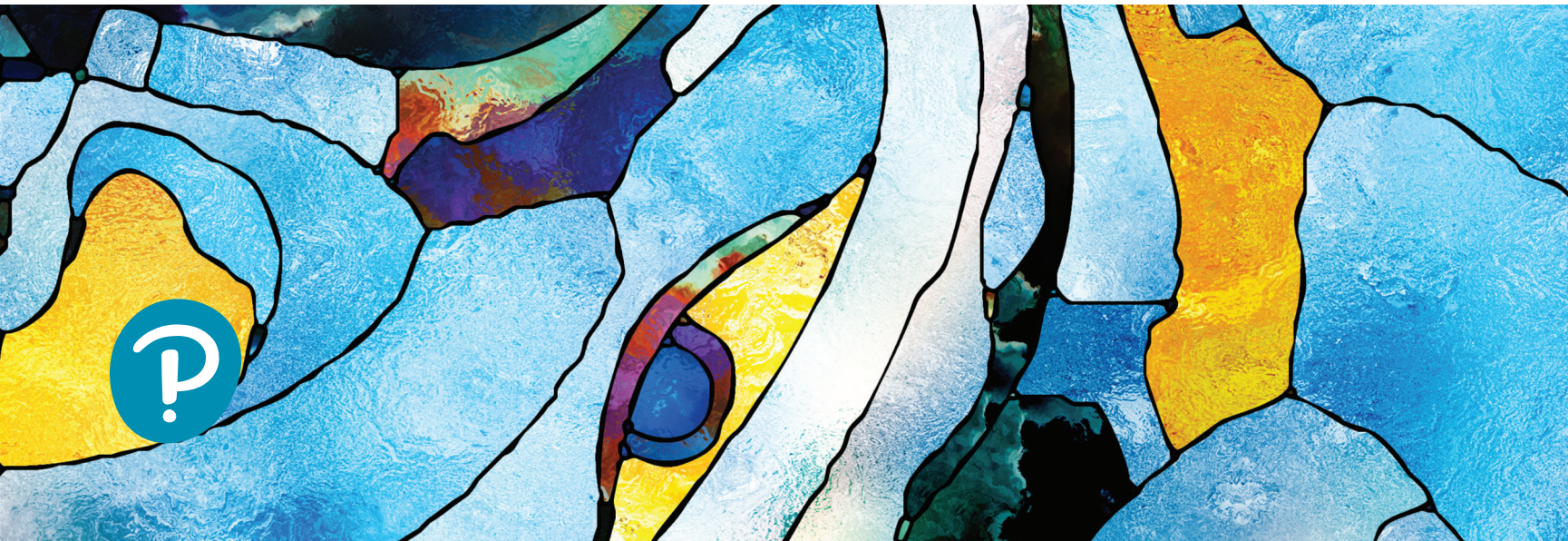
ABNORMAL PSYCHOLOGY

EIGHTEENTH EDITION

JILL M. HOOLEY | MATTHEW K. NOCK | JAMES N. BUTCHER



Abnormal Psychology

Eighteenth Edition

Global Edition

Jill M. Hooley
Harvard University

Matthew K. Nock
Harvard University

James N. Butcher
University of Minnesota

Pearson

Harlow, England • London • New York • Boston • San Francisco • Toronto • Sydney • Dubai • Singapore • Hong Kong
Tokyo • Seoul • Taipei • New Delhi • Cape Town • São Paulo • Mexico City • Madrid • Amsterdam • Munich • Paris • Milan

and adolescents as well, affecting about 9 percent (Guarnaccia et al., 2005). Individuals who experience *ataque de nervios* also seem to be vulnerable to a wider range of other anxiety and mood disorders (Guarnaccia et al., 2010).

Looking at anxiety disorders from a cross-national perspective, one very large study of more than 60,000 people across 14 countries (8 developed and 6 less developed) by the World Health Organization (WHO World Mental Health Survey Consortium, 2004) showed that anxiety disorders were the most common category of disorder reported in all but one country (Ukraine). However, reported prevalence rates for all the anxiety disorders combined varied from 2.4 percent (Shanghai, China) to 18.2 percent (United States). Other countries with moderately high rates of reported anxiety disorders were Colombia, France, and Lebanon, and other countries with moderately low rates were China, Japan, Nigeria, and Spain. We now turn to several examples of cultural variants on anxiety disorders that illustrate the range of expressions of anxiety that are exhibited worldwide (see also *The World Around Us* box).

In the Yoruba culture of Nigeria, three primary clusters of symptoms are associated with generalized anxiety: worry, dreams, and bodily complaints. However, the sources of worry are very different than those in Western society; they focus on creating and maintaining a large family and on fertility. Dreams are a major source of anxiety because they are thought to indicate that one may be bewitched. The common somatic complaints are also unusual from a Western standpoint: "I have the feeling of something like water in my brain," "Things like ants keep on creeping in various parts of my brain," and "I am convinced some types of worms are in my head" (Ebigbo, 1982; Good & Kleinman, 1985). Nigerians with this syndrome often have paranoid fears of malevolent attack by witchcraft (Kirmayer et al., 1995). In India also there are many more worries about being possessed by spirits and about sexual inadequacy than are seen in generalized anxiety in Western cultures (Carstairs & Kapur, 1976; Good & Kleinman, 1985).

Another culture-related syndrome that occurs in places like China and other Southeast Asian countries is *koro*, which for men involves intense, acute fear that the penis is retracting into the body and that when this process is complete the sufferer will die. *Koro* occurs less frequently in women, for whom the fear is that their nipples are retracting and their breasts shrinking. *Koro* tends to occur in epidemics (sometimes referred to as a form of mass hysteria; Sinha, 2011)—especially in cultural minority groups

The World Around Us

Taijin Kyofusho

Some evidence indicates that the form that certain anxiety disorders take has actually evolved to fit certain cultural patterns (Hinton, Park, et al., 2009). A good example is the Japanese disorder *taijin kyofusho*, which is related to the Western diagnosis of social anxiety disorder. Like social anxiety, it is a fear of interpersonal relations or of social situations (Kim et al., 2008; Kirmayer, 1991). However, Westerners with social anxiety are afraid of social situations where they may be the object of scrutiny or criticism. By contrast, most people with *taijin kyofusho* are concerned about doing something that will embarrass or offend others (Kim et al., 2008). For example, they may fear offending others by blushing, emitting an offensive odor, staring inappropriately into the eyes of another person, or through their perceived physical defects or imagined deformities (which can reach delusional levels; Kim et al., 2008). This fear of bringing shame on others or offending them is what leads to social avoidance (Kleinknecht et al., 1997). Body dysmorphic disorder, described earlier, also commonly occurs in people with *taijin kyofusho* (Nagata et al., 2006).

Kirmayer (1991) and colleagues (1995) have argued that the pattern of symptoms that occurs in *taijin kyofusho* has clearly been shaped by cultural factors. Japanese children are raised to be highly dependent on their mothers and to have a fear of the outside world, especially strangers. As babies and young children, they are praised for being obedient and docile. A great deal of emphasis is also placed on implicit communication—being able to guess another's thoughts and feelings and being sensitive to them. People who make too much eye contact are likely to be considered aggressive and insensitive, and children are taught to look at the throat of people with whom they are conversing rather than into their eyes. The society is also very hierarchical and structured, and many subtleties in language and facial communication are used to communicate one's response to social status.

At a more general level, cross-cultural researchers have noted that recognition of the cognitive component of most anxiety disorders leads one to expect many cross-cultural variations in the form that different anxiety disorders take. Anxiety disorders can be considered, at least in part, disorders of the interpretive process. Because cultures influence the categories and schemas that we use to interpret our symptoms of distress, there are bound to be significant differences in the form that anxiety disorders take in different cultures (Barlow, 2002; Good & Kleinman, 1985; Kirmayer et al., 1995).

Should different manifestations of anxiety seen in different cultures be considered different disorders, or simply different manifestations of the same underlying condition? Why or why not?

Unresolved Issues

The Choice of Treatments: Medication or Cognitive-Behavior Therapy?

Many people with anxiety or obsessive-compulsive disorders are unaware of the treatment options that are available to them. They also know little about the pros and cons of different types of treatment. Many mental health professionals are similarly uninformed or lack the training to conduct some of the more specialized treatments. For these reasons they may not recommend referral to what could be a more effective form of treatment. For example, in the United States specialized training in exposure and response prevention treatment for OCD is often not given to therapists in training. Numerous graduate programs in clinical psychology are also not very scientifically based (Baker et al., 2008).

Some people prefer treatment with medications because they believe it is easier to take pills than to engage in cognitive-behavior therapy (which might be more costly or involve homework assignments). On the other hand, therapy (unlike medications) does not typically lead to unpleasant side effects other than briefly elicited fear or anxiety. Over the longer term, therapy can also be more cost effective because people treated with medications routinely stay on them indefinitely, but therapy usually has very long-lasting effects that do not wear off with time. Medications sometimes also have limited effectiveness relative to the treatment effects that are seen with properly administered cognitive-behavior therapy.

Finding a well-trained cognitive-behavior therapist, however, is far from easy. And even trained therapists are frequently limited in the range of disorders they have been trained to treat. One solution is to provide therapists in training with proficiency in treating a broader range of disorders. The Association for Psychological Science is trying to improve this situation by developing a new system for accrediting clinical training programs that teach their students well-validated forms of effective treatments. Although progress is being made, the pace of change is much slower than would be desirable.

when their survival is threatened—and it is often attributed to either malicious spirits or contaminated food. A variant on this syndrome also occurs in West African nations, where afflicted individuals report shrinking of the penis or breasts (but not retraction), which they fear will lead to loss of sexual functioning and reproductive capacity (but not death). Frequently, another person who was present at the time is blamed and often severely beaten or otherwise punished (Dzokoto & Adams, 2005). They both occur in a cultural context where there are serious concerns about male sexual potency (Barlow, 2002; Kirmayer et al., 1995).

Summary

6.1 Distinguish between fear and anxiety.

- The anxiety disorders have anxiety or panic or both at their core.
- Fear or panic is a basic emotion that involves activation of the fight-or-flight response of the autonomic nervous system; it occurs in response to imminent danger.
- Anxiety is a more diffuse blend of emotions that includes high levels of negative affect, worry about possible threat or danger, and the sense of being unable to predict threat or to control it if it occurs.

6.2 Describe the essential features of anxiety disorders.

- Anxiety disorders all are characterized by unrealistic, irrational fears or anxieties that cause significant distress and/or impairments in functioning.
- Among the anxiety disorders recognized in *DSM-5* are specific phobia, social anxiety disorder (social phobia), panic disorder, agoraphobia, and generalized anxiety disorder.
- People with these varied disorders differ from one another both in terms of the amount of fear or panic versus anxiety symptoms that they experience and in the kinds of objects or situations that most concern them.

6.3 Explain the clinical features of specific phobias.

- With specific phobias, an individual has an intense and irrational fear of specific objects or situations that leads to a great deal of avoidance behavior; when confronted with a feared object, the person with a phobia often shows activation of the fight-or-flight response, which is also associated with panic.

6.4 Discuss the clinical features of social anxiety.

- In social anxiety disorder, a person has disabling fears of one or more social situations, usually because of fears of negative evaluation by others or of acting in an embarrassing or humiliating manner; in some cases a person with social anxiety may actually experience panic attacks in social situations.
- People with social anxiety also have prominent perceptions of unpredictability and uncontrollability and are preoccupied with negative self-evaluative thoughts that tend to interfere with their ability to interact in a socially skillful fashion.

6.5 Describe the clinical features of panic disorder.

- In panic disorder, a person experiences recurrent, unexpected panic attacks that often create a sense of stark terror and numerous other physical symptoms of the fight-or-flight response; panic attacks usually subside in a matter of minutes.
- Many people who experience panic attacks develop anxious apprehension about having another attack; this apprehension is required for a diagnosis of panic disorder. Many people with panic disorder also develop agoraphobic avoidance of situations in which they fear that they might have an attack.
- Biological theories of panic disorder emphasize that the disorder may result from biochemical abnormalities in the brain as well as abnormal activity of the neurotransmitters norepinephrine and serotonin. Panic attacks may arise primarily from the brain area called the amygdala, although many other areas are also involved in panic disorder.
- The learning theory of panic disorder proposes that initial panic attacks can become associated with both internal cues (interoceptive, such as dizziness or rapid heartbeat) and external cues (exteroceptive, such as crowds). Because of this pairing, those internal and external cues can later trigger the onset of panic attacks.
- The cognitive theory of panic disorder holds that this condition may develop in people who are prone to making catastrophic misinterpretations of their bodily sensations, a tendency that may be related to preexisting high levels of anxiety sensitivity.

6.6 Explain the clinical aspects of generalized anxiety disorder.

- In generalized anxiety disorder, a person has chronic and excessively high levels of worry about a number of events or activities and responds to stress with high levels of psychic and muscle tension.
- Generalized anxiety disorder may occur in people who have had extensive experience with unpredictable or uncontrollable life events. People with generalized anxiety seem to have danger schemas about their inability to cope with strange and dangerous situations that promote worries focused on possible future threats.
- The neurobiological factor most implicated in generalized anxiety is a functional deficiency in the neurotransmitter GABA, which is involved in inhibiting anxiety in stressful situations; the limbic system is the brain area most involved.
- Once a person has an anxiety disorder, mood-congruent information processing, such as attentional and interpretive biases, seems to help maintain it. This explains why, without treatment, anxiety disorders are often chronic conditions.
- Many people with anxiety disorders are treated by physicians, often with medications designed to allay anxiety or with antidepressant medications that also have antianxiety effects when taken for at least 3 to 4 weeks. Such treatment focuses on suppressing the symptoms, and some anxiolytic medications have the potential to cause physiological dependence. Once the medications are discontinued, relapse rates tend to be high.
- Behavioral and cognitive therapies have a very good track record with regard to treatment of the anxiety disorders. A key ingredient of effective treatment is prolonged exposure to feared situations.
- Cognitive therapies focus on helping clients understand their underlying automatic thoughts, which often involve cognitive distortions such as unrealistic predictions of catastrophes that in reality are very unlikely to occur. Clients then learn to change these inner thoughts and beliefs through a process of logical reanalysis known as cognitive restructuring.

6.7 Describe the clinical features of obsessive-compulsive disorder and how it is treated.

- In obsessive-compulsive disorder, a person experiences unwanted and intrusive distressing thoughts or images that are usually accompanied by compulsive behaviors performed to neutralize those thoughts or images. Checking and cleaning rituals are most common.
- Biological causal factors are also involved in obsessive-compulsive disorder, with evidence coming from genetic studies, studies of brain functioning, and psychopharmacological studies.
- Once this disorder begins, the anxiety-reducing qualities of the compulsive behaviors may help to maintain the disorder.
- Behavior therapies that involve exposure are effective in the treatment of OCD. Rituals must also be prevented following exposure to the feared situations.

6.8 Summarize some examples of cultural differences in sources of worry.

- In Nigeria, sources of worry center on creating and maintaining a large family, being bewitched in one's dreams, and having problems with one's brain (such as experiencing insects or worms crawling in the brain).
- In China and other Southeast Asian countries that have cultural concerns about male sexual potency, a common source of worry is the penis retracting into the body.

In Review Questions

Q1. What do you understand by the "fight or flight" response of the autonomic nervous system? Explain the components of fear and panic.

Q2. Describe the cognitive and physiological components of anxiety. What is the adaptive value of anxiety?

Q3. Discuss the cultural variants on anxiety disorder in Nigeria, India, and China.

Chapter 7

Mood Disorders and Suicide

Nikola Volrábová/123RF

Learning Objectives

7.1 Describe the types of mood disorders, their primary symptoms, and their prevalence.

7.2 Distinguish between the different types of depressive disorders.

7.3 Describe the factors believed to cause unipolar mood disorders.

7.4 List and distinguish among different types of bipolar disorders.

7.5 Describe the causal factors influencing the development and maintenance of bipolar disorders.

7.6 Explain how cultural factors can influence the expression of mood disorders.

7.7 Describe and distinguish between different treatments for mood disorders.

7.8 Describe the prevalence and clinical picture of suicidal behaviors.

7.9 Explain the efforts currently used to prevent and treat suicidal behaviors.

A Successful "Total Failure"

Sophie, a junior in college, was getting all A's in her classes, working in her spare time as a research assistant in a psychology laboratory, and had a lot of great friends and a 2-year relationship with the guy of her dreams. Things soon changed, however, when her boyfriend unexpectedly told her that he was breaking up with her because he had fallen in love with someone else. Following her initial shock and anger, she began to have uncontrollable crying spells and doubts about her other relationships and even about her abilities in the classroom and research lab. Decision making became an ordeal. Her spirits rapidly sank, and she began to spend more and more time in bed, refusing to talk with anyone. Her alcohol consumption increased to the point where she was seldom entirely sober. Within a period of weeks, her grades plummeted due to her inability, or refusal, to attend class or complete any assignments. She felt she was a "total failure," even when her friends reminded her of her considerable achievements; indeed, her self-criticism gradually spread to all aspects of her life and her personal history. Finally, her parents intervened and forced her to accept an appointment with a clinical psychologist.

Was something "wrong" with Sophie, or was she merely experiencing normal human emotions because of her boyfriend having deserted her? The psychologist concluded that she was suffering from a serious mood disorder and initiated treatment. The diagnosis, based on the severity of the symptoms and the degree of impairment, was major depressive disorder. Secondarily, she had also developed a serious drinking problem—a condition that frequently co-occurs with major depressive disorder.

Most of us feel depressed from time to time. Failing an exam, arguing with a friend, not being accepted into one's first choice of college or job, and breaking up with a romantic partner are all examples of events that can cause a depressed mood in many people. However, **mood disorders** involve much more severe alterations in mood for much longer periods of time. In such cases the disturbances of mood are intense and persistent enough to lead to serious problems in relationships and work performance.

Mood disorders are diverse in nature, as is illustrated by the many types of depression recognized in the *DSM-5* that we will discuss. Nevertheless, in all mood disorders (formerly called *affective disorders*), extremes of emotion or *affect*—soaring elation or deep depression—dominate the clinical picture. Other symptoms are also present, but abnormal mood is the defining feature.

Mood Disorders: An Overview

7.1 Describe the types of mood disorders, their primary symptoms, and their prevalence.

The two key moods involved in mood disorders are **depression**, which usually involves feelings of extraordinary sadness and dejection, and **mania**, often characterized by intense and unrealistic feelings of excitement and euphoria. Some people with mood disorders experience only time periods or episodes characterized by depressed moods. However, other people experience manic episodes at certain time points and depressive episodes at other time points. Normal mood states can occur between both types of episodes. Manic and depressive mood states are often conceived to be at opposite ends of a mood continuum, with normal mood in the middle. Although this concept is accurate to a degree, sometimes an individual may have symptoms of mania and depression during the same time period. In these *mixed-episode* cases, the person experiences rapidly alternating moods such as sadness, euphoria, and irritability, all within the same episode of illness.

Types of Mood Disorders

We will first discuss **unipolar depressive disorders**, in which a person experiences only depressive episodes, and then move on to **bipolar disorders**, in which a person experiences both depressive *and* manic episodes.

The most common form of mood disturbance involves a **depressive episode**, in which a person is markedly depressed or loses interest in formerly pleasurable activities (or both) for at least 2 weeks, as well as other symptoms such as changes in sleep or appetite, or feelings of worthlessness.

The other primary kind of mood episode is a **manic episode**, in which a person shows a markedly elevated, euphoric, or expansive mood, often interrupted by occasional outbursts of intense irritability or even violence—particularly when others refuse to go along with the manic person's wishes and schemes. These extreme moods must persist for at least a week for this diagnosis to be made. In addition, three or more additional symptoms must occur in the same time period, ranging from behavioral symptoms (such as a notable increase in goal-directed activity), to mental symptoms where self-esteem becomes grossly inflated and mental activity may speed up (such as a "flight of ideas" or "racing thoughts"), to physical symptoms (such as a decreased need for sleep or psychomotor agitation). (See the *DSM-5* box for diagnostic criteria.)

In milder forms, similar kinds of symptoms can lead to a diagnosis of **hypomanic episode**, in which a person experiences abnormally elevated, expansive, or irritable mood for at least 4 days. In addition, the person must have at least three other symptoms similar to those involved in mania but to a lesser degree (inflated self-esteem, decreased need for sleep, flights of ideas, pressured speech, etc.). Although the symptoms listed are the same for manic and hypomanic episodes, there is much less impairment in social and occupational functioning in hypomania, and hospitalization is not required.