundy Raped and murdered college students in Florida

Aileen Wuornos One of relatively few female serial killers

Jeffrey Dahmer Convicted of serial killing and cannibalism

David Berkowitz Son of Sam killer in New York City during the late 1970s

Henry Lee Lucas Texas serial killer; “orange socks” was most famous case

Ottis Toole Partner of Henry Lee Lucas

Richard Ramirez “The Nightstalker” who terrorized California in the 1980s

Dennis Rader “BTK” killer—“bind, torture, kill”

Cho Seung-hui Shooter at Virginia Tech
Charles Manson:
http://youtube.com/watch?v=xioCGmZVoqw&feature=related
http://youtube.com/watch?v=anJpG-NCk8c&feature=related
http://youtube.com/watch?v=VHamSwIHRHY&feature=related

Sirhan Sirhan:
http://youtube.com/watch?v=kbgK4hf7_eA
http://youtube.com/watch?v=SZ5T7-Gr9ho&feature=related

Ted Bundy:
http://www.youtube.com/watch?v=nsVJ8p1UPc8
http://www.youtube.com/watch?v=Ksfa0AddkLM

Aileen Wuornos:
http://youtube.com/watch?v=yFBcjII3QAE
http://youtube.com/watch?v=t7KM7ur7Z7g&feature=related
http://youtube.com/watch?v=w_f6m41UVIE&feature=related

Jeffrey Dahmer:
http://youtube.com/watch?v=9unVL8e31Vo&feature=related
http://youtube.com/watch?v=ikT7Gn9l0oM&feature=related
http://youtube.com/watch?v=LTBui9ot1bk&feature=related

David Berkowitz:
http://youtube.com/watch?v=RFAuo9XVp8E
http://www.youtube.com/watch?v=rpQXZzWOENM
http://youtube.com/watch?v=SHWjEhdMZGc&feature=related

Henry Lee Lucas and Ottis Toole:
http://youtube.com/watch?v=myPfHsjsxFs&feature=related
http://youtube.com/watch?v=sfUX0eoOQ68&feature=related
http://youtube.com/watch?v=YLClhgc9iA8&feature=related
http://youtube.com/watch?v=AHkGhOAOcY8&feature=related
http://youtube.com/watch?v=mdsncZhew6Dg&feature=related

Richard Ramirez:
http://www.youtube.com/watch?v=MC5huwZoPZA

Dennis Rader:
http://youtube.com/watch?v=J2XyuQ6n0UQ&feature=related
http://youtube.com/watch?v=fCh_9Oe2OA8&feature=related
http://youtube.com/watch?v=VnUCRS9DHKQ

Cho Seung-hui:
http://youtube.com/watch?v=SEYs8ZPgNNM&feature=related

Classroom Exercise 15.5

Personal Personality Disorders

- If your students would like to find out whether they might be socialized psychopaths, direct them to a quick test:
  http://bob.bob.bofh.org/~robm/misc/psycho.html
  http://crime.about.com/od/quiz/a/psychopathquiz.htm

- If your students would like to find out just where they score on the Machiavellian dimension, try this:
  http://bob.bob.bofh.org/~robm/misc/MachIV.html

- Are they dating someone really, really bad? Check and see:
  http://abcnews.go.com/GMA/story?id=2050044

- Maybe they’re a hypersensitive narcissists?
  http://www.wellesley.edu/Psychology/Cheek/sensitive.html

- Just what kind of personality disorder do they have?
  http://www.4degreeez.com/misc/personality_disorder_test.mv
Multimedia Suggestions

**Feature Film: Helter Skelter (1976, 119 min, not rated)** Steve Railsback stars as Charles Manson in this made-for-TV movie about the life and times of the Manson Family. The focus of the film is Manson’s trial, but numerous flashback scenes depict the activities of Tex Watson, Squeaky Fromme, Leslie Van Houten, and the rest of the gang at Spahn Ranch. This slightly sanitized version of antisocial personality disorder is recommended mainly for its notoriety; most students will be familiar with the name “Charles Manson,” if only from their American history books.

**Feature Film: American Psycho (2000, 101 min, rated R)** Christian Bale stars in this adaptation of the Brett Easton Ellis story of a yuppie banking executive with psychopathic tendencies. Some have seen this as a comedy, others as an account of the insanity that permeated the avarice-driven, go-go 1980s. In any event, there are worthwhile scenes illustrating antisocial behavior to share with your students.

**Feature Film: Henry: Portrait of a Serial Killer (1990, 83 min, not rated)** Michael Rooker stars in this compelling but grisly look into the life of a serial killer (loosely based on real-life Texas murderer Henry Lee Lucas). This movie depicts several scenes of rapes and murders and includes the gruesome reactions of Henry and his roommate. This film is not for everyone, and it should definitely be pre-screened before showing it to a general audience. Nonetheless, if you think your students can stomach the violence, they will gain some insights into the workings of the mind of an individual with antisocial personality disorder.

**Feature Film: Monster (2003, 109 min, rated R)** Charlize Theron won an Academy Award for her portrayal of serial killer Aileen Wuornos. Aileen Wuornos came from a troubled and difficult home life marked by abuse and drug use, and she entered into a life of prostitution at the age of thirteen. The film focuses on the period in her life when she was working as a highway prostitute and began murdering her truck driver clientele rather than servicing them sexually. Christina Ricci plays a fictionalized version of Wuornos’ lesbian partner who slowly comes to realize that Aileen is behind the growing string of unsolved murders.

See the Preface for product information on the following item:

**Interactive Presentation Slides for Introductory Psychology:** 15.3 Personality, Dissociative, and Somatoform Disorders

**Worth Video Series** Video Anthology for Introductory Psychology: Psychological Disorders – The Mind of the Psychopath

IX. Self-Harm Behaviors: When the Mind Turns against Itself

(Chapter Objective 18)

Each year in the United States more than twice as many people die by their own hands than at the hands of others. **Suicide** is among the top ten leading causes of death in the
United States and is the second most common cause of death among 15–24 year olds. Men are four times more likely than women to kill themselves, but women make more suicide attempts than do men. The goal of nonsuicidal self-injury (NSSI), in contrast, is not to end one’s life but to deliberately damage one’s body tissue. While this behavior has been observed throughout human history, studies suggest that NSSI is increasing in the population, with this behavior reported by 15%–20% of adolescents and at equal rates for males and females and across different racial and ethnic groups.

**Lecture Suggestion 15.15**

Risk Factors for Suicide

Patterson et al. (1983) proposed the mnemonic SAD PERSONS as a way to identify risk factors for suicide.

**S:** Sex—While women make more attempts, men are four times more likely to complete a suicide attempt.

**A:** Age—Risk of suicide increases in the elderly; while the elderly make up just 10% of the population, they account for 25% of all suicides. Adolescents are also at a greater than normal risk.

**D:** Depression—90% of individuals who commit suicide have some form of psychological disorder, and depression is the most common disorder associated with suicide.

**P:** Previous attempt—A history of previous attempts is the best single predictor of a completed suicide.

**E:** Ethanol abuse—The suicide rate for individuals with alcohol dependence is 50 times higher than in the general population. Alcohol lowers one’s inhibitions, increasing the likelihood of doing something impulsive like committing suicide.

**R:** Rational thinking loss—Psychosis is a risk factor, and 10% of individuals with chronic schizophrenia commit suicide.

**S:** Social supports lacking—Social isolation increases the risk of suicide.

**O:** Organized plan—Individuals with an organized plan for ending their lives are at the most risk of following through.

**N:** No spouse—Divorced, widowed, and single individuals are all at greater risk for suicide than individuals who are married. Risk is heightened for those who have recently lost a relationship.

**S:** Sickness—Chronic illness is a risk factor.
Don’t Try Suicide

About 50% of suicides occur during the recovery phase of a depressive episode. Knowing the risk factors for suicide can be helpful; in fact, it just might save a life.

Laura Madson and Corey Vas suggest a classroom activity to help students learn about risk factors.

- Give students four scenarios describing fictional people with various life circumstances.

- Ask them to rank on a 1–4 scale the likelihood of suicide in each case (1 = greatest likelihood, 4 = least likelihood). Madson and Vas point out that “greater” or “lesser” are somewhat subjective. Although risk factors and protective factors may be present, individual circumstances nonetheless may lead to “unpredicted” suicides, a point that should be made clear to your students.

Madson and Vas provide the scenarios in their report; you can use those, or construct some of your own. The core ideas in each scenario are these:

Person 1—laid off from work, family obligations, money problems

Person 2—previous suicide attempt and the breakup of a long-term relationship

Person 3—ostracized by family for sexual orientation, dramatic change in school and work habits

Person 4—substance abuse, access to firearms, giving away possessions

Person 2 is usually described as having the greatest risk, followed by Person 4. Again, you can follow the guidelines listed above in Lecture Suggestion 15.15 to incorporate risk factors into your own scenarios, and/or also visit any of several Web sites that list common risk factors for suicide.

Discussion:

After your students have completed their rankings, go over the “right” (or at least “intended”) answers with them, and use it as a forum for discussing suicidal ideation, suicide prevention, and the links between suicide and affective disorders. This might also be a fine opportunity to distribute information or pamphlets you gathered from your
university’s counseling center, or to publicize the counseling services that are available on your campus.

Sources:


http://www.apa.org/monitor/feb00/suicide.aspx

http://www.apa.org/monitor/nov01/suiciderisk.aspx

http://www.cdc.gov/ViolencePrevention/index.html


http://www.yellowribbon.org/WarningSigns.html

**Multimedia Suggestions**

**Feature Film: The Bridge (2007, 94 min, rated R)** *The Bridge* is a documentary film about suicides that result from jumping off the Golden Gate Bridge—a site from which people chose to end their lives more than anywhere else in the world. The film includes interviews with eyewitnesses, the family and friends of those who committed or attempted suicide, and even with some of the attempters themselves. Watching the film can be unsettling as the filmmakers captured a number of suicides during the year they filmed the documentary.

**Worth Video Series** Video Anthology for Introductory Psychology: Psychological Disorders – Suicide: Case of the “3-Star” Chef

**Other Film Sources**

*Acute and Posttraumatic Stress Disorders* (2003, 22 min, IM). PTSD is big business these days. Interventions and effective early treatment are the emphases of this video.

*Acutely Anxious* (2006, 47 min, FHS). Anxiety can be crippling to social interactions, and this video tells you why.

*Adult Psychiatric Diagnosis using the DSM-IV-TR* (2005, 360 min, FHS). Consider showing parts of this video to illustrate how the diagnostic process takes place.

*Antidepressants and Mood Stabilizers* (2001, 24 min, IM). Depression and its causes are the focus of this video. Neurotransmitters and chemicals that affect them receive special attention.
**Antipsychotic Agents** (2005, 23 min, IM). Medical professionals and patients discuss the medications used to treat psychotic disturbances. Course of treatment, side effects, and benefits are examined.

**Art Brut: Outsider Art, Outsider Artists** (2006, 36 min, FHS). Art brut is created outside the boundaries of the norm culture. In many respects, artists who happen to have mental illnesses fit that designation. This video looks at their lives and work.

**The Basic Mental Status Examination** (1997, 4 volumes, 30 min each, IM). A patient with memory loss runs through a standard interview.

**Beating Depression** (2004, 46 min, FHS). Three cases of chronic depression and two cases of bipolar disorder are used to examine how depression can be combated.

**Bipolar Disorders** (2001, 29 min, IM). The full range and nuances of bipolar disorder are examined in this thorough video.

**Bipolar Disorders: Current Concepts in Diagnosis and Treatment** (2000, 60 min, IM). Have you been wondering what the current concepts in diagnosis and treatment of bipolar disorder are? This video will answer your questions.

**Bipolar Disorders: Research Advancements** (2005, 30 min, IM). What’s new in the treatment of bipolar disorders? Have a look and see for yourself.

**A Case Study of Multiple Personality: The Three Faces of Eve** (1954, 30 min, IM). This classic video contains interview sessions with each personality residing within Chris Sizemore and includes scenes recorded after her successful treatment.

**Childhood Depression** (2000, 28 min, IM). Depression is often overlooked or misdiagnosed among children. This video looks at the prevalence of depression among children and available treatments.

**Circuits of Fear: Anxiety Disorder** (2001, 52 min, IM). Anxiety disorders account for about one-third of the nation’s mental health costs each year. Both patients and medical professionals tell you what they’re doing about that in this video.

**A Closer Look at the Diagnosis and Treatment of Schizophrenia** (2000, 60 min, IM). A more in-depth study of schizophrenia.

**Cutting: Addicted to Self-Injury** (2006, 10 min, FHS). This short video looks at the alarming trend of self-cutting, with a particular emphasis on its addictive qualities.

**Dealing with Social Anxiety** (2002, 22 min, IM). Being a little shy is one thing, but feeling paralyzed in social settings is another. The antecedent conditions and consequences of social anxiety are the focus of this video.

**Deeply Depressed** (2006, 47 min, FHS). Depression is bad, and deep depression is worse. Watch this film to find out why.

Depression: A Living Hell! (1999, 2 parts, 50 min each, FHS). This BBC production takes a long and thorough look at the depressive experience.

Depression: Not a Normal Part of Aging (2002, 55 min, FHS). There’s a myth circulating that growing older is a depressing event. As this video explains, social support, contentment, physical fitness, and other factors can keep the mind and body spry as the years go passing by.

Depressive Disorders 1 (2001, 29 min, IM). The symptoms, epidemiology, and biology of major depressive disorder are considered in this video.

Depressive Disorders 2 (2001, 29 min, IM). Life events, stress, and cognition are examined for their role in depression. Treatments, such as ECT and short-term psychotherapy, are also featured.


DSM-IV Personality Disorders (1999, 78 min, IM). Using a series of vignettes, each of the 14 DSM personality disorders is considered in this video.

DSM-IV Personality Disorders: The Subtypes (1999, 240 min, IM). This video provides a closer look at the variations on personality disorders noted in the DSM.

Fires of the Mind (2001, 4 parts, 52 min each, FHS). Ed Asner narrates this four-part series on mental disorders. Schizophrenia, depression, anxiety, and autism are the focus of the various installments.

Four Lives: A Portrait of Manic Depression (1987, 60 min, IM). Four patients know what they want but they just don’t know how to go about getting it. This is an award-winning film.

From Depression to Discovery: A Teenager’s Guidebook (2005, 25 min, FHS). Here are two observations: (1) Many of your students may be just out of their teens, and (2) depression is increasingly diagnosed in teens. This video might be of interest to your students.

Going to Extremes: Mood Disorders and Schizophrenia (2006, 30 min, IM). Kay Redfield Jamison and Stephen Hinshaw discuss the features of depression, bipolar disorder, and schizophrenia.

Hypochondriacs: Inside Health Anxiety Disorder (2007, 50 min, FHS). Case studies are used to examine the world of hypochondriacs.
The Iceman and the Psychiatrist (2002, 50 min, IM). The Iceman is Richard Kuklinski, a pathological killer who committed 200 homicides. The psychiatrist is Park Dietz, noted forensics expert. The content is mature as these two discuss murder and the mind.

Imagining Robert: My Brother, Madness, and Survival (2002, 56 min, FHS). This award-winning film profiles Jay Neugeboren and his brother, Robert, who suffers from schizophrenia and bipolar disorder. The trials and tribulations of coping with mental illness for decades are discussed, along with a few triumphs.

Kay Redfield Jamison: Surviving Bipolar Disorder (2002, 21 min, FHS). Jamison is a psychiatry professor and clinical psychologist. She’s also one of the many people who have been diagnosed with bipolar disorder. In this video she talks about her personal and clinical experiences with this disorder.

Late-Life Depression (2003, 28 min, FHS). Three senior citizens describe how they coped with this increasingly prevalent disorder.

Losing the Thread: The Experience of Psychosis (1992, 54 min, IM). The film presents what textbooks alone cannot; a vivid, first-person account of what it is like to experience a psychotic break with reality. Rachel Corday, who has dealt with intermittent psychosis over 25 years, discusses her experiences.

Madness: A History (2001, 51 min, FHS). The path from possession to biology in understanding mental illness is traced in this video.

Maintaining Mental Health (2002, 55 min, FHS). As people age, the adage “use it or lose it” takes on increased significance. It applies to mental as well as physical health, as this video demonstrates.

The Many Faces of Marsha (1991, 48 min, IM). A woman with 200 personalities is the focus of this discussion of multiple personality disorder. Part of a 48 Hours presentation.

The Mind of a Serial Killer (1992, 60 min, IM). This video shows the ins and outs of how the FBI uses profiling in tracking serial killers.

Multiple Personalities (1999, 50 min, IM). Sybil takes center stage, but several other cases of MPD are also examined in an attempt to understand this mysterious disorder.

Multiple Personality: Reality and Illusion (1998, 56 min, IM). Chris Sizemore, or “Eve,” of her eponymous fame, discusses her struggle with MPD and presents some of her artwork for your appraisal.

My Name Is Walter James Cross: The Reality of Schizophrenia (55 min, FHS). Walter James Cross suffers from schizophrenia so much that he tried to kill himself. He didn’t succeed, and instead decided to narrate this personal account of living with this disorder. This film has been well received at professional conferences and by various training organizations for mental health practitioners.
Neurotic, Stress-Related, and Somatoform Disorders (1997, 45 min, IM). OCD, anxiety, phobias, dissociative disorder, and stress reactions are the focus of this video. Differential diagnosis among these variants is discussed.

Obsessions: Understanding OCD (2003, 2 parts, 50 min each, IM). Actual case studies provide the basis for this look at how OCD can be managed through a variety of treatment options.

Obsessive-Compulsive Disorder: The Tyranny of Rituals (2000, 52 min, FHS). This film presents a nice introduction to what some students might see as eccentric quirks: compulsive washing, intrusive thoughts, and so on.

Organic Disorders (1995, 45 min, IM). Organicity is the basis for this look at different types of disorders.

Out of Balance: Anxiety and Personality Disorders (2006, 30 min, IM). Here’s an interesting starting point: Disorders are exaggerations of typical human experiences. See how that plays out in the realms of anxiety and personality disorders.

Panic Disorder and Agoraphobia: When Fear Takes Control (2001, 53 min, FHS). When fear takes control, you can be in for a rough ride. This video shows you why, with its emphasis on anxiety disorders.

The PCL-R Checklist: A Measure of Evil (2005, 47 min, IM). This film shows you how to identify and classify criminals using a checklist method, and how to predict who will re-offend.

People Say I’m Crazy (2003, 84 min, FHS). John Cadigan experienced a psychotic breakdown during his senior year of college, and life has been pretty challenging since then. Here he discusses his life and times.

Personality Disorders (1997, 26 min, IM). The most common types of personality disorders (i.e., antisocial, paranoid, histrionic) are examined.

Phobias: Living In Terror (1998, 51 min, FHS). How could anyone be afraid of a little spider, or a cozy elevator? For some people, the very thought of such things inspires fits of terror. This video explains why.

The Psychology of Criminal Behavior (2001, 25 min, IM). Biological, environmental, and sociological factors are considered in explaining why some people turn bad.

Psychopath (30 min, PENN). This video provides a case history of a patient diagnosed with antisocial personality disorder.

Recognizing and Managing Anxiety Disorders (2005, 60 min, IM). This film looks at the diagnosis, treatment, and symptoms of OCD, PTSD, panic disorder, social anxiety, and specific phobias.
Recognizing the DSM-IV-TR: Personality Disorders (2005, 360 min, FHS). Sections of this film are useful for illustrating how diagnoses are made according to categories and criteria.

Schizophrenia and Delusional Disorders (1997, 46 min, IM). The focus is on diagnosis in this look at delusional disorders.

Seeking Perfection (2003, 50 min, FHS). One aspect of obsession is never being satisfied with one’s job, one’s life, one’s body, or one’s hobbies. Case studies are used to illustrate how the quest for perfection can lead to psychological distress.


Skin Deep: Understanding Self-Injury (2000, 21 min, IM). This recent video looks at people who harm themselves and attempts to explain this behavior.

Suicide: The Parent’s Perspective (1990, 26 min, FHS). Grief, guilt, and bereavement are a difficult combination. This program helps parents listen to their teenagers in a proactive, mutually beneficial way.

Suicide: The Teenager’s Perspective (1990, 26 min, FHS). The stress of teenage life, and the promise for relief and support from peers, are important factors in determining suicide attempts among teenagers. This program offers solutions for help before it is too late. It summarizes the symptoms and causes of schizophrenia, phobias, and affective disorders.

The Torment of Schizophrenia (2000, 53 min, FHS). Schizophrenia was probably what inspired phrases such as “bedevilment of the mind.” “Torment” is a good word for it. This video illustrates the ups and downs of schizophrenia.

Trouble in Mind (1999, 13 volumes, 30 min each, IM). This video collection considers the symptoms and behaviors associated with different disorders in each of its installments. Alzheimer’s disease, ADHD, PTSD, OCD, and other disorders receive attention.

Troubled Minds: The Lithium Revolution (2004, 52 min, IM). This award-winning video traces the lithium revolution from its discovery to its current uses.

Unchaining the Mind: Advances in Schizophrenia Research (2004, 36 min, IM). Actual schizophrenia patients provide the starting point for this discussion of the symptoms and treatments available for treating psychoses.

Understanding Borderline Personality Disorder (1995, 35 min, IM). Segments from actual case sessions make up part of this look at the causes and treatment of this disorder.

Understanding Mental Illness and Schizophrenia (2004, 27 min, IM). The causes, symptoms, and defining features of depression, schizophrenia, and bipolar disorder are examined in this brief video.
Understanding Personality Disorders (2003, 25 min, IM). When does “normal personality” become “disordered personality?” That’s the riddle this video seeks to address.

Understanding Psychological Disorders (2001, 2 parts, 30 min each, IM). This two-part series examines the etiology and symptoms of various disorders. Part one looks at the origin and symptoms of obsessive-compulsive disorder. Part two looks at the symptoms and forms of schizophrenia.

What Is Normal? (30 min, IM). Explores the question of what distinguishes normal from abnormal and the classification of psychological disorders using the DSM; includes criticisms of the DSM.

When the Brain Goes Wrong (1992, 45 min, IM). This video looks at head injury, epilepsy, addiction, schizophrenia, stroke and other brain-related problems.


Women and Depression: When the Blues Won’t Go Away (2000, 28 min, FHS). American women suffer a high rate of depression; this film examines why, presenting a positive, hopeful approach to understanding a potentially debilitating problem.

The Worried Well (1996, 6 parts, 15 min each, FHS). This six-part series of short videos examines the scope of anxiety disorders. Segments include panic attacks, obsessive-compulsive disorder, self-harm, eating disorders, PTSD, and body dysmorphic disorder. These clips are a good way to start discussion of the forms and frequency of anxiety disorders.

*Due to loss of formatting, Handouts are only available in PDF format.*