## LESSON PLANNING CALENDAR

Use this Lesson Planning Calendar to determine how much time to allot for each topic.

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# ACTIVITY PLANNER FROM THE TEACHER’S RESOURCE MATERIALS

Use this Activity Planner to bring active learning to your daily lessons.

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Consider Gene Saunders. Gene was a manager at a manufacturing company. Work had become a struggle, with missed production goals, criticism from his supervisor, and disappointment when an expected promotion didn't come through. The stress at work led to additional problems at home, including a violent argument with his teenage son. Two days after the argument, Gene disappeared. A year and a half later, police in a town hundreds of miles away picked up a drifter who had been working as a short-order cook. The drifter's name was Burt Tate, and although Burt knew what town he was in, he had no knowledge of his life before arriving in town. There were no physical or drug problems that would account for the memory loss. You guessed it—Gene and Burt were the same person (Spitzer et al., 1989).

Consider Emilio. His twelfth hospitalization occurred when he was 40 because his mother, with whom he lived, feared him. He dressed in a ragged old coat and bedroom slippers, with several medals around his neck. Much of what he said was simply nonsense. When interviewed, he claimed he had been "eating wires and lighting fires." He alternated from being angry toward his mother to childlike giggling, and he heard nonexistent voices. Emilio had been unable to hold a job since his first hospitalization at age 16 (Spitzer et al., 1989, 2002).
Dissociative, Schizophrenic, and Personality Disorders

Consider Gene Saunders. Gene was a manager at a manufacturing company. Work had become a struggle, with missed production goals, criticism from his supervisor, and disappointment when an expected promotion didn’t come through. The stress at work led to additional problems at home, including a violent argument with his teenage son. Two days after the argument, Gene disappeared. A year and a half later, police in a town hundreds of miles away picked up a drifter who had been working as a short-order cook. The drifter’s name was Burt Tate, and although Burt knew what town he was in, he had no knowledge of his life before arriving in town. There were no physical or drug problems that would account for the memory loss. You guessed it—Gene and Burt were the same person (Spitzer et al., 1989).

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Resource Manager

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Consider Mary. She was 28 years old when referred for hospitalization by her therapist because she had urges to cut herself with a razor. For more than 10 years, Mary struggled with issues related to religion and philosophy. Her academic performance in college dropped when she began experimenting with a variety of drugs. When Mary entered therapy, she became both hostile and demanding, sometimes insisting on two therapy sessions a day. She did not exhibit stability in her moods or relationships (Spitzer et al., 1989).

Gene, Emilio, and Mary suffer from psychological disorders we discuss in this module. These disorders are not nearly as common as anxiety disorders (such as phobias) and mood disorders (such as depression), but they represent an interesting sample of the types of disturbances that can plague people. Keep in mind that in this text we do not come even close to examining all disorders—the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR), lists more than 200 specific mental disorders. Several of the people you read about in this module have lost some aspect of their sense of self like Gene (dissociative disorders). Others have lost contact with reality like Emilio (schizophrenic disorders). And still others have developed lasting and counterproductive patterns of behavior like Mary (personality disorders).

**Dissociative Disorders**

_Dissociate_ is the opposite of _associate_ (to make connections). If a person has a _dissociative disorder_, his _sense of self_ has become separated (dissociated) from his memories, thoughts, or feelings. Dissociative disorders are quite rare and usually represent a response to overwhelming stress. Three specific forms are dissociative amnesia, fugue, and identity disorder (see Figure 32.1).

![Figure 32.1 Dissociative Disorders](https://www.cartoonstock.com)

**Dissociative Amnesia**
- Loss of memory of a traumatic event

**Dissociative Fugue**
- Loss of identity
- Travel to a new location

**Dissociative Identity Disorder**
- Two or more distinct personalities

At this point, you may want to watch _Lost in the Mirror_.

The DSM-IV-TR lists 14 different categories of disorders. Disorders that aren’t discussed in detail in this textbook include the following:

- Disorders first diagnosed in infancy, childhood, or adolescence, such as mental retardation, learning disorders, and tic disorders (that is, Tourette’s syndrome)
- Delirium, dementia, amnesia, and other cognitive disorders, including Alzheimer’s disease and organic amnesia
- Mental disorders due to a general medical condition
- Substance-related disorders
- Fictitious disorders, including Munchausen’s syndrome and malingering
- Sexual and gender identity disorders, such as sexual dysfunction and paraphilia
- Eating disorders
- Sleep disorders
- Impulse control disorders, such as kleptomania, pathological gambling, and pyromania
- Adjustment disorders

We often joke about forgetfulness, but the dissociative disorders all involve serious disruption of memory.
Dissociative Amnesia

Can you remember the meaning of the word amnesia? Amnesia is memory loss, and any number of factors, including drug use, can cause it. Drinking too much alcohol, for example, can lead to a blackout of all memories of the drinking episode. Head injury, fatigue, and physical disorders such as Alzheimer’s disease can also cause amnesia. To qualify as dissociative amnesia, however, the memory loss must be a reaction to a traumatic event. Serious personal threats are the most common causes of dissociative amnesia. Combat soldiers may report losing their memory for hours or days (van der Hart et al., 1999). Survivors of natural disasters, such as floods or wildfires, sometimes experience similar losses (Kihlstrom, 1993).

In one case of dissociative amnesia, an 18-year-old man lost his memory of sailing with friends off the coast of Florida. A storm had come up, and only he had the foresight to put on a life jacket and tie himself to the boat. His friends were swept overboard in the high waves. Because of the emotional trauma, the young man lost all memory of the tragic storm and the several days he spent hoping to be rescued (Spitzer et al., 1989).

Dissociative Fugue

Dissociative fugue is an extended form of dissociative amnesia characterized by loss of identity and travel to a new location. (The word fugue comes from the same root as fugitive.) A dissociative fugue state can be short, lasting only a few hours, or long, lasting months or even years. The person may develop a new identity, form new friendships, or even enter a new line of work. As with other dissociative disorders, the development of a fugue state is an unconscious response to extreme stress. The case of Gene Saunders at the beginning of this module represents dissociative fugue. His stressful work and home situations led to his disappearance, and even he was not aware of the history behind his transformation into Burt Tate.

Dissociative Identity Disorder

Have you ever felt like a different person? Have you ever said, “I have no idea why I did that”? Magnified to an extreme, these feelings are central features of dissociative identity disorder (formerly known as multiple personality disorder)—a rare and controversial disorder in which an individual exhibits two or more distinct and alternating personalities. These subpersonalities reportedly can differ in age, sex, and self-perception of physical characteristics. Some researchers have even reported changes in brain function (Elinga et al., 2007; Putnam, 1991) or handedness (Henniger, 1992) as a patient switches from one personality to another. Sometimes subpersonalities seem to be aware of one another; sometimes they do not.

Active Learning

Dissociative Amnesia

A famous case of dissociative amnesia concerns the daughter of the last Russian czar, Nicholas II. In 1920, people believed that an amnesiac woman named Anna Anderson was Anastasia, the youngest daughter of the czar. Have students research the Romanov family and the conflicting evidence surrounding Anna Anderson.

- Why did Anna arouse suspicions concerning her identity?
- What evidence supports Anna’s claims? What evidence disputes them?
- What means can researchers use to verify claims like Anna’s?

At this point, you may want to use Enrichment Lesson: Psychogenic Versus Organic Amnesia.

Teaching Tip

Students should understand that dissociation is not the same as psychosis. Dissociation involves breaking away from the sense of self, either by losing memory and identity or by adding personalities. Psychosis involves a break with reality, believing things that are untrue, or having hallucinations about things that aren’t there. At this point, you may want to use Analysis Activity: Questionnaire of Experiences of Dissociation.

Differentiation

There are two types of amnesia:

- Retrograde amnesia occurs when old memories are lost. This is the most common type of amnesia. Memories for experiences that occurred in the time surrounding an event fall under this type of amnesia.
- Anterograde amnesia occurs when the ability to form new memories is lost. This form is less common, but some instances of head trauma or brain disease can affect a person’s ability to form new memories.

At this point, you may want to use Enrichment Lesson: Psychogenic Versus Organic Amnesia.

FYI

The Latin root of the word fugue means “flight,” which makes this an appropriate name for the disorder dissociative fugue.

Beyond the Classroom

Bellringers Use the following prompts as discussion starters:

- Have you ever wanted to pick up, move, and start over somewhere else? Why? What would be the advantages and disadvantages of such a move?
- Do you behave differently in different situations? Have people ever accused you of having different personalities? How did that make you feel?

At this point, you may want to use Enrichment Lesson: The Dissociative Disorders Interview Schedule and Multiple Personality.
Beyond the Classroom

Analyze Dissociative identity disorder is so controversial partly because the claims of patients are so difficult to confirm. Typically, it is not diagnosed until later in life when evidence of past abuse or trauma may no longer be present.

- Does the difficulty of confirming evidence necessarily deny patients’ claims?
- How do investigators prove claims of abuse that happened long ago?

At this point, you may want to use *The Brain (2nd ed.), Module 23: “Multiple Personality.”*

TEACHING TIP

If you show any of the popular films that depict dissociative identity disorder, help students watch with a critical eye. The goal of movies is not to depict reality but to entertain and tell a compelling story. The facts might not be an accurate depiction of what actually happened.

Beyond the Classroom

Explore Mental health professionals have only recently begun treating female patients as having characteristics different from male patients. Freud and his contemporaries believed that women who attended college had shrunken ovaries because they did not bear as many children as their less educated sisters. Also, illnesses such as dissociative and somatoform disorders were often only reported in women. Have students explore old stereotypes and new advances in women’s health.

- What were some other common beliefs about women’s health issues?
- What kind of influence did Freud and others have on the study of women’s health?
- When did women’s health issues start to get serious notice as being distinct from men’s health issues?
- What advances have been made in recent years that have made women’s health issues better understood?

Diagnosed cases of dissociative identity disorder increased dramatically in the final decades of the twentieth century. Before the 1970s, fewer than 100 cases had ever been reported in professional journals. Then, in the 1980s alone, reports of more than 20,000 diagnosed cases of dissociative identity disorder appeared, almost all of them in North America (McHugh, 1995). The average number of subpersonalities also increased—from 3 to 12 (Goff & Simms, 1993). In some cases, dozens of personalities were reported.

Psychologists debate whether dissociative identity disorder really exists. Are clinicians simply more knowledgeable about and willing to make the diagnosis? Are better diagnostic rules reducing the number of cases that in the past were misdiagnosed as other disorders, such as schizophrenia? Skeptics believe the power of suggestion has been at work here. Clinicians, who now have read a great deal about these fascinating cases, may unintentionally suggest multiple personalities to their clients (Kihlstrom, 2005). Questions such as “Have you ever felt another part of you is in control?” may lead the patient (who has also read about the disorder or seen depictions on television) to construct subpersonalities in an effort to please the therapist by responding to perceived expectations. This, of course, is also unintentional.

Sybil Dorsett’s famous case of dissociative identity disorder was the subject of a book, *Sybil,* and a made-for-TV movie of the same name in 1976 (remade in 2007). However, after the death of Sybil’s psychiatrist, a different picture emerged. After reading her recently released records, some experts have come to believe that Sybil’s multiple personalities were the result of her therapist’s suggestions. By giving names to Sybil’s emotional states and asking her to take on these roles as part of the therapeutic process, the psychiatrist could have led Sybil to believe that she possessed multiple personalities. (Other problems that originate in the mind can have physical results, as discussed in Psychology in the Real World: Mind and Body in Psychological Disorders.)

Active Learning

Mental Illness on Film

Have students research the lives of Chris Sizemore and Sybil Dorsett. Ask:

- What abuse did they say they experienced?
- What types of relationships did they have with their therapists?
- What was the result of their therapy sessions? Did they experience personality integration? Why or why not?
- What impact did the movie versions of their lives have on them?

Use *Enrichment Lesson: The Dissociative Disorders Interview Schedule and Multiple Personality.*
Psychology in THE REAL WORLD

Mind and Body in Psychological Disorders

The relationship between mind and body has fascinated psychologists since this science was born. Psychological disorders are a good place to look for this interaction, because such disorders almost always have both psychological and physical components. This is most dramatic in the somatoform disorders, in which the symptoms take a bodily form without apparent physical cause and the reasons behind many visits to the doctor are “medically unexplained” (Johnson, 2008). (Somatic comes from a Greek word for “body.”)

You’re probably already familiar with one of these disorders, hypochondriasis, which you may know as hypochondria, a somatoform disorder characterized by imagined symptoms of illness (see Figure 32.2). People with hypochondriasis experience symptoms of physical illness, such as headaches and fleeting joint pains, but medical exams reveal nothing physically wrong with their bodies. The disorder is, quite literally, all in the mind. People with hypochondriasis suffer, however, because they believe they are sick. All of us occasionally have hypochondriacal feelings, worrying that we may be sick but then turning out to be fine. Athletes, who must be tuned in to their bodies, may experience these worries frequently—but not usually to the extent seen in this mind-body disorder. And let’s be clear about one more thing: Pretending to be sick to avoid responsibility or to gain attention also does not qualify as hypochondriasis.

Another somatoform disorder, conversion disorder (formerly called hysteria), takes its name from its main symptom—the change, or conversion, of a psychological factor (typically anxiety) into an actual loss of physical function. A person with conversion disorder might suddenly experience blindness, laryngitis, or paralysis that has no physical cause. Have you ever been so frightened you momentarily lost the ability to move, or so stunned you momentarily lost the ability to speak? Then you’ve experienced, on a minor, short-term level, the core requirement of conversion disorder—loss of function for psychological reasons. Although some disorders, such as major depression, appear to be increasing in modern times, conversion disorder has become quite rare.

The symptoms of hypochondriasis and conversion disorder have no real physical basis. But sometimes psychological factors can lead to or aggravate real medical conditions. Stress, for example, contributes to asthma, ulcers, headaches, and high blood pressure. Such conditions, called psychophysiological or psychosomatic disorders, involve a more complete interaction of mind and body. With these disorders, as with other somatoform disorders, it’s not mind or body—it’s mind and body interacting to produce trouble.

Other somatoform disorders include the following:

- **Body dysmorphic disorder**, or a preoccupation with bodily imperfections
- **Pain disorder**, or complaints of severe pain in the absence of any attributable condition or malingering
- **Somatization disorder**, in which a person exhibits a variety of unexplained physical symptoms; typically found in individuals under 30 years of age

**Differentiation**

People with conversion disorder will typically suffer problems with parts of their bodies that directly relate to the stress they are under. For example, a quarterback for a football team might lose sensation in his throwing hand before the big game. However, he may report feeling fine and not admit to having stress about the event.
Schizophrenia is perhaps the most frightening and most misunderstood psychological disorder. Here are some facts to help dispel the myths:

- **Schizophrenia** is not one disorder. It is a family of severe disorders characterized by disorganized and delusional thinking, disturbed perceptions, and inappropriate emotions and behaviors.
- **Schizophrenia** is not “split personality.” Schiz does come from a word that means “split,” but the split represents a break from reality, not a division of personality. (There is no psychological disorder called split personality. Dissociative identity disorder, discussed earlier in this module, comes closest.)
- **Schizophrenia** occurs in about 1 percent of the world’s population (World Health Organization, 2008c). Schizophrenia typically develops in late adolescence or early adulthood and strikes men at a slightly greater rate than it strikes women (Aleman et al., 2003; Picchioni & Murray, 2007).

### Symptoms of Schizophrenia

A variety of symptoms characterize schizophrenia (see Figure 32.3). No one will experience them all, but everyone with the disorder will experience some of them. Common symptoms include delusions, hallucinations, and inappropriate emotions or behaviors.

**Delusions** A delusion is a false belief. We all believe false things sometimes, but the delusions of schizophrenia are more extensive, more complex, and often longer term. It may be that these delusions develop initially because individuals with schizophrenia have trouble focusing their attention on

**Figure 32.3 Symptoms of Schizophrenia**

- **Delusions**
- **Hallucinations**
- **Inappropriate Behavior**
- **Inappropriate Emotion**

**What's the Point?**

32-2 What are the symptoms, types, and causes of schizophrenic disorders?
appropriate environmental stimuli. Instead, their attention may be captured by insignificant things, or they may not notice important ones (Reichenberg & Harvey, 2007). Delusions fall into several broad categories:

- **Delusions of grandeur** are false beliefs that you are more important than you really are. People with schizophrenia may actually believe they are someone else, such as a famous political leader (Abraham Lincoln, for example) or religious figure (Jesus).
- **Delusions of persecution** are false beliefs that people are out to get you. A person may believe that she is being followed or that the CIA is engaging in an elaborate plot to capture her.
- **Delusions of sin or guilt** are false beliefs of being responsible for some misfortune. For instance, a person might believe he is responsible for a plane crash because he failed to brush his teeth one morning.
- **Delusions of influence** are false beliefs of being controlled by outside forces: “The devil made me do it.”

### Hallucinations

A **hallucination** is a false perception. The hallucinations people with schizophrenia most often experience are *auditory*. Many report hearing voices, and sometimes the voices tell them what to do. If the hallucination is *visual*, then the person sees nonexistent objects or distorted images of items or people. **Tactile** hallucinations occur when people feel skin stimulation, such as a tingling or burning or touch that is not real. Hallucinations can also distort *taste* and *smell*. Note the difference: Delusions are beliefs with no logical basis; hallucinations are perceptions with no outside stimulation. But hallucinations often provide “evidence” for delusions—it’s quite logical to believe someone is plotting to kill you if you can taste poison in your food. Life becomes unimaginably difficult if we can’t trust the input from our own senses.

### Inappropriate Emotions or Behaviors

Many specific symptoms fit into the broad category of inappropriate emotions or behaviors. Schizophrenia can produce wildly inappropriate emotions. A patient might laugh uncontrollably when sadness is called for. Another sufferer might have flat emotions, showing little or no emotional response. Inappropriate behaviors may be verbal or physical. Some people may not speak. Others may produce *nonsense talk* characteristic of some types of schizophrenia. (Remember Emil M in the beginning of this module? His claim of “eating wires and lighting fires” is one of several symptoms of schizophrenia he exhibits. Can you identify the others? After you have tried, check your answers in the next paragraph.) People with schizophrenia may act in inappropriate ways (examples include speaking too loudly or engaging in odd mannerisms) or be almost completely inactive. In rare cases, *waxy flexibility* occurs, a state in which you could place the person’s arm, as you would place a doll’s arm, in some position of your choice. The person would hold that position for hours. Quite often, people with schizophrenia withdraw from the affairs of the real

## Research

Some famous murderers have claimed that voices told them to commit their crimes. They also held ideas that would be considered delusional. Have students research the following cases:

- **David Berkowitz** (the Son of Sam): He claimed that a dog was possessed by Satan and instructed him to kill. He confessed to a yearlong murder spree in New York City, during which he killed six individuals and injured another seven.
- **John Hinckley, Jr.**: In 1981, he attempted to assassinate President Ronald Reagan in Washington, DC. Hinckley was motivated by a desire to attract the attention of Jodie Foster, the Hollywood actress and director.
- **Mark David Chapman**: In 1980, he killed former Beatles band member John Lennon in New York City. Chapman claimed that the “Little People,” a group of imaginary beings he talked to since childhood, told him to kill Lennon.

At this point, you may want to use *The Brain* (2nd ed.), Module 26: “Schizophrenia: Symptoms.”
Paranoid schizophrenia is the most widely recognizable form of the disorder. Movies depicting paranoids as either bumbling oddballs or psychopathic killers reinforce stereotypes of these patients.

**Differentiation**

Remind students that a genetic predisposition toward schizophrenia does not guarantee that one will develop the disorder. Environmental and behavioral influences play a significant role in the development of the illness.

At this point, you may want to watch *Silent Snow, Secret Snow.*

**Types of Schizophrenia**

The family of disorders known as schizophrenia is broken into four major types—paranoid, catatonic, disorganized, and undifferentiated (see Figure 32.4):

- **Paranoid schizophrenia** is characterized by delusions, particularly delusions of grandeur and persecution. Auditory and other hallucinations often support the delusions.

- **Catatonic schizophrenia** is characterized largely by variations in voluntary movements. A person with catatonic schizophrenia alternates between two phases—catatonic excitement, consisting of rapid movement, delusions, and hallucinations, and catatonic stupor, with little activity or speech. Flat emotion and waxy flexibility often are part of the stupor phase.

- **Disorganized schizophrenia** is characterized by bizarre behavior, delusions, and hallucinations. Individuals with disorganized schizophrenia are visibly disturbed. In historical times, they were thought to have “gone mad.” The case of Emilio from the beginning of this module illustrates disorganized schizophrenia.

- **Undifferentiated schizophrenia** is characterized by symptoms that are disturbed but are not clearly consistent with the paranoid, catatonic, or disorganized types of schizophrenia. Nevertheless, individuals with undifferentiated schizophrenia show clear evidence of the symptoms of schizophrenia.

**Figure 32.4**

*Types of Schizophrenia*

Schizophrenia is a family of related disorders.

**Cross-Curricular Connection**

**Literature**

Michael Gorman reports on a successful student project involving the book *The Eden Express* by Mark Vonnegut (son of the famous author Kurt Vonnegut). In this book, the author documents the hallucinations and suicide attempts he experienced during his schizophrenic breakdown. Later he describes his recovery, which he largely attributes to the drug Thorazine. Have students complete one of the following projects:

- An analysis of the depiction of schizophrenia in light of modern knowledge
- A reflective paper focusing on the student’s reaction to Vonnegut’s story
- A creative story based on Vonnegut’s account

Causes of Schizophrenia

Complex disorders have complicated causes, and there is probably no psychological disorder more complex than schizophrenia. As is often the case, biological factors and psychological factors seem to interact to produce schizophrenia.

Biological Factors The biological approach to schizophrenia has received so much research support in recent years that some experts say we are wrong to call it a psychological disorder. Rather, it is a brain disorder that produces changes in a person’s mind. Let’s examine the biological factors in more detail.

*Genetics*—The risk of schizophrenia increases substantially if relatives have the disorder (see Figure 32.5). Although roughly 1 percent of the general population has schizophrenia, the risk rises to about 10 percent if a parent or sibling has the disorder. These odds are even higher—almost 50 percent—if the relative with schizophrenia is an identical twin (Plomin et al., 1997). Notice that this evidence shows that, while genetics is an important factor, there is no single gene or set of genes that guarantees schizophrenia will develop. If there were, the risk for an identical twin whose co-twin had the disorder would be 100 percent, because identical twins have identical genes. Instead, genetics seems to produce a predisposition for schizophrenia—an increased likelihood that the disorder will develop. The search is on for the specific genes that might combine to alter the brain in a way that produces schizophrenia (Marx, 2007; Millar et al., 2005; Williams et al., 2007). Other factors, as you will see, determine whether the increased likelihood will lead to a full-fledged disorder. A similar situation exists for various kinds of heart disease. Genetics may put a person at risk, but factors such as exercise, diet, and smoking play a critical role in determining whether the disease will develop.

![Figure 32.5
Genetics and Schizophrenia: The Genain Quadruplets](image)

The names of the quadruplets featured in Figure 32.5 were changed to protect their privacy because they became recurrent research subjects. They have the unique distinction of being the only set of multiples who share this mental illness, and all were diagnosed by age 25. They also share a history of a nightmarish family life: Their father—who also suffered from schizophrenia—was a strict disciplinarian, and their mother was overly protective of them.

Mental Illness and Heredity

Have students examine the probability of inheriting mental illnesses other than schizophrenia. Consider the following conditions:

- Mood disorders, such as depression and bipolar disorder
- Anxiety disorders
- Somatoform disorders
- Substance-related disorders
- Personality disorders

At this point, you may want to use *The Brain (2nd ed.), Module 27: “Schizophrenia: Etiology.”*
Recent research using brain-imaging techniques has shed some light on the biological basis of schizophrenia.

- People who develop schizophrenia later in life have abnormal brain activity before the onset of symptoms, showing that it may be a developmental disorder.
- MRI studies show that gray matter in the brains of schizophrenic patients is markedly less dense than in patients without the disorder.
- Studies have also shown that patients who have auditory hallucinations experience temporal lobe activation, which indicates that they actually do hear voices that aren’t really there.

**Differentiation**

Link the discussion of dopamine to Module 4’s discussion of neurotransmitters and their functions. The chemical structure of dopamine is similar to that of cocaine, which explains why abusers of the drug experience schizophrenic-like symptoms. In addition, Parkinson’s disease is thought to result from a lack of dopamine channels in the brain. Patients who take medicine to treat schizophrenia usually develop symptoms, such as hand tremors, that are common in Parkinson’s patients.

At this point, you may want to use The Brain (2nd ed.), Module 27: “Schizophrenia: Etiology.”

**Psychological Factors**

For many years, explanations of schizophrenia focused mainly on psychological factors. Sigmund Freud targeted the relationship between mother and child as the primary cause of the disorder. He mistakenly thought that mothers who were cold, domineering, and selfish caused schizophrenia in their children (Fromm-Reichmann, 1948).

**Brain structure**—The brain structure of people with schizophrenia differs markedly from normal brain structure (see Figure 32.6). Brain scans show that schizophrenia is often associated with smaller amounts of brain tissue and larger, fluid-filled spaces around that tissue (Wright et al., 2000). Particular brain structures may be affected by schizophrenia. For example, the thalamus, responsible for the routing of incoming sensory information, is smaller when schizophrenia is present and may hinder the person’s ability to focus attention (Andreasen et al., 1994).

**Brain function**—Positive emission tomography (PET) scans, which show the parts of the brain that are active during particular tasks, reveal that the brain of a person with schizophrenia operates differently than does the brain of someone without the disorder. One difference appears in the frontal lobes—the center of our most advanced thinking abilities—which show less activity when schizophrenia is present (Morey et al., 2005; Resnick, 1992). Brain chemistry also differs for a person with schizophrenia. Researchers have discovered as many as six times the normal number of receptor sites for the neurotransmitter dopamine when they examined the brains of people with schizophrenia after death (Seeman et al., 1993). This abnormally high number of receptors may explain the delusions and hallucinations associated with schizophrenia. Medication that blocks these receptor sites reduces such symptoms. Researchers are working on medications for another neurotransmitter, glutamate, in an attempt to diminish other symptoms of schizophrenia (Javitt & Coyle, 2004).

**Prenatal viruses**—A maternal viral infection during pregnancy may cause schizophrenia (Patterson, 2007). The evidence for this is circumstantial but persuasive. Rates of schizophrenia rise for individuals who were born a few months after a flu epidemic (Mednick et al., 1994), and the riskiest birth months in general follow the flu season (Torrey et al., 1997). In the Southern Hemisphere, where the seasons are reversed, the high-risk months are reversed as well (McGrath & Welham, 1999).

For more information, see The Brain (2nd ed.).
Are there any psychological factors that do appear important? The two areas that seem most significant are stress and disturbed family communication patterns. Recall that the major genetic contribution to schizophrenia seems to be a predisposition—a tendency to develop the disorder. Stress may be the trigger that sets off the series of events that converts schizophrenia from a possibility into a reality. Disturbed family communications are also correlated with the development of schizophrenia, but at this point it’s impossible to tell whether they are a cause of schizophrenia or a result of the disorder. One study did find that young people who developed schizophrenia were more likely to be socially withdrawn and to exhibit odd behavior before becoming schizophrenic (Johnstone et al., 2005).

The bizarre world of schizophrenia has puzzled and fascinated students of human behavior for centuries. We are making progress both in understanding and in effectively treating this devastating disorder. It seems to result from a complex interaction of biological and psychological factors. To be effective, treatment must address both of these components.

### Personality Disorders

**What’s the Point?**

#### 32-3 What kinds of personality disorders are known?

Personality disorders are lasting, rigid behavior patterns that disrupt social functioning. The DSM-IV-TR lists 10 personality disorders divided into three clusters—related to anxiety, odd or eccentric behaviors, and dramatic or impulsive behaviors (see Figure 32.7). The specific personality disorders

- **Related to Anxiety**
  - Avoidant personality disorder
  - Dependent personality disorder

- **Dramatic or Impulsive Behaviors**
  - Borderline personality disorder
  - Antisocial personality disorder

- **Odd or Eccentric Behaviors**
  - Paranoid personality disorder
  - Schizoid personality disorder

### Beyond the Classroom

**Discuss** Personality disorders are difficult to diagnose and treat because the behaviors are enduring and rigid. Have students discuss why people may be unable to recognize that someone has a personality disorder.

- Where should the line be drawn between being eccentric, anxious, or odd and having a personality disorder?
- How might treatment for a personality disorder be difficult?

**Beyond the Classroom**

**Guest Speaker** Invite a psychologist to class to discuss treatment options for people with personality disorders. **Ask**:

- How can people be treated for personality disorders?
- How successful is treatment for these conditions?
- Are personality disorders normally identified in conjunction with other disorders? Why or why not?

**Beyond the Classroom**

**Bellringers** Use the following prompts as discussion starters:

- Do you feel you would qualify for a personality disorder? Why or why not?
- Have you known someone that you might suspect has a personality disorder? What behaviors would lead you to this conclusion?

**Differentiation**

Create a graphic organizer using the handout for Figure 32.7. Students who may have trouble with this portion of the module can complete the handout on their own or with a tutor. You can also use a transparency of this figure during class to reinforce your discussion of personality disorders.

### Personality Disorders

Have students investigate the incidence of personality disorders in other cultures. Are these disorders more common in Western cultures such as the United States? Why or why not?
are often difficult to diagnose because there is a lot of overlap among them. Because of the difficulties that mental health professionals have had in using the current categories of personality disorders, it is quite likely that this area will undergo significant change in the DSM-5, the new edition of the official diagnostic and classification system that is expected in 2013 (American Psychiatric Association, 2010; Clark, 2007; Widiger & Trull, 2007). The behavior patterns are usually evident by adolescence and obvious to others, but the person with the personality disorder often does not recognize the problem exists, which can make treatment difficult. Let’s take a look at the three clusters of personality disorders and a sample of the specific disorders included in each cluster.

**Personality Disorders Related to Anxiety**

Individuals with *avoidant personality disorder* are so sensitive about being rejected that personal relationships become difficult. Those with *dependent personality disorder* behave in clingy, submissive ways and display a strong need to have others take care of them. Juanita, for example, is a 28-year-old with dependent personality disorder. She still lives with her mother and feels unable to live in her own apartment because she has trouble making decisions about day-to-day life. She needs constant reassurance from her mother and is afraid to disagree with her parent because she wants to avoid criticism.

**Personality Disorders With Odd or Eccentric Behaviors**

Individuals with *paranoid personality disorder* (which is different from paranoid schizophrenia) show deep distrust of other people. This suspiciousness gets in the way of personal relationships. Those with *schizoid personality disorder* are detached from social relationships. They are the true hermits, preferring the life of the loner and avoiding intimate interactions with others at all costs. Henry is such a person. He does most of his shopping online because he doesn’t like having to talk to clerks in stores. He has always lived on his own and does not attend any family holiday celebrations despite repeated invitations from relatives. He does not own a telephone.

**Personality Disorders With Dramatic or Impulsive Behaviors**

Those with *borderline personality disorder* exhibit, above all else, instability — of emotions, self-image, behavior, and relationships. Mary, whose story is one of the cases that opens this module, is an example of a person with borderline personality disorder. Her academic struggles in college, inability to resolve religious and philosophical issues, unrealistic demands, and self-cutting all add up to a life filled with instability.
People with **antisocial personality disorder** (also known as psychopathic or sociopathic personality disorder) show a lack of conscience for wrongdoing and a lack of respect for the rights of other people. Antisocial personality disorder is the most dramatic and troubling of all personality disorders. Because of this lack of conscience, people with this disorder are willing to engage in wide-ranging criminal behaviors about which they show no remorse (see Figure 32.8). This disorder is more likely to occur in males than in females, and it usually develops by adolescence (Cale & Lilienfeld, 2002). People with the disorder are often charming and clever, which helps them get away with their misdeeds. In extreme forms, antisocial personality disorder may manifest itself in serial killing, where the murderer has no regard for the victims (think of Hannibal Lecter in the 1991 film *The Silence of the Lambs*). Vicious crimes are committed for trivial reasons and dismissed with such excuses as "Once I've done a crime, I just forget it" or "I think of killing like smoking a cigarette, like another habit" (Darrach & Norris, 1984). The horribly counterproductive behavior patterns of antisocial personality are caused by a combination of biological, psychological, and social factors. Once in place, the disorder is extremely difficult to treat effectively. As you can imagine, people with antisocial personality disorder often end up in jail instead of in treatment.

Dissociative disorders, schizophrenic disorders, and personality disorders help us understand that abnormal functioning is as varied as normal functioning and that the reasons for it are just as complex. Just as psychology can help us understand and promote productive behavior and mental processes, it can also help us comprehend the fascinating and sometimes frightening world of mental disorders. This is the first step on the road to effective treatment.

Harvey Cleckley identifies these characteristics of antisocial personality disorder:

- **Superficial charm and intelligence**
- **Poise, rationality, and the absence of neurotic anxiety**
- **The lack of a sense of personal responsibility**
- **Untruthfulness, insincerity, callousness, and manipulativeness**
- **Antisocial behavior without regret or shame**
- **Poor judgment and failure to learn from experience**
- **The inability to establish lasting, close relationships with others**
- **The lack of insight into personal motivations**

At this point, you may want to use Demonstration Activity: **Antisocial Personality Disorder.**


**Research**

While all serial killers are antisocial, not all people who are antisocial are serial killers. Have students explore the lives and crimes of these serial killers, all of whom are believed to have or have had antisocial personality disorder:

- Ted Bundy
- Kenneth Bianchi (one of the “Hillside Stranglers”)
- Jeffrey Dahmer
- Aileen Wuornos (America’s only known female serial killer)

At this point, you may want to use The Mind (2nd ed.), Module 35: “The Mind of the Psychopath.”

The terms *psychopath* and *sociopath* are synonymous. They are legal terms and are not used to diagnose psychological disorders.
SUMMARY AND FORMATIVE ASSESSMENT

MODULE 32
Thinking About Dissociative, Schizophrenic, and Personality Disorders

Dissociative Disorders

WHAT’S THE POINT?

32-1 What are the symptoms and causes of dissociative disorders?

- Dissociative amnesia is memory loss caused by a reaction to a traumatic event.
- Dissociative fugue is an extended form of dissociative amnesia characterized by loss of identity and travel to a new location.
- Dissociative identity disorder (formerly known as multiple personality disorder) is a rare and controversial disorder in which an individual exhibits two or more distinct and alternating personalities.
- Dissociative disorders are usually a response to overwhelming stress. They cause individuals to lose their sense of self and separate (dissociate) from their memories, thoughts, or feelings.

Apply What You Know

1. Psychologists skeptical about the increase in the number of people diagnosed with dissociative identity disorder believe the increase is likely due to
   a. better diagnostic criteria.
   b. an increase in severe child abuse.
   c. genetic factors that may trigger the disorder.
   d. therapists who “cause” the disorder through suggestion.

2. True or False: Dissociative amnesia is often caused by drug use or head injuries.

Schizophrenic Disorders

WHAT’S THE POINT?

32-2 What are the symptoms, types, and causes of schizophrenic disorders?

- Schizophrenic disorders include symptoms of delusions, hallucinations, and inappropriate emotions or behaviors.
- The main types of schizophrenia are paranoid schizophrenia, catatonic schizophrenia, disorganized schizophrenia, and undifferentiated schizophrenia.
- The risk of schizophrenia increases substantially if biological relatives have the disorder, indicating a genetic predisposition for the development of schizophrenia. Brain structure, brain function, and maternal viral infection during pregnancy may also contribute to schizophrenia.
- The psychological factors of stress and disturbed family communication patterns may be triggers for the underlying biological factors that cause a person to manifest schizophrenic symptoms.

Apply What You Know

3. Delusions of persecution and grandeur characterize ________ schizophrenia.

4. Briefly describe two biological factors that are associated with the development of schizophrenia.

Personality Disorders

WHAT’S THE POINT?

32-3 What kinds of personality disorders are known?

- Personality disorders are lasting, rigid behavior patterns that disrupt social functioning.
- Personality disorders are divided into three clusters related to anxiety, odd or eccentric behaviors, and to dramatic or impulsive behaviors.
- Antisocial personality disorder involves a lack of conscience and a lack of respect for the rights of other people.

The psychological factors of stress and disturbed family communication patterns may be triggers for the underlying biological factors that cause a person to manifest schizophrenic symptoms.

Apply What You Know

3. Delusions of persecution and grandeur characterize ________ schizophrenia.

4. Briefly describe two biological factors that are associated with the development of schizophrenia.

Exploring Psychological Disorders on the World Wide Web

Students can search the web for information on different disorders presented in Modules 30 through 32. Assign each student or group of students a disorder and have them gather information on it, creating a presentation to share with the class, school, or community. Some presentation options include the following:

- A formal research paper
- A poster presentation
- A public awareness campaign to educate people about the illness
- A documentary about someone with the disorder that educates people about the day-to-day life of people with the illness

Please refer to Alternative Assessment/Portfolio Project: Exploring Psychological Disorders on the World Wide Web for helpful websites and rubrics to aid in evaluating your students’ projects.
Apply What You Know

5. True or False: Personality disorders usually involve patterns of behavior that are obvious to others by the time an individual is a teenager.

6. Individuals with a deep distrust of others might be diagnosed with ________ personality disorder.
   a. paranoid
   b. avoidant
   c. borderline
   d. antisocial

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Using the Test Bank

The Test Bank that accompanies this textbook offers a wide variety of questions in different formats and levels of complexity. Use the software to construct whole tests or to integrate standardized questions into teacher-made tests.

Answers

Personality Disorders: Apply What You Know

5. True
6. (a)