## Chapter 10 Motivation and Emotion

**Self-Test—*Theories of Motivation* (p. 279)** 1. a 2. d. 3. b. 4. d. **Self-Test—*Motivation and Behavior* (p. 290)** 1. a. 2. c. 3. c. 4. c. **Self-Test—*Components and Theories of Emotion* (p. 298)** 1. a. 2. a. 3. d. 4. a. ***Research Challenge* (p. 286)**. Question 1: Descriptive. Question 2: Survey/interview.

## Chapter 11 Personality

**Self-Test—*Psychoanalytic/Psychodynamic Theories* (pp. 308–309)** 1. d. 2. b. 3. d. 4. c. 5. c. **Self-Test—*Trait Theories* (p. 313)** 1. c. 2. a. 3. d. 4. e. **Self-Test—*Humanistic Theories* (p. 317)** 1. a. 2. c. 3. c. 4. c. **Self-Test—*Social-Cognitive Theories* (p. 320)** 1. c. 2. d. 3. b. 4. a. **Self-Test—*Biological Theories* (p. 323)** 1. b. 2. d. 3. a. 4. b. **Self-Test—*Personality Assessment* (p. 329)** 1. d. 2. a. 3. d. 4. b. ***Research Challenge* (p. 311)**. Question 1: Descriptive and correlational. As you'll discover in later psychology classes, descriptive and correlational studies often overlap. Question 2: If you chose descriptive, the answer is naturalistic observation. If you chose correlational, this is a positive correlation.

## Chapter 12 Psychological Disorders

**Self-Test—*Studying Psychological Disorders* (p. 340)** 1. c. 2. b. 3. a. 4. Compare your answers with Figure 12.2 (p. 334). **Self-Test—*Anxiety Disorders* (p. 344)** 1. Compare your answers with Figure 12.4 (p. 341). 2. a. 3. a. 4. c. **Self-Test—*Depressive and Bipolar Disorders* (p. 350)** 1. c. 2. a. 3. d. 4. d. **Self-Test—*Schizophrenia* (p. 355)** 1. a. 2. c. 3. b. 4. a. **Self-Test—*Other Disorders* (pp. 359–360)** 1. b. 2. a. 3. b. 4. d. **Self-Test—*Gender and Cultural Effects* (p. 364)** 1. d. 2. d. 3. a. 4. b. ***Research Challenge*** (p. 337). Question 1: Descriptive. Question 2: Survey/interview.

## Chapter 13 Therapy

**Self-Test—*Talk Therapies* (p. 376)** 1. a. 2. c. 3. c. 4. b. **Self-Test—*Behavior Therapies* (pp. 380–381)** 1. b. 2. c. 3. c. 4. b. **Self-Test—*Biomedical Therapies* (p. 386)** 1. d. 2. b. 3. b. 4. c. **Self-Test—*Psychotherapy in Perspective* (p. 394)** 1. c. 2. c. 3. a. 4. d. ***Research Challenge* (p. 388)**. Question 1: Experimental. Question 2: IV = condition (whether completed writing exercises or not). DV = change in marital satisfaction.

## Chapter 14 Social Psychology

**Self-Test—*Social Cognition* (pp. 403–404)** 1. c. 2. c. 3. a. 4. a. cognitive, b. affective, c. behavioral. 5. b. **Self-Test—*Social Influence* (pp. 412–413)** 1. c. 2. c. 3. d. 4. b. 5. c. **Self-Test—*Social Relations* (p. 425)** 1. d. 2. a. 3. d. 4. b. 5. a. ***Research Challenge* (p. 402)**. Question 1: Experimental. Question 2: IV = amount paid ($1, $20). DV = attitudes towards the task.

Correlation coefficients can be quite helpful in making predictions. Bear in mind, however, that predictions are just that: *predictions.* They will have some error as long as the correlation coefficients on which they are based are not perfect (+1 or −1). Also, correlations cannot reveal any information regarding causation. Merely because two factors are correlated, it does not mean that one factor causes the other. Consider, for example, ice cream consumption and swimming pool use. These two variables are positively correlated with one another, in that as ice cream consumption increases, so does swimming pool use. But nobody would suggest that eating ice cream *causes* swimming, or vice versa. Similarly, just because LeBron James eats Wheaties and can do a slam dunk it does not mean that you will be able to do one if you eat the same breakfast. The only way to determine the *cause* of behavior is to conduct an experiment and analyze the results by using inferential statistics.

## Inferential Statistics

Knowing the descriptive statistics associated with different distributions, such as the mean and standard deviation, can enable us to make comparisons between various distributions. By making these comparisons, we may be able to observe whether one variable is related to another or whether one variable has a causal effect on another. When we design an experiment specifically to measure causal effects between two or more variables, we use *inferential statistics* to analyze the data collected. Although there are many inferential statistics, the one we will discuss is the t-test, since it is the simplest.

**TABLE A.10** **REACTION TIMES IN MILLISECONDS (MSEC) FOR PARTICIPANTS IN ALCOHOL AND NO ALCOHOL CONDITIONS AND COMPUTATION OF *t***

| RT (msec) Alcohol $X_1$ | RT (msec) No Alcohol $X_2$ |
|---|---|
| 200 | 143 |
| 210 | 137 |
| 140 | 179 |
| 160 | 184 |
| 180 | 156 |
| 187 | 132 |
| 196 | 176 |
| 198 | 148 |
| 140 | 125 |
| 159 | 120 |
| $SX_1 = 1{,}770$ | $SX_2 = 1{,}500$ |
| $N_1 = 10$ | $N_2 = 10$ |
| $\bar{X}_1 = 177$ | $\bar{X}_2 = 150$ |
| $s_1 = 24.25$ | $s_2 = 21.86$ |

$$\Sigma_{\bar{X}1} = \frac{s}{\sqrt{N_1 - 1}} = 8.08 \qquad \Sigma_{\bar{X}2} = \frac{s}{\sqrt{N_2 - 1}} = 7.29$$

$$S_{\bar{X}_1 - \bar{X}_2} = \sqrt{S_{\bar{X}_1}^2 + S_{\bar{X}_2}^2} = \sqrt{8.08^2 + 7.29^2} = 10.88$$

$$t = \frac{\bar{X}_1 - \bar{X}_2}{S_{\bar{X}1 - \bar{X}2}} = \frac{177 - 150}{10.88} = 2.48$$

$$t = 2.48, p < .05$$

*t-Test* Suppose we believe that drinking alcohol causes a person's reaction time to slow down. To test this hypothesis, we recruit 20 participants and separate them into two groups. We ask the participants in one group to drink a large glass of orange juice with one ounce of alcohol for every 100 pounds of body weight (e.g., a person weighing 150 pounds would get 1.5 ounces of alcohol). We ask the control group to drink an equivalent amount of orange juice with no alcohol added. Fifteen minutes after the drinks, we have each participant perform a reaction time test that consists of pushing a button as soon as a light is flashed. (The reaction time is the time between the onset of the light and the pressing of the button.) **Table A.10** shows the data from this hypothetical experiment. It is clear from the data that there is definitely a difference in the reaction times of the two groups: There is an obvious difference between the means. However, it is possible that this difference is due merely to chance. To determine whether the difference is real or due to chance, we can conduct a *t*-test. We have run a sample *t*-test in Table A.10.

The logic behind a *t*-test is relatively simple. In our experiment we have two samples. If each of these samples is from the *same* population (e.g., the population of all people, whether drunk or sober), then any difference between the samples will be due to chance. On the other hand, if the two samples are from *different* populations (e.g., the population of drunk individuals *and* the population of sober individuals), then the difference is a significant difference and not due to chance.

If there is a significant difference between the two samples, then the independent variable must have caused that difference. In our example, there is a significant difference between the alcohol and the no alcohol groups. We can tell this because $p$ (the probability that this $t$ value will occur by chance) is less than .05. To obtain the $p$, we need only look up the $t$ value in a statistical table, which is found in any statistics book. In our example, because there is a significant difference between the groups, we can reasonably conclude that the alcohol did cause a slower reaction time.

**TABLE A.8 COMPUTATION OF THE STANDARD DEVIATION FOR 10 IQ SCORES**

| IQ Scores $X$ | $X - \bar{X}$ | $(X - \bar{X})^2$ |
|---|---|---|
| 143 | 33 | 1089 |
| 127 | 17 | 289 |
| 116 | 6 | 36 |
| 98 | −12 | 144 |
| 85 | −25 | 625 |
| 107 | −3 | 9 |
| 106 | −4 | 16 |
| 98 | −12 | 144 |
| 104 | −6 | 36 |
| 116 | 6 | 36 |
| $\Sigma X = 1100$ | | $\Sigma(X - \bar{X})^2 = 2424$ |

$$\text{Standard Deviation} = s = \sqrt{\frac{\Sigma(X - \bar{X})^2}{N}} = \sqrt{\frac{2424}{10}}$$

$$= \sqrt{242.4} = 15.569$$

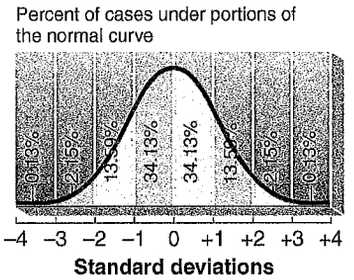



**FIGURE A.4 THE NORMAL DISTRIBUTION FORMS A BELL-SHAPED CURVE**

In a normal distribution, two-thirds of the scores lie between one standard deviation above and one standard deviation below the mean.

**Normal distribution** A symmetrical, bell-shaped curve that represents a set of data in which most scores occur in the middle of the possible range, with fewer and fewer scores near the extremes.

in **Figure A.4**. Distributions such as this are called **normal distributions**. In normal distributions, as shown in Figure A.4, approximately two-thirds of the scores fall within a range that is one standard deviation below the mean to one standard deviation above the mean. For example, the Wechsler IQ tests (see Chapter 7) have a mean of 100 and a standard deviation of 15. This means that approximately two-thirds of the people taking these tests will have scores between 85 and 115.

## Correlation

Suppose for a moment that you are sitting in the student union with a friend. To pass the time, you and your friend decide to play a game in which you try to guess the height of the next man who enters the union. The winner, the one whose guess is closest to the person's actual height, gets a piece of pie paid for by the loser. When it is your turn, what do you guess? If you're like most people, you'll probably try to estimate the mean of all the men in the union and use that as your guess. The mean is almost always our best guess when we have no other information.

Now let's change the game a little and add a friend who stands outside the union and weighs the next man who enters the union. If your friend texts you with the information that this man weighs 125 pounds, without seeing him would you still predict that he's of average height? Probably not. You'd most likely guess that he's below the mean. Why? Because you intuitively understand that there is a *correlation* (Chapter 1), a relationship, between height and weight, with tall people usually weighing more than short people. Given that 125 pounds is less than the average weight for men, you'll probably guess a less-than-average height. The statistic used to measure this type of relationship between two variables is called a correlation coefficient.

***Correlation Coefficient*** A *correlation coefficient* (Chapter 1), measures the relationship between two variables, such as height and weight or IQ and annual income. Given any two variables, there are three possible relationships between them: *positive, negative*, and *zero* (no relationship). A *positive relationship* exists when the two variables vary in the same direction (e.g., as height increases, weight normally also increases). A *negative relationship* occurs when the two variables vary in opposite directions (e.g., as temperatures go up, hot chocolate sales go down). There is a *zero*

**Mean** The arithmetic average of a distribution, which is obtained by adding the values of all the scores and dividing by the number of scores (N).

**Median** The halfway point in a set of data; half the scores fall above the median, and half fall below it.

**Mode** The score that occurs most frequently in a data set.

## Measures of Central Tendency

Statistics indicating the center of the distribution are called *measures of central tendency* and include the mean, median, and mode. They are all scores that are typical of the center of the distribution. The **mean** is the arithmetic average, and it is what most of us think of when we hear the word "average." The **median** is the middle score in a distribution—half the scores fall above it and half fall below it. The **mode** is the score that occurs most often.

***Mean*** What is your average exam score in your psychology class? What is the average yearly rainfall in your part of the country? What is the average reading test score in your city? When these questions ask for the average, they are really asking for the "mean." The arithmetic *mean* is the weighted average of all the raw scores, which is computed by totaling all the raw scores and then dividing that total by the number of scores added together. In statistical computation, the mean is represented by an *"X"* with a bar above it ($\overline{X}$, pronounced *"X* bar"), each individual raw score by an "X," and the total number of scores by an *"N."* For example, if we wanted to compute the $\overline{X}$ of the raw statistics test scores in Table A.1, we would sum all the *X*'s ($\Sigma$, with $\Sigma$ meaning sum) and divide by *N* (number of scores). In Table A.1, the sum of all the scores is equal to 3100 and there are 50 scores. Therefore, the mean of these scores is

$$\overline{X} = \frac{3100}{50} = 62$$

**Table A.5** illustrates how to calculate the mean for 10 IQ scores.

**TABLE A.5 COMPUTATION OF THE MEAN FOR 10 IQ SCORES**

| IQ Scores X |
|---|
| 143 |
| 127 |
| 116 |
| 98 |
| 85 |
| 107 |
| 106 |
| 98 |
| 104 |
| 116 |
| $\Sigma X = 1100$ |
| $\text{Mean} = \overline{X} = \frac{\Sigma X}{N} = \frac{1{,}100}{10} = 110$ |

***Median*** The *median* is the middle score in the distribution once all the scores have been arranged in rank order. If *N* (the number of scores) is odd, then there actually is a middle score and that middle score is the median. When *N* is even, there are two middle scores and the median is the mean of those two scores. **Table A.6** shows the computation of the median for two different sets of scores, one set with 15 scores and one with 10.

this data, making the frequency distribution much more difficult to understand than the raw data. If there are more than 20 possible scores, therefore, a *group frequency distribution* is normally used.

In a *group frequency distribution*, individual scores are represented as members of a group of scores or as a range of scores (see **Table A.4**). These groups are called *class intervals*. Grouping these scores makes it much easier to make sense out of the distribution, as you can see from the relative ease in understanding Table A.4 as compared to Table A.3. Group frequency distributions are easier to represent on a graph.

**TABLE A.4** GROUP FREQUENCY DISTRIBUTION OF PSYCHOLOGY APTITUDE TEST SCORES FOR 50 COLLEGE STUDENTS

| Class Interval | Frequency |
|---|---|
| 1300–1390 | 1 |
| 1200–1290 | 1 |
| 1100–1190 | 4 |
| 1000–1090 | 5 |
| 900–990 | 5 |
| 800–890 | 4 |
| 700–790 | 7 |
| 600–690 | 10 |
| 500–590 | 9 |
| 400–490 | 4 |
| Total | 50 |

When graphing data from frequency distributions, the class intervals are represented along the *abscissa* (the horizontal or $x$ axis). The frequency is represented along the *ordinate* (the vertical or $y$ axis). Information can be graphed in the form of a bar graph, called a *histogram*, or in the form of a point or line graph, called a *polygon*. **Figure A.1** shows a histogram presenting the data from Table A.4. Note that the class intervals are represented along the bottom line of the graph (the $x$ axis) and the height of the bars indicates the frequency in each class interval. Now look at **Figure A.2**. The information presented here is exactly the same as that in Figure A.1 but is represented in the form of a polygon rather than a histogram. Can you see how both graphs illustrate the same information? Even though graphs like these are quite common today, we have found that many students have never been formally taught how to read graphs, which is the topic of our next section.

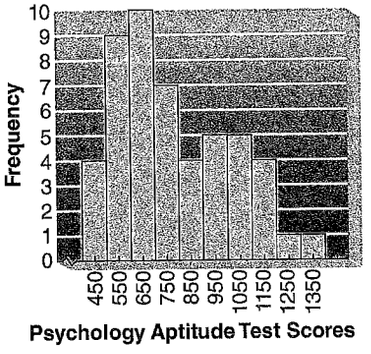



FIGURE A.1 A HISTOGRAM ILLUSTRATING THE INFORMATION FOUND IN TABLE A4

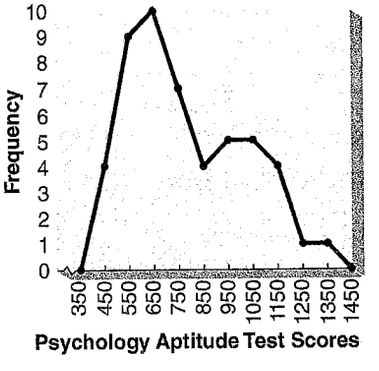



FIGURE A.2 A POLYGON ILLUSTRATING THE INFORMATION FOUND IN TABLE A4

factors that can assume more than one value and are therefore variables. Some will vary between people, such as sex (you are either male *or* female but not both at the same time). Some may even vary within one person, such as scores on a video game (the same person might get 10,000 points on one try and only 800 on another). Opposed to a variable, anything that remains the same and does not vary is called a *constant*. If researchers use only women in their research, then sex is a constant, not a variable.

In nonexperimental studies, variables can be factors that are merely observed through naturalistic observation or case studies, or they can be factors about which people are questioned in a test or survey. In experimental studies, the two major types of variables are independent and dependent variables.

*Independent variables* are those that are manipulated by the experimenter. For example, suppose we were to conduct a study to determine whether the sex of the debater influences the outcome of a debate. In this study, one group of participants watches a videotape of a debate between a man arguing the "pro" side and a woman arguing the "con"; another group watches the same debate, but with the pro and con roles reversed. In such a study, the form of the presentation viewed by each group (whether "pro" is argued by a man or a woman) is the independent variable because the experimenter manipulates the form of presentation seen by each group. Another example might be a study to determine whether a particular drug has any effect on a manual dexterity task. To study this question, we would administer the drug to one group and no drug to another. The independent variable would be the amount of drug given (some or none). The independent variable is particularly important when using *inferential statistics*, which we will discuss later.

The *dependent variable* is a factor that results from, or depends on, the independent variable. It is a measure of some outcome or, most commonly, a measure of the participants' behavior. In the debate example, each subject's choice of the winner of the debate would be the dependent variable. In the drug experiment, the dependent variable would be each subject's score on the manual dexterity task.

## Frequency Distributions

After conducting a study and obtaining measures of the variable(s) being studied, psychologists need to organize the data in a meaningful way. **Table A.1** presents test scores from a Math Aptitude Test collected from 50 college students. This information is called *raw data* because there is no order to the numbers. They are presented as they were collected and are therefore "raw."

The lack of order in raw data makes them difficult to study. Thus, the first step in understanding the results of an experiment is to impose some order on the raw data. There are several ways to do this. One of the simplest is to create a *frequency distribution*, which shows the number of times a score or event occurs. Although frequency distributions are helpful in several ways, the major advantages are that

**TABLE A.1 MATH APTITUDE TEST SCORES FOR 50 COLLEGE STUDENTS**

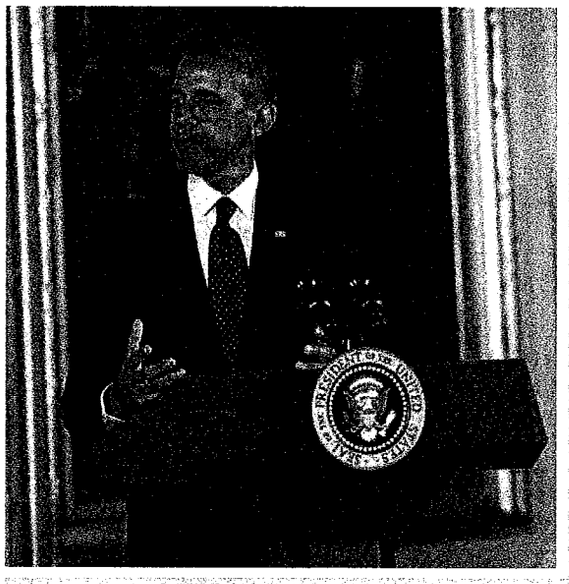
| | | | | |
|---|---|---|---|---|
| 73 | 57 | 63 | 59 | 50 |
| 72 | 66 | 50 | 67 | 51 |
| 63 | 59 | 65 | 62 | 65 |
| 62 | 72 | 64 | 73 | 66 |
| 61 | 68 | 62 | 68 | 63 |
| 59 | 61 | 72 | 63 | 52 |
| 59 | 58 | 57 | 68 | 57 |
| 64 | 56 | 65 | 59 | 60 |
| 50 | 62 | 68 | 54 | 63 |
| 52 | 62 | 70 | 60 | 68 |

## 2 MANAGEMENT PERSPECTIVE 464

- Recruitment begins with a **job analysis**, a detailed description of the tasks involved in a job, as well as the *KSAOs* an employee must possess to be successful on the job. Interviews are the most popular method of selection, and structured interviews are better predictors of job performance than unstructured interviews.
- Employee training typically begins with an orientation program. One of the major unstated goals of orientation is transmitting the **organizational culture**—the group's shared patterns of thought and action. **Performance evaluations**, the formal procedure an organization uses to assess the job performance of employees, can be objective or subjective. The subjective method is the most popular, but its efficiency is lessened by the **halo error** (the tendency to rate individuals too high or too low, based on one outstanding trait). To offset the halo error, some organizations use *360-degree multisource measures* and special rating scales.

## 3 WORKER PERSPECTIVE 470

- **Leadership** is the use of interpersonal influence to inspire or persuade others to support the goals and perform the tasks desired by the leader. According to the *trait approach*, or the **great-person theory**, leaders are born, not made. *Situational theorists* believe it is primarily the environment that produces leaders and that three major styles of leaders emerge at different times, according to the needs of the group: **autocratic (authoritarian)**, **democratic (participative)**, and **laissez-faire**. The *functional perspective* emphasizes the *behaviors* that contribute to the functioning of the group. Depending on the needs of the group, some people become **task-oriented leaders**, whereas others become **relationship-oriented leaders**.
- Researchers have identified five bases of a leader's power: **legitimate** (based on job title and position), **expert** (experience and expertise), **referent** (feelings of identification with another), **reward** (ability to give rewards for complying with desired behavior), and **coercive** (ability to use punishment, or the threat of it, for failure to comply with desired behavior).
- **Goal-setting theory** suggests that worker motivation is improved by having specific and difficult but attainable goals. **Equity theory** says workers are motivated if they perceive that their job inputs match the perceived rewards (outputs). **Expectancy theory** maintains that employees are motivated to work according to their expectancy of outcomes, the desirability of those outcomes, and the effort needed to achieve them.
- Job satisfaction is important to both employers and employees. Employers gain because they save money (lower absenteeism and fewer resignations) and increase productivity. Employees gain because they are under less stress, enjoy better physical health, and have improved overall quality and length of life.
- According to the **personality-job fit theory**, job satisfaction results from a match between personality and occupation.
- Organizational **communication** consists of eight elements: *senders and receivers*, *messages*, *encoding*, *decoding*, *channels*, *noise*, and *context*. Verbal communication is only part of the communication process.
- **Nonverbal communication** includes numerous elements, such as eye contact, clothing, physical appearance, facial expressions, gestures and body language (**kinesics**), physical and personal space (**proxemics**), and the pace, pitch, and volume of speech (**paralanguage**).
- The three keys to improved communication are *audience analysis*, *active/empathic listening*, and *feedback*.



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# applyingrealworldpsychology

We began this chapter with five intriguing Real World Psychology questions, and you were asked to revisit these questions at the end of each section. Questions like these have an important and lasting impact on all of our lives. See if you can answer these additional critical thinking questions related to real world examples.

1. Would you label President Obama's leadership style as autocratic, democratic, or laissez-faire? Explain.
2. Can you give an example of how he has used all five bases of power—legitimate, expert, referent, reward, and coercive?
3. Using examples in this chapter as a guide, do you think I/O psychology has an important role in business? Why or why not?
4. Imagine that you are the owner or top executive in a large company. How would you use information from this chapter to improve your company's profits and productivity?
5. What are the three most important lessons from this chapter that you want to remember and apply in the various leadership and managerial roles you play in the real world—as a family member, parent, worker, and student?

more details?" or "What do you think?" invites feedback on your communication and the opportunity to clarify any misperceptions. As a recipient of a communication, we have an equal responsibility to listen carefully and ask for clarification, if necessary.

*"All work and no play makes you a valued employee."*



## TIPS FOR EFFECTIVE FEEDBACK realworldpsychology

Ongoing feedback between sender and receiver, employer and employee, and business and customers is one of the most important components for success in today's global economy. Here are a few tips on giving useful feedback:

1. Be constructive, not destructive. Effective feedback helps people improve and build on their strengths; it should never weaken or demean them.

2. Emphasize specific, changeable behaviors. Saying "You're an idiot" after watching an employee mishandle a customer may accurately reflect the way you feel, but it is not effective feedback. To improve, recipients need specific details and examples of what they're doing wrong. In addition, feedback should focus on changeable behaviors—not general traits or uncontrollable situations.

   In this same situation, we can try saying, "When you make sarcastic comments to our customers, I get upset because it creates a negative impression that may hurt our business." Can you see how this feedback provides details about a specific behavior that can be changed?

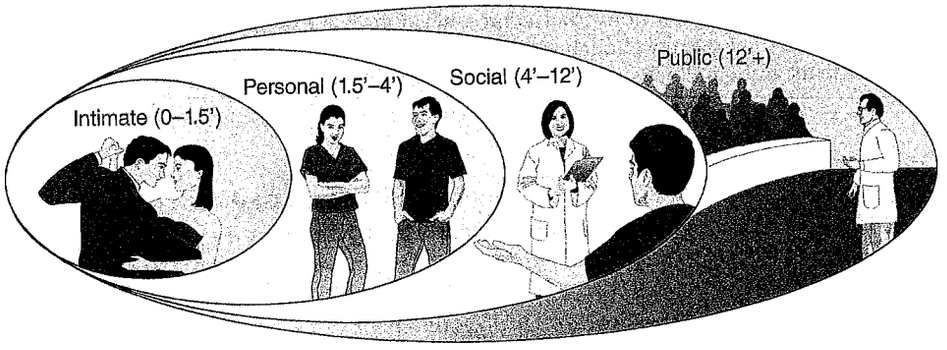
3. Focus on current behavior, not the past. Effective feedback emphasizes the here and now. Criticizing someone about something that happened in the past and can no longer be changed is almost always inappropriate and destructive. However, if a current problem is an extension or continuation of previous behaviors, this long-term pattern could be discussed along with present behaviors.

4. Avoid the four dirty words—should, ought, always, and never. Imagine yourself as an employee who hears "You should brush up on your people skills," "You ought to think before you speak," "You always let us down when we give you responsibility," or "You never come to work on time." Can you see why communication experts consider these four words "dirty words"? The first two seem patronizing and demeaning, and always and never invite defensive reactions.

5. Consider mindset and setting. What is the recipient's current listening mindset? Someone who is distracted, fatigued, or overwhelmed with work and personal crises cannot respond to even the best, and most perfectly worded, feedback. We need to be sensitive to what a person can handle and is ready to hear. Also, it's important to clarify that we're on the same team and genuinely interested in helping him or her succeed.

   Setting is also important. Giving feedback in public, especially negative feedback, can be embarrassing and force the receiver to go on the defensive to avoid public humiliation. When offering feedback, pick a private place that's conducive to good communication and assure the person that all feedback is confidential.

FIGURE 16.16 AVERAGE PREFERRED PERSONAL SPACES IN NORTH AMERICA




Choices about *personal space*—how close people stand or sit when communicating—also deliver important nonverbal messages. If you've traveled to other countries, you know that the amount of personal space people prefer varies from one culture to another. South Americans, for example, tend to stand closer to others than do people in North America. Anthropologist Edward Hall studied personal space among various cultures and determined that North Americans prefer four different "personal spaces," depending on the nature of the communication (Hall, 1969, 2008) **(Figure 16.16)**:

1. **Intimate distance (touching to about 18 inches apart)** This space is generally reserved for romantic partners, close family members, and intimate friends. Even then, we use this distance only in special situations, like comforting, embracing, or cuddling. If others intrude into this space, we tend to become tense and try to increase our distance from them.
2. **Personal distance (18 inches to about 4 feet)** We use this space during everyday conversations and interactions with friends and acquaintances.
3. **Social distance (4 to 12 feet)** We prefer this distance when we are having formal conversations with supervisors, coworkers, subordinates, customers, and other people we do not know well.
4. **Public distance (12 feet and beyond)** This distance is typically used for communication in formal lectures and speeches or large, formal business meetings.

**Paralanguage** A form of nonverbal communication that includes pace, pitch, volume, tone of voice and inflection.

Intruding too closely on these invisible zones can cause others to feel pressured, intimidated, defensive, or generally uncomfortable, whereas standing too far away may make them wonder whether we are angry with them or whether they have done something wrong. Of course, personal-space norms differ not only between cultures but also between men and women and between children and adults (Aliakbari et al., 2011; Bogovic et al., 2013; Knapp & Daly, 2011).

Jim Davis/The Boston Globe/Getty Images

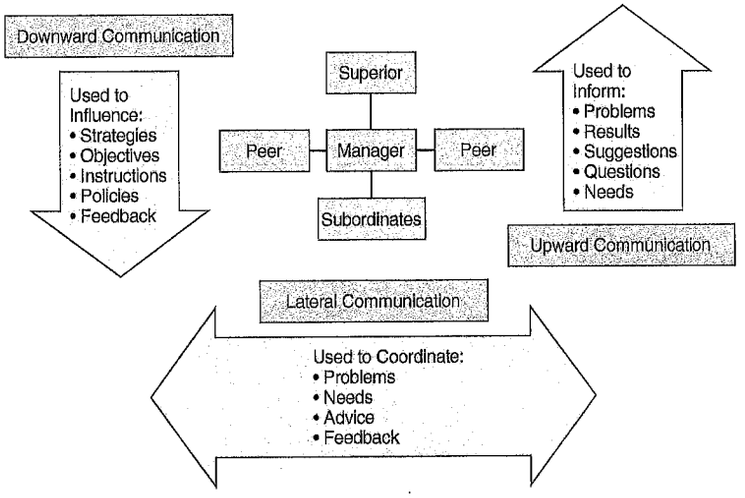
**Gender Differences in Nonverbal Communication**
In our North American culture, males are socialized toward little or no touching between men. But in certain situations, like sports, they are free to touch, hug, and be openly emotional.

***Paralanguage: The Way Words Are Spoken*** The third major element of nonverbal communication, **paralanguage**, includes the pace, pitch, and volume at which words are spoken and the tone of voice and inflections the speaker uses. Research has shown that only about 7% of the meaning of the average verbal communication is contained in the words themselves, while approximately 38% is contained in the paralanguage (Hammal, 2011; Mehrabian, 1968).

Think about how your friend's or employer's subtle inflection, or tone of voice, affects the way you perceive his or her messages. A subtle increase in pitch at the end of a sentence can imply a question, but also nervousness or insecurity. "I think everything is going to turn out okay, don't you?" Contrast this to a sharp drop in pitch, along with an increase in volume and a firmer tone at the end of the same sentence. "I think everything is going to turn out okay, don't you!" Similarly, telling

**FIGURE 16.14 ORGANIZATIONAL INFORMATION**

To serve customers in the modern workplace, organizations must quickly communicate downward, upward, and laterally with workers and across departmental or functional boundaries. Lateral communication is generally the most efficient method because it frequently skips levels in the hierarchy and helps maintain open communication--thus avoiding the "red tape" that often limits formal communication. (Adapted from Schermerhorn et al., 2010)




8. **Context** The environmental conditions surrounding communication make up the *context*. These include the *physical setting* (private or public, time of day, seating arrangements), *relationship issues* (employer/employee, husband/wife, previous interactions, unresolved conflicts), *psychological climate* (current moods and attitudes, the way we feel about ourselves and the sender or receiver), and *sociocultural factors* (previous socialization, ethnic backgrounds, cultural beliefs and practices).

Given all the factors that affect even a simple communication, it is amazing that we communicate as well as we do. Any one of the eight elements can interfere with our messages, and even the best communicators often admit that they have to continuously work at communicating. But, with practice, anyone can improve his or her communication skills (Banihashemi, 2011; Dunn & Goodnight, 2014). Being aware of these eight elements in the communication process is a good starting point.

## Nonverbal Communication

As we all know, verbal communication is only part of the communication process. It's also important to consider the messages we communicate nonverbally. **Nonverbal communication** is the process of sending and receiving messages through means other than words. It includes numerous elements, such as eye contact, clothing, physical appearance, facial expressions, *kinesics* (gestures and body language), *proxemics* (the way people use space in communicating), and *paralanguage* (the pace, pitch, and volume of speech). Simply stated, nonverbal communication is all aspects of the message except for the literal meaning of the words used.

**Nonverbal communication** The process of sending and receiving messages through means other than words.

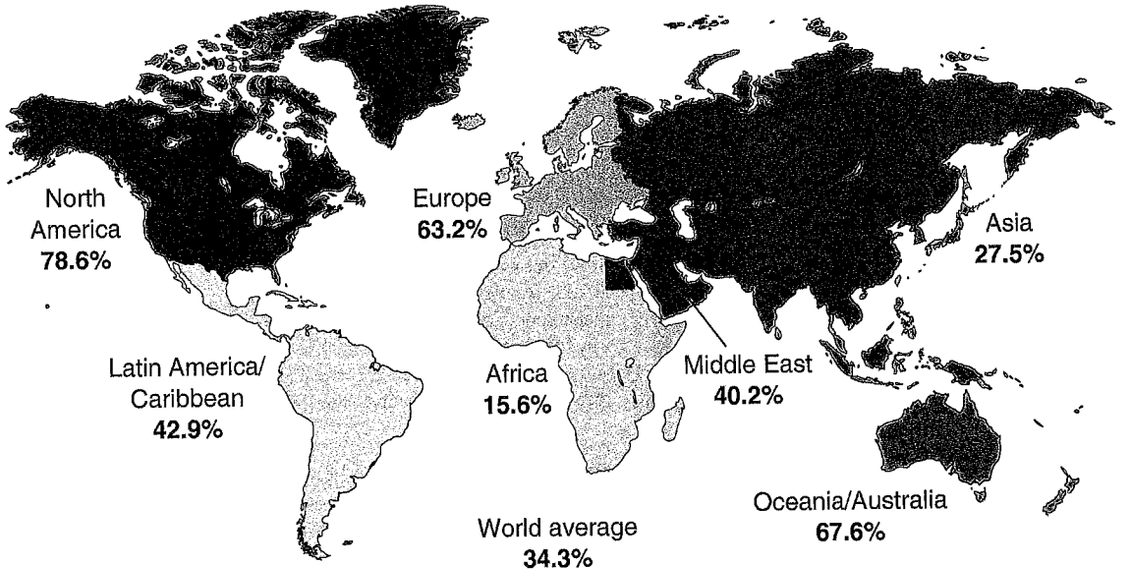
In earlier chapters, we discussed several theories and concepts related to the importance of eye contact and facial expressions in communication. Therefore, in this section we will focus our discussion on *kinesics*, *proxemics*, and *paralanguage*.

***Kinesics: Body Language and Gestures*** To get along with others or to do business in another culture, we obviously must learn the appropriate **kinesics**, meaning the body language and gestures of that culture. Even if we're fluent in the verbal language of the culture, if we don't understand or ignore kinesics, we'll miss a great deal of the meaning of the communication—while also running the risk of appearing foolish or ignorant or even giving offense. For example, upon

**Kinesics** A form of nonverbal communication using the body language and gestures of a particular culture.

**FIGURE 16.12 WORLDWIDE USE OF THE INTERNET**

Note the large discrepancies in the numbers of Internet users in various regions of the world. Some have suggested that Internet dominance is a form of "media imperialism" that threatens other national cultures and identity. What do you think?




*Source*: Based on Internet World Stats: www.internetworldstats.com/stats.htm. Copyright © 2001–2013, Miniwatts Marketing Group. All rights reserved worldwide.

Yellow Dog/The Image Bank/Getty Images

**Communication in the Global Economy**
Technological advances allow instant communication for people who not long ago were isolated from events in the rest of the world. How do you think technological changes affect these people?

## The Communication Process

Although many people think of communication as a simple one-way flow from the sender to the receiver, experience teaches us that it is often a complex, dynamic event in which miscommunication and misunderstandings can lead to disastrous results. For example, an ad for men's cologne that featured a pastoral scene with a man and his dog failed in Islamic countries because dogs are considered unclean. Similarly, staff unloading boxes in an African port saw the "internationally recognized" symbol for "fragile," which is a broken wine glass, and presumed all the contents were broken and threw all the boxes into the ocean (Cross Cultural Marketing Blunders, 2013).

Similar mistakes occur using social media outlets. For example, an employee of Apple was fired after updating his Facebook status to read "Apple sucks, bro!!!!!!" The spokesperson for insurance giant Aflac was fired after making tasteless jokes on Twitter about a tsunami in Japan. And an employee under contract with Chrysler was immediately fired for "dropping the f-bomb." He thought he was tweeting from his private account, but it turned out not to be as private as he thought (Burnett, 2011).

On a simpler level, some of the newer devices on "smart" phones that "autocorrect" text messages can lead to interesting exchanges like the one below:

Texter A: I'm going to take a howler

Texter B: The moon isn't full

Texter A: Lol shower!!!

Texter A: Sry I was teething

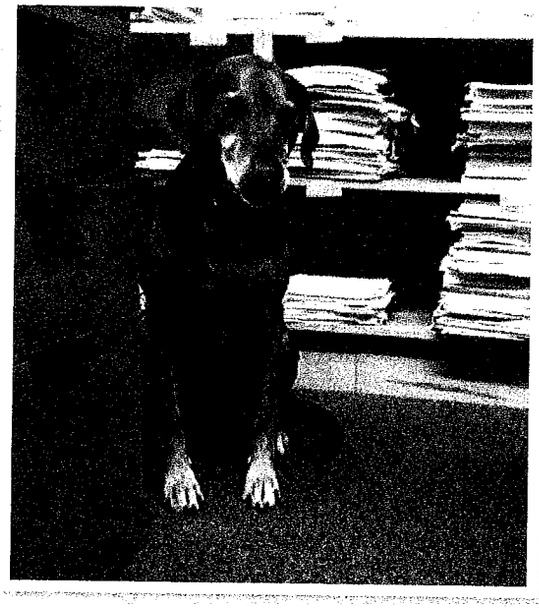
Texter B: Teething?

Tester B: Dang it, I meant tweeting. Stupid auto correct

How can we prevent communication disasters? As illustrated in **Figure 16.13**, we first must recognize that there are at least eight important elements in all communication.

**FIGURE 16.11 BRING YOUR PET TO WORK?**

Can you see how the job perk of bringing your dog to work might appeal to many employees? It certainly increases the job satisfaction of one of your authors, Catherine Sanderson, who's dog "Hobey" is pictured here in her college office.



courtesy Catherine Sanderson

## Benefits to Management and Employees

Workers obviously prefer jobs that are rewarding and satisfying. But why should managers or business owners care whether their employees are satisfied? Research has uncovered several reasons (Dalal & Crede, 2013; Jain & Jain, 2013; Swider et al., 2011):

1. **Decreased absenteeism and resignations** Dissatisfied workers are more likely to resign or be absent from work. Replacing employees is expensive, and absenteeism is one of the highest expenses for employers.
2. **Less stress and improved health** Job satisfaction carries over to the employee's life inside and outside the office—the *spillover hypothesis*. For example, studies show that satisfied workers have less stress, less burnout, and better physical and psychological health (Laaksonen et al., 2012; Landy & Conte, 2013). A study on physical health found that women with more stress at work are 67% times more likely to experience a heart attack than women with lower work stress (Slopen et al., 2012). On a lighter note, research finds that people who bring their dogs to work experience greater job satisfaction and lower levels of stress (Barker et al., 2012) **(Figure 16.11)**.
3. **Increased productivity** Research shows that job satisfaction almost always leads to increased productivity. In the retail sector, worker satisfaction is also associated with higher levels of customer satisfaction in stores and an increased number of customers who intend to purchase (Evanschitzky et al., 2010; Merrill et al., 2013).
4. **Improved organizational citizenship behavior** Behavior that goes beyond the formal job requirements and is beneficial to the organization is referred to as **Organizational citizenship behavior (OCB)**. Examples include helping another employee or supervisor (even when doing so is not required), making innovative suggestions for improvement, and doing more than is required.

**Organizational citizenship behavior (OCB)** Actions that go beyond formal job requirements and are beneficial to an organization.

## Personality/Job Factors

Now that we know job satisfaction is important to both employer and employee, how do we discover what creates it? One of the most interesting and influential answers comes from John Holland (1964, 1985, 1994). According to his **personality–job fit theory**, a match (or a "good fit") between a person's personality and occupation is a major factor.

**Personality–job fit theory** The theory that job satisfaction is determined by a "good fit" between personality type and occupation.

Holland developed a *Self-Directed Search* questionnaire that scores people on six personality types and then matches them with various occupations. The resulting

imbalance occurs, we will adjust our input, output, or psychological perceptions (Choi, 2011; Hysom & Fisek, 2011; Lambert, 2011; Moghaddam, 2008; Schmidt et al., 2013).

According to equity theory, in our search for balance, we begin by comparing our contributions, job rewards, and compensations to those of our coworkers, friends, neighbors, and colleagues in other organizations. If we perceive that our *job input* (contributions) matches our *job outcome* (rewards), we are happy because there is a state of balance, or *equity*. On the other hand, if we detect an imbalance—say, if we're giving more than we're getting in return—we may adjust our input by decreasing our efforts or quitting. We also may seek to increase our output by asking for more pay or other compensations. Or we can adjust our perceptions by focusing on other compensations, such as time off, ease of work, and work friendships.

Note that *actual* equity is less important than *perceived* equity. As a supervisor, you may have overwhelming objective evidence that workers are being treated equitably. However, if your employees *perceive* that they are being short-changed, they may decrease their input, increase their requests for output, or adjust their perceptions. In addition, people who believe they are paid less than their peers with the same job experience report lower levels of work satisfaction (Pérez-Asenjo, 2010). This finding has important implications for human resource managers when they set and negotiate salaries. Q5

Obviously, it's important for supervisors to communicate effectively with employees and to understand how they perceive the situation. But an accurate perception of equity is sometimes difficult to achieve and maintain. Huseman and Hatfield (1989) have offered three explanations for these difficulties:

1. **Wrong psychological currency** We tend to give people what *we* would like to get, or what we *think* they want, rather than what *they* really want. For example, supervisors may give their employees more money despite repeated requests for more job flexibility. This can leave both supervisors and workers feeling frustrated and resentful.
2. **Trust bankruptcy** Many workers do not trust others because they've been "burned" by broken promises in the past.
3. **Hidden expectations** Our desires and expectations are often unspoken or poorly communicated, yet we still expect others to satisfy them.

## THE IMPORTANCE OF EQUITY realworldpsychology

Are you an employer, a parent, or a partner who wants to increase the perceived equity in your relationships with others? If so, try Huseman and Hatfield's (1989) five-step model, the *equity power paradigm*:

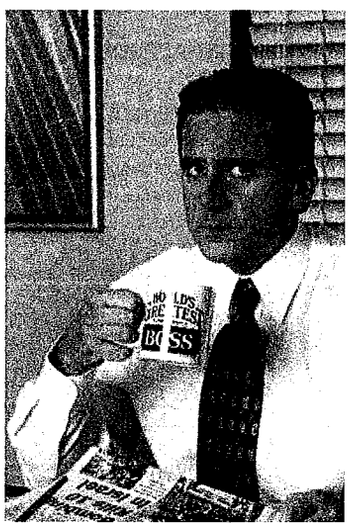
1. **Perspective** Work to understand the perceptions of others and to communicate your own perspective before problems arise.
2. **Positive expectations** Let others know you have high expectations and confidence in them.
3. **Goal setting** Provide specific challenging but attainable goals.
4. **Performance feedback** Offer regular evaluation and feedback—especially constructive, positive suggestions.
5. **Rewards** Provide important and frequent rewards for appropriate behaviors.

**Expectancy theory** A cognitive theory of work motivation which proposes that workers are motivated by the expectancy of outcomes, their desirability, and the effort needed to achieve them.

### Expectancy

One of the oldest and most popular theories of worker motivation is Vroom's (1964, 1994) **expectancy theory** (Aamodt, 2013; Pousa & Mathieu, 2010; Vroom, 1964). This theory suggests that workers perform in line with their *expectancy* of outcomes, the *desirability* of those outcomes, and the *effort* needed to achieve them (Abadi et al., 2011; De Clercq et al., 2011; Zaniboni et al., 2011).

**Legitimate Power?**
Michael Scott (played by actor Steve Carell), was the official boss in the TV series, *The Office*. However, his employees obviously did not respect the title, which gave him little or no power.



NBC/Getty Images

**Legitimate power** Authority based on a job title or position (president, police officer).

**Expert power** Authority based on experience and expertise (physician, lawyer).

**Referent power** Authority derived from identification with another (movie stars, athletes, friends).

**Reward power** Authority based on the ability to give or promise rewards.

## Power

In addition to studying various styles and gender differences in leadership, researchers also have attempted to identify various sources of power among leaders and explain how a leader's use of power affects subordinates. French and Raven (1959) identified five important bases of leader power **(Table 16.1)**:

1. **Legitimate power** comes with a job title or position. It is also often accompanied by the allocation of prime physical space. Have you noticed that the president or CEO of a company almost always has the biggest office, the largest desk, and the best view? Legitimate power is valid, however, only so far as employees respect the job title, accept the authority that comes with it, and fear some form of punishment if they fail to obey the leader's directives.
2. **Expert power** is derived from a leader's experience and expertise. Physicians, lawyers, programmers, and plumbers have power because of their knowledge of their respective fields. People recognized as experts in an area crucial to a company's functioning may wield far more power than those whose power comes from a job title. Many managers have learned, to their dismay, how much expert power an administrative assistant has when he or she isn't there to keep everything running smoothly. In many organizations, it's a standing joke that the most powerful person is the computer or copy-machine repair person.
3. **Referent power** comes from our feelings of identification with another. We "refer to" the source of referent power for direction and leadership. Because certain professional athletes and movie stars are admired by thousands of fans who want to be like them, advertisers frequently pay these figures huge sums of money to endorse their products.

   In the workplace, referent power typically depends on how much subordinates like the supervisor. Taking time to develop close, supportive personal relationships with subordinates generally increases referent power.
4. **Reward power** is power based on the ability to give rewards for complying with desired behavior. Business leaders give promotions, pay raises, bonuses, and the like for compliance with their directives.

   Reward power often increases as a leader's legitimate power increases. For example, an executive vice president generally has more reward power than a

**TABLE 16.1 FIVE BASES OF SOCIAL POWER**

| Base of Power | Description |
|---|---|
| Legitimate power | Based on a job title or position (president, senator, mayor) |
| Expert power | Based on experience and expertise (physician, teacher, lawyer) |
| Referent power | Based on feelings of identification with another (movie stars, athletes, friends) |
| Reward power | Based on ability to give rewards for complying with desired behavior (teacher awarding good grades, supervisor giving promotions) |
| Coercive power | Based on ability to use punishment, or the threat of it, for failure to comply with desired behavior (teacher assigning bad grades, supervisor firing a worker) |

Frazer Harrison/Getty Images, Inc.

**Power and Advertising**
Using the five bases of power in this table, can you identify the type of power on display in this photo?

work will be accomplished, which, in turn, increases both efficiency and job satisfaction (Kopelman et al., 2010; Russ, 2013; Weisbord, 2011).

Can you see that democratic, participative leaders more often have a Theory Y philosophy? They use this approach to empower workers and make them feel valued. They also tend to be more people oriented than autocratic leaders and appreciate the ideas and opinions of their subordinates. Democratic leadership is generally viewed as more appropriate than the autocratic style for skilled, career-oriented workers because it takes advantage of their training and expertise.

**Laissez-faire leader** A leader whose leadership style features minimal involvement in the decision-making process; such a leader encourages worker to self-manage.

3. In comparison to autocratic and democratic leaders, **laissez-faire leaders** work best in groups requiring little or no management. These leaders are minimally involved in decision making; they encourage workers to make their own decisions and manage themselves. (*Laissez-faire* literally means "to leave alone.") Laissez-faire leaders believe in hiring the right people and then trusting them to do the job right. They see themselves as facilitators whose primary function is to coordinate the efforts of their subordinates. Management at Google reportedly take this approach.

The laissez-faire approach is generally most effective with mature, professional, career-oriented workers who are highly disciplined self-starters. The freedom of action they enjoy under this approach can be highly motivating, and employees can fully use their creativity and imagination to accomplish work-related goals. The major drawback is that some workers may abuse the freedom. Also, the structure of some groups or situations requires active leadership. Consider what would happen if a college instructor allowed all students to confer about what material should be assigned, what books to read, how work would be graded, and when to meet. Can you imagine the chaos?

Which one of these leadership styles works best around the world? Effective leaders and managers may sometimes use all three approaches, depending on the situation and the subordinates with whom they are working (Day & Antonakis, 2012; Hogg, 2013; Limbare & Kochargaonkar, 2013). For example, new workers tend to appreciate leaders who assign them to clear, structured tasks, whereas expert workers do not respond as well to directive leadership.

Courtesy Zoological Society of San Diego

realworldpsychology **Work Groups and the San Diego Zoo**

When the San Diego Zoo reorganized animal exhibits into separate, cage-free areas that resemble natural habitats, employees formed teams that assumed responsibility for operating and maintaining these exhibits. For example, the Tiger River exhibit pictured here is self-managed by a team of horticulturists, mammal and bird specialists, and maintenance and construction workers. Do you think this arrangement reflects an autocratic, democratic, or laissez-faire type of leadership style?

## Functional Perspective

As you've just seen, the *trait approach* to leadership focuses on an individual's inherited personality traits, whereas the *situational perspective* emphasizes the environment, which gives rise to *autocratic*, *democratic*, and *laissez-faire* leaders. The third perspective, the *functional approach*, suggests that certain individuals become leaders because they contribute to group needs or functioning.

**Task-oriented leader** A leader whose leadership style is characterized by direct assistance with group tasks to help reach a particular goal.

**Relationship-oriented leader** A leader whose leadership style is to seek to maintain group morale, satisfaction, and motivation.

Most groups need two types of leaders to function well—*task oriented* and *relationship oriented*. When groups meet to complete a task or reach a particular goal, they need someone to keep the group focused on the problem or question, offer new or fresh ideas, elaborate on the ideas of others, and summarize the proceedings. The person who performs these functions is a **task-oriented leader**. Conversely, someone who helps maintain group morale, satisfaction, and motivation is a **relationship-oriented leader**.

The surprising part came when later research found that antisocial traits, such as superficial charm and disregard for others, or narcissistic traits like a need to be admired, were correlated with higher salaries and higher career achievements (Wille et al., 2013)! If you wonder about these findings, think about the top leaders of Enron, which collapsed in scandal, or Bernie Madoff and his enormously successful Ponzi scheme. Obviously, we're not promoting these traits as a way to succeed in business! They bring great harm to our society. However, science does sometimes reveal startling results, requiring us to apply our critical thinking skills.

On a different, but related, note, *Psych Science* describes how particular personality traits may predict job performance in U.S. presidents.

### Situational Perspective

As we've just seen, the trait perspective suggests that leaders are born, not made. In contrast, situational theorists believe it is primarily the environment that produces leaders. Specific people emerge as leaders because they have the skills, knowledge, and personal traits most valued in a particular situation and at a particular point in history. They are simply the right person, in the right place, at the right time.

PSYCHSCIENCE

## PERSONALITY AND PRESIDENTIAL LEADERSHIP

**Are there specific personality traits that predict who will become** a "good" or "bad" president? Interested researchers studied personality assessments of 42 previous presidents made by biographers, journalists, and presidential scholars (Lilienfield et al., 2012). They first evaluated their target presidents using standardized psychological measures of personality, intelligence, and behavior. Next, they gathered data from two large surveys of presidential historians, which ranked the presidents on different aspects of job performance. Their findings revealed that certain personality traits did predict better presidential performance, not only in terms of leadership but also on measures of persuasiveness, crisis management, and interactions with Congress.

The personality trait "fearless dominance" was one of the strongest predictors of presidential performance. This may reflect the fact that people high on this trait are less apprehensive overall and better able to show skillful leadership in the face of crisis. Which presidents scored highest on this trait? Theodore Roosevelt ranked first, followed, in order, by John F. Kennedy, Franklin D. Roosevelt, Ronald Reagan, Rutherford Hayes, Zachary Taylor, Bill Clinton, Martin Van Buren, Andrew Jackson, and George W. Bush. (President Barack Obama was not evaluated.)

Can you imagine how fearless dominance may also predict better job performance in other professions, like business, sports, and the military?

### RESEARCH CHALLENGE

1. Based on the information provided, did this study (Lilienfeld et al., 2012) use descriptive, correlational, and/or experimental research?
2. If you chose:
   - descriptive research, is this a naturalistic observation, survey/interview, case study, or archival research?
   - correlational research, is this a positive, negative, or zero correlation?
   - experimental research, label the IV, DV, experimental group(s), and control group.

**>> CHECK YOUR ANSWERS IN APPENDIX B.**

NOTE: The information provided in this study is admittedly limited, but the level of detail is similar to what is presented in most textbooks and public reports of research findings. Answering these questions, and then comparing your answers to those in the Appendix, will help you become a better critical thinker and consumer of scientific research.

# WORKER PERSPECTIVE

**LEARNING OBJECTIVES**

RETRIEVAL PRACTICE While reading the upcoming sections, respond to each Learning Objective in your own words. Then compare your responses with those found at www.wiley.com/college/huffman.

1. **DESCRIBE** leadership and its three major perspectives.
2. **IDENTIFY** the five key bases of a leader's power.
3. **DESCRIBE** the three major theories on worker motivation.
4. **EXPLAIN** why job satisfaction is important.
5. **SUMMARIZE** the key elements of organizational communication.

**Organizational psychology** A branch of the I/O field of psychology that focuses on the employee within the social context of the workplace.

When it comes to work, most people are social animals—they generally prefer to work with others. **Organizational psychology** focuses on the individual employee within the social context of the workplace (Griffin & Moorhead, 2012). In this section, we explore five topics of special interest to organizational psychologists: *leadership*, *power*, *worker motivation*, *job satisfaction*, and *communication*.

## Leadership

Think back to your past jobs and favorite college instructors. Did you work harder for leaders who inspired you, set a good example, performed their jobs competently, and didn't abuse their power? Industrial/organizational psychologists are particularly interested in leadership and power in the workplace because they greatly affect worker productivity, which in turn is linked to corporate profits.

**Leadership** The process of using interpersonal influence to inspire or persuade others to support the goals and perform the tasks desired by the leader.

What is **leadership**? One of the most widely accepted definitions is *the use of interpersonal influence to inspire or persuade others to support the goals and perform the tasks desired by the leader* (Chrobot-Mason et al., 2013; Day & Antonakis, 2012). Leaders can be *informal* or *formal*. Each member of our families may assume an informal leadership role at various times or for different tasks and activities. However, larger groups, such as colleges, government agencies, and corporations, tend to have more formalized leadership structures. As shown in **Figure 16.8**, leadership in large groups often relies on a clearly defined chain of command, with

**FIGURE 16.8 A FORMALIZED LEADERSHIP STRUCTURE**

This is a greatly simplified version of a typical university's bureaucratic structure, which may help you understand the chain of command at your college or university.

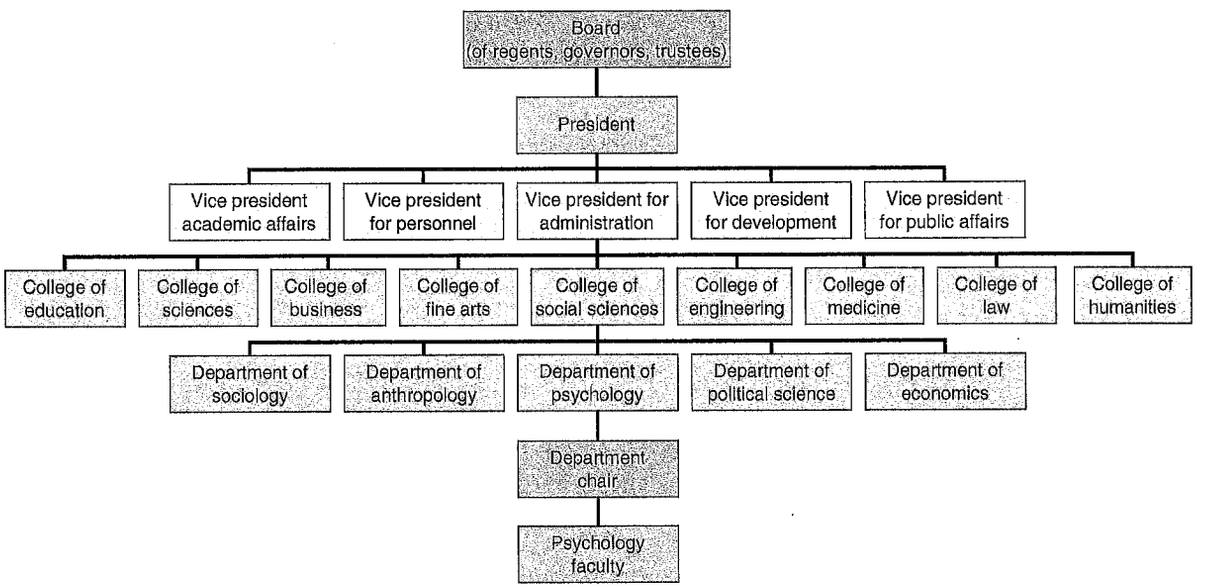
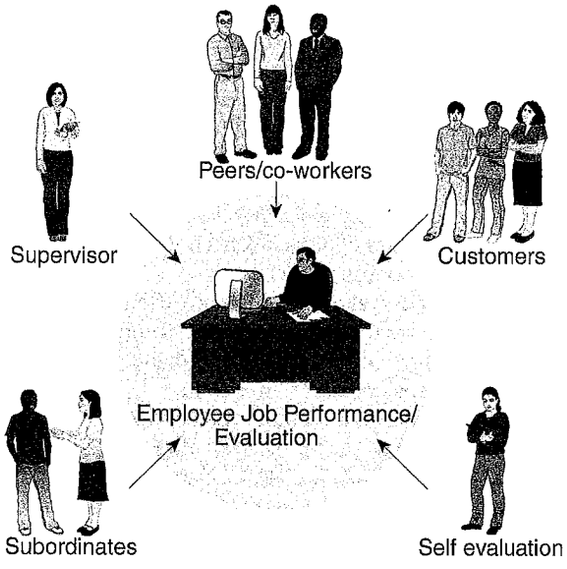


**FIGURE 16.6 360-DEGREE PERFORMANCE EVALUATION**

These multisource evaluations allow everyone who is affected by an employee to have input into his or her performance evaluation. They also provide valuable feedback to both the employee and employer.



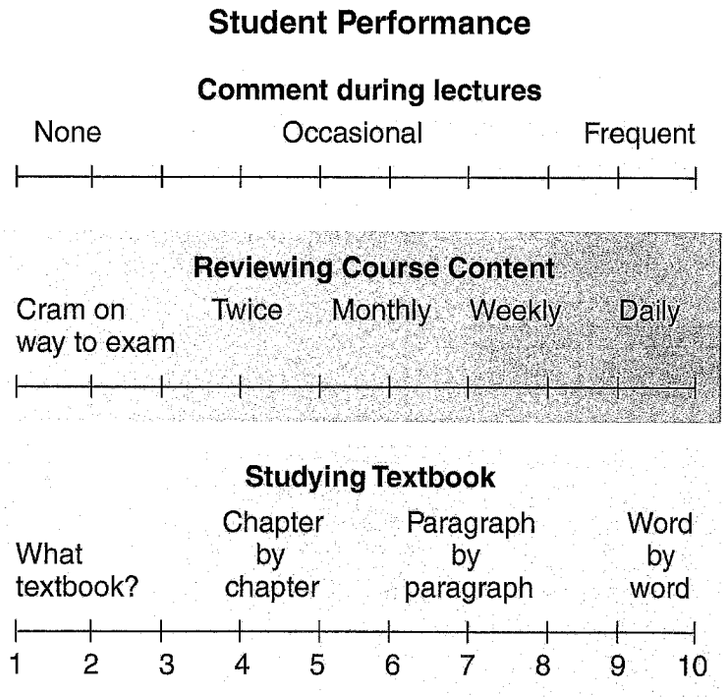

In response to potential errors with subjective evaluations, some organizations use "360-degree" performance evaluations (Doherty & Brodsky, 2011; Massingham et al., 2011; Rai & Singh, 2013). These evaluations gather multiple ratings from supervisors, peers, subordinates, and even customers **(Figure 16.6)**.

To further offset potential biases, organizations can also use specially designed *rating scales*, with which the supervisor evaluates an employee in certain critical areas by assigning a numerical rating. As **Figure 16.7** shows, your job as a student could be evaluated with this type of rating scale. The idea is that raters will be more accurate if they focus on specific *behaviors* rather than *traits* such as friendliness.

Although rating scales are helpful, they also have drawbacks. As you know, some college instructors can be hard graders, while others may be easy. Supervisors

**FIGURE 16.7 A POSSIBLE RATING SCALE FOR STUDENTS**

How would you score on this rating scale? Would you like this kind of performance evaluation, or do you prefer the traditional rating scale, known as "grades"?



### Head

- Keep your eyes focused on the interviewer without staring. Averting your gaze makes you seem less certain, less trustworthy, and less truthful.
- Occasionally smile during both questions and answers.

### Shoulders

- Keep your back straight, head up, arms at your side, and hands clasped below your waist.
- Minimize hand movements and keep them below shoulder level.
- When making an emphatic point, lean forward slightly.

### Knees and Toes

- Sit with your feet flat on the floor. If legs are crossed, it should be at the ankles and underneath the chair.
- If the interview is conducted while you are walking or standing, try not to shift your weight or rock back and forth.

One final point about recruitment and selection. Have you ever wondered whether posting photos of your latest wild party on Facebook or having an e-mail address like "luvs2party" might negatively affect your career options? If so, the answer is YES! Many organizations do consider informal information about job candidates found in social media, such as Facebook and Twitter, during hiring and promotion.

One study of employers from seven different industries—information technology, health care and wellness, education, law enforcement, food and drink, travel, and advertising—found that employers review Facebook profiles of job candidates to screen out weaker candidates based on their photographs and postings (de la Llama et al., 2012). Some medical schools also use social media information to gather additional information about applicants (Schulman et al., 2013). The message is clear: Never post anything that you wouldn't want a current or future employer to see!


Kelly Kincaid / CartoonStock.com

## Training and Evaluation

After applicants have been tested and interviewed and the best candidate hired, I/O psychologists often help train new employees in the knowledge and skills for the assigned job. This type of training helps reduce employee turnover and decreases frustration and stress for both employer and employee (Brown & Sitzmann, 2011; Kraiger & Culbertson, 2013).

Training typically begins with some form of *orientation*. Just as you may have had a college orientation designed to introduce you to the educational organization, new employees are normally given either a formal or an informal introduction to the business setting. If you attend a workplace orientation, pay close attention. It's designed to "clue in" new employees to the company's organizational structure and operations, as well as appropriate attitudes and allegiances.

Organizations typically develop characteristic attitudes toward diversity, creativity, attention to detail, team versus individual orientation, and stability versus innovation (Jacobs et al., 2013; Korte & Lin, 2013; Ray & Goppelt, 2011). Fitting into an organization means fitting into its **organizational culture**. How well you fit largely determines your job success.

**Organizational culture** A group's shared pattern of thought and action; common perception held by the organization's members.

I/O psychologists also help train and upgrade the skills of new and existing employees. These skills training sessions can be technical and highly job specific. You might be taught how to sell or service the company's product or how to operate the communication system. Training also may be provided on interpersonal skills like effective listening, communicating, and being a "team player." After orientation and skills training, employees are placed in jobs that best match their skills.

# MANAGEMENT PERSPECTIVE

LEARNING OBJECTIVES

RETRIEVAL PRACTICE While reading the upcoming sections, respond to each Learning Objective in your own words. Then compare your responses with those found at www.wiley.com/college/huffman.

1 **WHAT** does I/O psychology contribute to employee recruitment and selection?
2 **EXPLAIN** why I/O methods are useful for employee recruitment and selection.
3 **DISCUSS** how I/O psychology helps with worker training and evaluation.

Did you know that during your lifetime, you will spend more time at work than at any other single activity—with the possible exception of sleeping? Obviously, your career choice is vitally important to your long-term success and happiness. And just as you need an enjoyable career that makes the most of your skills, business and industry need employees who have the right level of skills and motivation to maximize productivity.

Finding "the right person for the right job" is a major component of the industrial branch of I/O psychology. In this section, we will discuss I/O's role in recruitment, selection, on-the-job training, and performance evaluation.

## Recruitment and Selection

**Job analysis** A detailed description of the tasks involved in a job, as well as the knowledge, skills, abilities, and other personal characteristics (KSAOs) a successful employee must possess.

The first step in finding the right person for a job is to carefully define the job itself. A well-done **job analysis** provides information about the tasks performed in a job. It also includes the KSAOs an employee must possess to be successful on the job. (The letters stand for **K**nowledge, **S**kills, **A**bilities, and **O**ther personal characteristics.) When the job responsibilities and KSAOs are carefully defined and specified in advance, both the applicant and the employer can be more efficient in their search (Krumn & Hertel, 2013; Ployhart & Moliterno, 2011).

**FIGURE 16.3 ONLINE RECRUITMENT**

Modern employers and applicants increasingly turn to the Internet for job announcements and job searches.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Can you imagine what the job analysis would be for a typical college instructor? Although the KSAOs vary by academic discipline (psychology, math, physical education), almost all instructors share similar tasks: teaching assigned classes, maintaining required office hours, preparing and grading exams and projects, attending department meetings, and serving on college committees. In addition, many colleges and universities expect professors to conduct research and publish in professional journals. Therefore, if a college wanted to hire a new instructor, it would begin with a job analysis based on the expected tasks of the job, followed by the recruitment of candidates.

For some jobs, it is relatively easy to recruit applicants because there is an abundant supply of suitable people, and organizations need only post position announcements on their own website or on sites like Monster.com, LinkedIn, or CareerBuilder **(Figure 16.3)**. When there is an undersupply of qualified applicants, the organization may require the full-time efforts of one or more recruiters.

laboratory simulation of an actual streetcar. This research allowed Munsterberg to develop selection criteria and training procedures that eventually led to the employment of better streetcar operators (Landy & Conte, 2013; Schmitt et al., 2013).

## I/O Psychology and World War I

Scott, Taylor, and Munsterberg all demonstrated the value of applying psychology in the workplace. However, for many people in industry, it took World War I to give I/O psychology real respectability (Salas et al., 2007; Vinchur & Koppes, 2011). At the beginning of the war, the American Psychological Association (APA), led by its president Robert Yerkes, approached Army officials and proposed that psychological testing be used to evaluate the mental ability of recruits. The results could then help establish criteria for assigning recruits to appropriate military jobs.

The Army agreed. Yerkes and a group of psychologists were assigned to develop the first group intelligence test, the *Army Alpha*. Finding that approximately 30% of the World War I recruits were functionally illiterate, they later developed the first nonverbal intelligence test, the *Army Beta*. Although plans for complete testing of all recruits were never fully implemented, World War I saw a significant expansion of I/O psychology.

## The Hawthorne Effect

During the period between World War I and World War II, I/O psychology continued to grow. Many companies added human resource departments for the first time, and a number of colleges and universities began to offer training in I/O psychology. Considerable research also was being conducted on advertising and employee selection and training. But the focus of most I/O research during this period was on workplace testing. In 1924, the most extensive—and by far the most famous—of these workplace projects began at the Hawthorne Works of the Western Electric Company, just outside Chicago.

**Hawthorne effect** A change in behavior resulting from the novelty of the research situation or from simply being observed.

In the original study, researchers from Harvard University installed lights of varying brightness levels in different workrooms where electrical equipment was assembled. The light in some rooms was intense, and it was as subdued as moonlight in others. The objective was to study the relationship between worker efficiency and lighting.

The results were quite surprising. Researchers found that worker productivity had little or nothing to do with the lighting level. Productivity improved under both *increased* and *decreased* brightness! Even more surprising, when the brightness level remained *unchanged*, productivity still increased. Simply knowing they were being used as research participants apparently improved the workers' performance. The workers' reaction is now known as the **Hawthorne effect**, meaning people change their behavior because of the novelty of the research situation or because they know they are being observed **(Figure 16.1)**.

**FIGURE 16.1 THE HAWTHORNE EFFECT AT WORK**

The Western Electric Hawthorne Works was the site of a famous study of workplace behavior conducted between World War I and World War II.

Hulton Archive/Getty Images, Inc.

The major contribution of the Hawthorne studies was documenting how a worker's behavior is influenced not only by the physical setting but also by social factors in the workplace. But over the years, the term *Hawthorne effect* has taken on numerous contradictory meanings (Chiesa & Hobbs, 2008; Vinchur & Koppes, 2011). However, as defined here, it does explain several everyday reactions. For example, if you're walking down the street singing along with the music from your headphones, you'll probably stop singing if you notice other people staring at you. Similarly, people are more likely to wash their hands after using a public restroom when others are watching. And when doctors are watched by researchers, they provide superior care to their patients, which in turn leads to greater patient satisfaction (Leonard, 2008).

## Modern Times

By the beginning of World War II, I/O psychology was an established force in the workplace. Many companies had personnel offices that routinely tested and placed employees, and they had implemented scientifically designed worker-training programs to improve productivity. Researchers also were beginning to conduct studies in human

# chapteroverview

*Choose a job you love, and you will never have to work a day in your life.*
—Confucius (551–479 BC), Chinese philosopher

*Work and play are words used to describe the same thing under differing conditions.*
—Mark Twain (1835–1910), U.S. humorist, writer, and lecturer

*Every man's work, whether it be literature, or music or pictures or architecture or anything else, is always a portrait of himself.*
—Samuel Butler (1612–1680), British poet and satirist

Have you noticed that the first thing a new acquaintance often asks is: "What do you do for a living?" Whether we like it or not, work defines us! For most of us, it's also necessary for our basic survival. Given the importance of work, how are you going to find a job that you love, work that is play, and a career that will paint a great and satisfying portrait of yourself? These are among the questions and topics investigated by *industrial/organizational (I/O) psychologists.*

# INTRODUCING I/O PSYCHOLOGY

**LEARNING OBJECTIVES**

**RETRIEVAL PRACTICE** While reading the upcoming sections, respond to each Learning Objective in your own words. Then compare your responses with those found at www.wiley.com/college/huffman.

1. **DESCRIBE** industrial/organizational psychology and its two branches.
2. **IDENTIFY** the three key founding figures in I/O psychology and their contributions.
3. **DESCRIBE** how I/O psychology changed from World War I to the present.

Whether you're looking for a lifetime of part-time work, seeking full-time employment with great benefits, or hoping to run your own business, the field of industrial/organizational psychology has important information that will help you succeed—at home and at work.

## What Is I/O Psychology?

**Industrial/organizational (I/O) psychology** The field of psychology concerned with the development and application of scientific principles to the workplace.

As discussed in Chapter 1, psychology is subdivided into many specializations. Some are concerned primarily with the science of psychology (*basic research*). Others emphasize the application of scientific principles (*applied research*). **Industrial/organizational (I/O) psychology** includes both basic and applied research, but it's most clearly aligned with the development and application of scientific principles in the workplace (Bryan & Vinchur, 2013; Fouad, 2007; Outtz, 2011).

As its two-part name implies, I/O psychology has two major divisions—*industrial* and *organizational* psychology. Although the two are closely interrelated, industrial psychology emphasizes a management perspective and focuses on job design, employee recruitment, selection, training, and evaluation. In contrast, organizational psychology focuses on the individual employee within the social context of the workplace, and is concerned with leadership, power, worker motivation, job satisfaction, and communication.

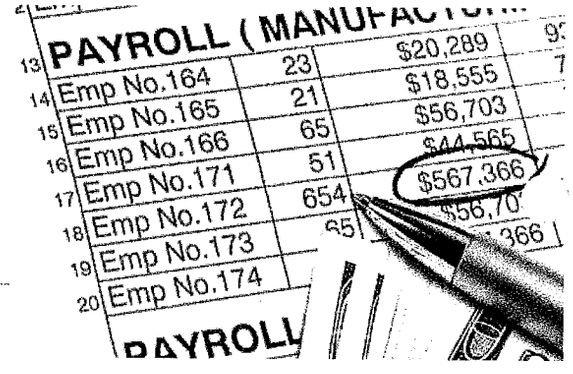
Before we get further into the chapter, see *Test Yourself* to gauge your current knowledge of I/O psychology.

# chapter sixteen


# Industrial/ Organizational Psychology

## CHAPTER OUTLINE





- Our **gender identity**—self-identification as a man or woman—and **gender roles**—learned societal expectations for "appropriate" male and female behaviors and attitudes—are largely formed in the first few years of life.
- **Transsexualism** is a mismatch between biological sex and gender identity, whereas *transvestism* is **cross-dressing** for emotional and sexual gratification. **Sexual orientation** (being heterosexual, gay, lesbian, or bisexual) is unrelated to either transsexualism or transvestism.

## 3 SEX PROBLEMS 437

- People who experience personal distress over their sexual interests or whose sexual arousal or response depends entirely on these interests may be classified as having a **paraphilic disorder**, such as *fetishistic disorder* or *exhibitionistic disorder.*
- Biology plays a key role in both sexual arousal and response. Ejaculation and orgasm are partly reflexive, and the parasympathetic nervous system must be dominant for sexual arousal to occur. The sympathetic nervous system must dominate for orgasm to occur. Psychological factors like negative early sexual experiences, fears of negative consequences from sex, and **performance anxiety** contribute to **sexual dysfunction**. Sexual arousal and response are also related to social forces, such as early gender-role training and **sexual scripts**, which teach us what to consider as the "best" sex.
- During sex therapy, tests and interviews are often used to determine the cause(s) of the **sexual dysfunction**. William Masters and Virginia Johnson emphasize the couple's relationship, biological and psychosocial factors, cognitions, and specific behavioral techniques.
- The dangers and rate of sexually transmitted infections (STIs) are high, and they are higher for women than for men. However, most STIs can be cured in their early stages. **AIDS (acquired immunodeficiency syndrome)** is transmitted only through sexual contact or exposure to infected bodily fluids, though many people have irrational fears of contagion. At the same time, an increasing number of North Americans are **HIV positive** and therefore carriers.

## 4 SEX AND MODERN LIFE 446

- **Child sexual abuse** and **rape** are two of the most common forms of sexual victimization. The effects vary according to a number of factors, but they often cause long-term psychological, physical, and behavioral problems. There are several ways to prevent or reduce the risks of sexual victimization.
- Sexual communication not only reduces the risks of sexual victimization but is also essential in healthy sexual relationships. Understanding male/female differences in communication, managing conflict, and learning how to say "no" are three key steps to improved communication.

# applyingrealworldpsychology

We began this chapter with five intriguing Real World Psychology questions, and you were asked to revisit these questions at the end of each section. Questions like these have an important and lasting impact on all of our lives. See if you can answer these additional critical thinking questions related to real world examples.

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1. This type of public display of affection is considered immoral and disgusting in some cultures. Is that response an example of ethnocentrism? Why or why not?
2. Do you think male infants should be circumcised? Why or why not?
3. If you had your life to live over, what would you see as advantages and disadvantages of coming back as the other sex?
4. Modern music, TV, and movies generally portray sex as glamorous and immediately satisfying for both partners. How might this popular portrayal contribute to sexual problems?
5. Were you surprised to learn that child sexual abuse is far more likely to be committed by a friend or family member than a stranger? Can you explain why this is not a highly publicized fact?
6. Which of the three topics—gender differences, conflict, or lack of assertiveness—do you think is the biggest contributor to sexual communication problems?

disregarding potential harm to others and possibly using insults, threats, and even physical intimidation and attacks. Aggressive behavior is more likely than passive behavior to get you what you want in the short term. But like passiveness, it too has negative long-term consequences. Others may initially give in to aggressive people and feel intimidated by them, yet they rarely like or respect them. Think about how much you liked or respected classroom or playground bullies when you were growing up. Aggressive behavior also often provokes aggressive responses that can easily escalate into violence.

**Assertiveness** The act of confidently and directly standing up for your rights, or putting forward your views, without infringing on the rights or views of others; striking a balance between passivity and aggression.

**Assertiveness**, standing up for your rights without infringing on those of others, strikes a balance between passive and aggressive behavior. It means you directly and honestly request things you want and say "no" to things you don't want. When we are assertive, we are much more likely to achieve our goals and to be liked and respected by others.

Assertive people also tend to have higher levels of self-esteem, self-worth, and self-satisfaction because they have more control over their life choices and direction (McPherson et al., 2003; Sarkova et al., 2013). Most important, they are more likely to avoid serious conflicts and to resolve them more effectively. For example, college women who are sexually assertive are less likely to experience rape and other forms of sexual assault (Schry & White, 2013).

How assertive are you in your everyday life? Do you stick up for your rights, or do you allow others to walk all over you? Do you say what you feel, or do you say what you think other people want you to say? Do you initiate relationships with attractive people, or do you shy away from them? Beginning in childhood, most of us were socialized to be "nice," to say "yes," and to please others. However, being overly nice often means sacrificing our own needs, which in turn allows hostility and frustration to accumulate and weaken our relationships. Some of the most helpful tips for becoming assertive are in *How to Say "No"* below.

## HOW TO SAY "NO" psychology and you

One of the most important steps to becoming assertive is learning how to say "No." When faced with a situation in which you want to refuse the requests of another or to protect your own rights, try the following:

- **Be assertive nonverbally** Look the person in the eye, keep your head up and keep your body firm but relaxed. Stand at an appropriate distance—not too close or too far away. Don't be a "shrinking violet."
- **Use strong verbal signals** Speak clearly, firmly, and at a volume that can be easily heard.
- **Be strong** People are often persistent in their requests. Be prepared to repeat your refusal. Stick to your guns!
- **Just say "no"** You don't have to explain why you're refusing. If you feel that you must explain why you're declining, try saying: "Thanks, but no. I really can't . . ." "I really appreciate the offer, but no. I'm not interested/too busy/don't want any . . ." "Please don't take this personally. I like you, but no, I don't . . ." or "I enjoy your company, and I'd like to do something together, but no . . ."

Can you see how studying and accepting our right to be assertive may strengthen our resolve to speak up and defend ourselves in sexual situations and in all other parts of life? Keep in mind that assertive behavior doesn't guarantee that we'll achieve our goals or force others to respect our rights. But it can definitely increase our chances of doing so.

to solve a conflict. For example, if your partner seems to be avoiding your sexual advances, you could discuss how his or her resistance makes you feel and possible solutions. (Perhaps he or she is exhausted from work, and you could renegotiate the work load at home.)

*Loyalty* is defined as remaining committed to a relationship and simply waiting patiently for things to get better. Loyalty sounds as if it could be a good strategy, but it is not associated with favorable consequences, possibly because it is a less visible and more indirect strategy (Rusbult et al., 1995).

Other strategies used to handle conflict are clearly destructive. *Neglect*, giving up on the relationship and withdrawing from it emotionally, and *exit*, leaving the relationship, are far too common and should be avoided if you want to build or maintain a healthy sexual relationship. Not surprisingly, people who have high relationship investment and satisfaction are more likely to use a constructive strategy for resolving conflicts (Drigotas et al., 1995).

## TEST YOURSELF: HOW DO YOU HANDLE CONFLICT?

### psychology and you

Rate how likely you would be to use each strategy for handling conflict in a romantic relationship on a scale of 1 to 5 (1 meaning "I would definitely not do this" and 5 meaning "I would definitely do this").

1. I would end the relationship.
2. I would tell my partner to leave.
3. I would talk to my partner about what was bothering me.
4. I would suggest things that I thought would help us.
5. I would hope that if I just hung in there, things would get better.
6. I would wait patiently.
7. I guess I would just sort of let things fall apart.
8. I would get angry and wouldn't talk at all.

What were your highest and lowest scores? Items 1 and 2 measure exit, items 3 and 4 measure voice, items 5 and 6 measure loyalty, and items 7 and 8 measure neglect (Rusbult et al., 1982).

Another researcher, John Gottman, has conducted extensive research on relationship conflict (Gottman & Levenson, 2002; Gottman & Silver, 2012). Using a variety of measures (physiological, nonverbal, verbal, and questionnaire) to assess and follow large samples of couples over long periods of time, his research has revealed four styles of conflict that are particularly destructive:

- *Criticism*—complaining about some features of the spouse or the relationship
- *Contempt*—acting as if sickened or repulsed by the partner
- *Defensiveness*—protection of the self
- *Stonewalling*—emotionally withdrawing and refusing to participate in conversation

All these strategies can lead to increased isolation and withdrawal. In fact, Gottman calls these messages the "Four Horsemen of the Apocalypse," meaning that the end of a relationship, the *apocalypse*, will be brought on by four horsemen—the four negative styles of conflict.

The *stonewalling* approach is part of another commonly observed conflict behavior called the *demand/withdraw interaction pattern*. This pattern refers to the relatively common situation in which one partner attempts to start a discussion by criticizing, complaining, or suggesting change (Christensen & Heavey, 1990;

## Male/Female Differences in Communication

Have you heard that men and women communicate so differently that they seem to be from two separate cultures or planets—as in the title of the popular book *Men Are from Mars, Women Are from Venus?* This idea is appealing because of popular stereotypes and our own occasional difficulties communicating "across genders." However, research shows that these differences are small and not characteristic of all men and women or of all mixed-gender conversations (Carothers & Reis, 2013). On the other hand, they may help explain and prevent some communication misunderstandings.

Take, for example, the findings that in general men tend to use speech to convey information, exert control, preserve independence, and enhance their status. In contrast, women tend to use speech to achieve and share intimacy, promote closeness, and maintain relationships **(Table 15.4)**. If men more often see conversations as a contest they must "win" and women use language as a way to "bond with others," it's easier to see why the two sexes might have certain communication problems. Can you see how a woman who sees language as a way to maintain relationships and create closeness and connection might call her partner at work to ask about his day or when he will be home so she can make plans? In turn, the man might interpret her call as a challenge to his freedom and resist what he perceives

**TABLE 15.4 COMMUNICATION DIFFERENCES BETWEEN THE GENDERS**

| In General, Men Tend To | In General, Women Tend To |
|---|---|
| Use speech to convey information, exert control, preserve independence, and enhance their status. | Use speech to achieve and share intimacy, promote closeness, and maintain relationships. |
| Talk more than women, interrupt women more than women interrupt men, and interrupt women more often than they interrupt other men. | Talk more than men when they have more power in a relationship. |
| Be more directive and assertive ("I want to get there by noon."). | Be more indirect and tentative, using hedges ("kind of") and disclaimers ("I'm not sure what time we should get there."). |
| Talk more about politics, sports, and careers when they're in same-gender pairs. | Talk more about feelings and relationships when they're in same-gender pairs. |
| Remain calm and problem oriented during conflict and seek compromise solutions to problems. | Become more sensitive to the feelings of others during conflict, more easily express both positive and negative emotions, and send double messages (such as smiling while making a critical comment). |
| Prefer spoken communication. | Prefer written communication. |
| Prefer to work out their problems by themselves. | Prefer to talk out solutions with another person. |
| Make critical comments on the work of a colleague. | Compliment the work of a colleague. |
| Be less sensitive to reading and sending nonverbal messages. | Be better at reading and sending nonverbal messages. |

Sources: Dunn & Goodnight, 2014; Eckert & McConnell-Ginet, 2013; Farris et al., 2008; Hall, 2008; Leaper & Robnett, 2011; Matlin, 2012; Speer & Stokoe, 2011; Tannen, 1990, 2007, 2011.

**What's wrong with this communication?**
Can you use Table 15.4 to identify possible problems?

Aurelie and Morgan David de Lossy/Cultura/Getty Images, Inc.

children. During these prevention discussions, be sure to also include the positive aspects of loving touch and sexuality, which the child will discover as an adult.

2. **Reduce the risk** Recognizing that abusers are most often family members, friends, or trusted people in positions of authority, create and lobby for open-door policies and the reduction or elimination of private, one-adult/one-child situations.
3. **Child empowerment** Teach children to know the difference between "okay" and "not okay" touches and to trust their own feelings when they think something is wrong. Remind them that they have rights. They can say "no" to any adult who asks them to participate in any activity or bodily contact that makes them feel uncomfortable. If you suspect abuse, or if a child reports it, stay calm, protect the child from further contact with the abuser, and report it to the police.

## Rape

**Rape** The unlawful act of coercing oral, anal, or vaginal penetration upon a person without consent, or upon someone incapable of giving consent (due to age or physical or mental incapacity).

The legal definition of **rape** varies from state to state, but it is generally defined as unlawfully coercing oral, anal, or vaginal penetration upon a person without consent or upon someone who is incapable of giving consent (due to age or physical or mental incapacity). As clear-cut as this definition seems, many people misunderstand what constitutes rape. To test your own knowledge, try the *Test Yourself.*

### TEST YOURSELF: MYTHS ABOUT RAPE

*psychology and you*

**TRUE OR FALSE?**

____1. A woman cannot be raped against her will.

____2. A man cannot be raped by a woman.

____3. If you are going to be raped, you might as well relax and enjoy it.

____4. Women secretly want to be raped.

____5. Male sexuality is biologically overpowering and beyond control.

All these statements are false. But a large number of men and women believe rape myths like these (Crooks & Baur, 2013; Hyde et al., 2014; Mouilso & Calhoun, 2013; Suarez & Gadalla, 2011). Using your critical thinking skills, can you explain how gender role conditioning, media portrayals, and lack of general information help perpetuate these myths?

Keith Srakocic/AP Photos

**Without Consent, It's Rape!**
In March 2013, Trent Mays, age 17, and Ma'lik Richmond, age 16, were found guilty of sexually assaulting a 16-year-old female classmate who was intoxicated and thus unable to give legal consent. Sadly, this type of sexual assault occurs far too often in both high schools and colleges.

Like child sexual abuse, rape directly or indirectly affects many people. In the United States alone, more than 1 million women are raped each year (CDC, 2013). Nationwide surveys reveal that 8% of high school students (11.8% of female students and 4.5% of male students) report having been forced to have sex, as do 20% to 25% of college women. Although these numbers may seem very high, many victims of sexual violence don't report the incident, so the official numbers most likely underestimate the true prevalence of such violence.

## RETRIEVAL PRACTICE: SEX PROBLEMS

### Self-Test

Completing this self-test and comparing your answers with those in Appendix B provides immediate feedback and helpful practice for exams. Additional interactive, self-tests are available at www.wiley.com/college/huffman.

**1.** The only thing that sexually arouses Jim is the sight of women's high heels. His type of paraphilic disorder is called _____.

a. transvestism
b. frotteurism
c. exhibitionism
d. fetishism

**2.** _____ teach us "what to do, when, where, how, and with whom."

a. Sex surrogates
b. Sex therapists
c. Sex manuals
d. Sexual scripts

**3.** All of the following are principles of Masters and Johnson's approach to sex therapy except _____.

a. setting goals to improve sexual performance
b. examining the relationship between the two people
c. using medical histories and physical examinations
d. exploring individual attitudes and sex education

**4.** The fear of being judged in connection with sexual activity is known as _____.

a. decreased sexual desire
b. sexual dysfunctions
c. inhibited orgasm
d. performance anxiety

**5.** With regard to preventing STIs, remaining abstinent, not using intravenous illicit drugs, and avoiding contact with blood, vaginal secretions, and semen are considered _____.

a. a waste of time
b. unusual sexual practices
c. the only ways to prevent STI transmission
d. methods of lessening your chance of contracting an STI

### Think Critically

1. Do you believe biological, psychological, or social factors best explain sexual problems?
2. If you had a sexual problem, would you go to a sex therapist? Why or why not?

## realworldpsychology

**How can infertility treatment reduce sexual pleasure?**

**Is "hooking up" more common today than dating?**

HINT: LOOK IN THE MARGIN FOR Q3 AND Q4

# SEX AND MODERN LIFE

LEARNING OBJECTIVES

RETRIEVAL PRACTICE While reading the upcoming sections, respond to each Learning Objective in your own words. Then compare your responses with those found at www.wiley.com/college/huffman.

1. **DISCUSS** the risks and methods of prevention for sexual victimization, including child sexual abuse and rape.
2. **DESCRIBE** how gender differences, conflict, and the ability to say "no" are important elements of sexual communication.

Sexuality can be a source of vitality and tender bonding. But when sexual activity becomes a forcible act against the wishes of another person, it can be very traumatizing. In this section, we look at the dark side of human sexuality—*sexual victimization*. Then, we conclude with perhaps the most important topic of all—*sexual communication*.

## Sexual Victimization

Any sexual activity that includes lack of consent, or the coercion, exploitation, or assault of another, is a serious problem. Although we often think about sexual violence as caused by a stranger, in most cases it is committed by someone known to the victim, such as a friend, neighbor, or family member. Both men and women can

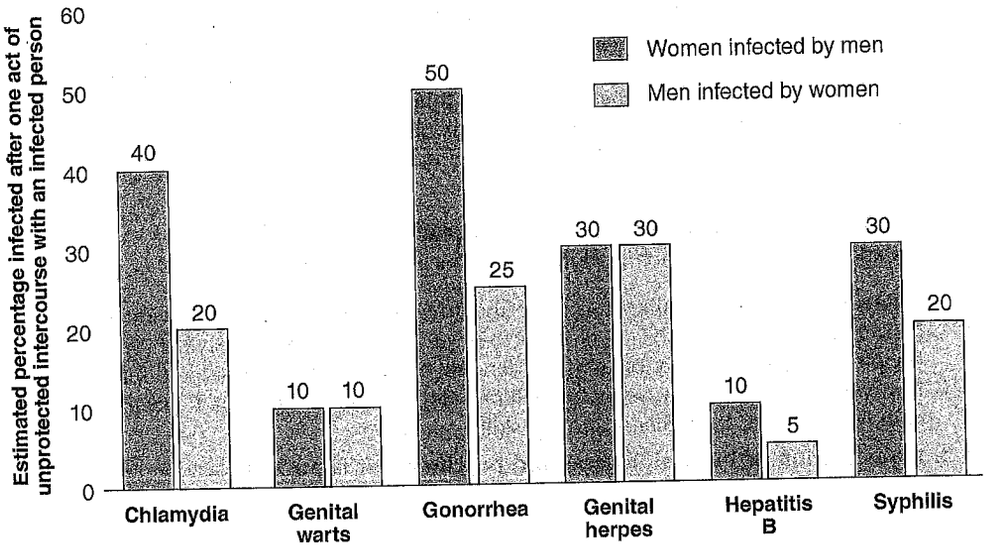


**FIGURE 15.4 MALE–FEMALE DIFFERENCES IN SUSCEPTIBILITY TO SEXUALLY TRANSMITTED INFECTIONS (STIs)**

These percentages represent the chances of infection for men and women after a single act of intercourse with an infected partner. Note that women are at much greater risk than men for four of these six STIs, due in part to the internal and less visible nature of the parts of female genitalia.

disorders caused by more than 25 infectious organisms transmitted through sexual activity.

Each year, of the millions of North Americans who contract one or more STIs, a substantial majority are under age 35. Also, as **Figure 15.4** shows, women are at much greater risk than men of contracting major STIs. It is extremely important for sexually active people to get medical diagnosis and treatment for any suspicious symptoms and to inform their partners. If left untreated, many STIs can cause severe problems, including infertility, ectopic pregnancy, cancer, and even death.

STIs such as genital warts and chlamydial infections have reached epidemic proportions. Yet **AIDS (acquired immunodeficiency syndrome)** has received the largest share of public attention. AIDS results from infection with the *human immunodeficiency virus (HIV)*. A standard blood test can determine whether someone is **HIV positive**, which means he or she has been infected by the HIV virus. Being infected, however, is not the same as having AIDS. AIDS is the final stage of the HIV infection process.

**AIDS (Acquired Immunodeficiency Syndrome)** A disease in which human immunodeficiency virus (HIV) destroys the immune system's ability to fight other diseases, thus leaving the body vulnerable to a variety of opportunistic infections and cancers.

**HIV positive** The state of being infected by the human immunodeficiency virus (HIV).

Recent advances in the treatment of AIDS have increased the survival time of victims, and some studies find that people who are HIV positive and are treated are no more likely to die of AIDS than anyone in the general population (Lewden et al., 2012; Nakagawa et al., 2013). The key is early treatment with antiretroviral drugs. Nonetheless, AIDS remains a serious, potentially fatal health risk.

Myths about AIDS are widespread. For instance, many people still believe AIDS can be transmitted through casual contact, such as sneezing, shaking hands, sharing drinking glasses or towels, social kissing, or contact with sweat or tears. Some also think it is dangerous to donate blood. Others are mistrustful of gay people, because gay men were the first highly visible victims. All these are *false* beliefs.

HIV spreads only by direct contact with bodily fluids—primarily blood, semen, and vaginal secretions, but also occasionally through breast milk and nonsterile needles. Blood *donors* are at *no* risk whatsoever. Contrary to popular stereotypes, AIDS is not limited to the gay community. In fact, in the United States and elsewhere around the world, the AIDS epidemic is now spreading most quickly among heterosexuals, women, African Americans, Hispanics, and children (Adih et al., 2010; Swenson et al., 2010; Wand et al., 2013).

The good news is that most STIs are readily cured in their early stages. See **Figure 15.5** for an overview of the signs and symptoms of the most common STIs. As

Another change is the increasing prevalence of "hooking up" among high school and college students. Not so recently, dating was the major route to sexual interactions. Following predictable scripts, the man was expected to initiate the first date, organize it, and initiate sexual activity, whereas the woman waited to be asked out and accepted or rejected the man's sexual overtures. Today, more casual, no-strings-attached, hooking-up relationships have at least partially replaced the more traditional romantic dating relationships (Garcia et al., 2012; Shulman & Connolly, 2013).

Q4 Sexual behavior in college, however, is still more likely to occur in dating relationships. For example, one study of first-year college women found that 56% of the women reported having sex with a romantic partner, whereas only 40% reported having sex in the context of a hookup (Fielder et al., 2012).

Sexual scripts may be less rigid today than they once were, but a major difficulty remains. Many sexual behaviors do not fit society's scripts and expectations, and we all unconsciously internalize societal messages without recognizing that they affect our values and behaviors. For example, some heterosexual women and men still expect (and prefer) the man to make the first move. In addition, media portrayals imply that men are more interested in casual sex than women are, though recent research finds that women and men are actually equally likely to accept offers of casual sex from a potential partner they believe would "be a great lover" (Conley et al., 2011).

## Sex Therapy

How do therapists work with sex problems? Clinicians usually begin with interviews and examinations to determine whether the problem is organic, psychological, or, more likely, a combination of both (Cacchioni & Wolkowitz, 2011; Hall & Graham, 2013; Janssen, 2011).

Organic causes of sexual dysfunction include medical conditions such as diabetes mellitus and heart disease, medications such as antidepressants, and drugs such as alcohol and tobacco—see **Table 15.3**. In fact, many who are addicted to drugs or alcohol experience sexual problems even after they stop using these substances (Vallejo-Medina & Sierra, 2012). Erectile disorders are the problems most likely to have an organic component. In 1998, a medical treatment for erectile problems, Viagra, quickly became the fastest-selling prescription drug in U.S. history. Other medications for both men and women are currently being tested.

Sex therapists also emphasize psychological and social factors. Years ago, the major psychological treatment for sexual dysfunction was long-term psychoanalysis. This treatment was based on the assumption that sexual problems resulted from *deep-seated conflicts* that originated in childhood. During the 1950s and 1960s, behavior therapy was introduced. It was based on the idea that sexual dysfunction

**TABLE 15.3 SEXUAL EFFECTS OF LEGAL AND ILLEGAL DRUGS**

| Drug | Effects |
|---|---|
| Alcohol | Moderate to high doses inhibit arousal; chronic abuse causes damage to testes, ovaries, and the circulatory and nervous systems |
| Tobacco | Decreases blood flow to the genitals, thereby reducing the frequency and duration of erections and vaginal lubrication |
| Cocaine and amphetamines | Moderate to high doses and chronic use result in inhibition of orgasm and decrease in erection and lubrication |
| Barbiturates | Moderate to high doses lead to decreased desire, erectile disorders, and delayed orgasm |

*Source*: Crooks & Baur, 2013; Hyde et al., 2014; King, 2012.

## Biological Factors

Although many people may consider it unromantic, a large part of sexual arousal and behavior is clearly the result of biological processes (Giuliano et al., 2013; Hayes, 2011; Hyde et al., 2014; King, 2012). *Erectile dysfunction*, the inability to get or maintain an erection firm enough for intercourse, and *orgasmic dysfunction*, the inability to respond to sexual stimulation to the point of orgasm, often reflect lifestyle factors like cigarette smoking. They are also related to medical conditions such as diabetes, alcoholism, hormonal deficiencies, circulatory problems, and reactions to certain prescription and nonprescription drugs. In addition, hormones (especially testosterone) have a clear effect on sexual desire in both men and women, though their precise role is not well understood.

Sexual responsiveness is also affected by the spinal cord and sympathetic nervous system. The human brain is certainly engaged in all parts of the sexual response cycle. However, certain key sexual behaviors do not require an intact cerebral cortex to operate. In fact, some patients in comas still experience orgasms.

How is this possible? Recall from Chapter 2 that some aspects of human behavior are reflexive. They are unlearned and automatic, and they occur without conscious effort or motivation. Sexual arousal for both men and women is partially reflexive and somewhat analogous to simple reflexes. For example, a puff of air produces an automatic closing of the eye. Similarly, certain stimuli, such as stroking of the genitals, can lead to automatic arousal in both men and women. In both situations, nerve impulses from the receptor site travel to the spinal cord. The spinal cord then responds by sending messages to target organs or glands. Normally, the blood flow into organs and tissues through the arteries is balanced by an equal outflow through the veins. During sexual arousal, however, the arteries dilate beyond the capacity of the veins to carry the blood away. This results in erection of the penis in men and an engorged clitoris and surrounding tissue in women.

If this is so automatic, why do some people have difficulty getting aroused? Unlike the case in simple reflexes such as the eye blink, negative thoughts or high emotional states may block sexual arousal. Recall from Chapter 2 that the autonomic nervous system (ANS) is intricately linked to emotional and sexual responses. It is composed of two subsystems: the sympathetic, which prepares the body for "fight or flight," and the parasympathetic, which maintains bodily processes at a steady, even balance. The parasympathetic branch is dominant during initial sexual excitement and throughout the plateau phase. The sympathetic branch dominates during ejaculation and orgasm. Can you see why the parasympathetic branch *must* be in control during arousal? The body needs to be relaxed enough to allow blood to flow to the genital area.

**Performance anxiety** The fear of being judged in connection with sexual activities.

## Psychological Influences

Our bodies may be biologically prepared to become aroused and respond to erotic stimulation. But psychological forces also play a role. For example, anxieties associated with many sexual experiences, such as fear of pregnancy and sexually transmitted infections, may cause sympathetic dominance, which in turn blocks sexual arousal. Many individuals discover that they need locked doors, committed relationships, and reliable birth control to fully enjoy sexual relations. On the other hand, those who are having difficulty becoming pregnant and are using fertility treatments such as in vitro fertilization may experience lower levels of sexual desire and pleasure (Smith & Madeira, 2012). In this case, their anxiety about not becoming pregnant can interfere with their enjoyment of sex. Q3

In short, if a man or woman stays in arousal and parasympathetic dominance long enough, orgasms will occur. Unfortunately, in addition to the psychological factors discussed above, many people fail to recognize that drinking alcohol to excess, being stressed, ill or fatigued also interfere with sexual functioning. One of the least recognized blocks of sexual arousal is **performance anxiety**, the fear of being judged in connection with sexual activity. Men commonly experience problems with erections (especially after drinking alcohol) and wonder whether their "performance" will satisfy their partner. Women frequently worry about their attractiveness and their ability to reach orgasm. Can you see how these performance

Snapshots

Jason Love/www.CartoonStock.com

Another form of performance anxiety.

2013). For example, someone could have a silk fetish and become aroused by seeing and touching silky material, or a foot fetish and become aroused by touching or smelling someone's foot. A person with a fetish does not simply find a particular object or body part appealing but rather has considerable difficulty becoming aroused or achieving orgasm without either having or imagining this stimulus. The fetish therefore interferes with normal sexual functioning.

### Exhibitionistic Disorder

*Exhibitionistic disorder*, often called "indecent exposure," is a disorder in which individuals, almost always male, experience recurrent and intense sexual arousal from fantasies, urges, or behaviors associated with exposing their genitals to unsuspecting and nonconsenting observers (American Psychiatric Association, 2013). This behavior might consist simply of exposing (or "flashing") the genitals, but it can also include masturbating or performing sexual acts in a public location. An important aspect of the arousal is the surprise experienced by the victim, but the exhibitionist generally does not desire any sexual contact with that person. People who have this paraphilia may engage in exhibitionism or may have recurring sexual fantasies about doing so.

### Explaining and Treating Paraphilic Disorders

As you discovered in Chapter 12, the precise cause of psychological disorders is often difficult to determine, in part because numerous biological, psychological, and sociocultural factors may interact and contribute to such disorders. For example, the psychoanalytic perspective believes that paraphilias represent a person's reverting to a sexual habit or behavior from childhood. On the other hand, the learning, or behaviorist, perspective describes paraphilias as a result of conditioning. A person who engages in a pleasurable sexual activity in the presence of a nonsexual object, such as a shoe or silk material, may over time become dependent on having this object present in order to experience sexual pleasure. Particular sexual habits also may be learned from observing other people or from receiving reinforcement or reward for engaging in them. A person with exhibitionistic behavior, for example, may experience increased arousal from anxiety about being caught engaging in such behavior, which can be quite rewarding. Biological perspectives on paraphilias emphasize the impact of hormones, genes, and neurotransmitters on such behaviors.

Regardless of the cause, treatments are clearly needed to help people with such disorders find healthier and more positive methods of experiencing sexual pleasure. One of the most common is medication. Drugs called *antiandrogens* lower testosterone levels, which in turn decreases the sex drive in males and reduces the distraction of paraphilic urges, often increasing the ability to focus on therapy.

Paraphilias also can be treated using cognitive-behavior therapy, which focuses on replacing the positive associations between a particular object or behavior and sexual pleasure with negative ones. This is the first step toward eliminating the unhealthy patterns of arousal. For example, in aversive conditioning, the person might be told to imagine a particularly arousing scene (such as the fetish object and/or exhibitionism). Then he would be asked to immediately visualize a negative outcome, such as getting his penis stuck in the zipper of his pants. After creating new negative associations with the fetish object or behavior to replace the existing positive ones, the therapist can work on creating more positive and healthier associations.

## Other Sexual Dysfunctions

**Sexual dysfunction** A problem that interferes with initiation of, consummation of, or satisfaction with sexual activities.

In addition to paraphilic disorders, there are numerous other forms of **sexual dysfunction**, or difficulty in sexual functioning. Their causes are complex **(Table 15.2)**. In this section, we discuss how biology, psychology, and social forces, as represented in the *biopsychosocial model*, all contribute to sexual difficulties.

(having a gender identity that does not match the biological sex). Although some may see the story of "John/Joan" as a form of transsexualism, "true" transsexuals are born chromosomally and anatomically one sex. But they have a deep and lasting discomfort with their sexual anatomy. They report feeling as if they are victims of a "birth defect" and are at increased risk of experiencing psychiatric problems, including self-mutilation, attempted suicide, and drug use (Spack et al., 2012). In some cases, they undergo medical procedures and/or drug therapies to change their bodies physically to be more like the other sex.

**Cross-dressing** The practice of wearing clothing and adopting gender role behaviors commonly associated with the other sex.

People sometimes confuse transsexualism with **cross-dressing**, in which individuals adopt the dress (cross-dress), and often the gender-role behaviors, typical of the other sex. Some individuals occasionally or routinely dress up as the other sex for personal or erotic pleasure, and some entertainers cross-dress as part of their job. In contrast, transsexuals feel that they are really members of the other sex, imprisoned in the wrong body. Their gender identity does not match their gonads, genitals, or internal accessory organs. Transsexuals may also cross-dress. But their motivation is to look like the "right" sex, the one that matches their gender identity.

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realworldpsychology **Musical Gender-Benders** Some pop culture celebrities, like Lady Gaga, Dennis Rodman (pictured here), and Kurt Cobain, are sometimes referred to as "gender-benders" because they occasionally adopt dress, behaviors, and attitudes that "bend" expected gender roles. They may do this as a form of social activism, challenging societal expectations of what it means to be male or female. Other gender bending may reflect transsexualism or transgenderism.

**Sexual orientation** Our emotional and erotic attraction, which can be primarily toward members of the same sex (homosexual, gay, lesbian), both sexes (bisexual), or the other sex (heterosexual).

Many people also confuse cross-dressing and/or transsexualism with **sexual orientation**, our emotional and erotic attraction, which can be primarily toward the other sex (heterosexual), our own sex (gay or lesbian), or both sexes (bisexual). Cross-dressers are usually heterosexual, whereas a transsexual can be heterosexual, gay, lesbian, or bisexual.

Just as the meaning of the terms *intelligence* (Chapter 8) and the diagnostic labels for psychological disorders (Chapter 12) have evolved and changed over the years, so too have these sexuality labels. For example, the term *homosexual* has largely been replaced with *gay* both to refer to men or women with an attraction to the same sex and as an umbrella term to include all lesbian, gay, bisexual, and transgendered (LGBT) people.

The important thing to remember is that different definitions may be equally valid and that labels can lead to dangerous forms of prejudice and misunderstandings. In addition, some people may technically fit under these various categories but not identify themselves as such. It is each person's right to accept and/or reject any definition or label imposed by others.

## RETRIEVAL PRACTICE: SEXUAL IDENTITY

### Self-Test

Completing this self-test and comparing your answers with those in Appendix B provides immediate feedback and helpful practice for exams. Additional interactive, self-tests are available at www.wiley.com/college/huffman.

**1.** The term _____ refers to the socially constructed differences between men and women, whereas _____ refers to the biological differences between men and women.

a. sex; gender identity
b. gender; gender role
c. androgyny; gender role
d. gender; sex

**2.** _____ refers to one's self-identification as either a man or a woman.

a. Sex role
b. Assigned sex
c. Gender dysphoria
d. Gender identity

# SEXUAL IDENTITY

LEARNING OBJECTIVES

RETRIEVAL PRACTICE While reading the upcoming sections, respond to each Learning Objective in your own words. Then compare your responses with those found at www.wiley.com/college/huffman.

1 **CONTRAST** sex, gender, transgender, gender identity, and gender role.
2 **EXPLAIN** how sexual and gender traits are influenced by both nature and nurture.
3 **DIFFERENTIATE** between transsexualism, cross-dressing, and sexual orientation.

**Sex** The biological differences between men and women, such as having a penis or vagina; also, physical activities, such as masturbation and intercourse.

**Gender** The socially constructed differences between men and women.

**Transgendered** Being gender diverse and nonconforming to social expectations of masculinity and femininity; being between, beyond, or some combination of genders.

**Gender identity** Our self-identification as being a man or a woman or some transgendered position between the two; usually includes awareness and acceptance of our biological sex.

Why is it that the first question most people ask after a baby is born is "Is it a girl or a boy?" What would life be like if there were no divisions according to maleness or femaleness? Would your career plans or friendship patterns change? These questions reflect the role of *sex* and *gender* in our lives.

The term **sex** generally refers to the biological differences between men and women (such as having a penis or vagina) or to physical activities (such as masturbation and intercourse). **Gender**, on the other hand, encompasses the socially constructed differences between men and women (such as "masculinity" and "femininity"). There are at least seven dimensions or elements of *sex* and two of *gender* **(Table 15.1)**.

## Describing Sex and Gender

Most of us have a stable, internal sense of being female, male, or some **transgendered** position between the two. This personal **gender identity**—our self-identification as

TABLE 15.1 DIMENSIONS OF SEX AND GENDER

| | Male | Female |
|---|---|---|
| ***Sex Dimensions*** | | |
| 1. Chromosomes | XY | XX |
| 2. Gonads | Testes | Ovaries |
| 3. Hormones | Mainly androgens | Mainly estrogens |
| 4. External genitals | Penis, scortum | Labia minor, clitoris, vaginal opening |
| 5. Internal accessory organs | Prostate gland, seminal vesicles, vas deferens, ejaculatory duct, Cowper's gland | Vagina, uterus, fallopian tubes, cervix |
| 6. Secondary sex characteristics | Beard, lower voice, wider shoulders, sperm emission | Breasts, wider hips, menstruation |
| 7. Sexual orientation | Heterosexual, gay, bisexual | Heterosexual, lesbian, bisexual |
| ***Gender Dimensions*** | | |
| 8. Gender identity (self-definition) | Perceives self as male | Perceives self as female |
| 9. Gender-role (societal expectations) | Masculine ("Boys like trucks and sports") | Feminine ("Girls like dolls and clothes") |

This type of "dressing up" is a good example of which dimension of gender?

Elizabeth Crews/The Image Works

Answer: Gender role

In addition to surveys, interviews, and case studies, some researchers have employed biological research methods, as well as direct laboratory experimentation and observational methods. For example, modern biological researchers have found that different parts of the brain are activated when people engage in tasks that trigger sexual arousal, such as looking at erotic photographs, than in tasks that trigger feelings of love, such as looking at a photograph of a romantic partner (Cacioppo et al., 2012).

Direct laboratory experimentation and observation were first conducted by William Masters and Virginia Johnson (1961, 1966, 1970) and their research colleagues. To experimentally document the physiological changes that occur in sexual arousal and response, they first enlisted several hundred male and female volunteers. Then, using intricate physiological measuring devices, the researchers carefully monitored participants' bodily responses as they masturbated or engaged in sexual intercourse. Masters and Johnson's research findings have been hailed as a major contribution to our knowledge of sexual physiology. Some of their results are discussed in later sections of this chapter.

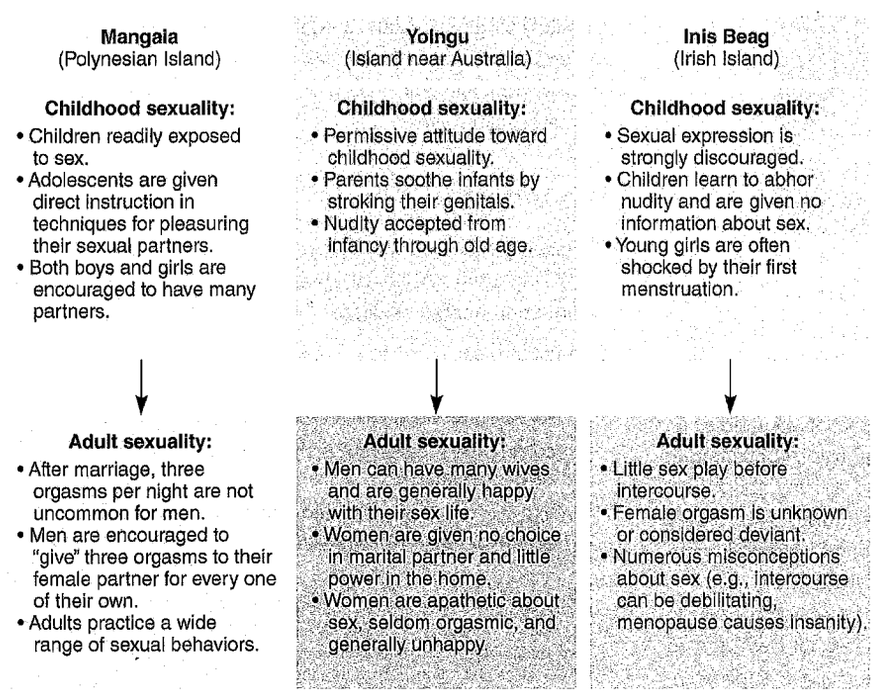
## Sexuality Across Cultures

Sex researchers interested in both similarities and variations in human sexual behavior conduct cross-cultural studies of sexual practices, techniques, and attitudes (Barber, 2008; Beach, 1977; Buss, 1989, 2008, 2011; Crooks & Bauer, 2013; Hall & Graham, 2013; Herdt & Polen-Petit, 2014). Their studies of different societies put sex in a broader perspective. For example, a cross-cultural study asked both U.S. and Dutch parents whether they would allow their teenage child to spend the night with a dating partner in their own home. Of the U.S. parents, 91% said they would not allow such a sleepover, whereas 93% of Dutch parents said they would (Schalet, 2011). This difference in perspectives illustrates cultural differences in attitudes about sexuality, and in particular about adolescent sexuality. In the Netherlands, and many Scandinavian countries, comprehensive sex education, including information about birth control and sexual pleasuring, is required. In contrast, such programs continue to be controversial in the United States.

Cross-cultural studies of sex also help counteract *ethnocentrism*, the tendency to judge our own cultural practices as "normal" and preferable to those of other groups. For example, did you know that kissing is unpopular in Japan and unknown among some cultures in Africa and South America? Does it surprise you that members of Tiwi society, off the northern coast of Australia, believe young girls will not develop breasts or menstruate unless they first experience intercourse? Adolescent boys in Mangaia, a small island in the South Pacific, routinely undergo superincision, a painful initiation rite in which the foreskin of the penis is slit and folded back (Hyde et al., 2014; Gregersen, 1996; Marshall, 1971). **Figure 15.2** gives other examples of cultural variations in sexuality.

**FIGURE 15.2 CROSS-CULTURAL DIFFERENCES IN SEXUAL BEHAVIOR**

Note: "Inis Beag" is a pseudonym used to protect the privacy of residents of this Irish island, which is another interesting cultural difference. The other communities cited apparently don't require pseudonyms.




*Sources:* Crooks & Baur, 2013; Hyde et al., 2014; Marshall, 1971; Money et al., 1991.

# chapteroverview

Sex is used and abused in many ways. It is a way to satisfy sexual desires, and it is a major theme in literature, movies, and music. We also use and abuse sex to gain love and acceptance from partners and peer groups, to express love or commitment in a relationship, to dominate or hurt others, and, perhaps most conspicuously, to sell products. To understand these uses and abuses, we need to start with a brief look at the history of sex and sex research. We'll then discuss sexual identity, sexual problems, and sex in modern life. (Sexual arousal and response are covered in Chapters 2 and 10, and gender-role development is discussed in Chapter 9.)

# STUDYING HUMAN SEXUALITY

**LEARNING OBJECTIVES**

**RETRIEVAL PRACTICE** While reading the upcoming sections, respond to each Learning Objective in your own words. Then compare your responses with those found at www.wiley.com/college/huffman.

**1 DESCRIBE** the early studies and modern research findings on sexuality.
**2 DISCUSS** the major findings and value of cross-cultural studies of sexuality.

People have probably always been interested in understanding their sexuality. But historical and cultural forces have often led them to suppress and control this interest.

## Early Studies

During the nineteenth century, people in polite society avoided mentioning any part of the body covered by clothing, so the breast of chickens became known as "white meat." Male doctors examined female patients in totally dark rooms, and some people even covered piano legs for the sake of propriety (Clark, 2011; Marcus 2008; Money, 1985).

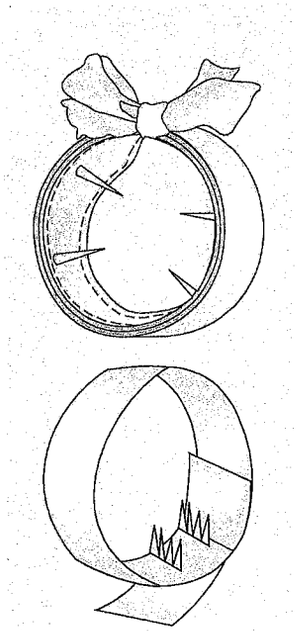
Throughout this Victorian period, medical experts warned that masturbation led to blindness, impotence, acne, and insanity (Allen, 2000; Michael et al., 1994). Believing a bland diet helped suppress sexual desire, Dr. John Harvey Kellogg and Sylvester Graham developed the original Kellogg's Corn Flakes and Graham crackers and marketed them as foods that would discourage masturbation (Markel, 2011; Money et al., 1991). One of the most serious concerns of many doctors was nocturnal emissions (during so-called "wet dreams"), which were believed to cause brain damage and death. Special devices were even marketed for men to wear at night to prevent sexual arousal **(Figure 15.1)**.

In light of modern knowledge, it is hard to understand these practices and myths. One of the first physicians to question them was Havelock Ellis (1858–1939). When he first heard of the dangers of nocturnal emissions, Ellis was frightened; he had had personal experience with the problem. His fear led him to frantically search the medical literature, where instead of a cure he found only predictions of gruesome illness and eventual death. He was so upset he contemplated suicide.

Ellis eventually decided he could give meaning to his life by keeping a detailed diary of his deterioration. He planned to dedicate the book to science when he died. However, after several months of careful observation, Ellis realized that the experts were wrong. He wasn't dying. He wasn't even sick. Angry that he had been so misinformed, he spent the rest of his life developing reliable and accurate sex information. Today, Havelock Ellis is acknowledged as one of the most influential pioneers in the field of sex research.

**FIGURE 15.1 VICTORIAN SEXUAL PRACTICE**

During the nineteenth century, men were encouraged to wear spiked rings around their penises at night. Can you explain why?

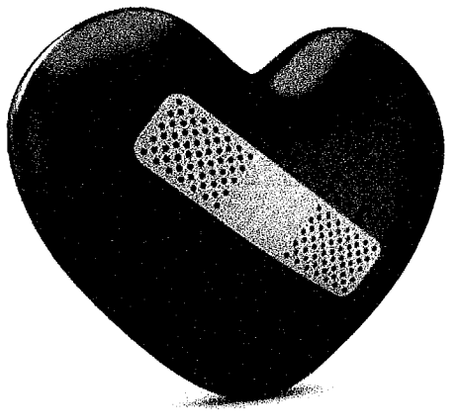


*Answer:* The Victorians believed nighttime erections and emissions ("wet dreams") were dangerous. If the man had an erection, the spikes would cause pain and awaken him.

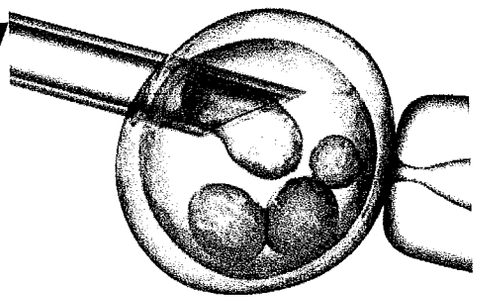
## Modern Research

One of the earliest efforts in modern sex research came from Alfred Kinsey and his colleagues (1948, 1953), who personally interviewed more than 18,000 participants, asking detailed questions about their sexual activities and preferences. The results

# chapter fifteen



# Gender and Human Sexuality



## CHAPTER OUTLINE



**polarization**—a group's movement toward more extreme decisions—and **groupthink**—a group's tendency to strive for agreement and to avoid inconsistent information—tend to occur. Both processes may hinder effective decision making.

## 3 SOCIAL RELATIONS 413

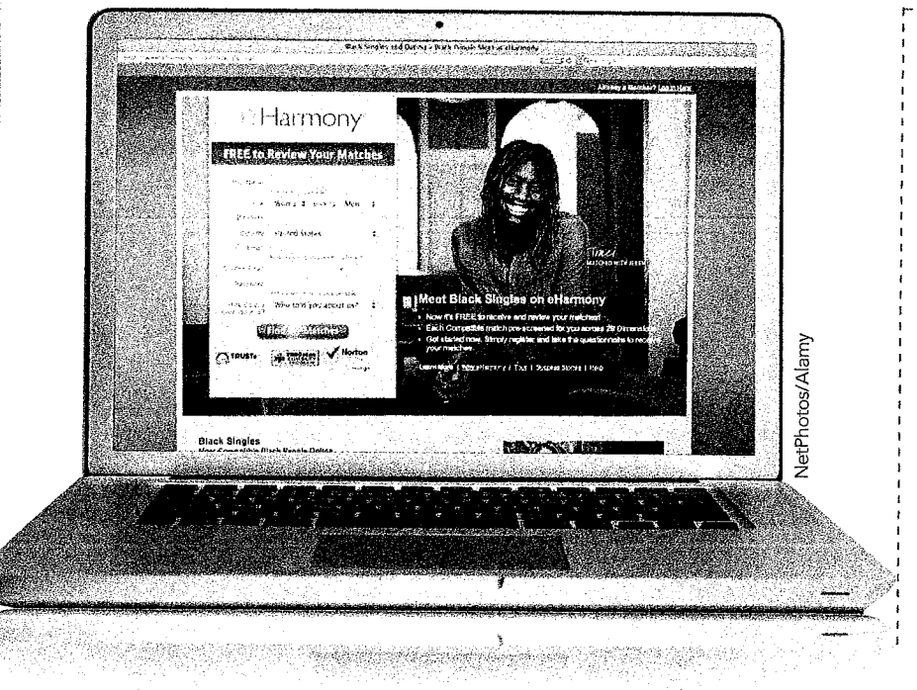
- Like all other attitudes, **prejudice** includes three ABC components: *affective*, *behavioral*, and *cognitive*. Although the terms prejudice and **discrimination** are often used interchangeably, they are not the same. Five commonly cited sources of prejudice are *learning*, *personal experience*, *limited resources*, *displaced aggression*, and *mental shortcuts*.
- Several biological factors may help explain **aggression**, including genetic predisposition, aggression circuits in the brain, hormones, and neurotransmitters. Psychosocial explanations for aggression include substance abuse, aversive stimuli, media violence, and social learning.
- Evolutionary theory suggests that **altruism** is an evolved, instinctual behavior. Other research suggests that helping may actually be self-interest in disguise—the **egoistic model**. The **empathy–altruism hypothesis** proposes that although altruism is occasionally based on selfish motivations, it is sometimes truly selfless and motivated by empathy or concern for others. Latané and Darley found that in order for helping to occur, the potential helper must notice what is happening, interpret the event as an emergency, take personal responsibility for helping, decide how to help, and then actually initiate the helping behavior.
- Psychologists have found three compelling factors in **interpersonal attraction:** physical attractiveness, proximity, and similarity. Sternberg suggests that **consummate love** depends on a healthy degree of intimacy, passion, and commitment. **Romantic love** is an intense but generally short-lived attraction based on mystery and fantasy, whereas **companionate love** is a strong, lasting attraction based on trust, caring, tolerance, and friendship.

William Philpott/Reuters/© Corbis

# applyingrealworldpsychology

We began this chapter with five intriguing Real World Psychology questions, and you were asked to revisit these questions at the end of each section. Questions like these have an important and lasting impact on all of our lives. See if you can answer these additional critical thinking questions related to real world examples.

1. What were the major social factors that contributed to Rosa Parks, pictured here, being willing to stand up against the bus driver who ordered her to give her seat to a white man? Does her model of disobedience encourage you to follow her example? Why or why not?
2. Can you think of an example from your own life, or from the life of one of your friends, in which attitudes did not match behavior? How might strong attitudes be a better predictor of actual behavior than weak ones?
3. In both Asch's conformity experiment and Milgram's study of obedience, the presence of another person greatly affected the behaviors of the research participants. How would you explain this?
4. Thinking about the most important romantic relationship in your life, explain how each of the major factors in interpersonal attraction—physical attractiveness, proximity, and similarity—affect this relationship.
5. Imagine yourself with a career as a social psychologist. Which of the key factors discussed in this chapter would you be most and least interested in studying? Why?




NetPhotos/Alamy

## realworldpsychology

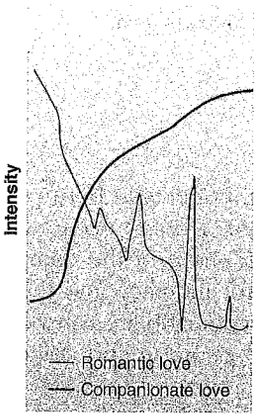
**Can You Find Lasting Love Via On-Line Dating?** To test this question, researchers conducted an on-line survey of over 19,000 Americans (Cacioppo et al., 2013). Participants were asked if they were currently married, if they had ever been divorced, and/or if they met their current or former spouse on-line. Those who were married also completed a measure of relationship satisfaction.

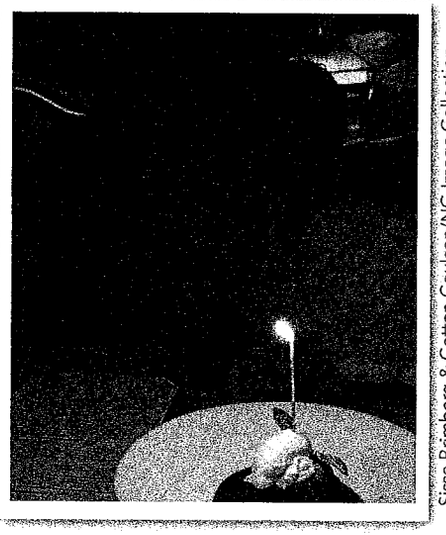
Researchers then compared divorce rates and marital satisfaction for those who met their spouse on-line versus not on-line. Interestingly, they found a higher level of marital satisfaction and a significantly lower divorce rate for those whose marriages started on-line versus those that started off-line. Can you think of topics from this or any other chapter in this text, or from your own life experiences, that might explain why relationships which start on-line may in fact be longer lasting and more satisfying than those that start in more traditional ways?

### FIGURE 14.19 LOVE OVER THE LIFESPAN

How can we keep romantic love alive? One of the most constructive ways is to recognize its fragile nature and nurture it with carefully planned surprises, flirting, flattery, and special dinners and celebrations. In the long run, however, romantic love's most important function might be to keep us attached long enough to move on to the deeper and more enduring companionate love.

As you can see in the figure, romantic love is high in the beginning of a relationship, but it tends to diminish over time, with periodic resurgences, or "spikes." In contrast, companionate love usually steadily increases over time. One reason may be that satisfaction grows as we come to recognize the lasting value of companionship and intimacy (Gottman, 2012; Jacobs Bao & Lyubomirsky, 2013; Regan, 2011). One tip for maximizing companionate love is to overlook each other's faults. People are more satisfied with relationships when they have a somewhat idealized perception of their partner (Barelds & Dijkstra, 2011; Campbell et al., 2001; Fletcher & Simpson, 2000; Regan, 2011). This makes sense in light of research on cognitive dissonance (discussed earlier). Idealizing our mates allows us to believe we have a good deal—and thereby avoid any cognitive dissonance that might arise when we see an attractive alternative. As Benjamin Franklin wisely said, "Keep your eyes wide open before marriage, and half shut afterwards."



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## Similarity

The major cementing factor for long-term relationships, whether liking or loving, is *similarity*. We tend to prefer, and stay with, people who are most like us—those who share our ethnic background, social class, interests, and attitudes (Böhm et al., 2010; Caprara et al., 2007; Morry et al., 2011; Sanbonmatsu et al., 2011). In other words, "Birds of a feather flock together."

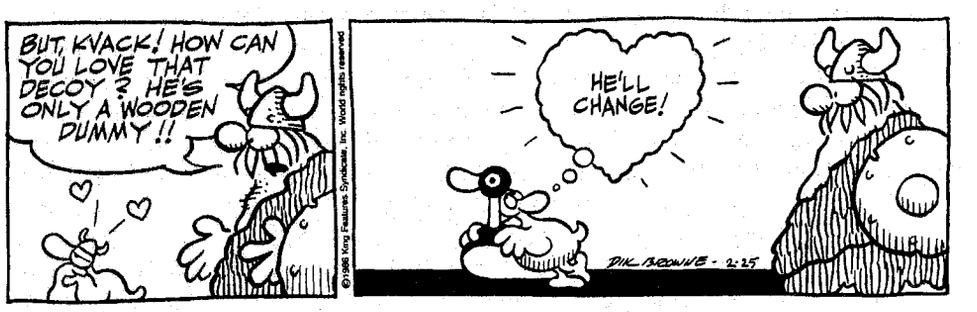
What about the old saying "opposites attract"? The term *opposites* here probably refers to personality traits rather than to social background or values. An attraction to a seemingly opposite person is more often based on the recognition that in one or two important personality traits, that person offers something we lack. In sum, lovers can enjoy some differences, but the more alike people are, the more both their loving and their liking endure.

The following *Psychology and You* feature offers a fun test of your understanding of the three factors in interpersonal attraction. Try it!

### TEST YOURSELF: UNDERSTANDING INTERPERSONAL ATTRACTION

## psychology and you

Based on your reading of this section, can you explain Kvack's love for the wooden dummy?






Answers: Research shows that similarity is the best predictor of long-term relationships. As shown here, however, many people ignore dissimilarities and hope that their chosen partner will change over time.

## Loving Others

It's easy to see why interpersonal attraction is a fundamental building block of our feelings about others. But how do we make sense of love? Why do we love some people and not others? Many people find the subject to be alternately mysterious, exhilarating, comforting—and even maddening. In this section, we explore four perspectives on love—*Sternberg's triarchic theory, consummate love, romantic love,* and *companionate love.*

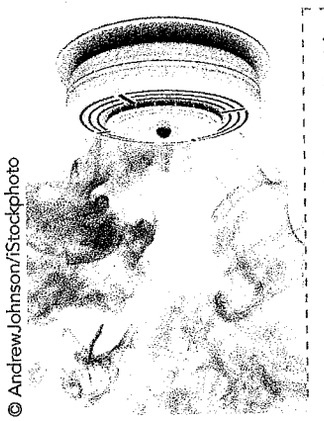
**Triarchic theory of love** Sternberg's theory that different stages and types of love result from three basic components—*intimacy, passion,* and *commitment.*

Robert Sternberg, a well-known researcher on creativity and intelligence (Chapter 8), produced a **triarchic** (triangular) **theory of love** (Sternberg, 1986, 1988, 2006). As you can see in **Figure 14.18**, his theory suggests that different types and stages of love result from three basic components:

- **Intimacy**—emotional closeness and connectedness, mutual trust, friendship, warmth, self-disclosure, and forming of "love maps."
- **Passion**—sexual attraction and desirability, physical excitement, a state of intense longing to be with the other.
- **Commitment**—permanence and stability, the decision to stay in the relationship for the long haul, and the feelings of security that go with this intention.

**Bystander effect** A phenomenon in which the greater the number of bystanders, the less likely it is that any one individual will feel responsible for seeking help or giving aid to someone who is in need of help.

How does this sequence explain television news reports and "caught on tape" situations in which people are robbed or attacked, and no one comes to their aid? The breakdown generally comes at the third stage—*taking personal responsibility for helping*. In follow-up interviews, most onlookers report that they failed to intervene because they were certain that someone must already have called the police. This so-called **bystander effect** is a well-known problem that affects our helping behaviors (see *Psychology and You*).



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**psychology and you** **Saving Your Own Life!** In one of the earliest studies of the power of the bystander effect, participants were asked to complete a questionnaire, either alone or with others. While they were working, a large amount of smoke was pumped into the room through a wall vent to simulate an emergency. As you might expect, most of the participants working alone, about 75%, quickly reported the smoke. In contrast, fewer than 40% reported smelling smoke when three other participants were in the room, and only 10% reported the smoke when they were with passive participants who ignored the smoke (Latane & Darley, 1968). Keep this study in mind when you're in a true emergency situation. Do not simply rely on others for information. Make your own quick decisions to act. It may save your life!

Why are we less likely to help when others are around? Researchers have suggested that when others are present we assume the responsibility for acting is shared, or diffused, among all onlookers. In contrast, when we're the lone observer, we recognize that we have the sole responsibility for acting. How can we promote helping? Considering what we've just learned about the bystander effect and the *diffusion of responsibility*, it's important to clarify when help is needed and then assign responsibility. For example, most parents teach their children to scream as loud as they can if they're being abducted by a stranger. Given that children often scream, can you see why this might not work? Instead, they should be taught to make eye contact with anyone who may be watching and then to shout something like: "This isn't my parent. Help me!" On the other hand, if you notice a situation in which it seems unclear whether someone needs help, simply ask: "Do you need help?" Highly publicized television programs, like ABC's "What Would You Do?" and "CNN Heroes," which honor and reward altruism, also increase helping. Finally, enacting laws that protect helpers from legal liability, so-called "good Samaritan" laws, also encourages helping behavior.

## Interpersonal Attraction

**Interpersonal attraction** Positive feelings toward another.

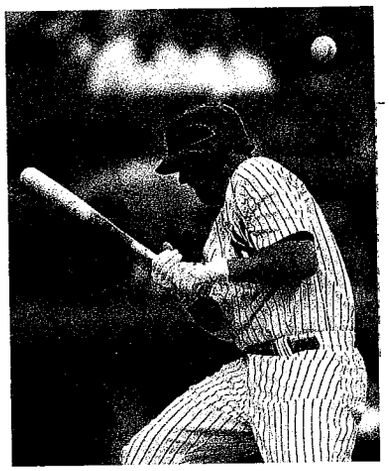
What causes us to feel admiration, liking, friendship, intimacy, lust, or love? All these social experiences are reflections of **interpersonal attraction**, our positive feelings toward another. Psychologists have found three compelling factors in interpersonal attraction: *physical attractiveness*, *proximity*, and *similarity*. Each influences our attraction in different ways.

### Physical Attractiveness

The way we look—including facial characteristics, body size and shape, and manner of dress—is one of the most important factors in our initial attraction, liking, or loving of others (Back et al., 2011; Buss, 2003, 2008, 2011; Cunningham et al., 2008; Regan, 2011; Sanderson, 2010). In addition, attractive individuals are seen as more poised, interesting, cooperative, achieving, sociable, independent, intelligent, healthy, and sexually warm than unattractive people (Jaeger, 2011; McColl & Truong, 2013; Moore et al., 2011; Tsukiura & Cabeza, 2011).

Interestingly, standards for attractiveness appear consistent across cultures, with most people showing a preference for faces that are average as opposed to "distinct" (Cunningham et al., 1995, 2002; Langlois et al., 2000; McArthur & Berry, 1987; Swami

developed by John Dollard and colleagues (1939), another aversive stimulus—frustration—creates anger, which for some leads to aggression (see *Real World Psychology*).



Rich Schultz/Getty Images

**realworldpsychology** **Aggression in Major League Baseball**

Researchers who examined 57,293 Major League Baseball games from 1952 through 2009 found that on hot days baseball pitchers were more likely to deliberately throw and hit a batter in retaliation after a batter on their own team has been hit by the opposing pitcher (Larrick et al., 2011)! Can you see how this finding supports both aversive stimuli and frustration as psychosocial explanations for aggression?

In addition, social-learning theory suggests that people raised in a culture with aggressive models will develop more aggressive responses (Cohen & Leung, 2011; Matsumoto & Juang, 2013; Rhee & Waldman, 2011). For example, the United States has a high rate of violent crime, and there are widespread portrayals of violence on TV, the Internet, movies, and video games which may contribute to aggression in both children and adults (Anderson et al., 2010; Bastian et al., 2012; Donnerstein, 2011; Hasan et al., 2013; Huesmann et al., 2013). However, the research is controversial (Ferguson, 2010, 2012, 2013; Valadez & Ferguson, 2012), and the link between violent media and aggression appears to be at least a two-way street. Laboratory studies, correlational research, and cross-cultural studies have found both that exposure to violence increases aggressiveness and that aggressive children tend to seek out violent programs (Bartlett et al., 2008; Carnagey et al., 2007; Kalnin et al., 2011; Krahé, 2013; Qian et al., 2013).

How can we control or eliminate aggression? Some people suggest we should release their aggressive impulses by engaging in harmless forms of aggression, such as exercising vigorously, punching a pillow, or watching competitive sports. But studies suggest that this type of *catharsis* doesn't really help and may only intensify the feeling (Bushman, 2002; Kuperstok, 2008).

A more effective approach is to introduce *incompatible responses*. Because certain emotional responses, such as empathy and humor, are incompatible with aggression, purposely making a joke or showing some sympathy for an opposing person's point of view can reduce anger and frustration (Baumeister & Bushman, 2014; DeWall et al., 2013; Kaukiainen et al., 1999; Weiner, 2006).

## Altruism

After reading about prejudice, discrimination, and aggression, you will no doubt be relieved to discover that human beings also behave in positive ways. People help and support one another by donating blood, giving time and money to charities, helping stranded motorists, and so on. There are also times when people do not help. Let's consider both responses.

**Altruism**, or *prosocial behavior*, consists of actions designed to help others, with no obvious benefit to the helper. There are three key approaches to explaining why we help others, and a five-step decision process explains when and why we don't help **(Figure 14.15)**.

The **evolutionary theory of helping** suggests that altruism is an instinctual behavior that has evolved because it favors survival of the altruist's genes (Boyd et al., 2011; Curry et al., 2013; McNamara et al., 2008; Preston, 2013). By helping our own child or other relative, for example, we increase the odds of our genes' survival.

Other research suggests that altruism may actually be self-interest in disguise. According to this **egoistic model of helping**, we help others only because we

**Altruism** Prosocial behaviors designed to help others, with no obvious benefit to the helper.

**Evolutionary theory of helping** A theory which states that altruism is an instinctual behavior that has evolved because it favors survival of one's genes.

**Egoistic model of helping** A theory which states that altruism is motivated by anticipated gain—later reciprocation, increased self-esteem, or avoidance of distress and guilt.

**Implicit bias** A hidden, automatic attitude that may guide behaviors independent of a person's awareness or control.

Unfortunately, stereotypes and prejudice can operate even without a person's conscious awareness or control. This process is known as automatic bias, or **implicit bias** (Cattaneo et al., 2011; Chapman et al., 2013; Columb & Plant, 2011; Soderberg & Sherman, 2013). The most prominent method for measuring implicit bias, the *Implicit Association Test* (*IAT*), measures how quickly people sort stimuli into particular categories.

## Overcoming Prejudice and Discrimination

What can we do to reduce and combat prejudice and discrimination? Four major approaches have been suggested: *cooperation and common goals*, *intergroup contact*, *cognitive retraining*, and *cognitive dissonance* **(Figure 14.14)**.

***Cooperation and Common Goals*** Research shows that one of the best ways to combat prejudice and discrimination is to encourage *cooperation* rather than *competition* (Kuchenbrandt et al., 2013; Price et al., 2013). Muzafer Sherif and his colleagues (1966, 1998) conducted an ingenious study to show the role of competition in promoting prejudice. The researchers artificially created strong feelings of ingroup and outgroup identification in a group of 11- and 12-year-old boys at a summer camp. They did this by physically separating the boys into different cabins and assigning different projects to each group, such as building a diving board or cooking out in the woods.

Once each group developed strong feelings of group identity and allegiance, the researchers set up a series of competitive games, including tug-of-war and touch football. They awarded desirable prizes to the winning teams. Because of this treatment, the groups began to pick fights, call each other names, and raid each other's camps. Researchers pointed to these behaviors as evidence of the experimentally produced prejudice.

The good news is that after using competition to create prejudice between the two groups, the researchers created "mini-crises" and tasks that required expertise, labor, and cooperation from both groups. Prizes were awarded to all and prejudice between the groups slowly began to dissipate. By the end of the camp, the earlier hostilities and *ingroup favoritism* had vanished. Sherif's study showed not only the importance of cooperation as opposed to competition but also the importance of *superordinate goals* (the "mini-crises") in reducing prejudice.

***Intergroup Contact*** A second approach to reducing prejudice is to increase contact and positive experiences between groups (Butz & Plant, 2011; Cameron et al., 2007;

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**FIGURE 14.14 HOW CAN WE REDUCE PREJUDICE?**

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Can you see how the four approaches to combatting prejudice are at work in this simple game of tug-of-war? Similarly, how might large changes in social policy, such as school busing, integrated housing, and increased civil rights legislation gradually change attitudes and eventually lead to decreased prejudice and discrimination?

How do prejudice and discrimination originate? Why do they persist? Five commonly cited sources of prejudice are *learning*, *personal experience*, *limited resources*, *displaced aggression*, and *mental shortcuts*.

## Learning

People learn prejudice the same way they learn other attitudes—primarily through *classical* and *operant conditioning* and *social learning* (Chapter 6). For example, repeated exposure to stereotypical portrayals of minorities and women in movies, online, magazines, and TV teach children that such images are correct. Similarly, hearing parents, friends, and teachers express their prejudices also reinforces prejudice (Amodio & Hamilton, 2013; Biernat & Danaher, 2013; Conger et al., 2013; Ferguson & Porter, 2013). *Ethnocentrism*, believing our own culture represents the norm or is superior to others, is also a form of a learned prejudice.

### Voices from the Classroom

**Learning and Gender Role Stereotypes** My friends were working outside with their 2 ½-year-old son nearby, when a heavy hammer fell on one parent's foot, followed by a very "colorful" exclamation of intense pain. Both parents quickly distracted their child, hoping to prevent him from learning and repeating the word. Disaster seemed to have been averted until the next day at church, when the boy dropped a Bible on his own foot and loudly repeated the same "colorful" word! Knowing that the parents were very embarrassed, the minister reassured the couple after the service by joking to the dad about thinking twice before using "colorful" language again. To his surprise, the father responded that he was not the one who used the word. It was his wife!

Like the minister, students in my class are equally surprised by this story. I use it as an example of gender-role stereotypes and how societal expectations and assumptions may not always be accurate.

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## Personal Experience

We also develop prejudice through direct experience. For example, when people make prejudicial remarks or "jokes," they often gain attention and even approval from others. Sadly, denigrating others also seems to boost some people's self-esteem (Fein & Spencer, 1997; Hodson et al., 2010; Nelson, 2013). Also, once someone has one or more negative interactions or experiences with members of a specific group, he or she may generalize the resulting bad feelings and prejudice to all members of that group.

## Limited Resources

Most of us understand that prejudice and discrimination exact a high price on their victims, but few appreciate the significant economic and political advantages they offer to the dominant group (Costello & Hodson, 2011; Danso & Lum, 2013; Kteily et al., 2011; Schaefer, 2008). For example, the stereotype that African Americans and Latinos are inferior to European Americans helps justify and perpetuate a social order in the United States in which European Americans hold disproportionate power and resources.

## Displaced Aggression

As we discuss in the next section, frustration sometimes leads people to attack the perceived cause of that frustration. But, as history has shown, when the source is ambiguous, or too powerful and capable of retaliation, people often redirect their aggression

**FIGURE 14.11 HOW GROUPTHINK OCCURS** | realworldpsychology

Ⓐ The process of groupthink begins when group members feel a strong sense of cohesiveness and isolation from the judgments of qualified outsiders. Add a directive leader and little chance for debate, and we have the recipe for a potentially dangerous decision.

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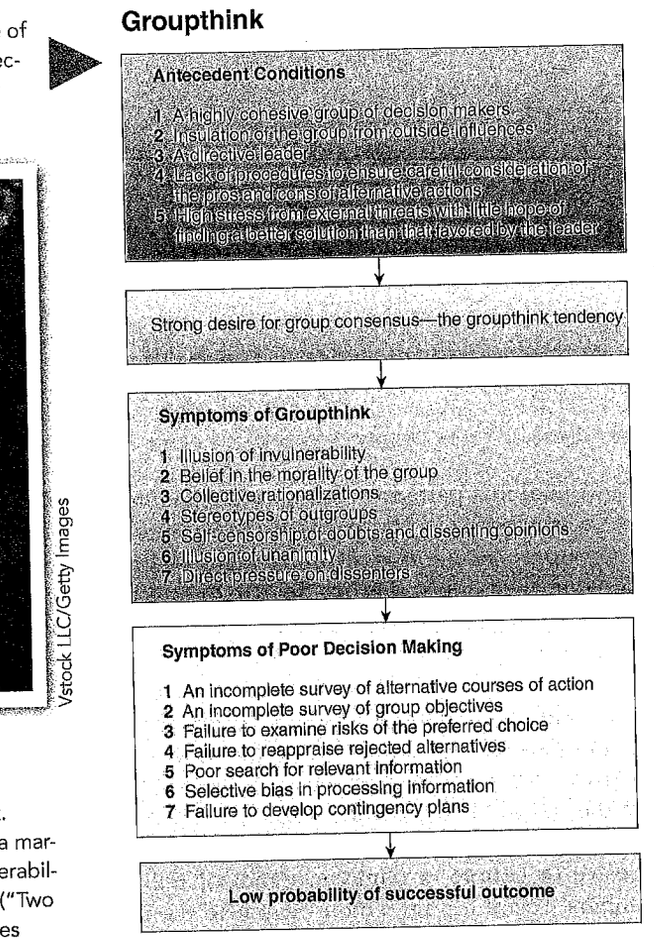
Ⓑ Few people realize that the decision to marry can be a form of groupthink. (Remember that a "group" can have as few as two members.) When planning a marriage, a couple may show symptoms of groupthink such as an illusion of invulnerability ("We're different—we won't ever get divorced"), collective rationalizations ("Two can live more cheaply than one"), shared stereotypes of the outgroup ("Couples with problems just don't know how to communicate"), and pressure on dissenters ("If you don't support our decision to marry, we don't want you at the wedding").




## RETRIEVAL PRACTICE: SOCIAL INFLUENCE

### Self-Test

Completing this self-test and comparing your answers with those in Appendix B provides immediate feedback and helpful practice for exams. Additional interactive, self-tests are available at www.wiley.com/college/huffman.

**1.** The act of changing behavior as a result of real or imagined group pressure is called _____.

a. norm compliance
b. obedience
c. conformity
d. mob rule

**2.** What percentage of people in Milgram's original study were willing to give the highest level of shock (450 volts)?

a. 45 percent
b. 90 percent
c. 65 percent
d. 10 percent

**3.** Which of the following factors may contribute to destructive obedience?

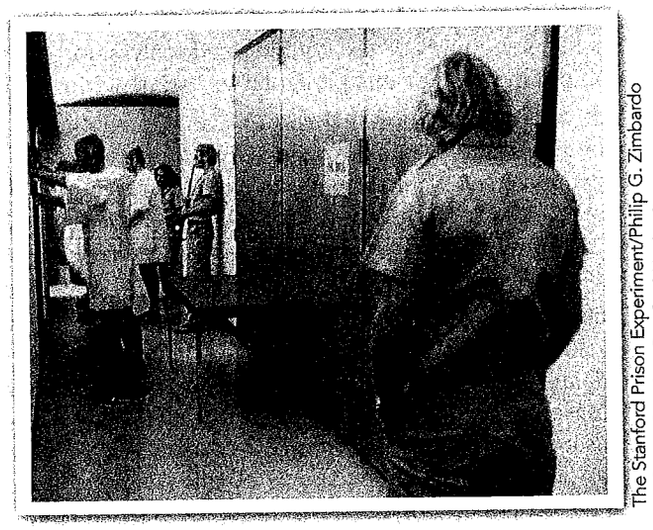
a. remoteness of the victim
b. foot-in-the-door
c. socialization
d. All these options.

**4.** One of the most critical factors in deindividuation is _____.

a. loss of self-esteem
b. anonymity
c. identity diffusion
d. group cohesiveness

**5.** Faulty decision making resulting from a highly cohesive group striving for agreement to the point of avoiding inconsistent information is known as _____.

a. the risky-shift
b. group polarization
c. groupthink
d. destructive conformity



The Stanford Prison Experiment/Philip G. Zimbardo
Professor Emeritus Stanford Unviersity

**FIGURE 14.8 POWER CORRUPTS**

Zimbardo's prison study showed how the demands of roles and situations could produce dramatic changes in behavior in just a few days. Can you imagine what happens to prisoners during life imprisonment, six-year sentences, or even a few nights in jail?

Not even Zimbardo foresaw how the study would turn out. Although some guards were nicer to the prisoners than others, they all engaged in some abuse of power. The slightest disobedience was punished with degrading tasks or the loss of "privileges" (such as eating, sleeping, and washing). As demands increased and abuses began, the prisoners became passive and depressed. One prisoner fought back with a hunger strike, which ended with a forced feeding by the guards.

Four prisoners had to be released within the first four days because of severe psychological reactions. The study was stopped after only six days because of the alarming psychological changes in the participants.

Note that this was not a true experiment in that it lacked a control group, and clear measurements of the dependent variable (Chapter 1). However, it did provide valuable insights into the potential effects of roles on individual behavior **(Figure 14.8)**. According to interviews conducted after the study, the students became so absorbed in their roles that they forgot they were participants in a university study (Zimbardo et al., 1977).

**Deindividuation** The reduced self-consciousness, inhibition, and personal responsibility that sometimes occurs in a group, particularly when the members feel anonymous.

Zimbardo's study also demonstrates **deindividuation**. To be deindividuated means that we feel less self-conscious, less inhibited, and less personally responsible as a member of a group than when we're alone **(Figure 14.9)**. Groups sometimes actively promote deindividuation by requiring members to wear uniforms, for example, as a way to increase allegiance and conformity.

## Group Decision Making

We've just seen how group membership affects the way we think about ourselves, but how do groups affect our decisions? Are two heads truly better than one?

Most people assume that group decisions are more conservative, cautious, and middle-of-the-road than individual decisions. But is this true? Initial investigations indicated that after discussing an issue, groups actually supported riskier decisions than decisions they made as individuals before the discussion (Stoner, 1961).

Subsequent research on this *risky-shift phenomenon*, however, shows that some groups support riskier decisions while others support conservative decisions (Liu & Latané, 1998; Tindale et al., 2013). How can we tell whether a given group's decision will be risky or conservative? A group's final decision depends primarily on its dominant *preexisting* tendencies. If the dominant initial position is risky, the final decision will be even riskier, and the reverse is true if the initial position is conservative—a process called **group polarization** (Baumeister & Bushman, 2014; Sanderson, 2010; Tindale & Posavac, 2011; Zhu, 2013).

**Group polarization** The tendency for groups to make decisions that are more extreme (either riskier or more conservative), depending on the members' initial dominant tendency.

Why? It appears that as individuals interact and share their opinions, they pick up new and more persuasive information that supports their original opinions, which may help explain why American politics has become so polarized in recent years (Miller, 2013). Can you see how if we only interact and work with like-minded people, or only talk politics with those who agree with us, we're likely to become even more polarized? An interesting study in Washington, DC found that interns

beyond 150 volts and that fewer than 1% of those tested would "go all the way." But, as Milgram discovered, 65% of his participants—men and women of all ages and from all walks of life—administered the highest voltage. The study was replicated many times and in many other countries, with similarly high levels of obedience.

Although there have been some recent partial replications of Milgram's study (e.g., Burger, 2009), his full, original setup could never be undertaken today due to ethical and moral considerations. Deception is a necessary part of some research, but the degree of it in Milgram's research and the discomfort of the participants would never be allowed under today's research standards. Keep in mind, however, that immediately following the study, Milgram carefully debriefed each participant and then followed up with the participants for several months. Most of his "teachers" reported finding the experience personally informative and valuable.

One final, important reminder: The *"learner" was an accomplice of the experimenter and only pretended to be shocked.* Milgram provided specific scripts that they followed at every stage of the experiment. In contrast, the "teachers" were true volunteers who believed they were administering real shocks. Although they suffered and protested, in the final analysis, they still obeyed.

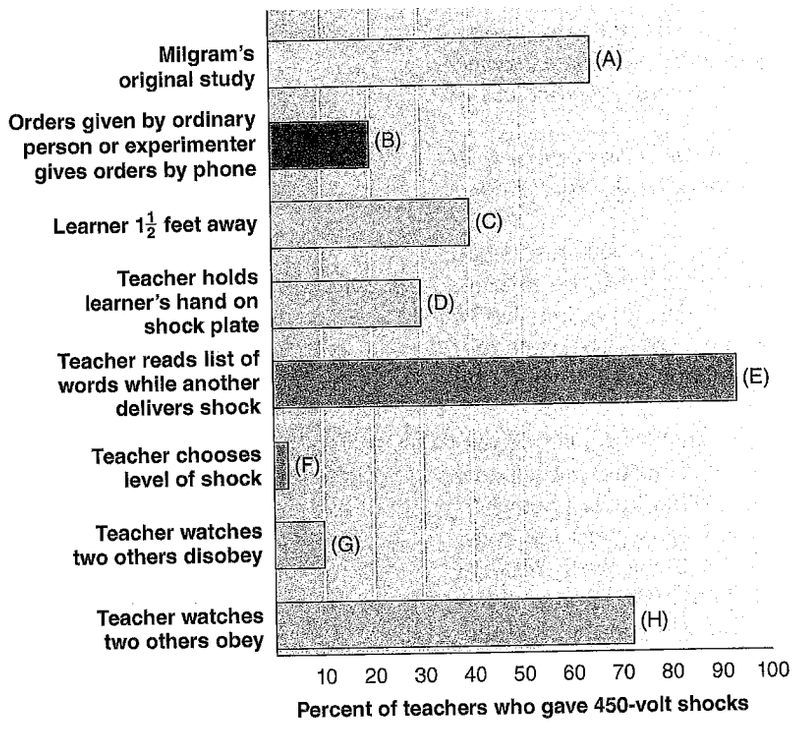
Why did the teachers in Milgram's study obey the orders to shock a fellow participant, despite their moral objections? Are there specific circumstances that increase or decrease obedience? In a series of follow-up studies, Milgram found several important factors that influenced obedience: *legitimacy and closeness of the authority figure*, *remoteness of the victim*, *assignment of responsibility*, and *modeling or imitation of others* (Blass, 1991, 2000; De Vos, 2010; Forsyth, 2013; Moghaddam, 2013; Pina e Cunha et al., 2010). See **Figure 14.7**.

In addition to the four factors that Milgram identified, other social psychologists have emphasized several additional influences, including the following:

- **Socialization** Can you see how socialization might help explain many instances of mindless and sometimes destructive obedience? From an early age, we're all taught to listen to and respect people in positions of authority. In this case, participants in Milgram's study came into the research lab with a lifetime of

**FIGURE 14.7 FOUR FACTORS THAT AFFECT WHY WE OBEY**

As you can see in the first bar on the graph, 65% of the participants in Milgram's early studies gave the learner the full 450-volt level of shocks. Note also how the color coding on the other bars on the graph (dark pink, yellow, green, and blue) corresponds to the four major conditions that either increased or decreased obedience to authority.




**1. Legitimacy and closeness of the authority figure**
When orders came from an ordinary person, and when the experimenter left the room and gave orders by phone, 20% of the teachers gave the full 450-volt shocks. (Bar B on graph.)

**2. Remoteness of the victim**
When the learner was only 1½ feet away from the teacher, 40% of the teachers gave the highest level of shocks. Surprisingly, when the teacher had to actually hold the learner's hand on the shock plate, obedience was still 30%. (Bars C and D on graph.)

**3. Assignment of responsibility**
When the teacher simply read the list of words, while another delivered the shock, obedience jumped to almost 94%. However, when the teacher was responsible for choosing the level of shock, only 3% obeyed. (Bars E and F on graph.)

**4. Modeling or imitating others**
When teachers watched two other teachers refuse to shock the learner, only 10% gave the full 450-volt shocks. However, when they watched two other teachers obey, their obedience jumped to over 70% (Milgram, 1963, 1974). (Bars G and H on graph.)

**Informational social influence** Conforming to a group out of a need for information and direction.

- **Informational social influence** Have you ever bought a specific product simply because of a friend's recommendation? In this case, you probably conformed not to gain your friend's approval, a case of normative social influence, but because you assumed that he or she had more information than you did, a case of informational social influence. Given that participants in Asch's experiment observed all the other participants giving unanimous decisions on the length of the lines, can you see how they may have conformed because they believed the others had more information than they did?

## Voices from the Classroom

**Santa and Informational Social Influence** Conformity is a fun and pertinent topic because there is always a good, recent example to which students can relate. For example, when discussing *informational social influence*, I talk about kids lining up to meet Santa. It's a relatively novel experience for them, and they are often unsure of how to act, so they look to others for information. When one child becomes frightened by Santa or an elf and screams or cries, there's a ripple effect throughout the line. Soon all the other kids also are scared and crying.

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**Reference groups** The people we conform to, or go along with, because we like, admire, and want to be like them.

**Obedience** Following direct commands, usually from an authority figure.

- **Reference groups** The third major factor in conformity is the power of *reference groups*—people we most admire, like, and want to resemble. Attractive actors and popular sports stars are paid millions of dollars to endorse products because advertisers know that we want to be as cool as LeBron James or as beautiful as Natalie Portman. Of course, we also have more important reference groups in our lives—parents, friends, family members, teachers, religious leaders, and classmates—all of whom affect our willingness to conform. For example, popular high school students' attitudes about alcohol use have been shown to have a substantial influence on alcohol consumption by other students in their high school (Teunissen et al., 2012). Surprisingly, popular peers who had *negative* attitudes toward alcohol use were even more influential in determining rates of teenage drinking than those with positive attitudes! This finding suggests that capitalizing on popular peers who have negative drinking attitudes might be a very effective strategy for reducing underage drinking. Q2

**FIGURE 14.5 GOOD REASONS FOR CONFORMING AND OBEYING**

These people willingly obey the firefighters who order them to evacuate a building, and many lives are saved. What would happen to our everyday functioning if most people did not go along with the crowd or generally did not obey orders?

David McNew/Getty Images

## Obedience

As we've seen, conformity means going along with the group. A second form of social influence, **obedience**, involves going along with direct commands, usually from someone in a position of authority. From very early childhood, we're socialized to respect and obey our parents, teachers, and other authority figures.

Conformity and obedience aren't always bad **(Figure 14.5)**. In fact, we generally conform and obey most of the time because it's in our own best interests (and everyone else's) to do so. Like most other North Americans, we stand in line at a movie theatre instead of pushing ahead of others. This allows an orderly purchasing of tickets. Conformity and obedience allow social life to proceed with safety, order, and predictability.

**Think Critically**

1. Why do we tend to blame others for their misfortunes but deny responsibility for our own failures?
2. Have you ever changed a strongly held attitude? What caused you to do so?
3. Can you think of an example of cognitive dissonance from your own life?

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**Why do athletes often blame their losses on bad officiating?**

HINT: LOOK IN THE MARGIN FOR Q1

# SOCIAL INFLUENCE

**LEARNING OBJECTIVES**

**RETRIEVAL PRACTICE** While reading the upcoming sections, respond to each Learning Objective in your own words. Then compare your responses with those found at www.wiley.com/college/huffman.

1. **IDENTIFY** conformity and the factors that contribute to it.
2. **DESCRIBE** obedience and the factors that contribute to it.
3. **EXPLAIN** how groups affect behavior and decision making.

**Social influence** How situational factors and other people affect us.

In the previous section, we explored the way we think about and interpret ourselves and others through *social cognition*. We now focus on **social influence**: how situational factors and other people affect us. In this section, we explore three key topics—*conformity*, *obedience*, and *group processes*.

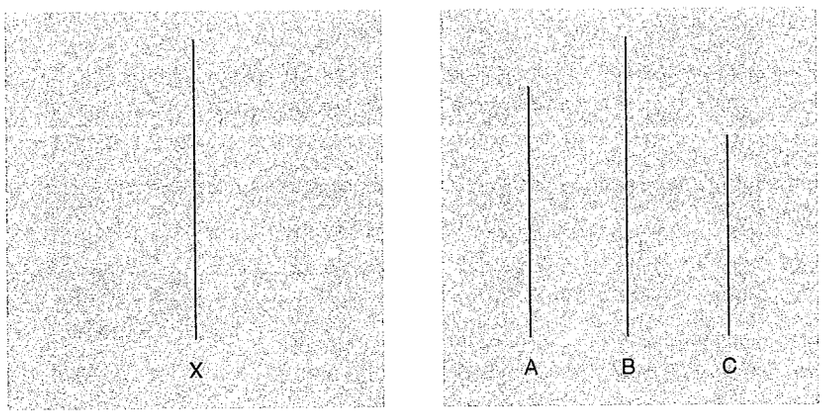
## Conformity

Imagine that you have volunteered for a psychology experiment on visual perception. All participants are shown two cards. The first card has only a single vertical line on it, while the second card has three vertical lines of varying lengths. Your task is to determine which of the three lines on the second card (marked A, B, or C) is the same length as the single line on the first card (marked X).

You are seated around a table with six other people, and everyone is called on in order. Because you are seated to the left of the seventh participant, you are always next to last to provide your answers. On the first two trials, everyone agrees on the correct line. However, on the third trial, your group is shown two cards like those in **Figure 14.4**. The first participant chooses line A as the closest in length to line

**FIGURE 14.4 SOLOMON ASCH'S STUDY OF CONFORMITY**

Which line (A, B, or C) is most like line X? Could anyone convince you otherwise?



**Cognitive dissonance** The unpleasant tension and anxiety caused by a discrepancy between two or more conflicting attitudes or between attitudes and behaviors.

feelings of discomfort, known as **cognitive dissonance** (Baumeister & Bushman, 2014; Moghaddam, 2013; Samnani et al., 2012; Sanderson, 2010; Sharpe et al., 2013). (See *Psych Science.*) Once we've created or experienced cognitive dissonance, how can we reduce it **(Figure 14.3)**?

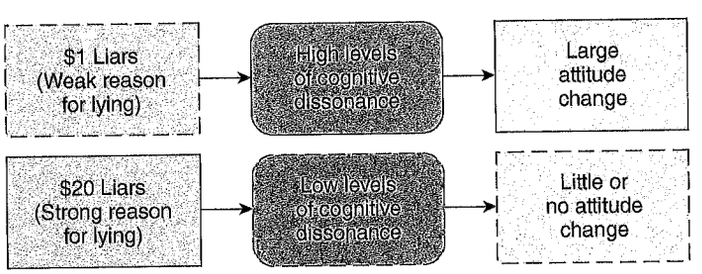
## Culture and Cognitive Dissonance

The experience of cognitive dissonance may depend on a distinctly Western way of thinking about and evaluating the self. As we mentioned earlier, people in Eastern cultures tend not to define themselves in terms of their individual accomplishments. For this reason, making a bad decision may not pose the same threat to self-esteem that it would in more individualistic cultures, such as the United States (Dessalles, 2011; Imada & Kitayama, 2010; Kokkoris & Kühnen, 2013; Stephens & Swartz, 2013).

In sum, psychologists have long been particularly interested in how attitudes are formed—and how they can change. This emphasis on attitudes is important because they often, but not always, predict behavior. For example, research has found that teenage drivers' attitudes about speeding are a strong predictor of whether they actually speed—and receive speeding tickets—later on (Rowe et al., 2013).

# PSYCHSCIENCE

## WOULD YOU LIE FOR $1.00?




**In one of the best-known tests of cognitive dissonance theory,** Leon Festinger and J. Merrill Carlsmith (1959) paid participants either $1 or $20 to lie to fellow research participants by telling them that a boring experimental task in which they had just participated was actually very enjoyable and fun. Surprisingly, those who were paid just $1 to lie subsequently changed their minds about the task and actually reported more positive attitudes toward it than those who were paid $20.

Why was there more attitude change among those who were paid only $1? All participants who lied to other participants presumably recognized the discrepancy between their initial attitude (the task was boring) and their behavior (telling others it was enjoyable and fun). However, as you can see in the figure above, the participants who were given insufficient monetary justification for lying (the $1 liars) apparently experienced greater *cognitive dissonance.* Therefore, they expressed more liking for the dull task than those who received sufficient monetary justification (the $20 liars). This second group had little or no motivation to change their attitude—they lied for the money! (Note that in 1959, when the experiment was done, $20 would be worth about $200 today.)

### RESEARCH CHALLENGE

1. Based on the information provided, did this study (Festinger & Carlsmith, 1959) use descriptive, correlational, and/or experimental research?
2. If you chose:
   - descriptive research, is this a naturalistic observation, survey/interview, case study, or archival research?
   - correlational research, is this a positive, negative, or zero correlation?
   - experimental research, label the IV, DV, experimental group(s), and control group.

**>> CHECK YOUR ANSWERS IN APPENDIX B.**

NOTE: The information provided in this study is admittedly limited, but the level of detail is similar to what is presented in most textbooks and public reports of research findings. Answering these questions, and then comparing your answers to those in the Appendix, will help you become a better critical thinker and consumer of scientific research.

## Self-Serving Bias

**Self-serving bias** A type of attributional bias in which we take credit for our successes, but blame our failures on other people or events.

Unlike the FAE, which commonly occurs when we're explaining others' behaviors, the **self-serving bias** more often happens when we explain our own behavior. In this case, we tend to favor internal (personality) attributions for our successes and blame external (situational) attributions for our failures. This bias is motivated by our desire to maintain positive self-esteem and a good public image (Martin & Carron, 2012; Sanjuán & Magallares, 2013; Vaillancourt, 2013). For example, students often take personal credit for doing well on an exam. If they fail a test, however, they tend to blame the instructor, the textbook, or the "tricky" questions. Similarly, elite Olympic athletes more often attribute their wins to internal (personal) causes, such as their skill and effort, while attributing their losses to external (situational) causes, such as bad equipment or poor officiating (Aldridge & Islam, 2012).

**Actor–observer effect** The tendency to attribute one's own actions to external (situational) factors while attributing others' actions to internal (dispositional) causes.

How do we explain the discrepancy between the attributions we make for ourselves and those we make for others? According to the **actor–observer effect** (Jones & Nisbett, 1971), when examining our own behaviors, we are the *actors* in the situation and know more about our own intentions and behaviors and naturally look to the environment for explanations: "I didn't tip the waiter because I got really bad service." In contrast, when explaining the behavior of others, we are *observing* the actors and therefore tend to blame the person, using a personality attribution: "She didn't tip the waiter because she's cheap" **(Figure 14.1)**.

### FIGURE 14.1 THE ACTOR–OBSERVER EFFECT

We tend to explain our own behavior in terms of external factors (situational attributions) and others' behavior in terms of their internal characteristics (dispositional attributions).


## Culture and Attributional Biases

Interestingly, both the fundamental attribution error and the self-serving bias may depend in part on cultural factors (Han et al., 2011; Imada & Ellsworth, 2011; Lien et al., 2006; Sanjuán & de Lopez, 2013; Wirtz & Chiu, 2008). In highly individualistic cultures, like the United States, people are defined and understood as individual selves, largely responsible for their own successes and failures.

In contrast, people in collectivistic cultures, like China and Japan, are primarily defined as members of their social network, responsible for doing as others expect. Accordingly, they tend to be more aware of situational constraints on behavior, making the FAE less likely (Leung et al., 2012; Matsumoto & Juang, 2013; McClure et al., 2011).

The self-serving bias is also much less common in collectivistic cultures because self-esteem is related not to doing better than others but to fitting in with the group (Berry et al., 2011; Markus & Kitayama, 2003; Smith, 2011). In Japan, for instance, the ideal person is aware of his or her shortcomings and continually works to overcome them—rather than thinking highly of himself or herself (Heine & Renshaw, 2002; Shand, 2013).

## Attitudes

When we observe and respond to the world around us, we are seldom completely neutral. Rather, our responses toward subjects as diverse as pizza, AIDS, and abortion

# chapteroverview

For many students and psychologists, your authors included, *social psychology* is the most exciting of all fields because it's about you and me and because almost everything we do is *social*! Unlike earlier chapters that focused on individual processes, like sensation and perception, memory, or personality, this chapter studies how large social forces, such as groups, social roles, and norms, bring out the best and worst in all of us. It is organized around three central themes: *social cognition*, *social influence*, and *social relations*. Before reading on, check the misconceptions you may have about these topics in *How Much Do You Know About the Social World?*

## TEST YOURSELF: HOW MUCH DO YOU KNOW ABOUT THE SOCIAL WORLD?

## psychology and you

### TRUE OR FALSE?

____1. Most people judge others more harshly than they judge themselves.

____2. Persuasion is the most effective way to change attitudes.

____3. Groups generally make riskier or more conservative decisions than a single individual does.

____4. People wearing masks are more likely than unmasked individuals to engage in aggressive acts.

____5. Emphasizing gender differences may create and perpetuate prejudice.

____6. Substance abuse (particularly alcohol abuse) is a major factor in aggression.

____7. When people are alone, they are more likely to help another individual than when they are in a group.

____8. Looks are the primary factor in our initial feelings of attraction, liking, and love.

____9. Opposites attract.

____10. Romantic love generally starts to fade after 6 to 30 months.

Answers: Two of these statements are false. You'll find the answers within this chapter.

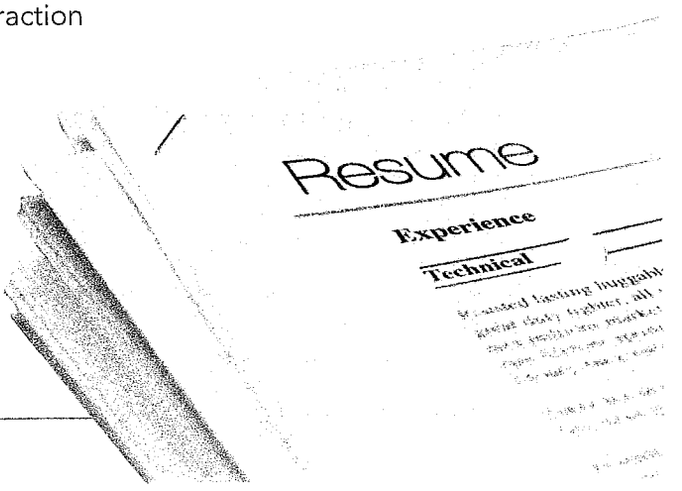
Jason Stitt/Shutterstock

# chapter fourteen

# Social Psychology

## CHAPTER OUTLINE





## RETRIEVAL PRACTICE: PSYCHOTHERAPY IN PERSPECTIVE

### Self-Test

Completing this self-test and comparing your answers with those in Appendix B provides immediate feedback and helpful practice for exams. Additional interactive, self-tests are available at www.wiley.com/college/huffman.

1. Which of the following is *not* a culturally universal feature of therapy?

   a. Naming the problem
   b. Demonstrating the right qualities
   c. Establishing rapport among family members
   d. Placing the problem in a familiar framework

2. A Japanese therapy designed to help clients discover personal guilt for having been ungrateful and troublesome to others and to develop gratitude toward those who have helped them is known as _____.

   a. Kyoto therapy
   b. Okado therapy
   c. Naikan therapy
   d. Nissan therapy

3. A(n) _____ group does not have a professional leader, and members assist each other in coping with a specific problem.

   a. self-help
   b. encounter
   c. peer
   d. behavior

4. _____ treats the family as a unit, and members work together to solve problems.

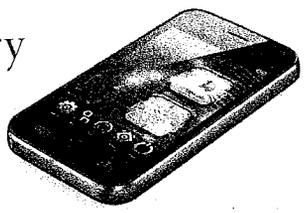
   a. Aversion therapy
   b. An encounter group
   c. A self-help group
   d. Family therapy

### Think Critically

1. Which of the universal characteristics of therapists do you believe is the most important? Why?
2. If a friend were having marital problems, how would you convince him or her to go to a marriage or family therapist, using information you've gained in this chapter?

## realworldpsychology

**Can therapy that is delivered over the telephone lead to lower levels of depression?**



HINT: LOOK IN THE MARGIN FOR Q5

# Summary

## 1 TALK THERAPIES 369

- Talk therapies are forms of **psychotherapy** that seek to increase insight into clients' difficulties.
- In **psychoanalysis**, the therapist seeks to identify the patient's unconscious conflicts and to help the patient resolve them. In modern **psychodynamic therapy**, treatment is briefer, and the therapist takes a more directive approach (and puts less emphasis on unconscious childhood memories) than in traditional psychoanalysis.
- **Humanistic therapy**, such as Rogers's **client-centered therapy**, seeks to maximize personal growth, encouraging people to actualize their potential and relate to others in genuine ways.
- **Cognitive therapy** seeks to help clients challenge faulty thought processes and adjust maladaptive behaviors. Ellis's **rational-emotive behavior therapy (REBT)** and Beck's **cognitive-behavior therapy (CBT)** are important examples of cognitive therapy.

## 2 BEHAVIOR THERAPIES 377

- In **behavior therapy**, the focus is on the problem behavior itself rather than on any underlying causes. The therapist uses learning principles to change behavior.
- Classical conditioning techniques include **systematic desensitization** and **aversion therapy**.
- Operant conditioning techniques used to increase adaptive behaviors include *shaping* and *reinforcement*.
- In **modeling therapy**, clients observe and imitate others who are performing the desired behaviors.

## 3 BIOMEDICAL THERAPIES 381

- **Biomedical therapies** are based on the premise that chemical imbalances or disturbed nervous system functioning contributes to problem behaviors.
- **Psychopharmacology** is the most common form of biomedical therapy. Major classes of drugs used to treat psychological disorders are **antianxiety drugs**, **antipsychotic drugs**, **mood stabilizer drugs**, and **antidepressant drugs**.

Although there are basic similarities in therapies across cultures, there are also important differences. In the traditional Western European and North American model, the emphasis is on the patient's self and on his or her having independence and control over his or her life—qualities that are highly valued in individualistic cultures. In collectivist cultures, however, the focus of therapy is on interdependence and the patient's accepting the realities of his or her life (Ross, 2013).

Sky Bonillo/PhotoEdit

realworldpsychology **Emphasizing Interdependence** In Japanese Naikan therapy, patients sit quietly from 5:30 a.m. to 9:00 p.m. for seven days and are visited by an interviewer every 90 minutes. During this time, they reflect on their relationships with others in order to discover personal guilt for having been ungrateful and troublesome and to develop gratitude toward those who have helped them (Moodley & Sutherland, 2010; Nakamura, 2006; Ozawa-de Silva, 2007; Shinfuku & Kitanishi, 2010).

Not only does culture affect the types of therapy that are developed, it also influences the perceptions of the therapist. What one culture considers abnormal behavior may be quite common—and even healthy—in others. For this reason, recognizing cultural differences is very important for building trust between therapists and clients and for effecting behavioral change (Barnow & Balkir, 2013; Frew & Spiegler, 2013; Moodley, 2012).

## Gender and Therapy

In our individualistic Western culture, men and women present different needs and problems to therapists. Research has identified four unique concerns related to gender and psychotherapy (Bruns & Kaschak, 2011; Geller et al., 2013; Jordan, 2011; Remer, 2013):

1. **Rates of diagnosis and treatment of mental disorders** Women are diagnosed and treated for mental illness at a much higher rate than men. Are women "sicker" than men as a group, or are they just more willing to admit their problems? Or are the categories of illness biased against women? More research is needed to answer these questions.
2. **Stresses of poverty** Women are disproportionately likely to be poor. Poverty contributes to stress, which is directly related to many psychological disorders.
3. **Violence against women** Rape, incest, and sexual harassment—which are much more likely to happen to women than to men—may lead to depression, insomnia, posttraumatic stress disorders, eating disorders, and other problems.
4. **Stresses of multiple roles** Women today are mothers, wives, homemakers, wage earners, students, and more. The conflicting demands of their multiple roles often create special stresses.

Therapists must be sensitive to possible connections between clients' problems and their gender. Rather than prescribing drugs to relieve depression in women, for example, it may be more appropriate for therapists to explore ways to relieve the stresses of multiple roles or poverty. Can you see how helping a single mother identify parenting resources, such as play groups, parent support groups, and high-quality child care, might be just as effective at relieving depression as prescribing drugs? In the case of men, how might relieving loneliness

Anonymous are examples of self-help groups. Although group members don't get the same level of individual attention found in one-on-one therapies, group and self-help therapies provide their own unique advantages (Corey, 2011; Jaffe & Kelly, 2011; Kivlighan et al., 2012; Messer & Gurman, 2011; Piper & Hernandez, 2013). They are far less expensive than one-on-one therapies and provide a broader base of social support. Group members also can learn from each other's experiences, share insights and coping strategies, and role-play social interactions together.

Therapists often refer their patients to group therapy and to self-help groups in order to supplement individual therapy. For example, recovering alcoholics who choose to help others in Alcoholics Anonymous group sessions actually show lower levels of alcohol use themselves as long as 10 years later (Pagano et al., 2013). In sum, research on self-help groups for alcoholism, obesity, and other disorders suggests that they can be very effective, either alone or in addition to individual psychotherapy (Donovan et al., 2013; Jaffe & Kelly, 2011; Majer et al., 2013; Pomerantz, 2013).

## Marital and Family Therapies

Given that a family or marriage is a system of interdependent parts, the problem of any one individual inevitably affects everyone, and therefore all members are potential beneficiaries of therapy (Dattilio & Nichols, 2011; Friedlander et al., 2011; Hills, 2013; Lebow & Stroud, 2013). The line between family and marital or couples therapy is often blurred. Here, our discussion will focus on *family therapy*, in which the primary aim is to change maladaptive family interaction patterns **(Figure 13.16)**. All members of the family attend therapy sessions, though at times the therapist may see family members individually or in twos or threes.

Family therapy is also useful in treating a number of disorders and clinical problems. As we discussed in Chapter 12, schizophrenic patients are at increased risk of relapsing if their family members express emotions, attitudes, and behaviors that suggest criticism, hostility, or emotional overinvolvement (Lobban et al., 2013; Pharoah et al., 2010; Quinn et al., 2003). Family therapy can help family members modify their behavior toward the patient. It can also be the most favorable setting for the treatment of adolescent drug abuse (Alexander et al., 2013; Mead, 2012; Morgan et al., 2013; O'Farrell, 2011).

## Telehealth/Electronic Therapy

Today millions of people are receiving advice and professional therapy in newer, electronic formats, such as the Internet, e-mail, virtual reality (VR), and interactive web-based conference systems such as Skype. This latest form of electronic therapy,

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**FIGURE 13.16 FAMILY THERAPY**

Many families initially come into therapy believing that one member is the cause of all their problems. However, family therapists generally find that this "identified patient" is a scapegoat for deeper disturbances. How could changing ways of interacting within the family system promote the health of individual family members and the family as a whole?

# PSYCHSCIENCE

## CAN WRITING SAVE YOUR MARRIAGE?

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**Self-reflection and journaling are proven successful therapy** techniques, so researchers in one study asked 120 volunteer married couples to describe the most significant disagreement they had experienced with their spouse during the past four months (Finkel et al., 2013). Half of the couples were then asked to complete a series of three seven-minute writing exercises. These writing exercises asked both spouses to reflect on the disagreement while taking the perspective of a neutral third party who wants the best for all involved. The other half of the couples were NOT asked to complete the writing assignment.

The researchers then contacted the couples every four months for the next two years. During these follow-up contacts, couples also were asked to provide a similar neutral summary of their most significant marital disagreement in the past four months and to report their level of relationship satisfaction, love, intimacy, trust, passion, and commitment.

Couples in both groups showed decreased marital satisfaction over the first year (a typical finding in married couples), but those that completed the writing exercises by taking the perspective of a neutral third party showed no additional decline in marital satisfaction in the second year. In contrast, couples that did not take this neutral perspective continued to show even greater declines in satisfaction.

Can you see how taking the perspective of a neutral third party might have indirectly trained the couples to use more *empathy* and *unconditional positive regard with one another*—two terms we discussed earlier in this chapter? Similarly, can you understand how this writing exercise might have helped these couples avoid Beck's negative thinking patterns of *selective perception, overgeneralization, magnification,* and *all-or-nothing thinking*? Most importantly, can you apply the results of this research, and the terms we've just identified, to improving your own relationships with romantic partners, family members, and friends?

### RESEARCH CHALLENGE

1. Based on the information provided, did this study (Finkel et al., 2013) use descriptive, correlational, and/or experimental research?
2. If you chose:
   - descriptive research, is this a naturalistic observation, survey/interview, case study, or archival research?
   - correlational research, is this a positive, negative, or zero correlation?
   - experimental research, label the IV, DV, experimental group(s), and control group.

**>>CHECK YOUR ANSWERS IN APPENDIX B.**

NOTE: The information provided in this study is admittedly limited, but the level of detail is similar to what is presented in most textbooks and public reports of research findings. Answering these questions, and then comparing your answers to those in the Appendix, will help you become a better critical thinker and consumer of scientific research.

As we've just seen, some studies find that most therapies are equally effective for various disorders. However, other studies suggest that specific therapies are more effective for certain problems than others. For example, phobias and marital problems seem to respond best to behavioral therapies, whereas depression and obsessive-compulsive disorders can be significantly relieved with cognitive-behavior therapy (CBT) accompanied by medication (Craighead et al., 2013; Spiegler, 2013; Wilson, 2011).

Finally, in recent years, the *empirically supported*, or *evidence-based practice* (*EBP*), *movement* has been gaining momentum because it seeks to identify which therapies have received the clearest research support for particular disorders (Biegel et al., 2013; Duncan & Reese, 2013; Sharf, 2012; Thyer & Myers, 2011).

## RETRIEVAL PRACTICE: BIOMEDICAL THERAPIES

### Self-Test

Completing this self-test and comparing your answers with those in Appendix B provides immediate feedback and helpful practice for exams. Additional interactive, self-tests are available at www.wiley.com/college/huffman.

**1.** The study of the effects of drugs on behavior and mental processes is known as _____.

a. psychiatry
b. psychoanalysis
c. psychosurgery
d. psychopharmacology

**2.** The effectiveness of antipsychotic drugs is thought to result primarily from decreasing activity at the _____ receptors.

a. serotonin
b. dopamine
c. epinephrine
d. all these options

**3.** In electroconvulsive therapy (ECT), _____.

a. current is never applied to the left hemisphere
b. seizures activate the central and peripheral nervous systems, stimulate hormone and neurotransmitter release, and change the blood–brain barrier
c. convulsions are extremely painful and long lasting
d. most patients receive hundreds of treatments because it is safer than in the past

**4.** ECT is used primarily to treat _____.

a. phobias
b. conduct disorders
c. severe depression
d. schizophrenia

### Think Critically

1. Are the potential benefits of psychopharmacology worth the risks? Is it ever ethical to force someone to take drugs to treat his or her mental illness?
2. If you, or someone you loved, were seriously depressed would you be in favor of ECT? Why or why not?

## realworldpsychology

**How do psychotherapeutic drugs help decrease thoughts of suicide?**

HINT: LOOK IN THE MARGIN FOR Q4

# PSYCHOTHERAPY IN PERSPECTIVE

**LEARNING OBJECTIVES**

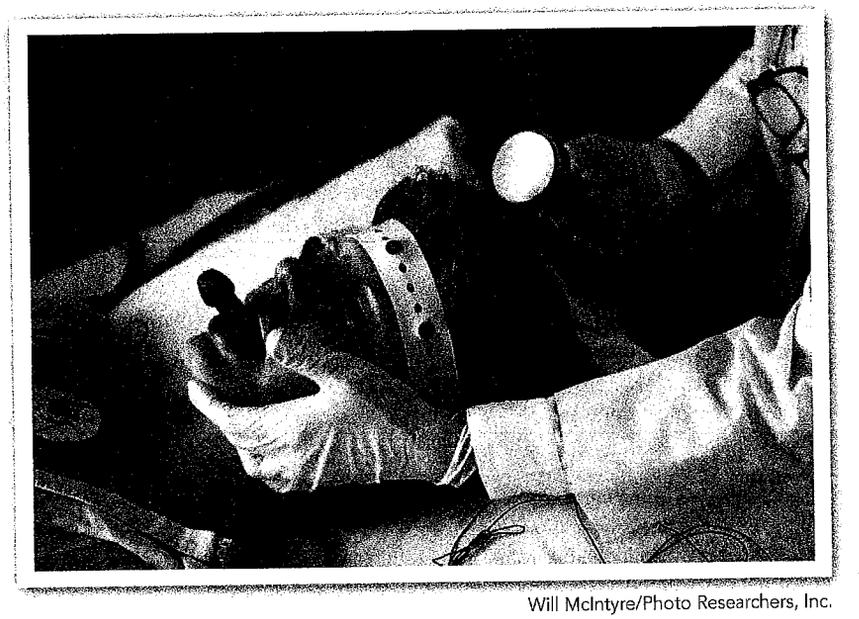
RETRIEVAL PRACTICE While reading the upcoming sections, respond to each Learning Objective in your own words. Then compare your responses with those found at www.wiley.com/college/huffman.

1. **SUMMARIZE** the goals and overall effectiveness of psychotherapy.
2. **DESCRIBE** group, marital, family, and telehealth/electronic therapies.
3. **IDENTIFY** the key cultural and gender issues important in therapy.
4. **SUMMARIZE** the major career options for someone interested in being a therapist.

Given that it's currently estimated that there are more than 400 forms of therapy, how would you choose one for yourself or someone you know? In the first part of this section, we discuss five goals common to all psychotherapies. Then we explore specific formats for therapy as well as considerations of culture and gender. Our aim is to help you synthesize the material in this chapter and put what you have learned about each of the major forms of therapy into a broader context.

## Therapy Goals and Effectiveness

All major forms of therapy are designed to help the client in five specific areas **(Figure 13.14)**.



Will McIntyre/Photo Researchers, Inc.

**FIGURE 13.12 ELECTROCONVULSIVE THERAPY (ECT)**

Modern ECT treatments are conducted with considerable safety precautions, including muscle-relaxant drugs that dramatically reduce muscle contractions and medication to help patients sleep through the procedure. Despite a 70% improvement for severe depression, ECT is used less often today, than in the past. Due to its known and unknown risks, it's generally only used when other treatments have failed, despite a 70% improvement rate for depression (Case et al., 2013; Perugi et al., 2012).

problems, the risks of untreated, severe depression are generally considered greater than the risks of ECT. It is used primarily on patients who have not responded to drugs and psychotherapy, and on suicidal patients, because it works faster than antidepressant drugs (Kobeissi et al., 2011; Loo et al., 2011; Pfeiffer et al., 2011).

**Psychosurgery** A neurosurgical alteration of the brain to bring about desirable behavioral, cognitive, or emotional changes, which is generally used when patients have not responded to other forms of treatment; also called neurosurgery for mental disorder (NMD).

**Lobotomy** An outmoded neurosurgical procedure for mental disorders, which involved cutting nerve pathways between the frontal lobes and the thalamus and hypothalamus.

The most extreme, and least used, biomedical therapy is **psychosurgery**—brain surgery performed to reduce serious debilitating psychological problems. Attempts to change disturbed thoughts, feelings, and behavior by altering the brain have a long history. In Roman times, for example, it was believed that a sword wound to the head could relieve insanity. In 1936, Portuguese neurologist Egaz Moniz first treated uncontrollable psychoses with a form of *psychosurgery* called a **lobotomy**, in which he cut the nerve fibers between the frontal lobes (where association areas for monitoring and planning behavior are found) and the thalamus and hypothalamus. Although these surgeries did reduce emotional outbursts and aggressiveness, patients were left with permanent brain damage.

realworldpsychology **A Modern Alternative to Lobotomies** Two of the most notable examples of the damage from early lobotomies are Rosemary Kennedy, the sister of President John F. Kennedy, and Rose Williams, sister of American playwright Tennessee Williams. Both women were permanently incapacitated from lobotomies performed in the early 1940s. Thankfully, in the mid-1950s, when antipsychotic drugs came into use, psychosurgery virtually stopped.

Recently, however, psychiatrists have been experimenting with a much more limited and precise neurosurgical procedure called *deep brain stimulation* (*DBS*). The surgeon drills two tiny holes into the patient's skull and implants electrodes in the area of the brain believed to be associated with a specific disorder. These electrodes are then connected to a "pacemaker" implanted in the chest or stomach that sends low-voltage electricity to the problem areas in the brain.

Over time, this repeated stimulation can bring about significant improvement in Parkinson's disease, epilepsy, major depression and other disorders (Campbell et al., 2012; Chopra et al., 2012; Kennedy et al., 2011; Lageman et al., 2013; Spindler et al., 2013). In addition, research has shown that patients who receive this type of DBS along with antidepressants show lower rates of depression than those who receive either treatment alone (Brunoni et al., 2013).

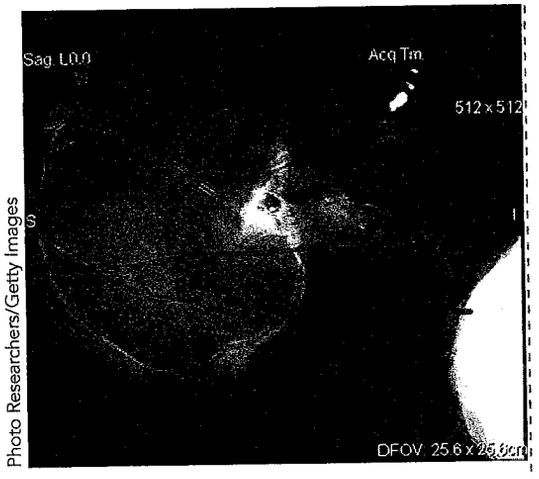



Photo Researchers/Getty Images

**Deep brain stimulation (DBS)** may bring relief to people with Parkinson's Disease, epilepsy, major depression, and other disorders.

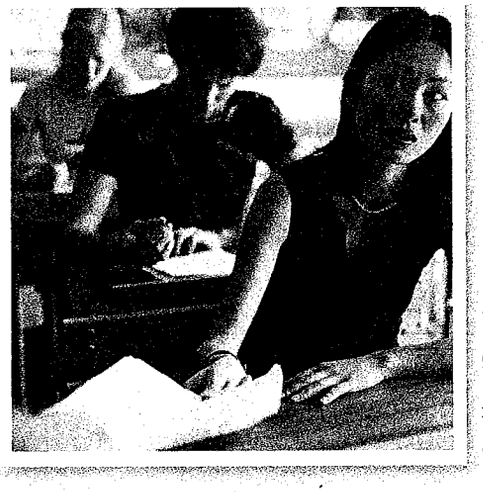
## TABLE 13.2 PSYCHOTHERAPEUTIC DRUG TREATMENTS FOR PSYCHOLOGICAL DISORDERS

| | Description | Examples (trade names) |
|---|---|---|
| **Antianxiety drugs** Medications used to reduce anxiety and decrease overarousal in the brain. | **Antianxiety drugs**, also known as *anxiolytics* and "minor tranquilizers," lower the sympathetic activity of the brain—the crisis mode of operation—so that anxiety is diminished and the person is calmer and less tense. However, they are potentially dangerous because they can reduce alertness, coordination, and reaction time. They also can have a synergistic (intensifying) effect with other drugs, which may lead to severe drug reactions and even death. | Ativan<br>Halcion<br>Librium<br>Restoril<br>Valium<br>Xanax |
| **Antipsychotic drugs** Medications used to diminish or eliminate hallucinations, delusions, withdrawal, and other symptoms of psychosis; also known as neuroleptics or major tranquilizers. | **Antipsychotic drugs**, or *neuroleptics*, reduce the agitated behaviors, hallucinations, delusions, and other symptoms associated with psychotic disorders, such as schizophrenia. Traditional antipsychotics work by decreasing activity at the dopamine receptors in the brain. A large majority of patients markedly improve when treated with antipsychotic drugs. | Clozaril<br>Haldol<br>Mellaril<br>Navane<br>Prolixin<br>Risperdal<br>Seroquel<br>Thorazine |
| **Mood-stabilizer drugs** Medications used to treat the combination of manic episodes and depression characteristic of bipolar disorders. | **Mood-stabilizer drugs** help steady mood swings, particularly for those suffering from bipolar disorder, a condition marked by extremes of both mania and depression. Because lithium acts relatively slowly—requiring up to three or four weeks to take effect—its primary use is in preventing future episodes and helping to break the manic-depressive cycle. | Eskalith CR<br>Lithium<br>Tegretol |
| **Antidepressant drugs** Medications used to treat depression, some anxiety disorders, and certain eating disorders (such as bulimia). | **Antidepressant drugs** are used primarily to treat people with depression, but they are also effective for some anxiety disorders and eating disorders. There are five types of antidepressant drugs: *tricyclics*, *monoamine oxidase inhibitors* (*MAOIs*), *selective serotonin reuptake inhibitors* (*SSRIs*), *serotonin and norepinephrine reuptake inhibitors* (*SNRIs*), and *atypical antidepressants*. Each class of drugs affects neurochemical pathways in the brain in a slightly different way, increasing or decreasing the availability of certain chemicals. SSRIs (such as *Paxil* and *Prozac*) are by far the most commonly prescribed antidepressants. The atypical antidepressants are prescribed for patients who fail to respond to or experience undesirable side effects from other antidepressants. | Anafranil<br>Celexa<br>Cymbalta<br>Effexor<br>Elavil<br>Nardil<br>Norpramin<br>Parnate<br>Paxil<br>Prozac<br>Tofranil<br>Wellbutrin<br>Zoloft |

*"Before Prozac, she loathed company."*

## TEST YOURSELF: DO YOU HAVE TEST ANXIETY?

### psychology and you



Stockbyte/Getty Images

Nearly everyone is somewhat anxious before an important exam. If you find this anxiety helpful and invigorating, skip ahead to the next section. However, if the days and evenings before a major exam are ruined by your anxiety and you sometimes "freeze up" while taking a test, try these tips, based on the three major forms of behavior therapy.

#### 1. Classical Conditioning

This informal type of systematic desensitization will help decrease your feelings of anxiety:

Step 1: Review and practice the relaxation technique taught in Chapter 3 (p. 87).

Step 2: Create a 10-step "test-taking" hierarchy—starting with the least anxiety-arousing image (perhaps the day your instructor first mentions an upcoming exam) and ending with actually taking the exam.

Step 3: Beginning with the least-arousing image—say, hearing about the exam—picture yourself at each stage. While maintaining a calm, relaxed state, mentally work your way through all 10 steps. If you become anxious at any stage, stay there, repeating your relaxation technique until the anxiety diminishes.

Step 4: If you start to feel anxious the night before the exam, or even during the exam itself, remind yourself to relax. Take a few moments to shut your eyes and review how you worked through your hierarchy.

#### 2. Operant Conditioning

One of the best ways to avoid "freezing up" or "blanking out" on a test is to be fully prepared. To maximize your preparation, "shape" your behavior! Start small by answering the multiple-choice questions at the end of each major section of each chapter and comparing your answers with those in Appendix B. Then move on to the longer self-grading quizzes that are available on our website, www.wiley.com/college/huffman. Following each of these "successive approximations," be sure to reward yourself in some way—call a friend, play with your children or pets, watch a video, or maybe check your Facebook page.

#### 3. Observational Learning

Talk with your classmates who are getting good grades. Ask them for tips on how they prepare for exams and how they handle their own test anxieties. This type of modeling and observational learning can be very helpful—and it's a nice way to make friends.

## RETRIEVAL PRACTICE: BEHAVIOR THERAPIES

### Self-Test

Completing this self-test and comparing your answers with those in Appendix B provides immediate feedback and helpful practice for exams. Additional interactive, self-tests are available at www.wiley.com/college/huffman.

**1.** The main focus in behavior therapy is to increase _____ and decrease _____.

a. positive thoughts and feelings; negative thoughts and feelings
b. adaptive behaviors; maladaptive behaviors
c. coping resources; coping deficits
d. all these options

**2.** The three steps in systematic desensitization include all *except* _____.

a. learning to become deeply relaxed
b. arranging anxiety-arousing stimuli into a hierarchy from least to most arousing
c. practicing relaxation in response to anxiety-arousing stimuli, starting with the most arousing
d. all these options

**3.** In behavior therapy, _____ techniques use shaping and reinforcement to increase adaptive behaviors.

a. classical conditioning
b. modeling
c. operant conditioning
d. social learning

**4.** In contrast to systematic desensitization, _____ uses classical conditioning techniques to create anxiety rather than prevent its arousal.

a. anxiety-modeling therapy
b. aversion therapy
c. anxiety therapy
d. subversion therapy

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**FIGURE 13.8 VIRTUAL REALITY THERAPY**

Rather than use mental imaging or actual physical experiences of a fearful situation, virtual-reality headsets and data gloves allow a client with a fear of heights, for example, to have experiences ranging from climbing a stepladder all the way to standing on the edge of a tall building.

Similarly, if you or a friend suffers from a spider phobia, you may be amazed to know that after just two or three hours of therapy, starting with simply looking at photos of spiders and then moving next to a tarantula in a glass aquarium, patients are able to eventually pet and hold the spider with their bare hands (Hauner et al., 2012)!

How does relaxation training desensitize someone? Recall from Chapter 2 that the parasympathetic nerves control autonomic functions when we are relaxed. Because the opposing sympathetic nerves are dominant when we are anxious, it is physiologically impossible to be both relaxed and anxious at the same time. The key to success is teaching the client how to replace his or her fear response with relaxation when *exposed* to the fearful stimulus, which explains why these and related approaches are often referred to as *exposure therapies*. Modern virtual reality technology also uses systematic desensitization to expose clients to feared situations right in a therapist's office **(Figure 13.8)**.

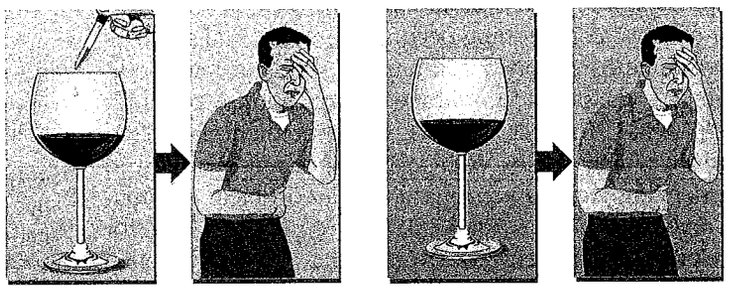
In contrast to systematic desensitization, **aversion therapy** uses classical conditioning techniques to create anxiety rather than extinguish it. People who engage in excessive drinking, for example, build up a number of pleasurable associations with alcohol. These pleasurable associations cannot always be prevented. However, aversion therapy provides *negative associations* to compete with the pleasurable ones **(Figure 13.9)**.

**Aversion therapy** A type of behavioral therapy characterized by the pairing of an aversive (unpleasant) stimulus with a maladaptive behavior in order to elicit a negative reaction to the target stimulus.

**FIGURE 13.9 AVERSION THERAPY**

The goal of aversion therapy is to create an undesirable, or *aversive*, response to a stimulus a person would like to avoid, such as alcohol.

**1 During conditioning** Someone who wants to stop drinking, for example, could take a drug called Antabuse that causes vomiting whenever alcohol enters the system.




**2 After conditioning** When the new connection between alcohol and nausea has been classically conditioned, engaging in the once desirable habit will cause an immediate aversive response.

## Operant Conditioning

*Shaping* is a common operant conditioning technique used for bringing about a desired or target behavior. Recall from Chapter 6 that shaping provides immediate rewards for successive approximations of the target behavior. Therapists have found this technique particularly successful in developing language skills in children with autism. First, the child is rewarded for connecting pictures or other devices with words; later, rewards are given only for using the pictures to communicate with others.

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**psychology and you** **Overcoming Shyness** Shaping can help people acquire social skills and greater assertiveness. If you are painfully shy, for example, a clinician might first ask you to role-play simply saying hello to someone you find attractive. Then you might practice behaviors that gradually lead you to suggest a get-together or date. During such role-playing, or behavior rehearsal, the clinician gives you feedback and reinforcement for each successive step you take toward the end goal.

## Evaluating Cognitive Therapies

Cognitive therapies are highly effective treatments for depression, as well as anxiety disorders, bulimia nervosa, anger management, addiction, and even some symptoms of schizophrenia and insomnia (Craighead et al., 2013; Grave, 2013; Thomas et al., 2011; Turner & Barker, 2013; Young et al., 2011). However, both Beck and Ellis have been criticized for ignoring or denying the client's unconscious dynamics, overemphasizing rationality, and minimizing the importance of the client's past (Granillo et al., 2013; Hammack, 2003).

Other critics suggest that cognitive therapies are successful because they employ behavior techniques, not because they change the underlying cognitive structure (Bandura, 1969, 1997, 2006, 2008; Corey, 2013; Frew & Spiegler, 2013; Pomerantz, 2013). Imagine that you sought treatment for depression and learned to construe events more positively and to curb your all-or-nothing thinking. Further imagine that your therapist also helped you identify activities and behaviors that lessened your depression. Obviously, it's difficult to identify whether changing your cognitions or changing your behavior was the most significant therapeutic factor. But for our everyday use, it doesn't matter. CBT combines both, and it has a proven track record for lifting depression!

## RETRIEVAL PRACTICE: TALK THERAPIES

### Self-Test

Completing this self-test and comparing your answers with those in Appendix B provides immediate feedback and helpful practice for exams. Additional interactive, self-tests are available at www.wiley.com/college/huffman.

**1.** Psychoanalysis/psychodynamic, humanistic, and cognitive therapies are often grouped together as _____.

a. talk therapies
b. behavior therapies
c. analytic therapies
d. cognitive restructuring

**2.** The system of psychotherapy developed by Freud that seeks to bring unconscious conflicts into conscious awareness is known as _____.

a. transference
b. cognitive restructuring
c. psychoanalysis
d. the "hot seat" technique

**3.** _____ therapy emphasizes conscious processes and current problems.

a. Self-talk
b. Belief-behavior
c. Psychodynamic
d. Thought analysis

**4.** Aaron Beck practices _____ therapy, which attempts to change not only destructive thoughts and beliefs but the associated behaviors as well.

a. psycho-behavior
b. cognitive-behavior
c. thinking-acting
d. belief-behavior

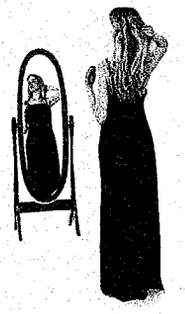
### Think Critically

**1** Would you rather go to a therapist who uses modern psychodynamic therapy or one who practices traditional psychoanalysis? Why?

**2** What is the significance of the term *client-centered therapy*?

## realworldpsychology

**Can changing your irrational thoughts and self-talk make you feel better about your body?**



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**Albert Ellis (1913–2007)**

**Rational-emotive behavior therapy (REBT)** Ellis's cognitive therapy that focuses on eliminating irrational emotional reactions through logic, confrontation, and examination of irrational beliefs.

### Ellis's REBT

One of the best-known cognitive therapists, Albert Ellis, suggested that irrational beliefs are the primary culprit in problem emotions and behaviors. He proposed that most people mistakenly believe they are unhappy or upset because of external, outside events, such as receiving a bad grade on an exam. Ellis suggested that, in reality, these negative emotions result from faulty interpretations and irrational beliefs (such as interpreting the bad grade as a sign of your incompetence and an indication that you'll never qualify for graduate school or a good job).

To deal with these irrational beliefs, Ellis developed **rational-emotive behavior therapy (REBT)** (Ellis, 2008; Ellis & Ellis, 2011; Vernon, 2011). (See the *Psychology and You* below)

## ELLIS'S RATIONAL-EMOTIVE BEHAVIOR THERAPY (REBT)

*psychology and you*

If you receive a poor performance evaluation at work, you might directly attribute your bad mood to the negative feedback. Psychologist Albert Ellis would argue that your self-talk ("I always mess up") between the event and the feeling is what actually upsets you. Furthermore, ruminating on all the other bad things in your life maintains your negative emotional state and may even lead to anxiety disorders, depression, and other psychological disorders.

To treat these problems, Ellis developed an A–B–C–D approach: **A** stands for *activating event*, **B** the person's *belief system*, **C** the emotional and behavioral *consequences*, and **D** the act of *disputing* erroneous beliefs. During therapy, Ellis helped his clients identify the A, B, C's underlying their irrational beliefs by actively arguing with, cajoling, and teasing them—sometimes in very blunt, confrontational language. Once clients recognized their self-defeating thoughts, he worked with them on how to *dispute* those beliefs and create and test out new, rational ones. These new beliefs then changed the maladaptive emotions—thus breaking the vicious cycle.

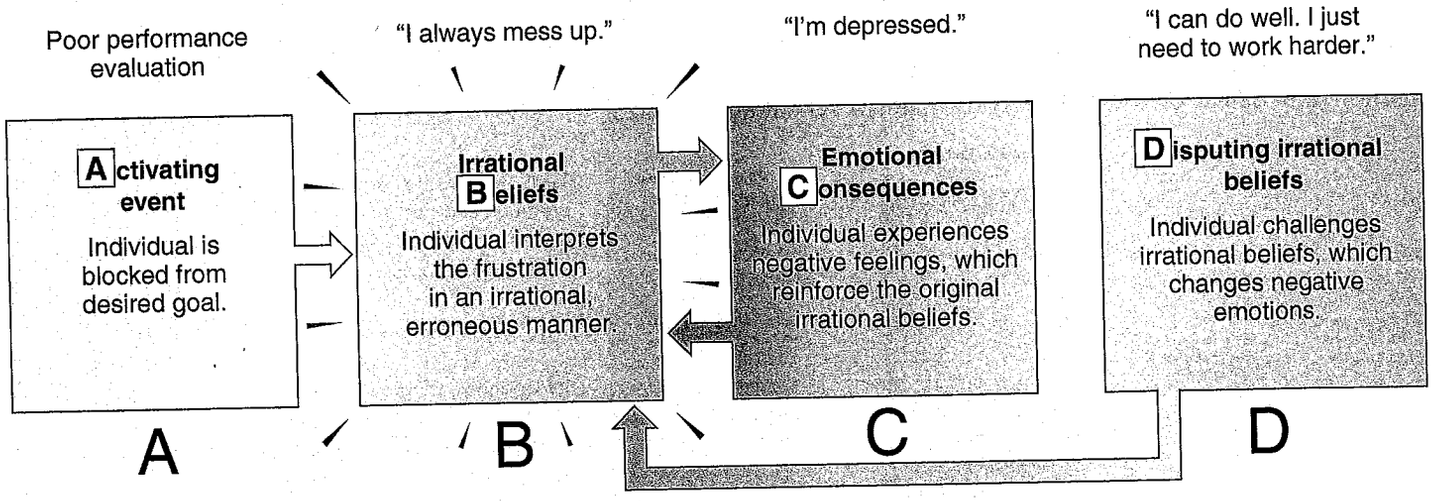

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**FIGURE 13.4 NURTURING GROWTH**

Recall how you've felt when you've been with someone who believes that you are a good person with unlimited potential, a person who believes that your "real self" is unique and valuable. These are the feelings that are nurtured in humanistic therapy.

**client-centered therapy (Figure 13.4)**. (Rogers used the term *client* because he believed the label *patient* implied that someone was sick or mentally ill rather than responsible and competent.)

Client-centered therapy, like psychoanalysis and psychodynamic therapies, explores thoughts and feelings as a way to obtain insight into the causes of behaviors. For Rogerian therapists, however, the focus is on providing an accepting atmosphere and encouraging healthy emotional experiences. Clients are responsible for discovering their own maladaptive patterns.

Rogerian therapists create a therapeutic relationship by focusing on four important qualities of communication: *empathy*, *unconditional positive regard*, *genuineness*, and *active listening*.

## Empathy

Using the technique of **empathy**, a sensitive understanding and sharing of another person's inner experience, therapists pay attention to body language and listen for subtle cues to help them understand the emotional experiences of clients. To further help clients explore their feelings, the therapist uses open-ended statements such as "You found that upsetting" or "You haven't been able to decide what to do about this" rather than asking questions or offering explanations.

**Client-centered therapy** Rogers's humanistic approach to therapy, which emphasizes the client's natural tendency to become healthy and productive; techniques include empathy, unconditional positive regard, genuineness, and active listening.

**Empathy** In Rogerian terms, an insightful awareness and ability to share another's inner experience.

**Unconditional positive regard** Rogers's term for complete love and acceptance of another, such as a parent for a child, with no conditions attached.

**Genuineness** In Rogerian terms, authenticity or congruence; the awareness of one's true inner thoughts and feelings and being able to share them honestly with others.

**Active listening** Listening with total attention to what another is saying; it includes reflecting, paraphrasing, and clarifying what the person says and means.

## Unconditional Positive Regard

Regardless of the clients' problems or behaviors, humanistic therapists offer them **unconditional positive regard**, a genuine caring and nonjudgmental attitude toward people based on their innate value as individuals. They avoid evaluative statements such as "That's good" and "You did the right thing" because such comments imply that the therapist is judging the client. Rogers believed that most of us receive conditional acceptance from our parents, teachers, and others, which leads to poor self-concepts and psychological disorders **(Figure 13.5)**.

## Genuineness

Humanists believe that when therapists use **genuineness** and honestly share their thoughts and feelings with their clients, the clients will in turn develop self-trust and honest self-expression.

## Active Listening

Using **active listening**, which includes reflecting, paraphrasing, and clarifying what the client is saying, the clinician communicates that he or she is genuinely interested and paying close attention (see *Psychology and You*).


Pat Byrnes/The Cartoon Bank, Inc.

*"Just remember, son, it doesn't matter whether you win or lose—unless you want Daddy's love."*

**FIGURE 13.5 UNCONDITIONAL VERSUS CONDITIONAL POSITIVE REGARD**

According to Rogers, clients need to feel unconditionally accepted by their therapists in order to recognize and value their own emotions, thoughts, and behaviors. As this cartoon implies, some parents withhold their love and acceptance unless the child lives up to their expectations.


"The way this works is that you say the first thing that comes to your mind..."



**FIGURE 13.2 FREUD'S FREE ASSOCIATION**

Psychoanalysis is often portrayed as a patient lying on a couch engaging in free association. Freud believed that this arrangement—with the patient relaxed and the therapist out of his or her view—helps the patient let down his or her defenses, making the unconscious more accessible.

**Dream analysis** In psychoanalysis, interpretation of the underlying true meaning of dreams to reveal unconscious processes.

images that have deeper symbolic meaning. Thus, using Freudian **dream analysis**, a therapist might interpret a dream of riding a horse or driving a car—the surface description, or *manifest content*—as a desire for, or concern about, sexual intercourse—the hidden, underlying meaning, or *latent content*.

## Analysis of Resistance

During free association or dream analysis, Freud found that patients often show an inability or unwillingness to discuss or reveal certain memories, thoughts, motives, or experiences. For example, if the patient suddenly "forgets" what he or she was saying or completely changes the subject, it is the therapist's job to identify these possible cases of **resistance** and then help the patient face his or her problems and learn to deal with them more realistically.

**Resistance** In psychoanalysis, the inability or unwillingness of a patient to discuss or reveal certain memories, thoughts, motives, or experiences.

## Analysis of Transference

Freud believed that during psychoanalysis, patients disclose intimate feelings and memories, and the relationship between the therapist and patient may become complex and emotionally charged. As a result, patients often apply, or *transfer*, some of their unresolved emotions and attitudes from past relationships onto the therapist. The therapist uses this process of **transference** to help the patient "relive" painful past relationships in a safe, therapeutic setting so that he or she can move on to healthier relationships.

**Transference** In psychoanalysis, the process by which a client attaches (transfers) to a therapist feelings formerly held toward some significant person who figured in a past emotional conflict.

## Interpretation

The core of all psychoanalytic therapy is **interpretation**. During free association, dream analysis, resistance, and transference, the analyst listens closely and tries to find patterns and hidden conflicts. At the right time, the therapist explains or interprets the underlying meanings to the client.

**Interpretation** A psychoanalyst's explanation of a patient's free associations, dreams, resistance, and transference; more generally, any statement by a therapist that presents a patient's problem in a new way.

# chapteroverview

Throughout this text, we have emphasized the *science* of psychology, and this chapter is no exception. However, psychology is also a *practice*, in which psychologists conduct research and apply psychological principles to help people suffering from psychological disorders (Chapter 12). In this chapter, we'll discuss the three major approaches to psychotherapy **(Figure 13.1)**, its general goals and effectiveness, and other important issues and topics in the field. Along the way, we'll work to demystify and destigmatize its practice and dispel some common myths **(Table 13.1)**.

FIGURE 13.1 AN OVERVIEW OF THE THREE MAJOR APPROACHES TO THERAPY

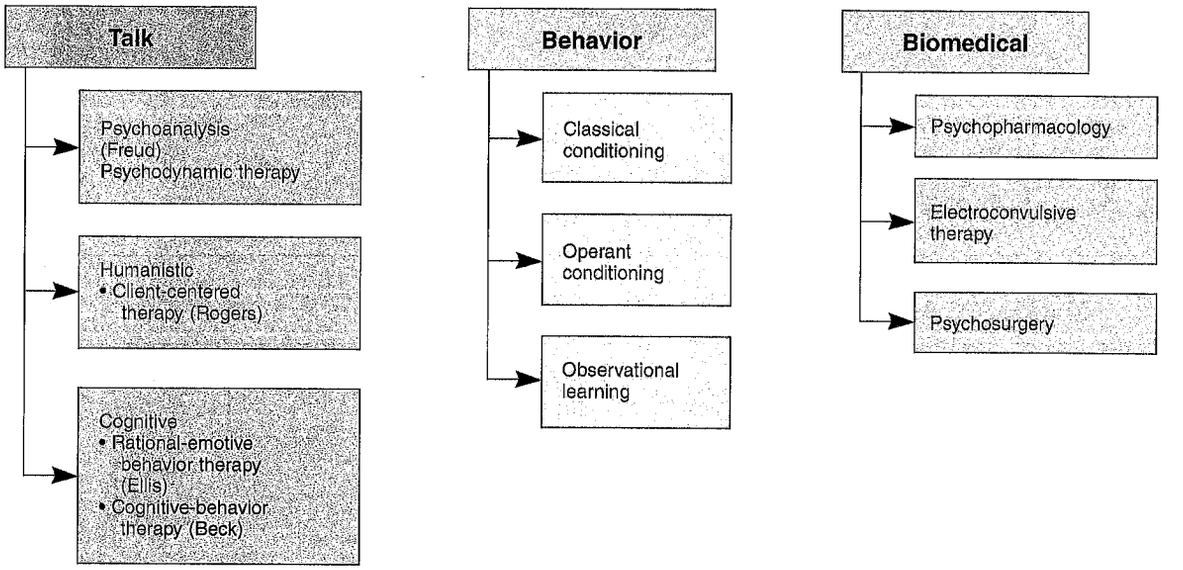


TABLE 13.1 MYTHS ABOUT THERAPY | realworldpsychology

- ***Myth: There is one best therapy.***
  **Fact:** Many problems can be treated equally well with many different forms of therapy.
- ***Myth: Therapists can read your mind.***
  **Fact:** Good therapists often seem to have an uncanny ability to understand how their clients are feeling and to know when someone is trying to avoid certain topics. This is not due to any special mind-reading ability; it simply reflects their specialized training and daily experience working with troubled people.
- ***Myth: People who go to therapists are crazy or weak.***
  **Fact:** Most people seek counseling because of stress in their lives or because they realize that therapy can improve their level of functioning. It is difficult to be objective about our own problems. Seeking therapy is a sign of wisdom and personal strength.
- ***Myth: Only the rich can afford therapy.***
  **Fact:** Therapy can be expensive. But many clinics and therapists charge on a sliding scale, based on the client's income. Some insurance plans also cover psychological services.
- ***Myth: If I am taking meds, I don't need therapy.***
  **Fact:** Medications, such as antidepressants, are only one form of therapy. They can change brain chemistry, but they can't teach us to think, feel, or behave differently. Research suggests that a combination of drugs and psychotherapy may be best for some situations, whereas in other cases, psychotherapy or drug therapy alone may be most effective.

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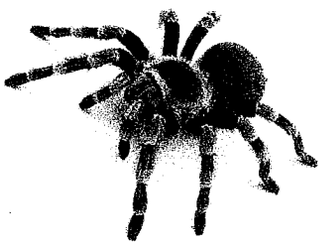
# chapter thirteen

# Therapy

## CHAPTER OUTLINE





## RETRIEVAL PRACTICE: GENDER AND CULTURAL EFFECTS

### Self-Test

Completing this self-test and comparing your answers with those in Appendix B provides immediate feedback and helpful practice for exams. Additional interactive, self-tests are available at www.wiley.com/college/huffman.

**1.** When studying gender differences in mental health, researchers found that _____.

a. women ruminate more frequently than men
b. men tend to be more disinhibited and more likely to externalize their emotions and problems
c. men are typically socialized to suppress their emotions
d. all these options

**2.** Which of the following are examples of culture-general symptoms of mental health difficulties that are useful in diagnosing disorders across cultures?

a. trouble sleeping
b. worry all the time
c. can't get along
d. all the above

**3.** Symptoms of mental illness that generally only appear in one population group are known as _____.

a. culture-bound symptoms
b. group specific disorders
c. group-think syndrome
d. none of these

**4.** What disorder has the following symptoms: wild, out-of-control, aggressive behaviors and attempts to injure or kill others?

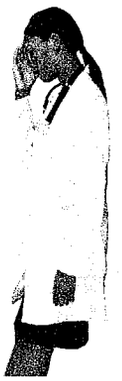
a. *Ataque de nervios* ("attack of nerves")
b. Running amok
c. Possession by the Zar
d. Koro

### Think Critically

1. Culture clearly has strong effects on mental disorders. How does this influence what you think about what is normal or abnormal?
2. Some research suggests that depression in men is often overlooked because men are socialized to suppress their emotions and encouraged to express their distress by acting out, being impulsive, or engaging in substance abuse. Does this ring true with your own experiences and/or observations of others? If so, how might we change this situation?

## realworldpsychology

**Are symptoms of depression in women more distressing, deserving of sympathy, and difficult to treat than the same signs in men?**



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# Summary

## 1 STUDYING PSYCHOLOGICAL DISORDERS 334

- Criteria for **psychological disorders** include *deviance*, *dysfunction*, *distress*, and *danger*. None of these criteria alone is adequate for classifying abnormal behavior.
- Superstitious explanations for abnormal behavior were replaced by the **medical model**, which eventually gave rise to the modern specialty of **psychiatry**. In contrast to the medical model, psychology offers a multifaceted approach to explaining abnormal behavior.

## 2 ANXIETY DISORDERS 340

- **Anxiety disorders** include **generalized anxiety disorder (GAD)**, **panic disorder**, and **phobias** (including agoraphobia, specific phobias, and social phobias).
- Psychological (faulty cognitions and maladaptive learning), biological (evolutionary and genetic predispositions, biochemical disturbances), and sociocultural (cultural pressures toward hypervigilance) factors likely all contribute to anxiety. Classical and operant conditioning also can contribute to phobias.

## 3 DEPRESSIVE AND BIPOLAR DISORDERS 345

- Both depressive and bipolar disorders are characterized by extreme disturbances in emotional states. People suffering from **depressive disorders** may experience a lasting depressed mood without a clear trigger. In contrast, people with **bipolar disorder** alternate between periods of depression and mania (characterized by hyperactivity and poor judgment).
- Biological factors play a significant role in mood disorders. Psychosocial theories of depression focus on environmental stressors and disturbances in interpersonal relationships, thought processes, self-concept, and learning history, including **learned helplessness**.

## 4 SCHIZOPHRENIA 350

- **Schizophrenia** is a group of disorders, each characterized by a disturbance in perception (including **hallucinations**), language, thought (including **delusions**), emotions, and/or behavior.
- In the past, researchers divided schizophrenia into multiple subtypes. More recently, researchers have proposed focusing

## Culture and Schizophrenia

Peoples of different cultures experience mental disorders in a variety of ways. For example, the reported incidence of schizophrenia varies in different cultures around the world. It is unclear whether these differences result from actual differences in prevalence of the disorder or from differences in definition, diagnosis, or reporting (Berry et al., 2011; Butler et al., 2011; Zandi, 2013). The symptoms of schizophrenia also vary across cultures (Barnow & Balkir, 2013; Burns, 2013), as do the particular stressors that may trigger its onset **(Figure 12.16)**.

Finally, despite the advanced treatment facilities and methods in industrialized nations, the prognosis for people with schizophrenia is actually better in nonindustrialized societies. The reason may be that the core symptoms of schizophrenia (poor rapport with others, incoherent speech, and so on) make it more difficult to survive in highly industrialized countries. In addition, in most industrialized nations, families and other support groups are less likely to feel responsible for relatives and friends who have schizophrenia (Barnow & Balkir, 2013; Eaton et al., 2011).

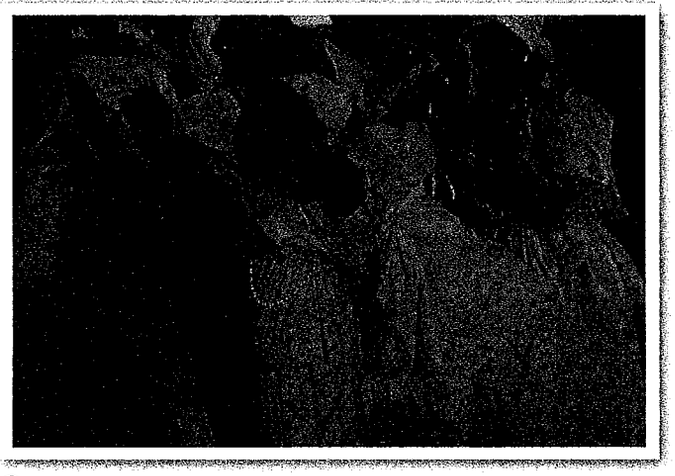
## Avoiding Ethnocentrism

Most research on psychological disorders originates and is conducted primarily in Western cultures. Such a restricted sampling can limit our understanding of disorders in general and can lead to an ethnocentric view of mental disorders.

Fortunately, cross-cultural researchers have devised ways to overcome these difficulties (Matsumoto & Juang, 2013; Triandis, 2007). For example, Robert Nishimoto (1988) has found several *culture-general symptoms* that are useful in diagnosing disorders across cultures **(Table 12.3)**.

In addition, Nishimoto found several *culture-bound symptoms*. For example, Vietnamese and Chinese respondents reported "fullness in head," Mexican respondents noted "problems with [their] memory," and Anglo-American respondents reported "shortness of breath" and "headaches." Apparently, people learn to express their problems in ways that are acceptable to others in the same culture (Brislin, 1997, 2000; Butler et al., 2011; Dhikav et al., 2008; Iwata et al., 2011; Kanayama & Pope, 2011; Marques et al., 2011).

**FIGURE 12.16 WHAT IS STRESSFUL?**



David Alan Harvey/Magnum Photos, Inc.

Ⓐ Some stressors are culturally specific, such as feeling possessed by evil forces or being the victim of witchcraft.

Benelux/Zefa/Corbis

Ⓑ Other stressors are shared by many cultures, such as the unexpected death of a loved one or loss of a job (Al-Issa, 2000; Cechnicki et al., 2011; Neria et al., 2002; Ramsay et al., 2012).

**3.** A serial killer would likely be diagnosed as a(n) _____ personality in the *Diagnostic and Statistical Manual (DSM)*.

a. dissociative disorder
b. antisocial personality disorder
c. multiple personality disorder
d. borderline psychosis

**4.** One possible biological contributor to BPD is a(n) _____.

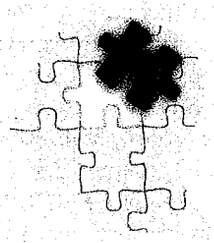
a. childhood history of neglect
b. emotional deprivation
c. impaired functioning of the frontal lobes
d. all these options

### Think Critically

1. How would you explain to others that schizophrenia is not the same as dissociative identity disorder (DID) (formerly called multiple personality disorder [MPD])?
2. Does the fact that research shows a genetic component to antisocial personality disorder change your opinion regarding the degree of guilt and responsibility someone like Adam Lanza has for the Sandy Hook shooting spree?

## realworldpsychology

**How do changes in the brain help explain severe antisocial personality disorder?**



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# GENDER AND CULTURAL EFFECTS

**LEARNING OBJECTIVES**

**RETRIEVAL PRACTICE** While reading the upcoming sections, respond to each Learning Objective in your own words. Then compare your responses with those found at www.wiley.com/college/huffman.

1. **DISCUSS** the possible gender differences in psychological disorders.
2. **EXPLAIN** why it is difficult to directly compare mental disorders across cultures.
3. **OUTLINE** strategies for avoiding ethnocentrism in psychological disorders.

Among the Chippewa, Cree, and Montagnais-Naskapi Indians in Canada, there is a disorder called *windigo*—or *wiitiko*—*psychosis*, characterized by delusions and cannibalistic impulses. Believing they have been possessed by the spirit of a windigo, a cannibal giant with a heart and entrails of ice, victims become severely depressed (Faddiman, 1997). As the malady begins, the individual typically experiences loss of appetite, diarrhea, vomiting, and insomnia, and he or she may see people turning into beavers and other edible animals. In later stages, the victim becomes obsessed with cannibalistic thoughts and may even attack and kill loved ones in order to devour their flesh (Berreman, 1971).

If you were a therapist, how would you treat this disorder? Does it fit neatly into any of the categories of psychological disorders that you have learned about? We began this chapter by discussing the complexities and problems with defining, identifying, and classifying abnormal behavior. Before we close, we need to add two additional confounding factors: gender and culture. In this section, we explore a few of the many ways in which men and women differ in their experience of abnormal behavior. We also look at cultural variations in abnormal behavior.

## Gender Differences

When you picture someone suffering from depression, anxiety, alcoholism, or antisocial personality disorder, what is the gender of each person? Most people tend to visualize a woman for the first two and a man for the last two. There is some truth to these stereotypes.

Research has found many gender differences in the prevalence rates of various mental disorders. Let's start with the well-established fact that around the world, the rate of severe depression for women is about double that for men (Dillard et al., 2012; Luppa et al., 2012; Sonnenberg et al., 2013; World Health Organization, 2011). Why is there such a striking gender difference?

## Personality Disorders

What would happen if the characteristics of a personality were so inflexible and maladaptive that they significantly impaired someone's ability to function? This is what occurs with **personality disorders**. Several types of personality disorders are included in this category in the fifth edition of the *DSM*, but here we will focus on antisocial personality disorder and borderline personality disorder (American Psychiatric Association, 2013).

**Personality disorder** A mental disorder characterized by chronic, inflexible, maladaptive personality traits, which cause significant impairment of social and occupational functioning.

### Antisocial Personality Disorder

People with **antisocial personality disorder**—also sometimes referred to as *psychopathy, sociopathy*, or *dissocial personality disorder*—show a pattern of disregard for, and violation of, the rights of others. These labels describe behavior so far outside the ethical and legal standards of society that many consider it the most serious of all mental disorders. Unlike people with anxiety, mood disorders, and schizophrenia, those with this diagnosis feel little personal distress (and may not be motivated to change). Yet their maladaptive traits generally bring considerable harm and suffering to others (Hervé et al., 2004; Noggle et al., 2013; Trull et al., 2013). Although serial killers are often seen as classic examples of people with antisocial personality disorder, most people who have this disorder generally harm others in less dramatic ways—for example, as ruthless businesspeople and crooked politicians.

**Antisocial personality disorder** The pervasive pattern of disregard for, and violation of, the rights of others beginning in childhood or early adolescence and continuing into adulthood; includes traits like unlawful behaviors, deceitful and manipulative behaviors, impulsivity, irritability and aggressiveness, consistent irresponsibility, reckless disregard for self and others, and lack of remorse.

RJ Samgostij Sangosti /AFP /NewsCom

**realworldpsychology** **The Media and Mental Illness** The world was shocked and deeply saddened on July 20, 2012, when 25-year-old James Holmes went on a horrific shooting spree, killing 12 people and wounding or injuring 58 in a movie theater in Aurora, Colorado. The shootings prompted intense debate over gun control and violence in the media. Perhaps because he had been seeing a psychiatrist prior to the shooting, it also heightened attention to the detection and treatment of mental illness. But few questions were asked about the intensive media coverage. Given what you've learned in this chapter, how might news and social media discussions of tragic shooting events like these increase myths and misconceptions about people with a mental illness?

Unlike most other adults, individuals with antisocial personality disorder act impulsively, without giving thought to the consequences. They are usually poised when confronted with their destructive behavior and feel contempt for anyone they are able to manipulate. They also change jobs and relationships suddenly, and they often have a history of truancy from school and of being expelled for destructive behavior. People with antisocial personalities can be charming and persuasive, and they have remarkably good insight into the needs and weaknesses of other people.

Twin and adoption studies suggest a possible genetic predisposition to antisocial personality disorder (Beaver et al., 2011; Kendler & Prescott, 2006). Biological contributions are also suggested by studies that have found abnormally low autonomic activity during stress, right hemisphere abnormalities, and reduced gray matter in the frontal lobes and biochemical disturbances (Anderson et al., 2011; Bertsch et al., 2013; Portnoy et al., 2013; Schiffer et al., 2011; Sundram et al., 2011). For example, MRI brain scans of criminals currently in prison for violent crimes, such as rape, murder, or attempted murder, and showing little empathy and remorse for their crimes, revealed reduced gray matter volume in the prefrontal cortex (Gregory et al., 2012). (Recall from Chapter 2 that this is the area of the brain responsible for emotions, such as fear, empathy, and/or guilt.)

Q5

Evidence also exists for environmental or psychological causes. People with antisocial personality disorder often come from homes characterized by abusive parenting styles, emotional deprivation, harsh and inconsistent disciplinary practices, and antisocial parental behavior (Calkins & Keane, 2009; Noggle et al., 2013; Torry & Billick, 2011; Wachlarowicz et al., 2012). Still other studies show a strong

parts, or putting things in a certain order. While everyone worries and sometimes double-checks, people with OCD have these thoughts and do these rituals for at least an hour or more each day, often longer (Chang et al., 2013; Roth et al., 2013).

Imagine what it would be like to worry so obsessively about germs that you compulsively wash your hands hundreds of times a day, until they are raw and bleeding. Most sufferers of **obsessive compulsive disorder (OCD)** realize that their actions are senseless. But when they try to stop the behavior, they experience mounting anxiety, which is relieved only by giving in to the compulsions. Given that numerous biological and psychological factors contribute to OCD, it is most often treated with a combination of drugs and cognitive-behavior therapy (Amin & Noggle, 2013; Roth et al., 2013). See Chapter 13 and **Figure 12.13**.

**Obsessive-compulsive disorder (OCD)** A mental disorder characterized by persistent, anxiety-provoking thoughts that will not go away (obsessions) and/or irresistible urges to perform repetitive behaviors (compulsions) according to certain rules or in a ritualized manner; compulsive behaviors persist because they help relieve the anxiety created by the obsessions.

## Voices from the Classroom

**OCD and Counting Stairs** When we discuss *obsessive-compulsive disorder* in my class, I explain that everyone has some obsessive-compulsive behaviors, but it's not considered a disorder unless it becomes disruptive to your life. Some people count stairs as they go up or down (you know who you are)—not out loud but just silently.

After making this same statement in class one day, a student replied: "But you HAVE to count them. And if you get to the top or bottom and they're an odd number, you have to go back and start over. This time you have to continue counting with the number you stopped with so that they come out even." Counting the stairs to yourself is just a little obsessive-compulsive behavior, but having to go back and do it again so that they come out even is disruptive.

Professor Mike Majors
Delgado Community College
New Orleans, Louisiana

**FIGURE 12.13 MANAGING OCD**

Many celebrities suffer from OCD, including soccer star David Beckham, actors Megan Fox (pictured here) and Leonardo DiCaprio, and singer/actor Justin Timberlake. Fortunately, people can learn to manage the symptoms of OCD, through therapy and/or medication, and lead highly productive and fulfilling lives.

Kevin Winter/Getty Images

these regions might explain the thought and language disturbances that characterize schizophrenia. This lower level of brain activity, and schizophrenia itself, may also result from an overall loss of neurons in the cerebral cortex (Salgado-Pineda et al., 2011; Trost et al., 2013; Williams et al., 2013).

Clearly, biological factors play a key role in schizophrenia. But the fact that the heritability of schizophrenia is only 48% even in identical twins—who share identical genes—tells us that nongenetic factors must contribute the remaining percentage. Most psychologists believe there are at least two possible psychosocial contributors.

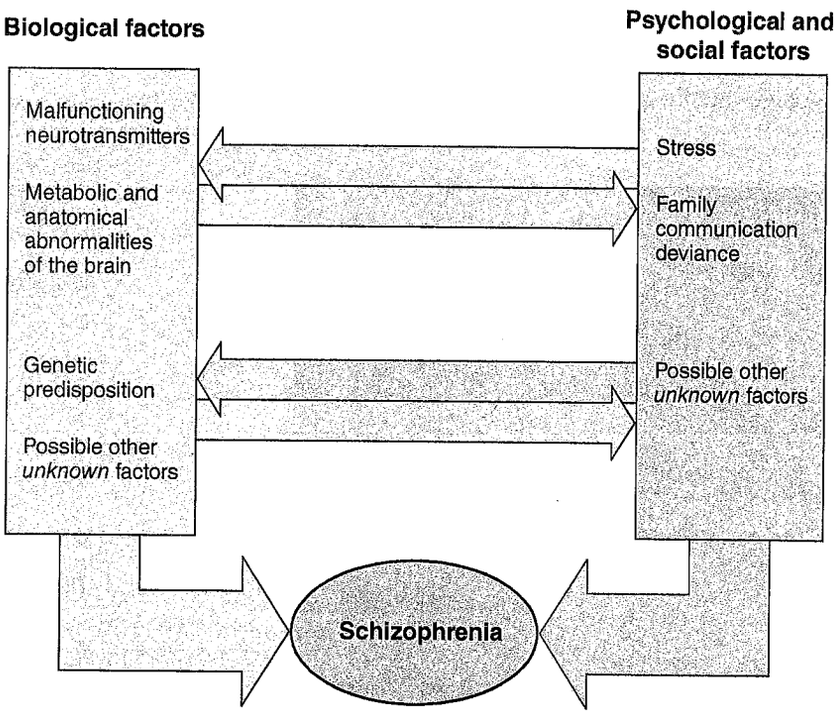
**Diathesis-stress model** A hypothesis about the cause of certain disorders, such as schizophrenia, which suggests that people inherit a predisposition (or "diathesis") that increases their risk for mental disorders if they are exposed to certain extremely stressful life experiences.

According to the **diathesis-stress model** of schizophrenia, stress plays an essential role in triggering schizophrenic episodes in people with an inherited predisposition (or diathesis) toward the disease (Arnsten, 2011; Beaton & Simon, 2011; Gallagher & Jones, 2013). In line with this model, children who experience severe trauma before age 16 are three times more likely than other people to develop schizophrenia (Bentall et al., 2012). People who experience stressful living environments, including poverty, unemployment, and crowding, are also at increased risk (Burns, 2013; Kirkbride et al., 2013).

Some investigators suggest that communication disorders in family members may also be a predisposing factor for schizophrenia. Such disorders include unintelligible speech, fragmented communication, and parents frequently sending severely contradictory messages to children. Several studies have also shown greater rates of relapse and worsening of symptoms among hospitalized patients who went home to families that were critical and hostile toward them or overly involved in their lives emotionally (McFarlane, 2011; Roisko et al., 2011; Wasserman et al., 2013).

How should we evaluate the different theories about the causes of schizophrenia? Critics of the dopamine hypothesis and the brain damage theory argue that those theories fit only some cases of schizophrenia. Moreover, with both theories, it is difficult to determine cause and effect. The disturbed-communication theories are also hotly debated, and research is inconclusive. Like almost all forms of mental illness, schizophrenia is probably the result of a combination of known and unknown interacting factors **(Figure 12.12)**.

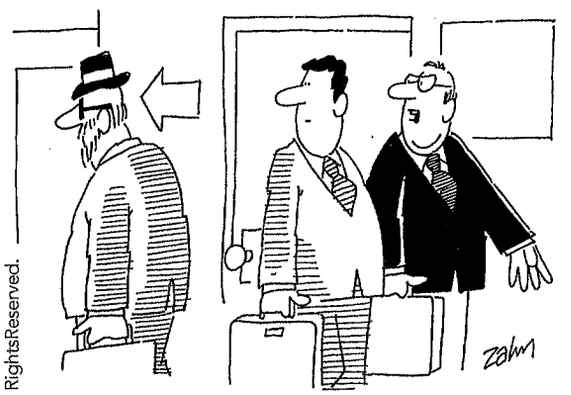
FIGURE 12.12 THE BIOPSYCHOSOCIAL MODEL AND SCHIZOPHRENIA



severe disturbances, the person jumbles phrases and words together (into a "word salad") or creates artificial words. The most common—and frightening—thought disturbance experienced by people with schizophrenia is lack of contact with reality (psychosis).

**Delusion** A false or irrational belief maintained despite clear evidence to the contrary.

**Delusions**, false beliefs or opinions despite invalidating evidence, are also common in people with schizophrenia. We all experience exaggerated thoughts from time to time, such as thinking a friend is trying to avoid us, but the delusions of schizophrenia are much more extreme. For example, if someone falsely believed that the postman who routinely delivered mail to his house every afternoon was a co-conspirator in a plot to kill him, it would likely qualify as a *delusion of persecution*. In *delusions of grandeur*, people believe that they are someone very important, perhaps Jesus Christ or the Queen of England. In *delusions of reference*, unrelated events are given special significance, as when a person believes a radio program is sending him or her special messages.






**"That's the doctor who is treating me for paranoia. I don't trust him."**

A recent trend among individuals suffering from various mental disorders is to join Internet groups where they can share their experiences with others. For example, people with schizophrenia and other psychotic disorders can now share with fellow sufferers their belief that they are being stalked or that their minds are being controlled by technology. Some experts consider Internet groups that offer peer support to be helpful to mentally ill individuals, but others believe they may reinforce troubled thinking and impede treatment. Those who use the sites report feeling relieved by the sense that they are not alone in their suffering, but the groups are not moderated by professionals and pose the danger of amplifying the symptoms of mentally ill individuals (Kershaw, 2008).

### Emotion

Changes in emotion usually occur in people with schizophrenia. In some cases, emotions are exaggerated and fluctuate rapidly. At other times, they become blunted. Some people with schizophrenia have *flattened affect*—almost no emotional response of any kind.

### Behavior

Disturbances in behavior may take the form of unusual actions that have special meaning to the sufferer. For example, one patient massaged his head repeatedly to "clear it" of unwanted thoughts. People with schizophrenia also may become *cataleptic* and assume a nearly immobile stance for an extended period.

## Types of Schizophrenia

For many years, researchers divided schizophrenia into five subtypes: *paranoid*, *catatonic*, *disorganized*, *undifferentiated*, and *residual*. Critics suggested that this system does not differentiate in terms of prognosis, cause, or response to treatment and that the undifferentiated type was merely a catchall for cases that are difficult to diagnose (American Psychiatric Association, 2013). For these reasons, researchers have proposed an alternative classification system:

1. **Positive schizophrenia symptoms** are additions to or exaggerations of normal thought processes and behaviors, including bizarre delusions and hallucinations.
2. **Negative schizophrenia symptoms** include the loss or absence of normal thought processes and behaviors and appear as impaired attention, limited or toneless speech, flat or blunted affect, and social withdrawal.

Positive symptoms are more common when schizophrenia develops rapidly, whereas negative symptoms are more often found in slow-developing schizophrenia. Positive symptoms are associated with better adjustment before the onset and a better prognosis for recovery.

## RETRIEVAL PRACTICE: DEPRESSIVE AND BIPOLAR DISORDERS

### Self-Test

Completing this self-test and comparing your answers with those in Appendix B provides immediate feedback and helpful practice for exams. Additional interactive, self-tests are available at www.wiley.com/college/huffman.

**1.** A major difference between depressive disorder and bipolar disorder is that only in bipolar disorder do people have _____.

a. hallucinations or delusions
b. depression
c. manic episodes
d. a biochemical imbalance

**2.** Depressive and bipolar disorders are sometimes treated by _____ drugs, which affect the amount or functioning of norepinephrine, dopamine, and serotonin in the brain.

a. antidepressant
b. antipsychotics
c. mood congruence
d. none of the above

**3.** Which of the following is a myth about suicide?

a. People who talk about it are less likely to actually do it
b. Suicide usually occurs with little or no warning
c. Most people have never thought about suicide
d. all of these options

**4.** According to the theory known as _____, when faced with a painful situation from which there is no escape, animals and people enter a state of helplessness and resignation.

a. autonomic resignation
b. helpless resignation
c. resigned helplessness
d. learned helplessness

### Think Critically

1. Have you ever felt seriously depressed? How would you distinguish between "normal" depression and a serious depressive disorder?
2. Can you think of a personal example of how major depression served as a possible evolutionary advantage?

### realworldpsychology

**Can eating fast food lead to depression later on?**

HINT: LOOK IN THE MARGIN FOR Q3

# SCHIZOPHRENIA

**LEARNING OBJECTIVES**

**RETRIEVAL PRACTICE** While reading the upcoming sections, respond to each Learning Objective in your own words. Then compare your responses with those found at www.wiley.com/college/huffman.

1. **IDENTIFY** schizophrenia and its common symptoms.
2. **COMPARE** the traditional five-subtype system for classifying different types of schizophrenia with the two-group system that has recently emerged.
3. **SUMMARIZE** the biological and psychosocial factors that contribute to schizophrenia.

Imagine that your 17-year-old son's behavior has changed dramatically over the past few months, and he has gone from being actively involved in sports and clubs to suddenly quitting all activities and refusing to go to school. He now also talks to himself—mumbling and yelling out at times—and no longer regularly showers or washes his hair. Recently he announced, "The voices are telling me to jump out the window" (Kotowski, 2012).

**Schizophrenia** A group of severe disorders involving major disturbances in perception, language, thought, emotion, and behavior.

This description is taken from the true case history of a patient who suffers from **schizophrenia**. People with schizophrenia have serious problems caring for themselves, relating to others, and holding a job. In extreme cases, the illness is considered a *psychosis*, meaning the person is out of touch with reality, and treatment often requires institutional or custodial care.

Schizophrenia is one of the most widespread and devastating mental disorders. Approximately 1 of every 100 people will develop it in his or her lifetime, and

7. **False**. When people are first coming out of a depression, they are in fact at greater risk because they now have the energy to actually commit suicide.
8. **False**. Suicide rates are highest among people with major depressive disorders. However, suicide is also the leading cause of premature death in people who suffer from schizophrenia, and a major cause of death in people with anxiety disorders and alcohol and other substance-related disorders. Furthermore, suicide is not limited to people with depression. Poor physical health, serious illness, substance abuse (particularly of alcohol), loneliness, unemployment, and even natural disasters may push some people over the edge.
9. **False**. Estimates from various studies are that 40 to 80% of the general public have thought about committing suicide at least once in their lives.
10. **False**. Because society often considers suicide a terrible, shameful act, asking directly about it can give the person permission to talk. In fact, not asking might lead to further isolation and depression.

abnormalities in various parts of the brain. Sadly, these changes may contribute to serious depression and increased risk of suicide **(Figure 12.9)**.

Other research points to imbalances of the neurotransmitters serotonin, norepinephrine, and dopamine as possible causes of mood disorders (Barton et al., 2008; Lopez-Munoz & Alamo, 2011; Pu et al., 2011; Wiste et al., 2008). Drugs that alter the activity of these neurotransmitters also decrease the symptoms of depression—and are therefore called antidepressants (Chuang, 1998). Interestingly, researchers in one study found that people who regularly ate fast food and commercially produced baked goods (such as croissants and doughnuts) were 51% more likely to develop depression later on. This may be the result of the chemicals in such foods leading to physiological changes in the brain and body (Sanchez-Villegas et al., 2011).

Some biological research indicates that both depressive and bipolar disorders may be inherited (Boardman et al., 2011; Gonzales et al., 2013; McGue & Christensen, 2013; Melas et al., 2013). In contrast, research that takes an evolutionary perspective suggests that moderate depression may be a normal and healthy adaptive response to a very real loss, such as the death of a loved one, which helps us to step back and reassess our goals (Baddeley, 2013; Carvalho et al., 2013; Nettle, 2011; Raison & Miller, 2013). And clinical, severe depression may just be an extreme version of this generally adaptive response.

**FIGURE 12.9 BRAIN DAMAGE AND PROFESSIONAL SPORTS**

Junior Seau, who played in the NFL for 20 years, committed suicide with a gunshot wound to his chest in 2012 at the age of 43. Later studies concluded that he suffered from *chronic traumatic encephalopathy* (CTE), a form of concussion-related brain damage that has also been found in other NFL players.

Kent C. Horner/Getty Images

**Bipolar disorder** A mental disorder characterized by repeated episodes of mania (unreasonable elation, often with hyperactivity) alternating with depression.

When depression is *unipolar*, and the depressive episode ends, the person generally returns to a normal emotional level. People with **bipolar disorders**, however, rebound to the opposite state, known as *mania* **(Figure 12.8)**.

During a manic episode, the bipolar person is overly excited, extremely active, and easily distracted. In addition, he or she exhibits unrealistically high self-esteem, an inflated sense of importance, and poor judgment—giving away valuable possessions or going on wild spending sprees. The person also is often hyperactive and may not sleep for days at a time yet does not become fatigued. Thinking is faster than normal and can change abruptly to new topics, showing "rapid flight of ideas." Speech is also rapid ("pressured speech"), making it difficult for others to get a word in edgewise. A manic episode may last a few days or a few months, and it generally ends abruptly. The ensuing depressive episode generally lasts three times as long.

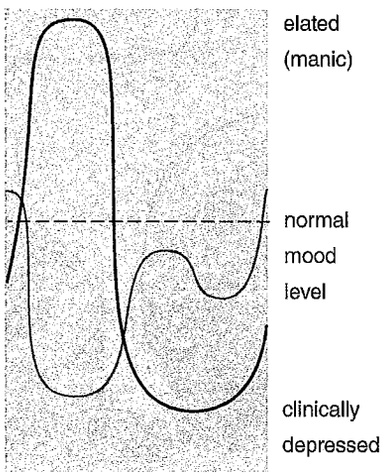
The lifetime risk for bipolar disorder is low—between 0.5 and 1.6%—but it can be one of the most debilitating and lethal disorders, with a suicide rate between 10 and 20% among sufferers (Bender & Alloy, 2011; Hammen & Keenan-Miller, 2013; Thaler et al., 2013). Suicide also is a serious risk for anyone suffering from several other mental health issues, particularly depressive disorders. See *Test Yourself: Danger Signs for Suicide* to first test your own level of depression and then to learn more about common suicide myths.

## Explaining Depressive and Bipolar Disorders

Biological factors appear to play a significant role in both depressive disorders and bipolar disorders. For example, both disorders are sometimes treated with antidepressants, which affect the amount or functioning of norepinephrine, dopamine, and/or serotonin in the brain. In addition, recent research suggests that structural brain changes may contribute to these mood disorders. Sadly, NFL players are at greater risk of developing depression as they age, possibly due to brain damage caused by repeated concussions. One recent study on former NFL players revealed that 41% show cognitive problems and 24% show clinical depression, which may result from neurological changes caused by concussions (Hart et al., 2013). Their brain scans also revealed changes in blood flow within the brain and

**FIGURE 12.8 DEPRESSIVE VERSUS BIPOLAR DISORDERS**

If depressive disorders and bipolar disorders were depicted on a graph, they might look something like this. Note that only in bipolar disorders do people experience manic episodes.



component. In addition, stress and arousal seem to play a role in panic attacks, and drugs such as caffeine or nicotine and even hyperventilation can trigger an attack, all suggesting a biochemical disturbance.

### Sociocultural Factors

In addition to psychological and biological components, sociocultural factors can contribute to anxiety. There has been a sharp rise in anxiety disorders in the past 50 years, particularly in Western industrialized countries. Can you see how our fast-paced lives—along with our increased mobility, decreased job security, and decreased family support—might contribute to anxiety? Unlike the dangers early humans faced in our evolutionary history, today's threats are less identifiable and less immediate. This may in turn lead some people to become hypervigilant and predisposed to anxiety disorders.

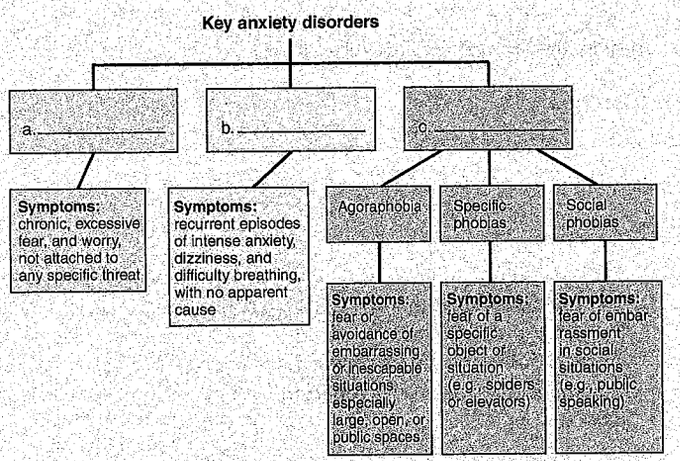
Further support for sociocultural influences on anxiety disorders is our recognition that they can have dramatically different forms in other cultures. For example, in a collectivist twist on anxiety, some Japanese experience a type of social phobia called *taijin kyofusho* (*TKS*), a morbid dread of doing something to embarrass *others*. This disorder is quite different from the Western version of social phobia, which centers on a fear of criticism.

## RETRIEVAL PRACTICE: ANXIETY DISORDERS

### Self-Test

Completing this self-test and comparing your answers with those in Appendix B provides immediate feedback and helpful practice for exams. Additional interactive, self-tests are available at www.wiley.com/college/huffman.

**1.** Label the three key anxiety disorders.




**2.** Anxiety disorders are _____.

a. characterized by overwhelming tension, irrational fear, and physiological arousal
b. the least frequent of the mental disorders
c. twice as common in men as in women
d. all these options

**3.** Persistent, uncontrollable, and free-floating, non-specified anxiety might be diagnosed as a _____.

a. generalized anxiety disorder
b. panic disorder
c. phobia
d. all these options

**4.** In the Japanese social phobia called TKS, people fear that they will _____.

a. evaluate others negatively
b. embarrass themselves
c. embarrass others
d. be embarrassed by others

### Think Critically

1. Why do you suppose anxiety disorders are among the easiest disorders to treat?
2. How would you explain the high number of anxiety disorders in the United States?

## realworldpsychology

**Do people with a phobia see the object that frightens them as larger than it really is?**

HINT: LOOK IN THE MARGIN FOR Q2

**FIGURE 12.5 SPIDER PHOBIA**

Can you imagine being so frightened by a spider that you would try to jump out of a speeding car to get away from it? This is how a person suffering from a phobia might feel.



attacks lead to a persistent concern about future attacks. A common complication of panic disorder is agoraphobia, discussed in the next section (Horwath & Gould, 2011; Kircher et al., 2013).

## Phobias

**Phobias** include a strong, irrational fear and avoidance of objects or situations that are usually considered harmless (elevators or the dentist, for example). Although the person recognizes that the fear is irrational, the experience is still one of overwhelming anxiety, and a full-blown panic attack may follow. The fifth edition of the *DSM* divides phobias into separate categories: agoraphobia, specific phobias, and social anxiety disorder (social phobia).

People with *agoraphobia* restrict their normal activities because they fear having a panic attack in crowded, enclosed, or wide-open places where they would be unable to receive help in an emergency. In severe cases, people with agoraphobia may refuse to leave the safety of their homes.

A *specific phobia* is a fear of a specific object or situation, such as needles, rats, spiders, or heights. Claustrophobia (fear of closed spaces) and acrophobia (fear of heights) are the specific phobias most often treated by therapists. People with specific phobias generally recognize that their fears are excessive and unreasonable, but they are unable to control their anxiety and will go to great lengths to avoid the feared stimulus **(Figure 12.5)**.

**Phobia** A persistent and intense, irrational fear and avoidance of a specific object or situation.

One factor that helps explain why people with phobias have such extreme reactions is that they perceive the feared objects as larger than they actually are. Researchers in one study asked people with spider phobias to stand beside a glass tank and observe five different tarantulas (Vasey et al., 2012). They were then asked to estimate the size of each tarantula by drawing a line on an index card to illustrate its length. Those who reported experiencing the highest levels of fear while standing beside the tank drew the longest lines.

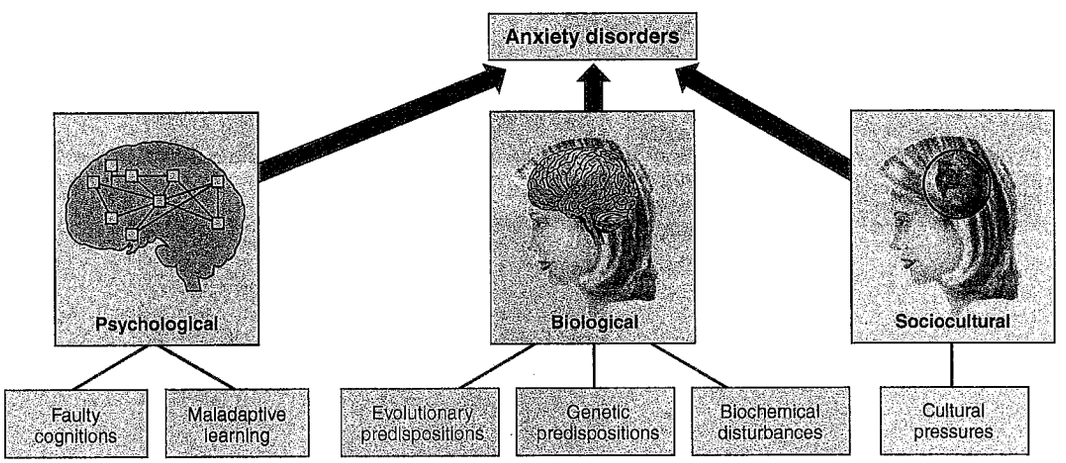
People with *social anxiety disorder* (or *social phobia*) are irrationally fearful of embarrassing themselves in social situations. Fear of public speaking and of eating in public are the two most common social phobias. The fear of public scrutiny and potential humiliation may become so pervasive that normal life is impossible (Kariuki & Stein, 2013; Moitra et al., 2011; Stopa et al., 2013).

## Explaining Anxiety Disorders

Why do people develop anxiety disorders? Research has focused on the roles of psychological, biological, and sociocultural processes (the *biopsychosocial model*) **(Figure 12.6)**.

**FIGURE 12.6 ANXIETY DISORDERS AND THE BIOPSYCHOSOCIAL MODEL**

The biopsychosocial model takes into account the wide variety of factors than can contribute to anxiety disorders.



## RETRIEVAL PRACTICE: STUDYING PSYCHOLOGICAL DISORDERS

### Self-Test

Completing this self-test and comparing your answers with those in Appendix B provides immediate feedback and helpful practice for exams. Additional interactive, self-tests are available at www.wiley.com/college/huffman.

1. *Abnormal behavior* is defined as _____.

   a. statistically infrequent patterns of pathological emotion, thought, or action
   b. patterns of emotion, thought, and action that are considered disordered
   c. patterns of behaviors, thoughts, or emotions considered pathological for one or more of four reasons: deviance, dysfunction, distress, or danger
   d. all these options

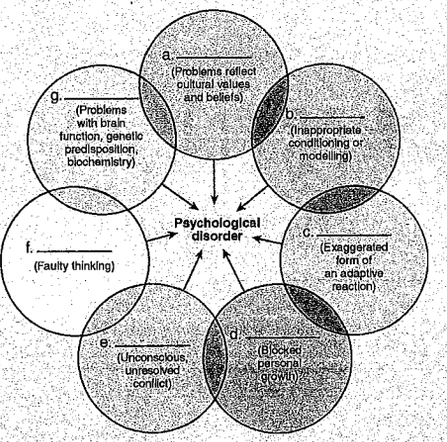
2. _____ is the branch of medicine that deals with the diagnosis, treatment, and prevention of mental disorders.

   a. Psychology
   b. Psychiatry
   c. Psychobiology
   d. Psychodiagnostics

3. In the early treatment of psychological disorders, _____ was used to allow evil spirits to escape, whereas _____ was designed to drive the Devil out through prayer, fasting, and so on.

   a. trephining; exorcism
   b. demonology; hydrotherapy
   c. the medical model; the dunking test
   d. none of these options

4. Label the seven psychological perspectives on psychological disorders.

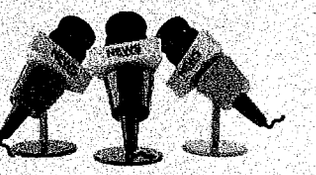



### Think Critically

1. Can you think of cases in which someone might have a psychological disorder not described by the four criteria deviance, dysfunction, distress, and/or danger?
2. Do you think the insanity plea, as it is currently structured, should be abolished? Why or why not?

## realworldpsychology

**How can media coverage of mass shootings create negative misperceptions about people with mental illness?**



HINT: LOOK IN THE MARGIN FOR Q1

# ANXIETY DISORDERS

### LEARNING OBJECTIVES

RETRIEVAL PRACTICE While reading the upcoming sections, respond to each Learning Objective in your own words. Then compare your responses with those found at www.wiley.com/college/huffman.

1. **DESCRIBE** anxiety disorders and the symptoms of generalized anxiety disorder (GAD), panic disorder, and phobias.
2. **SUMMARIZE** how psychological, biological, and sociocultural factors contribute to anxiety disorders.

**Anxiety disorder** A mental disorder characterized by overwhelming tension and irrational fear accompanied by physiological arousal.

Have you ever faced a very important exam, job interview, or first date and broken out in a cold sweat, felt your heart pounding, and had trouble breathing? If so, you have some understanding of anxiety, but the experiences and symptoms of those who suffer from **anxiety disorders** are much more intense and life disrupting. Fortunately, anxiety disorders are also among the easiest to treat and offer some of the best chances for recovery (Chapter 13).

## TABLE 12.2 SUBCATEGORIES OF MENTAL DISORDERS IN THE *DSM*

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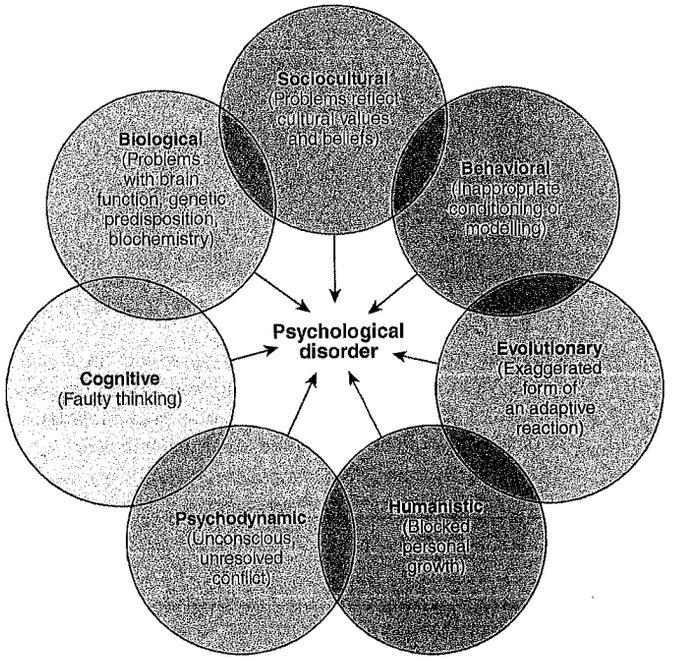
1. ***Anxiety disorders*** Problems associated with excessive fear and anxiety and related behavioral disturbances.
2. ***Depressive disorders*** Problems characterized by the presence of sad, empty, or irritable mood.
3. ***Bipolar and related disorders*** Problems associated with alternating episodes of depression and mania.
4. ***Schizophrenia spectrum and other psychotic disorders*** Group of disorders characterized by delusions, hallucinations, disorganized thinking or motor behavior, and negative symptoms, such as diminished emotional expression.
5. ***Obsessive-compulsive and related disorders*** Group of disorders characterized by the presence of obsessions, compulsions, preoccupations, and/or repetitive behaviors or mental acts.
6. ***Dissociative disorders*** Group of disorders characterized by the disruption and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior.
7. ***Personality disorders*** Problems related to an enduring pattern of experience and behavior that deviates markedly from the expectations of an individual's culture, and leads to distress or impairment.
8. ***Trauma- and stressor-related disorders*** Problems associated with exposure to a traumatic or stressful event (see Chapter 3).
9. ***Sleep–wake disorders*** Dissatisfaction regarding the quality, timing, and amount of sleep (see Chapter 5).
10. ***Substance-related and addictive disorders*** A cluster of cognitive, behavioral, and physiological symptoms related to alcohol, tobacco, other drugs, and gambling (see Chapter 5).
11. ***Feeding and eating disorders*** Problems related to persistent disturbance of eating or eating-related behavior (see Chapter 10).
12. ***Paraphilic disorders*** Problems involving an intense and persistent sexual interest causing distress or impairment to the person or whose satisfaction has entailed personal harm, or risk of harm, to others (see optional Chapter 15).
13. ***Sexual dysfunctions*** A significant disturbance in a person's ability to respond sexually or to experience sexual pleasure (see optional Chapter 15).
14. ***Gender dysphoria*** Distress that may accompany the incongruence between a person's experienced or expressed gender and one's assigned gender (see optional Chapter 15).
15. ***Neurodevelopmental disorders*** Developmental deficits that typically manifest early in development, often before the child enters grade school, and produce impairments of personal, social, academic, or occupational functioning.
16. ***Somatic symptom and related disorders*** Problems related to unusual preoccupation with physical health or physical symptoms producing significant distress and impairment.
17. ***Elimination disorders*** Problems related to the inappropriate elimination of urine or feces, usually first diagnosed in childhood or adolescence.
18. ***Disruptive, impulse-control, and conduct disorders*** Problems related to kleptomania (impulsive stealing), pyromania (setting of fires), and other disorders characterized by inability to resist impulses, drives, or temptations to perform certain acts harmful to self or others.
19. ***Neurocognitive disorders*** A group of disorders involving cognitive function, including Alzheimer's disease, Huntington's disease, and physical trauma to the brain.
20. ***Other mental disorders*** Residual category of mental disorders causing significant distress or impairment but do not meet the full criteria for any other disorder in DSM-5.
21. ***Medication-induced movement disorders and other adverse effects of medication*** These are not mental disorders but are included because of their importance in the management by medication and differential diagnosis of mental disorders.
22. ***Other conditions that may be a focus of clinical attention*** These are not mental disorders but are included to draw attention to and document issues that may be encountered in routine clinical practice.

*Sources*: American Psychiatric Association, 2013; American Psychiatric Association, NICHY, 2012.

**FIGURE 12.2 SEVEN PSYCHOLOGICAL PERSPECTIVES**

As you can see in this diagram, the seven major perspectives differ in their various explanations for the general causes of psychological disorders, but there is still considerable overlap.




Improvement came in 1792, when Philippe Pinel, a French physician, was placed in charge of a Parisian asylum. Believing that inmates' behavior was caused by underlying physical illness, he insisted that they be unshackled and removed from their unlighted, unheated cells. Many inmates improved so dramatically that they could be released. Pinel's **medical model** eventually gave rise to the modern specialty of **psychiatry**.

Unfortunately, when we label people "mentally ill," we may create new problems. One of the most outspoken critics of the medical model, psychiatrist Thomas Szasz (1960, 2004, 2012), proposed that it encourages people to believe they have no responsibility for their actions. Furthermore, he contended that mental illness is a myth used to label individuals who are peculiar or offensive to others and that these labels can become self-perpetuating. In other words, a person may begin to behave according to his or her diagnosed disorder.

In addition to potential problems for the identified person, the public also may develop negative attitudes about those labeled as mentally ill and about mental illness in general. This is particularly common following intensive media coverage of mass shootings committed by someone with such a disorder, despite the fact that most people with mental illness are not violent (McGinty et al., 2013). Q1

Despite these potential dangers, the medical model—and the concept of mental illness—remains a founding principle of psychiatry. Psychology, in contrast, offers a multifaceted approach to explaining abnormal behavior, as shown in **Figure 12.2**.

**Medical model** The diagnostic perspective which assumes that diseases (including mental illness) have physical causes that can be diagnosed, treated, and possibly cured.

**Psychiatry** The branch of medicine that deals with the diagnosis, treatment, and prevention of mental disorders.

## Voices from the Classroom

**Dangerous and Painful Labels** Our society seems to have a fascination with labeling people, especially people who struggle with psychiatric disorders. I wonder why that is. Should we really be calling someone a schizophrenic? An anorexic? An autistic? We don't refer to people by their illness in other fields, so why do we in psychology? I have a close friend, who happens to be a brilliant physician and an amazing mother of four, who has struggled with a handful of severe episodes of major depressive disorder. Thankfully, she has always recovered from these episodes. That said, they seem to creep up on her and have the power to really throw her life off kilter. Knowing that her depression easily spirals into terrifying suicidal thoughts and urges, she admits herself to the hospital for treatment. While she is under care from the hospital staff, she doesn't want to be called the depressive or the mental patient. It is dehumanizing and offensive. Undergoing treatment for any psychiatric disorder is challenging enough. Our society doesn't need to make it any harder by labeling people and chipping away at their self-esteem. If we really want to label people, perhaps we should use their legal label . . . their actual name.

Professor Paulina Multhaupt
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## Classifying Psychological Disorders

Without a clear, reliable system for classifying the wide range of psychological disorders, scientific research on them would be almost impossible, and communication among mental health professionals would be seriously impaired. Fortunately,

# chapteroverview

Are you excited? Throughout history, psychological disorders have been the subject of intense fascination. Now, you finally get to read and study the part of psychology you've probably been waiting for from the very beginning! Hopefully, while reading this chapter, you'll recognize how the earlier chapters have prepared you for a better understanding and appreciation of the complex issues surrounding abnormal behavior. We begin with a discussion of how psychological disorders are identified, explained, and classified. Then we explore six major categories of psychological disorders: anxiety disorders, depressive and bipolar disorders, schizophrenia, obsessive-compulsive disorder (OCD), and personality disorders. We close with a look at gender and cultural factors related to mental disorders.

# STUDYING PSYCHOLOGICAL DISORDERS

**LEARNING OBJECTIVES**

**RETRIEVAL PRACTICE** While reading the upcoming sections, respond to each Learning Objective in your own words. Then compare your responses with those found at www.wiley.com/college/huffman.

1. **DESCRIBE** abnormal behavior and the four criteria for identifying psychological disorders.
2. **EXPLAIN** how perspectives on the causes of psychological disorders have changed throughout history.
3. **DISCUSS** the purposes and criticisms of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*).

Most people agree that neither the artist who stays awake for 72 hours finishing a painting nor the shooter who kills 20 young school children is behaving normally. But what exactly is "normal"? How do we distinguish between eccentricity in the first case and abnormal behavior in the second?

## Identifying and Explaining Psychological Disorders

**Abnormal behavior** Patterns of behaviors, thoughts, or emotions considered pathological (diseased or disordered) for one or more of these four reasons: deviance, dysfunction, distress, or danger.

Mental health professionals generally agree on four criteria for identifying **abnormal behavior** (or psychopathology). Often called the four *D*'s, these signs are *deviance*, *dysfunction*, *distress*, and *danger* **(Figure 12.1)**. Keep in mind that abnormal behavior, like intelligence or creativity, exists on a continuum.

As you consider these criteria, remember that no single criterion is adequate for identifying all forms of abnormal behavior. Furthermore, when considering the two criteria *deviance* and *danger*, note that judgments of what is deviant vary historically and cross-culturally and that the public generally overestimates the danger posed by the mentally ill. (See **Table 12.1** for more about this and other myths of mental illness.)

What causes abnormal behavior? Historically, evil spirits and witchcraft have been blamed (Amin & Noggle, 2013; Goodwin, 2012; Millon, 2004; Petry, 2011; Riva et al., 2011). Stone Age people, for example, believed that abnormal behavior stemmed from demonic possession; the "therapy" was to bore a hole in the skull so the evil spirit could escape, a process we call *trephining*. During the European Middle Ages, a troubled person was sometimes treated with *exorcism*, an effort to drive the Devil out by praying, fasting, making noise, and beating the sufferer and administering terrible-tasting brews. During the fifteenth century, as the Renaissance got under way, many believed that some individuals chose to consort with the Devil. These supposed witches were often tortured, imprisoned for life, or executed.

As the Middle Ages ended, special mental hospitals called *asylums* began to appear in Europe. Initially designed to provide quiet retreats from the world and to protect society (Barlow & Durand, 2012; Coleborne & Mackinnon, 2011; Hamlett & Hoskins, 2013; Millon, 2004), the asylums unfortunately became overcrowded, inhumane prisons.