

XIV. Stress, Coping, and Health

We all experience stress, but we don't all find the same situations stressful. Some people find flying in planes highly stressful, while others take up skydiving as a hobby. Some people thrive in fast-paced, deadline-heavy careers, while others prefer less stimulating work. Stress means different things for different people, and everyone has their own way of coping with it. In some cases, people can worry themselves sick—literally—and some research links stress directly to illness.

Today, most researchers use a biopsychosocial model to explain disease. According to the biopsychosocial model, physical illness results from a complicated interaction among biological, psychological, and sociocultural factors. In recent decades, the recognition that psychological factors can affect health has given rise to a new branch of psychology called health psychology. Health psychologists study ways of promoting and maintaining health. Their research focuses on the relationship between psychosocial factors and the emergence, progression, and treatment of illness.

A) Stress and Stressors

Stress is difficult to define because researchers approach it in different ways. Some use the term *stress* to refer to circumstances that threaten well-being or to refer to the response people have to threatening circumstances. Others think of stress as the process of evaluating and coping with threatening circumstances. Yet others use the term to refer to the experience of being threatened by taxing circumstances. This chapter will use the term *stress* in the last sense: the experience of being threatened by taxing circumstances.

Appraisal

Researchers agree that stress is subjective. People don't have the same response to the same circumstances. Instead, stress depends on how people appraise or evaluate environmental events. If people believe that a challenge will severely tax or exceed their resources, they experience stress.

Types of Stressors

Stressors are psychologically or physically demanding events or circumstances. Research links stressors to increased susceptibility to physical illnesses such as heart disease as well as to psychological problems such as anxiety and depression.

Stressors don't always increase the risk of illness. They tend to affect health more when they are chronic, highly disruptive, or perceived as uncontrollable. Researchers who study stress usually distinguish among three types of stressors:

- **Catastrophic events:** Large earthquakes, hurricanes, wars
- **Major life changes, positive or negative:** Marriage, divorce, death of a parent, beginning a new job, starting college
- **Minor hassles:** Standing in line, traffic jams, noisy environments

Health, Wealth, and Power

People who live in conditions of poverty and powerlessness have an increased risk of poor health. Many factors make such people more susceptible to illness. For instance, poor people tend to have low access to preventive care. When ill, they often do not have access to good medical care. Their nutrition tends to be poor, since high-fat, high-salt foods are cheaper and more easily available than many healthy foods. They also encounter many chronic environmental stressors, including high crime rates, discrimination, and poor housing conditions.

Internal Sources of Stress

Exposure to difficult circumstances doesn't produce stress by itself. Rather, stress occurs when people experience frustration, conflict, or pressure:

- **Frustration** is the experience of being thwarted when trying to achieve a goal.

Example:

A student worked very hard on a term paper with the hope of getting an A but ends up with a B.

- **Conflict** occurs when people have two or more incompatible desires or motives. Conflict can occur in three forms:

1. The **approach-approach conflict**, the least stressful, occurs when people try to choose between two desirable alternatives.

Example:

A student tries to decide between two interesting classes.

1. The **approach-avoidance conflict**, typically more stressful and quite common, occurs when people must decide whether to do something that has both positive and negative aspects.

Example:

A boy invites a girl to a party. She finds him attractive, but going to the party means she won't have time to study for one of her final exams.

1. The **avoidance-avoidance conflict**, also typically stressful, occurs when people have to choose between two undesirable options.

Example:

Because of his financial situation, a man might have to choose whether to keep his nice-looking car, which breaks down frequently, or buy a badly dented, but reliable, used one.

- **Pressure** occurs when people feel compelled to behave in a particular way because of expectations set by themselves or others.

Example:

A high school student wants to be accepted by the popular crowd at school, so she tries hard to distance herself from her old friends because the popular crowd considers them geeky or undesirable.

The Physiology of Stress

The experience of stress is accompanied by many physiological changes.

Selye's General Adaptation Syndrome

Hans Selye, a pioneer in the field of stress research, proposed that stressors of many different kinds result in a nonspecific bodily response. He said the body's stress response consists of a **general adaptation syndrome**, which has three stages: alarm, resistance, and exhaustion.

Stage 1.

In the **alarm stage**, an organism recognizes a threatening situation. The sympathetic nervous system activates, giving rise to the fight-or-flight response. Digestive processes slow down, blood pressure and heart rate increase, adrenal hormones are released, and blood is drawn away from the skin to the skeletal muscles.

Stage 2.

The **resistance stage** occurs when stress continues. Physiological arousal stabilizes at a point that is higher than normal.

Stage 3.

If stress is prolonged, organisms reach the **exhaustion stage**. The body's resources run out, and physiological arousal decreases. In this stage, organisms become more susceptible to disease.

Modification of Selye's Theory:

Research has supported Selye's idea that prolonged stress can cause physical deterioration. Research has also shown, however, that the bodily response to stress isn't as nonspecific as Selye believed. Different kinds of stressors produce subtly different bodily responses. Also, different people respond to the same stressor differently, depending on their gender, medical condition, and genetic predisposition to problems such as high blood pressure and obesity.

Pathways from the Brain

In stressful situations, the brain sends signals to the rest of the body along two pathways.

In the first pathway, the hypothalamus of the brain activates the sympathetic division of the autonomic nervous system, which in turn stimulates the inner part of the adrenal glands, which is called the **adrenal medulla**. The adrenal medulla releases hormones called **catecholamines**, which include epinephrine and norepinephrine. The action of the catecholamines results in the fight-or-flight response.

In the second pathway, the hypothalamus sends signals to the pituitary gland. The pituitary releases **adrenocorticotropic hormone (ACTH)**, which in turn stimulates the outer part of the adrenal glands, which is called the **adrenal cortex**. The adrenal cortex then releases hormones called **corticosteroids**, which include cortisol. Corticosteroids increase blood sugar levels, providing energy. Corticosteroids also help to limit tissue inflammation in case injuries occur.

B) Coping

Coping refers to efforts to manage stress. Coping can be adaptive or maladaptive. Adaptive coping strategies generally involve confronting problems directly, making reasonably realistic appraisals of problems, recognizing and changing unhealthy emotional reactions, and trying to prevent adverse effects on the body. Maladaptive coping includes using alcohol or drugs to escape problems.

Some researchers believe that people have characteristic ways of coping, even in different sorts of situations. Other researchers believe that people use different coping styles in different situations and that people's ways of coping change over time.

Coping Strategies

There are many different coping strategies. Some common ones include:

- Relaxation
- Humor
- Releasing pent-up emotions by talking or writing about them
- Exercise
- Getting social support

- Reappraising an event or changing perspective on the problem
- Spirituality and faith
- Problem solving
- Comparing oneself to others who are worse off
- Altruism or helping others
- Using defense mechanisms
- Aggressive behavior
- Self-indulgent behavior, such as overeating, smoking, and excessive use of alcohol or drugs

The Frustration-Aggression Hypothesis

Several years ago, some researchers proposed the frustration-aggression hypothesis, which states that aggression is always caused by frustration. Today, researchers believe that frustration doesn't always lead to aggression and that it can lead to other responses, such as apathy. However, frustration does sometimes lead to aggressive behavior.

Factors That Improve Coping

Some people cope more effectively than others. Some important factors that influence coping are social support, optimism, and perceived control:

- **Social support:** Many studies show that having good social support correlates with better physical and mental health. Researchers believe that supportive social networks buffer the effects of stressful circumstances. In stressful situations, a social network can provide a person with care and comfort, access to helpful resources, and advice about how to evaluate and manage problems.
- **Optimism:** A tendency to expect positive outcomes, optimism is associated with better physical health. Optimistic people are more likely to find social support, appraise events in less threatening ways, take good care of themselves when sick, and use active coping strategies that focus on problem solving.
- **Perceived control:** The term **locus of control** refers to people's perception of whether or not they have control over circumstances in their lives. People with an **internal locus of control** tend to believe they have control over their circumstances. People with an **external locus of control** tend to believe that fate, luck, or other people control circumstances. Having an internal locus of control is associated with better physical and emotional health.

Primary and Secondary Control

Some researchers have pointed out that people in different cultures have different kinds of perceived control. The Western approach emphasizes the importance of primary control. When faced with a problematic situation, people in Western cultures tend to focus on changing the situation so that the problem no longer exists. A different approach, seen in many Asian cultures, emphasizes secondary control. When faced with a problematic situation, people in these cultures focus on accommodating the situation by changing their perspective on it. Both kinds of control can be beneficial

C) Stress and Disease

Chronic stress is linked to the development of many psychological problems, such as depression, anxiety, and schizophrenia. A large body of research also indicates that stress is linked to a variety of physical problems, including cancer, heart disease, rheumatoid arthritis, genital herpes, periodontal disease, yeast infections, and the common cold, to name just a few.

Stress and Immune Function

Stress affects the functioning of the immune system, as do age, nutrition, and genetic factors. The **immune system** is the body's defense against harmful agents such as bacteria, viruses, and other foreign substances. It communicates constantly with the brain and the endocrine system. The immune system has many different kinds of disease-fighting cells, including B lymphocytes, T lymphocytes, and macrophages:

- **B lymphocytes** are formed in the bone marrow and release antibodies. Antibodies are protein molecules that travel through the blood and lymph and defend the body against bacteria and cancer cells.
- **T lymphocytes** are formed in the thymus gland and defend the body against cancer cells, viruses, and other foreign substances.
- **Macrophages** destroy foreign substances by absorbing them.

Stress affects the immune system in many ways. For instance, hormones that are released in response to stress can inhibit the activity of lymphocytes.

The Link Between Emotions and Illness

Researchers have linked negative emotional states to disease.

Depression

Recent research suggests that depression makes people more vulnerable to heart disease.

Type A Behavior and Hostility

Researchers have identified a type of personality, called the **type A personality**, that is associated with a higher risk of coronary heart disease. People with type A personalities tend to be competitive, impatient, easily angered, and hostile. People with **type B personalities**, on the other hand, are relaxed, patient, easygoing, and amiable.

Type A personalities may be more prone to heart disease for several reasons:

- Type A people tend to be more physiologically reactive than type B people. In challenging situations, type A people have higher pulse rates, blood pressure, and hormone levels. This physiological reactivity can impair health in the long term. For instance, frequent release of stress hormones increases the likelihood of **atherosclerosis**, or hardening of the arteries because of cholesterol deposits.
- Type A people may encounter more stressors. For example, because of their behavior, they may be more likely to have marital stress and work-related problems.
- Type A people may have less social support because of their characteristic ways of relating to people.
- Type A people may pay less attention to health-promoting behaviors such as getting exercise and resting when tired. They also smoke more and consume more caffeine.

Hostility, a key type A personality feature, relates most to increased risk of heart disease. A tendency to get angry easily is associated not only with heart disease but also impaired immune function and high blood pressure.

Emotional Inhibition

People who have a tendency to suppress emotions such as fear, anxiety, and anger have a higher risk of becoming ill than people who can acknowledge and express their feelings.

Lifestyles That Endanger Health

People's lifestyles can endanger their health. Three features of problematic lifestyles include smoking, not exercising, and eating poorly.

Smoking

Smoking increases the risk of many cardiovascular and lung diseases, including heart disease, hypertension, stroke, bronchitis, and emphysema. Smoking also increases the risk of cancers of the lung, mouth, bladder, kidney, larynx, esophagus, and pancreas. Although formal smoking cessation programs don't help most people quit, many people eventually do stop smoking. Research shows that many people quit only after several unsuccessful attempts.

Lack of Exercise

Lack of exercise can also have strong negative effects. Regular exercise leads to longer life expectancy, promotes cardiovascular health, decreases obesity-related problems such as diabetes and respiratory problems, and decreases the risk of colon, breast, and reproductive system cancers.

Poor Nutrition

Research shows that bad eating habits contribute to health problems:

- Chronic overeating increases the risk of heart disease, hypertension, stroke, respiratory problems, arthritis, and back problems.
- Low-fiber diets and diets that increase serum cholesterol levels are linked to heart disease.
- Eating too much salt may contribute to high blood pressure.
- High-fat, low-fiber diets are linked to cancers of the colon, prostate, and breast.
- A low-calcium diet may contribute to osteoporosis.

Getting Medical Treatment

Once people develop symptoms of illness, their behavior influences whether their health will improve or worsen. People's behavior can have an impact at three different stages.

Seeking Medical Help

People who are highly anxious, who score high on the personality trait of neuroticism, who are very health-conscious, and who are very aware of bodily sensations tend to report more physical symptoms than other people.

Delaying seeking medical help can have serious consequences, as early diagnosis can improve the treatment of many health problems. Despite this, people often delay seeking medical help for several reasons:

- Fear of appearing ridiculous if their symptoms turn out to be benign
- Reluctance to bother their physicians
- The tendency to minimize symptoms
- Unwillingness to have a medical appointment interfere with other plans.

Communicating Effectively

People often have trouble communicating effectively with health care providers. Communication difficulties frequently happen for the following reasons:

- Medical providers often use jargon and unclear explanations when talking to patients.
- Patients sometimes forget to ask questions they should have asked.
- People sometimes forget to mention symptoms they have or avoid mentioning the extent of their problems for fear of a serious diagnosis.

- People are sometimes passive in their interactions with health care providers because they feel intimidated by health care providers' authority.

Adhering to Treatment Regimens

People's chances of recovery decrease if they don't adhere to the treatment regimens that their health care providers prescribe. People don't adhere to medical advice for three main reasons:

- Not understanding the instructions they are given
- Not following treatment regimens that are unpleasant or interfere significantly with daily routines
- Not following advice if they are displeased about their interactions with their health care provider

XV. Psychological Disorders

When people think of mental illness, they often think of imaginary voices or terrifying killers like Charles Manson. However, psycho-logical disorders are not always that dramatic—or that clear-cut. Suppose a person drinks heavily on weekends and doesn't spend any time with his family. Another person keeps to a strict diet in order to stay thin and still isn't satisfied with her body weight. Do these people have mental disorders?

The question of what classifies as a mental disorder is often difficult to answer. Psychologists use many criteria to evaluate and diagnose these disorders, and they use a detailed system to classify them into categories. The origins of psychological disorders are varied and often unclear, and understanding these disorders involves an understanding of biology, culture, and personality. Many factors help make us who we are, and those same factors may, in certain people, prove precarious.

A) What Is a Psychological Disorder?

Several criteria exist for defining a psychological disorder. Sometimes a person needs to meet only one criterion to be diagnosed as having a psychological disorder. In other cases, more than one of the following criteria may be met:

- Violation of cultural standards behavior

Example:

Ted's delusion that he is a prophet causes him to stand at street corners lecturing people about the morality of their behavior.

- Exhibition of behavior harmful to self or others

Example:

Bethanne's excessive use of alcohol makes her unable to hold down a job.

- Experiencing distress

Example:

David suffers from chronic and painful anxiety.

Model of Psychological Disorders

Psychologists use different conceptual models for understanding, describing, and treating psychological disorders.

The Medical Model

The **medical model** is a way of describing and explaining psychological disorders as if they are diseases. Many terms used to discuss psychological disorders come from the medical model. **Diagnosis** refers to the process of

distinguishing among disorders. **Etiology** refers to the cause or origin of a disorder. **Prognosis** refers to a prediction about the probable course and outcome of a disorder.

Critics argue that this model is not suitable for describing psychological problems. They say that psychological problems are not illnesses but rather behaviors and experiences that are morally or socially deviant.

The Vulnerability-Stress Model

The **vulnerability-stress model** states that psychological disorders result from an interaction between biological and environmental factors. According to this model, individuals who have a biological vulnerability to a particular disorder will have the disorder only if certain environmental stressors are present.

The Learning Model

The **learning model** theorizes that psychological disorders result from the reinforcement of abnormal behavior.

The Psychodynamic Model

The **psychodynamic model** states that psychological disorders result from maladaptive defenses against unconscious conflicts.

Disorder Assessment

Psychologists use two methods to assess a psychological disorder: objective testing and projective testing. **Objective tests** are usually pencil-and-paper standardized tests such as the **Minnesota Multiphasic Personality Inventory (MMPI)**. **Projective tests** require psychologists to make judgments based on a subject's responses to ambiguous stimuli. Word association tests or the **Rorschach test**, in which subjects interpret a series of inkblots, are examples of projective tests. (See pages 285–287 for more information on these tests.)

B) Classification

Psychologists and psychiatrists have classified psychological disorders into categories. Classification allows clinicians and researchers to describe disorders, predict outcomes, consider treatments, and encourage research into their etiology.

Insanity

Insanity is not a diagnostic label that psychologists use. Rather, it is a legal term that refers to the inability to take responsibility for one's actions. The law does not consider most people with psychological disorders to be insane. People can use an insanity defense only if they were unable to distinguish right from wrong at the time they committed a crime.

The DSM

Psychologists and psychiatrists use a reference book called the **Diagnostic and Statistical Manual of Mental Disorders (DSM)** to diagnose psychological disorders. The American Psychiatric Association published the first version of the *DSM* in 1952. It has been revised several times, and the newest version is commonly referred to as the *DSM-IV*.

The *DSM-IV* uses a multi-axial system of classification, which means that diagnoses are made on several different axes or dimensions. The *DSM* has five axes:

1. Axis I records the patient's primary diagnosis.
2. Axis II records long-standing personality problems or mental retardation.

3. Axis III records any medical conditions that might affect the patient psychologically.
4. Axis IV records any significant psychosocial or environmental problems experienced by the patient.
5. Axis V records an assessment of the patient's level of functioning.

Psychologists and Psychiatrists

People sometimes use the words psychologist and psychiatrist interchangeably, but they are not the same. Psychologist is a broad term that refers to anyone with advanced training in psychology who conducts psychological testing, research, or therapy. A psychiatrist has a medical degree and treats patients with mental and emotional disorders. A psychiatrist can also prescribe medication.

Criticisms of the DSM

Although the *DSM* is used worldwide and considered a very valuable tool for diagnosing psychological disorders, it has been criticized for several reasons:

- Some critics believe it can lead to normal problems of living being turned into “diseases.” For example, a child who displays the inattentive and hyperactive behavior normally seen in young children could be diagnosed with attention-deficit/hyperactivity disorder by an overzealous clinician. In earlier versions of the *DSM*, homosexuality was listed as a disorder.
- Some critics argue that including relatively minor problems such as caffeine-induced sleep disorder in the *DSM* will cause people to liken these problems to serious disorders such as schizophrenia or bipolar disorder.
- Other critics argue that giving a person a diagnostic label can be harmful because a label can become a self-fulfilling prophecy. A child diagnosed with attention-deficit/hyperactivity disorder may have difficulty overcoming his problems if he or other people accept the diagnosis as the sole aspect of his personality.
- Some critics point out that the *DSM* makes the process of diagnosing psychological disorders seem scientific when, in fact, diagnosis is highly subjective.

In general, psychologists view the *DSM* as a valuable tool that, like all tools, has the potential for misuse.

The *DSM* contains many categories of disorders, and the following sections will cover a few of these categories.

Culture and Psychological Disorders

Most of the major disorders listed in the DSM are found worldwide, although cultural factors often influence the symptoms and course of disorders. Culture-bound disorders, on the other hand, are limited to specific cultural contexts. They may or may not be linked to DSM diagnostic categories. One example of a culture-bound syndrome described in the DSM is dhat, a condition that occurs in India and is characterized by anxiety, hypochondria, discharge of semen, whitish urine color, weakness, and exhaustion. Similar conditions exist in Sri Lanka and China.

C) Anxiety Disorders

Anxiety is a common and normal occurrence. However, a chronic, high level of anxiety indicates an anxiety disorder.

Common Anxiety Disorders

Some of the more common anxiety disorders include:

- **Generalized Anxiety Disorder:** A person with **generalized anxiety disorder** experiences persistent and excessive anxiety or worry that lasts at least six months.
- **Specific Phobia:** A person who has **specific phobia** experiences intense anxiety when exposed to a particular object or situation. The person often avoids the feared object or situation because of a desire to escape the anxiety associated with it.

- **Social Phobia:** A person who has **social phobia** experiences intense anxiety when exposed to certain kinds of social or performance situations. As a result, the person often avoids these types of situations.
- **Panic Disorder and Agoraphobia:** A person with **panic disorder** experiences recurrent, unexpected panic attacks, which cause worry or anxiety. During **panic attack**, a person has symptoms such as heart palpitations, sweating, trembling, dizziness, chest pain, and fear of losing control, going crazy, or dying. Panic disorder can occur with or without agoraphobia. **Agoraphobia** involves anxiety about losing control in public places, being in situations from which escape would be difficult or embarrassing, or being in places where there might be no one to help if a panic attack occurred.
- **Obsessive-compulsive Disorder:** A person with **obsessive-compulsive disorder** experiences obsessions, compulsions, or both. **Obsessions** are ideas, thoughts, impulses, or images that are persistent and cause anxiety or distress. A person usually feels that the obsessions are inappropriate but uncontrollable. **Compulsions** are repetitive behaviors that help to prevent or relieve anxiety.
- **Post-traumatic Stress Disorder (PTSD):** A person with this disorder persistently re-experiences a highly traumatic event and avoids stimuli associated with the trauma. Symptoms include increased arousal such as insomnia, irritability, difficulty concentrating, hypervigilance, or exaggerated startle response.

Roots of Anxiety Disorders

Many different interactive factors influence the development of anxiety disorders.

Biological Factors

Many biological factors can contribute to the onset of anxiety disorders:

- **Genetic predisposition:** Twin studies suggest that there may be genetic predispositions to anxiety disorders. Researchers typically use concordance rates to describe the likelihood that a disorder might be inherited. **A concordance rate** indicates the percentage of twin pairs who share a particular disorder. Research has shown that identical twins have a higher concordance rate for anxiety disorders than fraternal twins.
- **Differing sensitivity:** Some research suggests that people differ in sensitivity to anxiety. People who are highly sensitive to the physiological symptoms of anxiety react with even more anxiety to these symptoms, which sets off a worsening spiral of anxiety that can result in an anxiety disorder.
- **Neurotransmitters:** Researchers believe there is a link between anxiety disorders and disturbances in neural circuits that use the neurotransmitters GABA and serotonin. GABA limits nerve cell activity in the part of the brain associated with anxiety. People who do not produce enough GABA or whose brains do not process it normally may feel increased anxiety. Inefficient processing of serotonin may also contribute to anxiety.
- **Brain damage:** Some researchers have suggested that damage to the hippocampus can contribute to PTSD symptoms.

SSRIs and Anxiety Disorders

Selective serotonin reuptake inhibitors (SSRIs) are a class of drug commonly used to treat anxiety disorders. They raise the level of serotonin in the brain by preventing it from being reabsorbed back into cells that released it. Serotonin is a neurotransmitter that affects sleep, alertness, appetite, and other functions. Abnormal levels of serotonin can lead to mood disorders.

Conditioning and Learning

Research shows that conditioning and learning also play a role in anxiety disorders:

- **Classical conditioning:** People can acquire anxiety responses, especially phobias, through classical conditioning and then maintain them through operant conditioning. A neutral stimulus becomes associated with anxiety by being paired with an anxiety-producing stimulus. After this classical conditioning process has occurred, a person may begin to avoid the conditioned anxiety-producing stimulus. This leads to a decrease in anxiety, which reinforces the avoidance through an operant conditioning process. For example, a near drowning experience might produce a phobia of water. Avoiding oceans, pools, and ponds decreases anxiety about water and reinforces the behavior of avoidance.
- **Evolutionary predisposition:** Researchers such as **Martin Seligman** have proposed that people may be more likely to develop conditioned fears to certain objects and situations. According to this view, evolutionary history biologically prepares people to develop phobias about ancient dangers, such as snakes and heights.
- **Observational learning:** People also may develop phobias through observational learning. For example, children may learn to be afraid of certain objects or situations by observing their parents' behavior in the face of those objects or situations.

Cognitive Factors

Some researchers have suggested that people with certain styles of thinking are more susceptible to anxiety disorders than others. Such people have increased susceptibility for several reasons:

- They tend to see threats in harmless situations.
- They focus too much attention on situations that they perceive to be threatening.
- They tend to recall threatening information better than nonthreatening information.

Personality Traits

The personality trait of neuroticism is associated with a higher likelihood of having an anxiety disorder.

D) Mood Disorders

Mood disorders are characterized by marked disturbances in emotional state, which affect thinking, physical symptoms, social relationships, and behavior. If mood is viewed as a continuum, mood disorders occur when a person experiences moods that lie at either extreme of the continuum. Mood disorders are of two basic types: unipolar or bipolar. People with unipolar disorders experience moods that are at the depressive end of the continuum. People with bipolar disorders experience moods that are at both ends of the continuum.

Mood disorders are generally episodic, which means they tend to come and go. The duration of the disturbed emotional state and the pattern of its occurrence determine how a mood disorder is diagnosed.

Dysthymic Disorder

A person with **dysthymic disorder** experiences a depressed mood for a majority of days over at least two years.

Major Depressive Disorder

Major depressive disorder is characterized by at least one major depressive episode. **Amajor depressive episode** is a period of at least two weeks in which a person experiences some or all of the following symptoms:

- Constant sadness or irritability
- Loss of interest in almost all activities
- Changed sleeping or eating patterns

- Low energy
- Feelings of worthlessness or guilt
- Difficulty concentrating
- Recurrent thoughts about suicide

Major depressive disorder is much more common in women than in men.

[Suicide](#)

People who are extremely depressed typically do not commit suicide. In the depths of a depressive episode, people usually feel too unmotivated and apathetic to form a suicide plan and carry it out. Suicide is more likely when a depressed person begins the process of recovery and becomes more energetic. Research shows that women are more likely to attempt suicide than men, but men are more likely to be successful at carrying out a suicide.

Bipolar Disorders

Bipolar disorders involve at least one distinct period when a person exhibits manic symptoms. Manic symptoms include any or all of the following:

- Irritability
- Feelings of being high
- Decreased need for sleep
- Inflated self-esteem or grandiosity
- Fast and pressured speech
- Agitation
- Increased interest in pleasurable activities that have the potential for harmful consequences.

People with bipolar disorders usually also experience major depressive episodes. Men and women are equally likely to suffer from bipolar disorders.

Etiology of Mood Disorders

Researchers believe that many different influences interact to produce mood disorders.

Biological Factors

Biological influences include the following:

- **Genetic predisposition:** Twin studies suggest that people can be genetically predisposed to major depressive disorder and bipolar disorders. Concordance rates for both major depressive disorder and bipolar disorders are higher for identical twins than fraternal twins. Genetic factors seem to be implicated more in depression among women than among men.
- **Neurotransmitters:** Research shows that the neurotransmitters norepinephrine and serotonin are involved in mood disorders.
- **Brain structure:** Some research indicates that people with chronic depression tend to have a smaller hippocampus and amygdala in the brain, perhaps because of an excess of the stress hormone cortisol.

Cognitive Factors

Many researchers have studied the various cognitive factors involved in depression:

- **Learned helplessness:** The psychologist **Martin Seligman** proposed that depression results from **learned helplessness**, or a tendency to give up passively in the face of unavoidable stressors. Seligman pointed out that people who have a pessimistic explanatory style are likely to experience depression.
- **Self-blame:** Depressed people tend to attribute negative events to internal, stable, and global factors. When a problem occurs, they blame themselves rather than situational factors. They believe the problem is likely to be permanent, and they overgeneralize from the problem to their whole lives.
- **Low self-esteem:** Some researchers have suggested that a pessimistic worldview is only one of several factors that contribute to depression. They say that other factors such as low self-esteem and stress also play an important role. All these lead to hopelessness, which then leads to depression.
- **Rumination:** Rumination, or brooding about problems, is associated with longer periods of depression. Some researchers believe that women have higher rates of depression because they tend to ruminate more than men.

Although many researchers believe negative thinking makes people susceptible to depression, most also acknowledge a two-way relationship between depression and negative thinking. Negative thinking makes people susceptible to depression, and depression makes people more likely to think negatively.

Interpersonal Factors

Various interpersonal influences are also linked to depression:

- **Lack of social network:** Depressed people tend to have less social support than other people, and the relationship between social support and depression is likely to be two-way. People with poor social skills may be more likely to develop depression. Once people are depressed, they tend to be unpleasant companions, which further reduces their social support.
- **Loss of an important relationship:** Some researchers have suggested that depression can result when people lose important relationships.

Environmental Stressors

The onset and course of mood disorders may be influenced by stress. Stress also affects people's responses to treatment and whether they are likely to have a relapse. Some researchers have suggested that women are more vulnerable to depression because they tend to experience more stress in the form of discrimination, poverty, and sexual abuse and because they may have less satisfying work and family lives than men.

Even if people are usually happy and have friends and family to rely on, they can still become depressed. Major catastrophes and personal traumas can also contribute to depression. For instance, living in a war zone, having a home destroyed by fire, suffering from a chronically painful or debilitating illness, going through a divorce, or losing a loved one can all bring on depression.

E) Eating Disorders

Eating disorders are characterized by the following:

- Problematic eating patterns
- Extreme concerns about body weight
- Inappropriate behaviors aimed at controlling body weight.

The two main types of eating disorders are anorexia nervosa and bulimia nervosa.

The large majority of eating disorders occur in females and are much more common in industrialized countries where people idealize thinness and have easy access to food. Eating disorders are also much more common in younger women.

Anorexia Nervosa

The main features of **anorexia nervosa** are a refusal to maintain a body weight in the normal range, intense fear about gaining weight, and highly distorted body image. In postpubescent women, another symptom of anorexia nervosa is absence of menstrual periods. Anorexia nervosa can result in serious medical problems, including anemia, kidney and cardiovascular malfunctions, dental problems, and osteoporosis.

Bulimia Nervosa

The main features of **bulimia nervosa** are habitual binge eating and unhealthy efforts to control body weight, including vomiting, fasting, excessive exercise, or use of laxatives, diuretics, and other medications. People with bulimia nervosa tend to evaluate themselves largely according to their body weight and shape. Unlike people with anorexia nervosa, people with bulimia nervosa typically have body weight in the normal range.

Bulimia nervosa can have serious medical consequences, including fluid and electrolyte imbalances and dental and gastrointestinal problems.

Etiology of Eating Disorders

Many different factors influence the development of eating disorders.

Biological Factors

Some evidence suggests a genetic vulnerability to eating disorders:

- Identical twins are more likely to both suffer from an eating disorder than are fraternal twins.
- Biological relatives of people with bulimia nervosa and anorexia nervosa appear to have an increased risk of developing the disorders.

Personality Factors

Some researchers have noted that people with eating disorders are more likely to have certain personality traits:

- People with anorexia nervosa tend to be obsessive, rigid, neurotic, and emotionally inhibited.
- People with bulimia nervosa tend to be impulsive and oversensitive and have poor self-esteem.

Cultural Factors

Cultural factors strongly influence the onset of eating disorders. One example is the high value placed on thinness in industrial countries.

Family Influences

Family environment may also influence the onset of eating disorders:

- Some theorists have suggested that eating disorders are related to insufficient autonomy within the family.
- Others have proposed that eating disorders might be affected by mothers who place too much emphasis on body weight.

Cognitive Factors

People with eating disorders show distortions of thinking, such as the tendency to think in rigid all-or-none terms. It is unclear whether this type of thinking causes the eating disorders or results from the eating disorders.

Stress

The onset of anorexia nervosa is often associated with stressful events such as leaving home for college.

F) Somatoform Disorders

Somatoform disorders are characterized by real physical symptoms that cannot be fully explained by a medical condition, the effects of a drug, or another mental disorder. People with somatoform disorders do not fake symptoms or produce symptoms intentionally.

Three common somatoform disorders are somatization disorder, conversion disorder, and hypochondriasis.

Somatization Disorder

Somatization disorder was formerly called *hysteria* or *Briquet's syndrome*. People with somatization disorder experience a wide variety of physical symptoms, such as pain and gastrointestinal, sexual, and pseudoneurological problems. The disorder usually affects women, begins before age thirty, and continues for many years.

Conversion Disorder

Conversion disorder is characterized by symptoms that affect voluntary motor functioning or sensory functioning. These symptoms cannot be explained medically. A conflict or other stressor precedes the onset or exacerbation of these symptoms, which implies a relationship between the symptoms and psychological factors.

Example:

After being sexually assaulted, a young girl loses the ability to speak. Her inability to speak has no medical explanation.

Hypochondriasis

People with **hypochondriasis** are preoccupied with fears that they have a serious disease. They base these fears on misinterpretations of physical symptoms. People with this disorder continue to worry about having a serious medical problem even after they receive reassurances to the contrary. People with hypochondriasis, however, are not delusional—they can acknowledge that their worries might be excessive.

Etiology of Somatoform Disorders

Personality, cognitive factors, and learning appear to be involved in the etiology of somatoform disorders.

Personality Factors

Some researchers have suggested that people with histrionic personality traits are more likely to develop somatoform disorders. **Histrionic** people enjoy being the center of attention. They tend to be self-focused, excitable, highly open to suggestion, very emotional, and dramatic.

Cognitive Factors

Researchers have proposed that several cognitive factors contribute to somatoform disorders:

- People with these disorders may pay too much attention to bodily sensations.
- They may make catastrophic conclusions when they experience minor symptoms.
- They may have distorted ideas about good health and expect healthy people to be free of any symptoms or discomfort.

Learning

People with somatoform disorders may learn to adopt a sick role because they are reinforced for being sick. Rewards that help to maintain sickness include attention and sympathy from others and avoidance of work and family challenges.

G) Substance-Related Disorders

The *DSM* describes many substance-related disorders, which occur when a person is intoxicated by, withdrawing from, using, abusing, or dependent on one or more drugs. Two common types of substance-related disorders are substance abuse and substance dependence.

Substance Abuse

The *DSM* defines **substance abuse** as a maladaptive pattern of drug use that results in repeated negative consequences such as legal, social, work-related, or school-related problems. A drug abuser may even use drugs in situations in which it is physically dangerous to do so.

Substance Dependence

Substance dependence, or drug addiction, involves continuing to use a drug despite persistent physical or psychological costs. A person who is addicted to drugs may make several unsuccessful attempts to give up the drug and may even develop tolerance for the drug. **Tolerance** is the gradual need for more and more of the drug to get the same effect. The person may also experience **withdrawal symptoms** such as sweating, nausea, muscle pain, shakiness, and irritability when he or she stops taking the drug.

Etiology of Substance-Dependence

Many researchers believe biology and environment interact to produce substance dependence.

Biological Influences

Several lines of research have examined genetic predispositions to drug dependence. Researchers think there may be a genetic predisposition to one particular type of alcoholism: the type that begins in adolescence and that is associated with impulsive, antisocial, and criminal behavior. With other types of alcoholism, many genes may interact to play a role.

Genes may influence traits such as impulsivity, which can make a person more likely to become alcoholic. Genes may also influence the level of dopamine in the brain. Researchers have suggested that high dopamine levels may in turn influence the susceptibility to alcoholism.

Just as biological factors may make a person susceptible to dependence, heavy use of drugs can affect a person's biological makeup. For example, excessive drug use can reduce the number of dopamine receptors in the brain. Since dopamine is involved in feeling pleasure, the reduced number of receptors can then make a person dependent on the drug. The person will crave more of the drug in order to feel the same amount of pleasure.

Environmental Influences

Research findings suggest that certain environmental factors play a key role in substance dependence:

- **Cultural norms:** The pattern of drug dependence varies according to cultural norms. For example, alcohol dependence is rarer in countries where children learn to drink responsibly and in moderation and where excessive drinking by adults is considered improper. Alcohol dependence is more common in societies that condone adult drunkenness and forbid children to drink.
- **Social policy:** Governmental policies that totally prohibit alcohol consumption tend to increase rates of alcohol dependence.

- **Variation in symptoms:** The existence of withdrawal symptoms after discontinuing a drug depends on many factors, including a person's expectations and context. This suggests that dependence is not just a biological phenomenon.
- **Reasons for drug use:** A person's tendency toward drug addiction depends not only on the properties of the drug but also on the reasons a person uses the drug. For example, people who receive prescription narcotics in hospitals for postsurgical pain may not become addicted, while others who use narcotics to escape stress may become addicted.

H) Schizophrenia

Schizophrenia is one of several psychotic disorders described in the *DSM*. People with psychotic disorders lose contact with reality and often have delusions or hallucinations. People with schizophrenia have a wide range of symptoms, which can be classified into positive or negative symptoms.

Positive Symptoms

Positive symptoms involve the presence of altered behaviors. Examples of positive symptoms include delusions, hallucinations, disorganized speech, and disorganized behavior. **Delusions** are false beliefs that are strongly held despite contradictory evidence. **Hallucinations** are sensory or perceptual experiences that happen without any external stimulus. Hallucinations can occur in any sensory modality, but auditory hallucinations are most common in schizophrenia. Disorganized speech can also take many forms. For example, a person with schizophrenia may produce *word salad*, which consists of words and sentences strung together in an incoherent way. Examples of disorganized behavior include inappropriate gestures or laughter, agitated pacing, or unpredictable violence.

Negative Symptoms

Negative symptoms involve an absence or reduction of normal behavior. Negative symptoms include emotional flatness, social withdrawal, sparse or uninflected speech, and lack of motivation.

Subtypes of Schizophrenia

Schizophrenia is classified into four subtypes, depending on the symptoms present at the time of evaluation:

1. **Paranoid type:** Characterized by marked delusions or hallucinations and relatively normal cognitive and emotional functioning. Delusions are usually persecutory, grandiose, or both. **Persecutory delusions** involve a belief that one is being oppressed, pursued, or harassed in some way. **Grandiose delusions** involve the belief that one is very important or famous. This subtype usually happens later in life than the other subtypes. Prognosis may also be better for this subtype than for other subtypes.
2. **Disorganized type:** Characterized by disorganized behavior, disorganized speech, and emotional flatness or inappropriateness.
3. **Catatonic type:** Characterized by unnatural movement patterns such as rigid, unmoving posture or continual, purposeless movements, or by unnatural speech patterns such as absence of speech or parroting of other people's speech.
4. **Undifferentiated type:** Diagnosis given to a patient that does not meet criteria for paranoid, disorganized, or catatonic schizophrenia.

Etiology of Schizophrenia

As with other psychological disorders, researchers have studied the etiology of schizophrenia from different perspectives.

Biological Factors

Research suggests that genes, neurotransmitters, and brain abnormalities play a role in the onset of schizophrenia:

- **Genetic predisposition:** Substantial evidence suggests that there is a genetically inherited predisposition to schizophrenia. For example, there is a concordance rate of about 48 percent for identical twins. The concordance rate for fraternal twins is considerably less, about 17 percent. **Concordance rate** refers to the percentage of both people in a pair having a certain trait or disorder. A person who has two parents with schizophrenia has about a 46 percent chance of developing schizophrenia. This probability is very high compared to the roughly 1 percent chance of developing schizophrenia in the general population.
- **Neurotransmitters:** Some researchers have proposed that schizophrenia is related to an overabundance of the neurotransmitter dopamine in the brain. Other researchers have suggested that both serotonin and dopamine may be implicated. The neurotransmitter glutamate may also play a role in the disorder. Underdevelopment of glutamate neurons results in the overactivity of dopamine neurons.
- **Brain structure:** Some researchers have suggested that schizophrenia may involve an inability to filter out irrelevant information, which leads to being overwhelmed by stimuli. With this idea in mind, researchers have looked for brain abnormalities in schizophrenia patients. The brains of people with schizophrenia do differ structurally from the brains of normal people in several ways. For example, they are more likely to have enlarged ventricles, or fluid-filled spaces. They are also more likely to have abnormalities in the thalamus and reduced hippocampus volume.
- **Brain injury:** Another line of research suggests that injuries to the brain during sensitive periods of development can make people susceptible to schizophrenia later on in life. For example, researchers believe that viral infections or malnutrition during the prenatal period and complications during the birthing process can increase the later risk of schizophrenia. Some researchers have suggested that abnormal brain development during adolescence may also play a role in schizophrenia.

Stress

Many researchers believe stress plays a role in bringing on schizophrenia in people who are already biologically vulnerable to this disorder.

I) Dissociative Disorders

Dissociative disorders are characterized by disturbances in consciousness, memory, identity, and perception.

Three kinds of dissociative disorders are dissociative amnesia, dissociative fugue, and dissociative identity disorder.

Dissociative Amnesia

The main feature of **dissociative amnesia** is an inability to remember important personal information, usually about something traumatic or painful. The memory loss is too extensive to be explained by normal forgetfulness.

Dissociative Fugue

People with **dissociative fugue** suddenly leave their homes and disappear unexpectedly. They do not remember their past and are confused about their identity. Sometimes, they may assume entirely new identities.

Dissociative Identity Disorder

Dissociative identity disorder was formerly called “multiple personality disorder.” In this disorder, certain aspects of identity, consciousness, and memory are not integrated. People with dissociative identity disorder cannot remember important personal information and have two or more identities or personality states that control their behavior. Often, each of these identities has a separate name, personal history, set of characteristics, and self-image.

The Dissociative Identity Disorder Controversy

Dissociative identity disorder is a controversial diagnosis. Some psychologists believe that the disorder is very rare and that the increase in its prevalence since the 1980s is due to overdiagnosis. These theorists point out that the presentation of dissociative identity disorder often changes according to its representation in the media, such as in the book Sybil. Others have suggested that clinicians sometimes induce this disorder in highly suggestible people. Some psychologists, however, believe that dissociative identity disorder is not rare and has only been unrecognized and underdiagnosed in the past.

Etiology of Dissociative Disorders

Many researchers believe that severe stress plays a role in the onset of dissociative disorders. However, they cannot explain why only a small minority of people who experience severe stress develop such disorders.

J) Personality Disorders

Personality disorders are stable patterns of experience and behavior that differ noticeably from patterns that are considered normal by a person's culture. Symptoms of a personality disorder remain the same across different situations and manifest by early adulthood. These symptoms cause distress or make it difficult for a person to function normally in society. There are many types of personality disorders, including the following:

- **Schizoid personality disorder:** entails social withdrawal and restricted expression of emotions
- **Borderline personality disorder:** characterized by impulsive behavior and unstable relationships, emotions, and self-image
- **Histrionic personality disorder:** involves attention-seeking behavior and shallow emotions
- **Narcissistic personality disorder:** characterized by an exaggerated sense of importance, a strong desire to be admired, and a lack of empathy
- **Avoidant personality disorder:** includes social withdrawal, low self-esteem, and extreme sensitivity to negative evaluation
- **Antisocial personality disorder:** characterized by a lack of respect for other people's rights, feelings, and needs, beginning by age fifteen. People with antisocial personality disorder are deceitful and manipulative and tend to break the law frequently. They often lack empathy and remorse but can be superficially charming. Their behavior is often aggressive, impulsive, reckless, and irresponsible. Antisocial personality disorder has been referred to in the past as sociopathy or psychopathy.

Etiology of Antisocial Personality Disorder (APD)

Researchers have proposed that the following biological factors might be related to the etiology of antisocial personality disorder:

- People with this disorder may have central nervous system abnormalities that prevent them from experiencing anxiety in stressful situations. Because they feel no anxiety, they never learn to avoid behavior with negative consequences.
- Such people may also have a genetically inherited inability to control impulses.
- Some researchers have suggested that antisocial personality disorder may be caused by brain damage. Injuries to the prefrontal cortex, which is involved in planning and impulse control, may be particularly involved.

As with other disorders, however, biological factors alone are often not enough to cause APD. Environmental factors, such as family abuse or dysfunction, also play a large role in the development of APD. Generally, it is the combination of these environmental factors with the biological vulnerability that brings on the disorder.

XVI. Psychological Treatment

Cartoon characterizations of psychological treatment typically involve a client lying tensely on a couch while a poker-faced therapist sits nearby, taking notes. Real treatments for psychological problems rarely fit this image. Hundreds of different treatments exist, including medication, electric shock, and surgery. Some types involve unorthodox and often strange procedures, such as making rapid eye movements.

Talk therapy is another common type of treatment. Therapists vary in their style and approach from client to client, and although some therapists still have their clients lie on couches, most therapists sit face-to-face with them. Some therapists take a relatively passive, listening role in therapy sessions, while others actively discuss problems or even argue with clients. All these treatments have different rationales and varying degrees of success. The type of treatment used and the effectiveness of that treatment sometimes depend as much on the client as on the treatment itself.

A) Types of Treatment

There are many different types of treatment for psychological disorders, all of which fit into three broad types: insight therapies, behavior therapies, and biomedical therapies.

- **Insight therapies** involve complex conversations between therapists and clients. The aim is to help clients understand the nature of their problems and the meaning of their behaviors, thoughts, and feelings. Insight therapists may use a variety of approaches, including psychodynamic, cognitive, or humanistic.
- **Behavior therapies** also involve conversations between therapists and clients but attempt to directly influence maladaptive behaviors. Behavior therapies are based on learning principles. (See Chapter 7 for more information on learning.)
- **Biomedical therapies** involve efforts to directly alter biological functioning through medication, electric shock, or surgery.

B) Psychotherapy

Psychotherapy is the treatment of psychological problems through confidential verbal communications with a mental health professional. All psychotherapies offer hope that a problem will improve, present new perspectives on the problem, and encourage an empathic relationship with a therapist. The approach a psychotherapist uses depends on his or her theoretical orientation. Types of approaches include psychodynamic, cognitive, humanistic, and behavioral.

Types of Mental Health Professionals

- *Clinical and counseling psychologists have a doctoral degree as well as specialized training for diagnosing and treating psychological disorders and problems of daily living.*
- *Psychiatrists are physicians. They have a medical degree and specialize in diagnosing and treating psychological disorders. Psychiatrists tend to focus on biomedical therapies, although they sometimes also provide psychotherapy.*
- *Psychiatric social workers and psychiatric nurses also provide psychotherapy, often in institutional settings, such as hospitals and social service organizations. They sometimes practice independently as well.*
- *Counselors who provide psychotherapy services usually work in schools, colleges, and social service organizations.*

Psychodynamic Approaches

All of the many psychodynamic therapies derive from the treatment called *psychoanalysis*, which **Sigmund Freud** developed and used in the late 1800s and early 1900s. (See Chapter 13 for more information on Freud and his theory of psychoanalysis.)

Psychoanalytic treatment focuses on uncovering unconscious motives, conflicts, and defenses that relate to childhood experiences. Freud believed that people experience anxiety because of conflicts among the **id**, **ego**, and **superego**. To manage these conflicts, people use defense mechanisms, which can often be self-defeating and unsuccessful at fully controlling anxiety.

Psychoanalytic Techniques

In the traditional form of psychoanalysis, clients meet with a psychoanalyst several times a week for many years. The psychoanalyst sits out of view of the client, who sometimes lies on a couch.

Some techniques commonly used in psychoanalysis include free association, dream analysis, and interpretation:

- **Free association:** Psychoanalysts encourage clients to say anything that comes to mind. Clients are expected to put all thoughts into words, even if those thoughts are incoherent, inappropriate, rude, or seemingly irrelevant. Free associations reveal the client's unconscious to the psychoanalyst.
- **Dream analysis:** Dreams also reveal the subconscious. Clients describe their dreams in detail, and the psychoanalyst interprets the latent content, or the hidden meaning, of these dreams.
- **Interpretation:** A key technique in psychoanalysis, interpretation refers to the psychoanalyst's efforts to uncover the hidden meanings in the client's free associations, dreams, feelings, memories, and behavior. Psychoanalysts are trained to make interpretations carefully and only when a client is ready to accept them. Ideally, such interpretations increase the client's insight.

Psychoanalytic Concepts

Three important concepts involved in psychoanalysis are transference, resistance, and catharsis:

- **Transference** refers to the process by which clients relate to their psychoanalysts as they would to important figures in their past. Psychoanalysts usually encourage transference because it helps them to uncover the client's hidden conflicts and helps the client to work through such conflicts.

Example:

A client who is resentful about her mother's authority over her might show angry, rebellious behavior toward the psychoanalyst.

- **Resistance** refers to the client's efforts to block the progress of treatment. These efforts are usually unconscious. Resistance occurs because the client experiences anxiety when unconscious conflicts begin to be uncovered.

Example:

Resistance can take many different forms, such as coming late to sessions, forgetting to pay for sessions, and expressing hostility toward the psychoanalyst.

- **Catharsis** is the release of tension that results when repressed thoughts or memories move into the patient's conscious mind.

Example:

Jane has a repressed childhood memory of being punished by her father after walking into her parents' bedroom while they were having sex. This memory comes into her conscious mind while she is undergoing psychotherapy. Subsequently, she feels a release of tension and is able to relate the incident to her current aversion toward sex.

Current Psychodynamic Therapies

Today, the classical form of psychoanalysis is rarely practiced. Psychodynamic therapies, however, are widely used for treating the full range of psychological disorders. Psychodynamic therapies differ in their specific approaches, but they all focus on increasing insight by uncovering unconscious motives, conflicts, and defenses.

Interpretation and the concepts of transference and resistance are important features of psychodynamic therapies. Unlike traditional psychoanalysts, psychodynamic therapists usually sit face-to-face with their clients. Sessions typically occur once or twice a week, and treatment usually does not last as long as psychoanalysis.

Cognitive Approaches

Cognitive therapies aim to identify and change maladaptive thinking patterns that can result in negative emotions and dysfunctional behavior. Psychologist **Aaron Beck** first developed cognitive therapy to treat depression, although cognitive therapies are now used to treat a wide range of disorders. Beck's cognitive therapy helps clients test whether their beliefs are realistic.

Cognitive therapists such as Beck believe that depression arises from errors in thinking. According to this theory, depressed people tend to do any of the following:

- Blame themselves for negative events. They underestimate situational causes.
- Pay more attention to negative events than to positive ones.
- Are pessimistic.
- Make inappropriately global generalizations from negative events.

Cognitive Therapy Techniques

Cognitive therapists try to change their clients' ways of thinking. In therapy, clients learn to identify automatic negative thoughts and the assumptions they make about the world. **Automatic thoughts** are self-defeating judgments that people make about themselves. Clients learn to see these judgments as unrealistic and to consider other interpretations for events they encounter.

Rational-Emotive Therapy

*Rational-emotive therapy is a type of cognitive-behavioral therapy started by the psychologist **Albert Ellis**. In this therapy, the therapist directly challenges the client's irrational beliefs. Ellis's therapy hinges on the idea that people's feelings are influenced not by negative events but by their catastrophic thoughts and beliefs about these events. Ellis points out that catastrophic thinking is based on irrational assumptions about what one must do or be. His therapy aims to identify catastrophic thinking and change the irrational assumptions that underlie it.*

Behavioral Approaches

Whereas insight therapies focus on addressing the problems that underlie symptoms, behavior therapists focus on addressing symptoms, which they believe *are* the real problem. Behavior therapies use learning principles to modify maladaptive behaviors. Many therapists combine behavior therapy and cognitive therapy into an approach known as cognitive-behavior therapy.

Behavior therapies are based on two assumptions:

- Behavior is learned.
- Behavior can be changed by applying the principles of classical conditioning, operant conditioning, and observational learning. (See Chapter 7 for more information.)

Behavior therapies are designed for specific types of problems. Three important types of behavior therapies include systematic desensitization, aversion therapy, and social skills training.

Systematic Desensitization

Systematic desensitization is a treatment designed by the psychologist **Joseph Wolpe**. It uses counterconditioning to decrease anxiety symptoms. This therapy works on the assumption that anxiety arises through classical conditioning. That is, a neutral stimulus begins to arouse anxiety when it is paired with an unconditioned stimulus that evokes anxiety.

Example:

A person might develop a fear of high places after experiencing an avalanche on a mountain trail. The avalanche is the unconditioned stimulus, and any high place becomes the conditioned stimulus, producing anxiety similar to that evoked by the avalanche.

Systematic desensitization aims to replace the conditioned stimulus with a response, such as relaxation, that is incompatible with anxiety. If psychotherapists can teach their clients to relax whenever they encounter an anxiety-producing stimulus, the anxiety will gradually decrease.

Exposure Therapies

*Systematic desensitization is a type of exposure therapy. **Exposure therapies** are commonly used to treat phobias. These therapies recognize the fact that people maintain phobias by avoiding anxiety-producing situations, and they involve eliminating anxiety responses by having clients face a real or imagined version of the feared stimulus. In recent years, therapists have started using virtual reality devices to help clients experience feared stimuli.*

***Flooding** is a more extreme type of exposure therapy than systematic desensitization. In flooding, exposure to anxiety-producing stimuli is sudden rather than gradual. For example, the person with the fear of heights would be taken to a mountain trail. No avalanche happens, so the person's anxiety is extinguished.*

Systematic desensitization involves a series of steps, which occur over several therapy sessions:

1. The therapist and client make up an anxiety hierarchy. The hierarchy lists stimuli that the client is likely to find frightening. The client ranks the stimuli from least frightening to most frightening.
2. The therapist teaches the client how to progressively and completely relax his body.
3. Next, the therapist asks the client to first relax and then imagine encountering the stimuli listed in the anxiety hierarchy, beginning with the least-frightening stimulus. If the client feels anxious while imagining a stimulus, he is asked to stop imagining the stimulus and focus on relaxing. After some time, the client becomes able to imagine all the stimuli on the hierarchy without anxiety.
4. Finally, the client practices encountering the real stimuli.

EMDR

***Eye movement desensitization and reprocessing (EMDR)** is a method that some therapists use to treat problems such as post-traumatic stress disorder and panic attacks. This treatment is a type of exposure therapy in which clients move their eyes back and forth while recalling memories that are to be desensitized. Many critics of EMDR*

claim that the treatment is no different from a standard exposure treatment and that the eye movements do not add to the effectiveness of the procedure.

Aversion Therapy

In **aversion therapy**, a stimulus that evokes an unpleasant response is paired with a stimulus that evokes a maladaptive behavior.

Example:

A therapist might give an alcoholic a nausea-producing drug along with alcoholic drinks.

Therapists use aversion therapy to treat problems such as deviant sexual behavior, substance abuse, and overeating. One major limitation of this type of therapy is that people know that the aversive stimulus occurs only during therapy sessions. Aversion therapy is usually used in combination with other treatments.

Criticisms of Aversion Therapy

Many doctors and psychologists criticize aversion therapy as both inhumane and ineffective. Therapists have sometimes used aversion therapy for controversial ends. For example, in the past, therapists used aversion therapy to “treat” homosexuality.

Social Skills Training

Social skills training aims to enhance a client’s relationships with other people. Techniques used in social skills training include modeling, behavioral rehearsal, and shaping:

- **Modeling** involves having clients learn specific skills by observing socially skilled people.
- **Behavioral rehearsal** involves having the client role-play behavior that could be used in social situations. The therapist provides feedback about the client’s behavior.
- **Shaping** involves having the client approach progressively more difficult social situations in the real world.

Token Economies

*A **token economy** is a behavior modification program based on operant conditioning principles. Token economies are sometimes successfully used in institutional settings, such as schools and psychiatric hospitals. People receive tokens for desirable behaviors, such as getting out of bed, washing, and cooperating. These tokens can be exchanged for rewards, such as candy or TV-watching time.*

Humanistic Approaches

Humanistic therapies are derived from the school of humanistic psychology (see Chapter 13). Humanistic therapists try to help people accept themselves and free themselves from unnecessary limitations. The influence of humanistic therapies led to the use of the term *clients*, rather than *patients*, in referring to people who seek therapy. Humanistic therapists tend to focus on the present situation of clients rather than their past.

The best-known humanistic therapy is client-centered therapy.

Client-Centered Therapy

Client-centered, or person-centered, **therapy** was developed by the psychologist **Carl Rogers**. (See Chapter 13 for more information on Carl Rogers.) It aims to help clients enhance self-acceptance and personal growth by providing a supportive emotional environment. This type of therapy is nondirective, which means that the therapist does not direct the course and pace of therapy. Client-centered therapists believe that people’s problems come from **incongruence**, or a disparity between their self- concept and reality. Incongruence arises because people are too dependent on

others for approval and acceptance. When people have incongruence, they feel anxious. They subsequently try to maintain their self-concept by denying or distorting reality.

In client-centered therapy, people learn to adopt a more realistic self-concept by accepting who they are and thus becoming less reliant on the acceptance of others. To do this, therapists have to be genuine, empathic, and provide **unconditional positive regard**, which is nonjudgmental acceptance of the client. Client-centered therapists use **active listening** to show empathy by accurately mirroring, or reflecting, the thoughts and feelings of the client. They help the client to clarify these thoughts and feelings by echoing and restating what the client has said.

Integrative Approaches to Therapy

*Many therapists use an **integrative approach**, which means they use the perspectives and techniques of many different schools of psychology rather than adhering rigidly to one school. For example, a therapist might use a psychodynamic approach to understand the unconscious motivations influencing a client's behavior, a client-centered approach when interacting empathically with the client, and a cognitive-behavioral approach to suggest strategies that may help the client cope with problems.*

Existential Therapies

***Existential therapies** aim to help clients find meaning in their lives. They address concerns about death, alienation from other people, and freedom. Existential therapists, like humanistic therapists, believe that people are responsible for their own lives.*

C) Family Therapies

In **family therapy**, a therapist sees two or more members of a family at the same time. Family therapies work on the assumption that people do not live in isolation but as interconnected members of families. A problem that affects one person in the family must necessarily affect the whole family, and any change a person makes will inevitably affect the whole family. Family therapists help people to identify the roles they play in their families and to resolve conflicts within families. Family therapists sometimes use family trees to help family members identify intergenerational patterns of behavior.

In **couples therapy**, therapists help couples identify and resolve conflicts. Therapists usually see both members of a couple at the same time. Family and couples therapists may use psychodynamic, cognitive, behavioral, or humanistic approaches.

D) Group Therapies

In group therapy, a therapist meets with several people at once. Psychotherapy groups usually have between four and fifteen people. Group therapies are cost-effective for clients and time saving for therapists.

Self-Help Groups

***Self-help groups**, such as Alcoholics Anonymous, resemble therapy groups except that they do not have a therapist. These groups allow people to feel less alone in dealing with their problems. Self-help group participants both give and receive help and can usually attend the group free of charge. Self-help groups are used very widely.*

Features of Psychotherapy Groups

Groups may be homogeneous or heterogeneous. In homogeneous groups, all members share one or more key characteristics. For example, a group may be composed of people who are all suffering from depression or people who are between the ages of twenty and thirty. Many groups are heterogeneous and contain people who differ in age, type of problem, gender, and so on.

The Therapist's Role

The therapist usually screens people to determine whether they would be suitable for a group, excluding people who are likely to be highly disruptive. In the group, the therapist's role is to promote a supportive environment, set goals, and protect the clients from harm.

The Role of Group Members

Group members discuss their problems and experiences with one another and consider different ways of coping. They provide each other with acceptance, support, and honest feedback. A therapy group is a place where people can practice coping strategies and ways of relating to others. Therapy groups also help people to realize they are not alone in their suffering.

E) Biomedical Therapies

Biomedical therapies include drug therapy, electroconvulsive therapy, and psychosurgery.

Drug Therapies

Drug therapy, or psychopharmacotherapy, aims to treat psychological disorders with medications. Drug therapy is usually combined with other kinds of psychotherapy. The main categories of drugs used to treat psychological disorders are antianxiety drugs, antidepressants, and antipsychotics.

Antianxiety Drugs

Antianxiety drugs include a class of drugs called **benzodiazepines**, or tranquilizers. Two commonly used benzodiazepines are known by the brand names Valium and Xanax. The generic names of these drugs are diazepam and alprazolam, respectively:

- **Effects:** Benzodiazepines reduce the activity of the central nervous system by increasing the activity of GABA, the main inhibitory neurotransmitter in the brain. Benzodiazepines take effect almost immediately after they are administered, but their effects last just a few hours. Psychiatrists prescribe these drugs for panic disorder and anxiety.
- **Side effects:** Side effects may include drowsiness, light-headedness, dry mouth, depression, nausea and vomiting, constipation, insomnia, confusion, diarrhea, palpitations, nasal congestion, and blurred vision. Benzodiazepines can also cause drug dependence. Tolerance can occur if a person takes these drugs for a long time, and withdrawal symptoms often appear when the drug use is discontinued.

Antidepressant Drugs

Antidepressants usually take a few weeks to have an effect. There are three classes of antidepressants: monoamine oxidase inhibitors, tricyclics, and selective serotonin reuptake inhibitors.

- **Monoamine oxidase inhibitors (MAOIs):** Include phenelzine (Nardil).
- **Tricyclics:** Include amitriptyline (Elavil). Tricyclics generally have fewer side effects than the MAOIs.
- **Selective serotonin reuptake inhibitors (SSRIs):** The newest class of antidepressants, including paroxetine (Paxil), fluoxetine (Prozac), and sertraline (Zoloft).

Antidepressants are typically prescribed for depression, anxiety, phobias and obsessive-compulsive disorder.

- **Effects:** MAOIs and tricyclics increase the level of the neurotransmitters norepinephrine and serotonin in the brain. SSRIs increase the level of serotonin.
- **Side effects:** Although antidepressants are not addictive, they often have side effects such as headache, dry mouth, constipation, nausea, weight gain, and feelings of restlessness. Of the three classes of antidepressants, MAOIs generally have the most side effects. People who take MAOIs also have to restrict

their diet, because MAOIs interact negatively with foods that contain the amino acid tyramine, such as beer and some cheeses and meats. SSRIs have fewer side effects than the other two classes of antidepressants. However, SSRIs can cause sexual dysfunction, and if they are discontinued abruptly, withdrawal symptoms occur.

Antipsychotic Drugs

Antipsychotic drugs are used to treat schizophrenia and other psychotic disorders. They include chlorpromazine (Thorazine), thioridazine (Mellaril), and haloperidol (Haldol). Antipsychotic drugs usually begin to take effect a few days after they are administered.

- **Effects:** Antipsychotic drugs, or neuroleptics, reduce sensitivity to irrelevant stimuli by limiting the activity of the neurotransmitter dopamine. Many antipsychotic drugs are most useful for treating positive symptoms of schizophrenia, such as hallucinations and delusions. However, a new class of antipsychotic drugs, called **atypical antipsychotic drugs**, also help treat the negative symptoms of schizophrenia. They reduce the activity of both dopamine and serotonin. Atypical antipsychotic drugs include clozapine (Clozaril), olanzapine (Zyprexa), and quetiapine (Seroquel). Atypical antipsychotic drugs can sometimes be effective for schizophrenia patients who have not responded to the older antipsychotic drugs.
- **Side effects:** Side effects include drowsiness, constipation, dry mouth, tremors, muscle rigidity, and coordination problems. These side effects often make people stop taking the medications, which frequently results in a relapse of schizophrenia. A more serious side effect is **tardive dyskinesia**, a usually permanent neurological condition characterized by involuntary movements. To avoid tardive dyskinesia, the dosage of antipsychotics has to be carefully monitored. The atypical antipsychotics have fewer side effects than the older antipsychotic drugs and are less likely to cause tardive dyskinesia. In addition, relapse rates are lower if people continue to take the drug. However, the relapse rate is higher with these drugs if people discontinue the drug.

Lithium

One drug used in the treatment of bipolar disorders is **lithium**.

Effects: Lithium prevents mood swings in people with bipolar disorders. Researchers have suggested that lithium may affect the action of norepinephrine or glutamate.

Side effects: Lithium can cause tremors or long-term kidney damage in some people. Doctors must carefully monitor the level of lithium in a patient's blood. A level that is too low is ineffective, and a level that is too high can be toxic. Discontinuing lithium treatment abruptly can increase the risk of relapse.

Recently developed alternatives to lithium include the drugs carbamazepine (Tegretol) and divalproex (Depakote).

Criticisms of Drug Therapies

Drug therapies are effective for many people with psychological disorders, especially for those who suffer from severe disorders that cannot be treated in other ways. However, drug therapies have been criticized for several reasons:

- Their effects are superficial and last only as long as the drug is being administered.
- Side effects can often be more severe and troubling than the disorder for which the drug was given. This can cause patients to discontinue the drugs and experience relapses.
- Patients often respond well to new drugs when they are first released into the market because of the enthusiasm and high expectations surrounding the drug. But such placebo effects tend to wane over time.

- The **therapeutic window** for drugs, or the amount of the drug that is required for an effect without toxicity, varies according to factors such as gender, age, and ethnicity. This makes it difficult for physicians to determine the right dose of a drug.
- New drugs, even those approved for long-term use, are often tested on only a few hundred people for a few weeks or months. This means that the risks of taking drugs long-term are unknown.
- Some critics point out that because of pressure from managed care companies, physicians may overprescribe drugs rather than recommend psychotherapy.
- Drugs are tested only on certain populations, for certain conditions. Physicians, however, sometimes prescribe a drug for conditions and populations that were not included in the testing.
- Researchers who study the effectiveness of medications may be biased because they often have financial ties to pharmaceutical companies.
- Freely prescribing drugs for psychological disorders gives the impression that such disorders can be treated only biochemically. However, the biological abnormalities present in such disorders can often be treated by changing thoughts and behavior.

Electroconvulsive Therapy

Electroconvulsive therapy (ECT) is used mainly for the treatment of severe depression. Electrodes are placed on the patient's head, over the temporal lobes of the brain. Anesthetics and muscle relaxants help minimize discomfort to the patient. Then an electric current is delivered for about one second. The patient has a convulsive seizure and becomes unconscious, awakening after about an hour. The typical number of ECT sessions varies from six to twenty, and they are usually done while a patient is hospitalized.

ECT is a controversial procedure. Research suggests that there are short-term side effects of ECT, such as attention deficits and memory loss. Critics of ECT believe that it is often used inappropriately and that it can result in permanent cognitive problems. Proponents of ECT, however, believe that it does not cause long-term cognitive problems, loss of memory, or brain damage. They believe that it is highly effective and that it is underused because of negative public ideas surrounding it.

Psychosurgery

Psychosurgery is brain surgery to treat a psychological disorder. The best-known form of psychosurgery is the prefrontal lobotomy. A **lobotomy** is a surgical procedure that severs nerve tracts in the frontal lobe. Surgeons performed lobotomies in the 1940s and 1950s to treat highly emotional and violent behavior. The surgery often resulted in severe deficits, including apathy, lethargy, and social withdrawal.

Lobotomies are now rarely performed, but some neurosurgeons perform **cingulotomies**, which involve destruction of part of the frontal lobes. These surgeries are usually performed on patients who have severe depressive or anxiety disorders and who do not respond to other treatments. The effectiveness of these surgeries is unclear.

Transcranial Magnetic Stimulation

Transcranial magnetic stimulation (TMS) is a recently developed, noninvasive procedure. It involves stimulating the brain by means of a magnetic coil held to a person's skull near the left prefrontal cortex. It is used to treat severe depression.

F) Effectiveness of Treatment

Research has shown that many people with psychological disorders benefit from treatment. Effectiveness depends on the specific disorder being treated and the skill of the therapist.

Ways of Assessing Effectiveness

The effectiveness of a particular therapeutic approach can be assessed in three ways: client testimonials, providers' perceptions, and empirical research.

Client Testimonials

Clients who get treatment for psychological problems often testify to their effectiveness. However, such testimonials can be unreliable for several reasons:

- **Regression toward the mean:** People often go into treatment because they are in extreme distress. When their distress becomes less extreme, they may attribute this to the treatment's effectiveness. But even without treatment, extreme distress tends to decrease. The tendency for extreme states to move toward the average when assessed a second time is called **regression toward the mean**.
- **The placebo effect:** People often feel better after being in treatment because of their expectations that they will improve. (See Chapter 1 for more information on placebo effects.)
- **The justification of effort effect:** People may believe that treatment was effective because they spent time, effort, and money on it. If people work hard to reach a goal, they are likely to value the goal more. This phenomenon is called **justification of effort**.

Providers' Perceptions

Treatment providers can say whether a treatment is effective, but this can be unreliable for several reasons:

- Regression toward the mean affects providers' perceptions of success. They may believe that a client who entered treatment in crisis became less extremely distressed because of the treatment. However, such an improvement may have occurred without any intervention.
- Providers' perceptions may be biased because clients often emphasize improvements in order to justify discontinuing treatment.
- Providers may also have biased perceptions because they continue to hear from past clients only when those clients were satisfied with treatment. They don't often hear from clients who found treatment ineffective.

Empirical Research

Another way to assess effectiveness is through careful empirical research. Research has shown that some treatments are more effective for a particular problem than a placebo or no treatment. These treatments are known as **empirically validated treatments**. Researchers have to conduct two or more studies in order to conclude that a specific treatment is effective for a particular problem.

Research shows that psychotherapy works for many psychological problems. Although people who do not receive therapy also sometimes improve with time, people who do receive therapy are more likely to improve. Research also shows that all approaches to therapy are about equally effective, though certain kind of therapies do seem somewhat more effective for specific problems.

Specific Disorder	Most Effective Treatment
Panic disorders	Cognitive therapy
Specific phobias	Systematic desensitization

Obsessive-compulsive disorder	Behavior therapy or medication
Depression	Cognitive therapy
Post-traumatic stress disorder and agoraphobia	Exposure treatment

Therapist Factors

Research shows that the effectiveness of therapy does not depend on the level of training or experience of the therapist or on the type of mental health professional providing therapy. However, the effectiveness of therapy does depend on the skill of the therapist. The most effective therapists tend to be empathic, genuine, and warm.

Who Benefits from Treatment?

Clients who are likely to benefit from therapy share some common features:

- Motivation to get better
- Family support
- Tendency to deal actively with problems rather than avoid them

Clients who are less likely to benefit from therapy also share some features:

- Hostility and negativity
- Personality disorders
- Psychotic disorders

Can Therapy Be Harmful?

Under some conditions, therapy can be harmful to the client. Clients may be harmed if:

- Therapists engage in unethical behavior, such as by having sexual relationships with clients
- Therapists act according to personal prejudices or are ignorant of cultural differences between themselves and their clients
- Therapists coerce clients into doing things they don't want to do
- Therapists use techniques that research has not demonstrated as being effective
- Therapists lead their clients to produce false memories of past traumas through careless use of techniques such as hypnosis or free association

G) Seeking Treatment

Although many people experience psychological problems over their lifetime, not everyone seeks treatment. Not everyone is willing to get psychotherapy for problems they experience. More women than men get psychotherapy, and people who are more educated and who have medical insurance are also more likely to seek treatment.

Barriers to Getting Treatment

People may not seek treatment even if they feel they need it. Common barriers to getting treatment are:

- Concerns about the cost of treatment

- Lack of health insurance
- The stigma associated with getting psychological treatment

Psychotherapy for Cultural and Ethnic Minorities

Modern psychotherapy is based on individualistic values, and many researchers have argued that such therapy may not be readily applied to ethnic minorities in the United States. Ethnic and cultural minorities may face several barriers to receiving psychotherapy:

- Some cultural groups may be hesitant to seek help from professionals, particularly in institutional settings such as hospitals and clinics. They may instead prefer to seek informal help from family, friends, elders, and priests.
- Cultural minorities may find it difficult to get psychotherapy services because therapists who speak their language are unavailable.
- Therapists trained to treat mainly white, middle-class clients may not be familiar with or responsive to the needs of clients from different ethnic and cultural backgrounds.

H) Treatment Trends

Two current trends that affect the treatment of psychological disorders are managed care and deinstitutionalization.

Managed Care

Managed care is an arrangement in which an organization, such as a health maintenance organization (HMO), acts as an intermediary between a person seeking health care and a treatment provider. People buy insurance plans from HMOs and then pay only a small copayment each time they get healthcare services. Prior to managed care, health care was done through fee-for-service arrangements. In **fee-for-service** arrangements, people pay for any health care services they believe they need. They may then be reimbursed by insurance companies or government health care programs, such as Medicaid and Medicare.

The advantages of managed care are that consumers pay lower fees to providers and that money is not usually spent on medically unnecessary services.

Criticisms of Managed Care

Managed care systems have many critics who argue that HMOs compromise the quality of health care in the following ways:

- Consumers are often denied treatment they need, or the length of treatment is inappropriately limited.
- Managed care creates barriers to accessing health care services by requiring people to get referrals through their primary care providers or by authorizing only a small number of therapy sessions at a time.
- Because of cost issues, the professionals who provide treatment are often less well-trained to treat severe disorders. For example, they may be counselors with master's degrees rather than doctoral-level psychologists or psychiatrists.
- Physicians might be required to prescribe older, less effective drugs rather than new drugs in order to keep costs down.
- Clients' confidentiality may be threatened because HMOs require therapists to disclose details about the clients' problems in order to have treatment authorized.

The Community Mental Health Movement

In the past, people with psychological disorders typically received inpatient treatment at **mental hospitals**, or medical institutions that specialize in providing such treatment. In the 1950s, however, it began to be clear that mental hospitals often made psychological problems worse instead of better. Mental hospitals were very crowded and had few properly trained professionals, and they were often in less populated areas, giving patients little access to support from their friends and families.

In the 1950s, the **community mental health movement** started. This movement advocated treating people with psychological problems in their own communities, providing treatment through outpatient clinics, and preventing psychological disorders before they arose.

Because of the community mental health movement, deinstitutionalization became popular. **Deinstitutionalization** refers to providing treatment through community-based outpatient clinics rather than inpatient hospitals. Although people are still hospitalized for serious psychological problems, inpatient stays are usually relatively short and occur in psychiatric wings of general hospitals, rather than in mental hospitals far away from people's communities.

- **Advantages of deinstitutionalization:** Treatment at outpatient clinics is less costly than inpatient care and often just as effective. Also, people often prefer the freedom of community-based treatment to inpatient hospitals.
- **Disadvantages of deinstitutionalization:** It has contributed to homelessness, since some people released from inpatient facilities have nowhere to go. Also, it has led to what is referred to as a "revolving door" population of chronically mentally ill people who are periodically hospitalized, released, and rehospitalized.