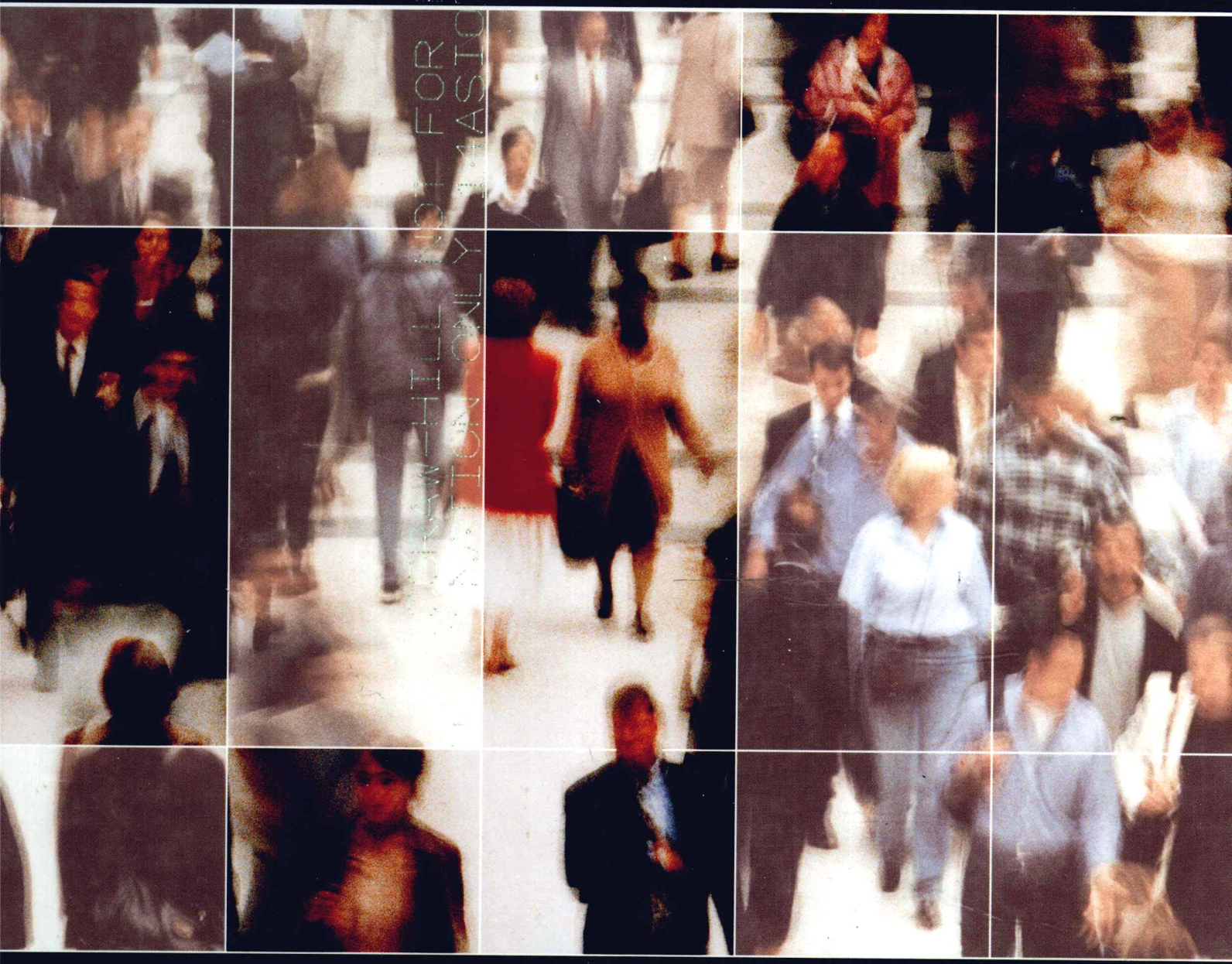
Fifth Edition

Abnormal Psychology

Clinical Perspectives on Psychological Disorders



Richard P. Halgin
Susan Krauss Whitbourne

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ABNORMAL PSYCHOLOGY

Clinical Perspectives on Psychological Disorders

Richard P. Halgin

Susan Krauss Whitbourne

University of Massachusetts at Amherst

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To our families, with love and appreciation

ABOUT THE AUTHORS

Richard Halgin and Susan Krauss Whitbourne are Professors of Psychology at the University of Massachusetts at Amherst. Both teach large undergraduate classes in addition to teaching and supervising doctoral students in clinical psychology. Their clinical experience has covered both inpatient and outpatient settings. Professors Halgin and Whitbourne are Fellows of the American Psychological Association. They have edited *A Case Book in Abnormal Psychology: From the Files of Experts* (Oxford University Press), containing case studies written by leading international authorities in the field of psychopathology. Both serve on the Editorial Boards of major professional journals.

Professor Halgin received his PhD from Fordham University and completed a 3-year fellowship in the Department of Psychiatry at New York Hospital-Cornell Medical Center prior to joining the faculty of the University of Massachusetts in 1977. He is a Board Certified Clinical Psychologist and has had over two decades of clinical, supervisory, and consulting experience. At the University of Massachusetts, his course in Abnormal Psychology is one of the most popular offerings on campus, attracting an enrollment of more than 500 students. He also holds the position of Visiting Professor of Psychology at Amherst College, where he teaches Abnormal Psychology on an annual basis. At the University of Massachusetts, he has been honored with the Distinguished Teaching Award, the Alumni Association's Distinguished Faculty Award, and has been the university's nominee for the Carnegie Foundation's U.S. Professor of the Year Award. His teaching has also been recognized by the Danforth Foundation and the Society for the Teaching of Psychology of the American Psychological Association. Professor Halgin is the author of more than fifty journal articles and book chapters in the fields of psychotherapy, clinical supervision, and professional issues in psychology. He is also the editor of *Taking Sides: Controversial Issues in Abnormal Psychology,* Third Edition (McGraw-Hill). Professor Halgin is a member of the Committee of Examiners for the Psychology Graduate Record Examination and has served on the Ethics Committee of the American Psychological Association.

Professor Whitbourne received her PhD from Columbia University and has dual specializations in life-span developmental psychology and clinical psychology. She has taught at the State University of New York at Geneseo and the University of Rochester. At the University of Massachusetts, she received the University's Distinguished Teaching Award and the College of Arts and Sciences Outstanding Teacher Award. In 2001, she received the Psi Chi Eastern Region Faculty Advisor Award and presented the Psi Chi Distinguished Lecture at the Eastern Psychological Association 2001 meeting. In 2002, she received the Florence Denmark Psi Chi National Advisor Award and presented the SEPA invited lecture at the Southeastern Psychological Association meeting. She is the Honors Coordinator in the Psychology Department and the Director of the Office of National Scholarship Advisement in the newly established Commonwealth Honors College. The author of fourteen books and over one hundred journal articles and book chapters, Professor Whitbourne is regarded as an expert in the field of personality development in adulthood and old age. She is currently the APA Council Representative of Division 20 of APA (Adult Development and Aging), having also served as Division 20 President and is a member of APA's Committee for the Structure and Function of Council. She also serves as the Division 2 (Teaching of Psychology) Liaison to the APA Committee on Aging and is the Chair of the Student Awards Committee of the Gerontological Society of America. Professor Whitbourne has developed nationally recognized approaches to technological innovations in teaching, and the website she created for her introductory psychology course was selected as a McGraw-Hill Web Cafe "Site of the Month."

"Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick."

—Susan Sontag, *Illness as Metaphor*

All human beings experience the duality of illness and wellness. Those who suffer from mental illnesses experience the "night-side" of life more intimately. Our hope is that by providing information on abnormal psychology students will learn about how individuals understand, cope with, and recover from psychological disorders. Our goal in writing this text is to share our understanding with students who come to this course from a variety of socioeconomic and cultural backgrounds, as well as academic pursuits. In our revisions for this fifth edition of *Abnormal Psychology,* we have focused our efforts on transcending those boundaries to reach our readers on a purely human level. We begin by sharing with you the following stories:

> Katya developed a deep interest in abnormal psychology after hearing about friends' and family's immigrant experiences. An immigrant herself, Katya firmly believes that migration can adversely affect human behavior. For example, how does geographical displacement contribute to the onset of major depression? How crucial a factor is "culture shock" in the manifestation of psychological disorders? These are the things Katya seeks to explore.
>
> Chung, an English major and aspiring writer, appreciates the fluctuations in human behavior. He is especially fascinated by and sensitive to its vast range because he knows that characters cannot be written solely from the imagination. A credible character should reflect an individual one would meet on the street, at the local bar, or in the workplace. Thus, it is important to Chung to be as informed as possible about all sides of human behavior.
>
> Jason's reason for taking a course in abnormal psychology is far more personal. A young man whose mother has long been suffering from schizophrenia, Jason seeks to learn more about the disorder so that he can better understand what his mother must endure daily, and to ensure that she is receiving the treatment most suitable for her. He also realizes that he might be genetically susceptible to developing the illness, so he is also interested in the course for his own well-being.

Like Katya, Chung, and Jason, many students find themselves studying abnormal psychology to deepen their own understanding, to satisfy a personal curiosity, or both. Whatever the specific reason, our goal as instructors and authors continues to be to engage students in the study of abnormal psychology from a clinical and human perspective.

In this fifth edition, we are pleased to include a powerful addition to our clinically based approach. *Nothing to Hide: Mental Illness in the Family* captures in photographs and prose the compelling stories of individuals and families whose lives have been touched by a psychological disorder. These excerpts from the book *Nothing to Hide: Mental Illness in the Family,* by Peggy Gillespie, Jean Beard, and Gigi Kaeser, set the stage for the explorations of psychological disorders in the text. As students read each story, they are certain to be moved by the artistic photographs and the words of real people.

Themes

Clinical Perspectives on Psychological Disorders

The study of abnormal psychology is strongly founded on clinical research. The subtitle of this fifth edition reflects our efforts to respond to the need for greater and clearer representation and articulation of disorders and their diagnostic features. We have expanded the wide presentation of case studies. Each disorder comes to life through a mini case, accompanied by a listing of the newly revised *DSM-IV-TR* diagnostic criteria associated with that disorder. Rather than merely list the criteria, we have paraphrased the features into language that is easily understood.

The Biopsychosocial Approach

An understanding of psychological disorders requires a biopsychosocial approach that incorporates biological, psychological, and sociocultural contributions to understanding causes and developing treatments. The disorders are as various as the students who take this course. We have written this text with that thought in mind and address the issue of diversity throughout the book. Each chapter concludes with a section that discusses the chapter's topic from the biopsychosocial perspective—weaving the multiple dimensions into an integrative statement about the interactions among biology, psychology, and the social context as they affect individuals who have psychological disorders.

The Life-Span Approach

Individuals grow and evolve throughout life, and we feel it is essential to capture this development dimension in our book. Therefore, we have incorporated research and theories that provide relevant understandings of how the disorders we cover vary by age. Given that the *DSM-IV-TR* is primarily focused on adulthood, most of this emphasis is reflected in our inclusion of middle age and aging when we examine epidemiology, etiology, and treatments.

The Human Experience of Psychological Disorders

Above all, the study of abnormal psychology is the study of profoundly human experiences. To this end, we have developed a feature entitled "Real Stories." These boxes present biographies and first-person quotations that give students insight into the feelings of people who have a disorder covered in the chapter. Many of the Real Stories boxes are about individuals who are

recognizable to undergraduates, and so their stories will have special relevance. Each biography is also tied into the content of the chapter so that it has a sound substantive base. In addition, the MindMAP Plus CD-ROM that accompanies this text contains seven clips of real people living with a disorder. Students who view these clips will see firsthand how people live with and suffer from disorders. We hope that students will take from this course the understanding that abnormal behavior is a very real part of our society, our humanity, and our world, and that it needs to be addressed with compassion and understanding.

The Scientist-Practitioner Framework

We have developed this text using a scientist-practitioner framework. While emphasizing empirically supported research, we share with the student stories of real people who are suffering from compelling personal problems and serious psychological disorders. Our hope is that, as students take this course and long after they have moved on to their respective careers, they will have learned to approach the study of abnormal psychology with the dispassionate eye of a scientist and the compassionate heart of a practitioner.

Organization

The table of contents reflects a building block approach. The first four chapters provide the fundamentals of history and research methods (Chapter 1); diagnosis, classification, and treatment planning (Chapter 2); assessment (Chapter 3); and theories (Chapter 4). These chapters provide a foundation for subsequent discussions regarding the understanding and treatment of psychological disorders.

From here, we move on to a consideration of the disorders, beginning with those on Axis I of *DSM-IV-TR*. Progressing through the major categories of psychological disorders, we begin with anxiety disorders and end with eating disorders and impulse-control disorders. Using a biopsychosocial approach, theory and treatment are both discussed in each chapter. For example, we examine anxiety disorders in terms of biological, psychological, and sociocultural influences that cause and maintain these conditions. We also discuss intervention in terms of the relative contributions offered by each perspective. In the final chapter of the text (Chapter 15) we cover ethical and legal issues.

Changes in the Fifth Edition

This new edition is packaged with a student CD-ROM, MindMAP Plus, which contains two types of multimedia enhancements to the book's content: (1) interactive exercises that give students firsthand exposure to key concepts and (2) video segments from interviews with clients as well as relevant clips from Discovery Channel. Students are cued into each multimedia unit with a MindMAP icon. For the instructor, a Media Resources Guide summarizes these activities and film segments and provides related discussion and test questions. We are excited to be able to offer this unique opportunity to bring to life many fascinating aspects of abnormal psychology.

The burgeoning of research in psychopathology in the last several years has prompted us to draw from rich new empirical sources that document the scientific basis for the diagnosis and treatment of disorders. References that are no longer relevant have been deleted; the classic sources in the literature have been retained. Expanded epidemiological databases now accessible via the Internet have also helped improve this edition. Ultimately, our goal is to offer a contemporary and concise approach to the field.

A number of changes in the text reflect new research directions, feedback from reviewers and student readers, and experience from our teaching of abnormal psychology. The fifth edition represents a much more focused approach than previous editions. With the goal of presenting only the most relevant research and clinical material, we have reduced the length of the text. We have accomplished this by deleting outdated content and by integrating into the chapter the material previously presented in boxes (i.e., Research Focus, Social Context). We are confident that students and instructors will find this approach more appealing and more educationally effective. Below is a summary of the most significant changes in each chapter.

CHAPTER 1. Understanding Abnormality: A Look at History and Research Methods

This fifth edition expands the discussion of challenges involved in characterizing abnormal behavior. By using Rosenhan's classic study as a launching pad, more contemporary points are explored which have emerged from recent considerations of what should be considered abnormal. The topic of stigma is also discussed in greater depth, as are the social problems associated with mentally ill individuals in prison.

CHAPTER 2. Classification, Diagnosis, and Treatment Plans

This edition includes a discussion of issues pertaining to the development of upcoming *DSM-V* and presents current epidemiological data on the international prevalence of mental disorders. The chapter also includes an expanded discussion of the debate regarding evidence-based treatments.

CHAPTER 3. Assessment

This chapter includes new material on structured and semistructured interviews, as well as discussion of the most recent editions of several assessment instruments (e.g., *Stanford-Binet Fifth Edition, Conners Ratings Scales–Revised,* and *The Neuropsychological Assessment Battery*).

CHAPTER 4. Theoretical Perspectives

This chapter has been substantially revised, such that only the most relevant theoretical perspectives and clinical approaches are discussed. Within the biopsychosocial perspective, recent

research advances that bring together divergent perspectives are explored, and findings on genetic causes for psychological disorders are discussed in depth. The discussion of the humanistic approach now incorporates consideration of motivational interviewing, and the section on cognitive perspectives includes discussion of significant advances in theory and technique which have emerged in recent years.

CHAPTER 5. Anxiety Disorders

This chapter expands upon discussion of the ways in which the biopsychosocial perspective applies to the understanding and treatment of anxiety disorders. For example, the influence of genetics in the development of anxiety disorders and the role of neurotransmitters in the experience of symptoms are explored. The discussion of PTSD has been significantly revamped in light of recent international events related to trauma, such as terrorism, war, and natural disasters.

CHAPTER 6. Somatoform Disorders, Psychological Factors Affecting Medical Conditions, and Dissociative Disorders

This chapter more explicitly discusses the challenges involved in the diagnosis of and treatment of somatoform disorders, health-related psychological conditions, and dissociative disorders. Critical analyses are incorporated into the chapter regarding debates about the validity of diagnoses within this group of disorders, as well as claims about the relationship between early abuse and the development of dissociative disorders.

CHAPTER 7. Sexual Disorders

This chapter includes updated information about the diagnosis and treatment of sexual disorders, and also addresses some of the controversies related to these conditions. For example, the chapter discusses the debate about characterizing the dysphoria related to gender identity as a disorder, particularly in the case of children. Also, increasing attention is given to the treatment of sexual dysfunction in women.

CHAPTER 8. Mood Disorders

Substantial revision of the chapter has been done in order to discuss several phenomena arising from research and clinical practice, such as the increasingly common diagnosis of bipolar disorder in children. In addition, a critical discussion of treatment techniques includes an analysis of controversies related to the use of antidepressant medications, particularly the prescription of SSRIs to young people. The discussion of suicide has been expanded in order to include more contemporary statistics and consideration of the factors that contribute to suicide.

CHAPTER 9. Schizophrenia and Related Disorders

This chapter includes an expanded discussion of emerging research regarding predictors of schizophrenia, such as the biobehavioral abnormalities that are linked to genetic and neurobiological causes. In addition, the chapter discusses abnormalities in cognitive processes that are being increasingly recognized as clues to the biological underpinnings of the development of schizophrenia. Emerging intervention trends are also explored, such as more recently introduced medications and the development of more effective social skills training programs.

CHAPTER 10. Personality Disorders

This edition includes an expanded discussion of the extent to which personality disorders should be considered as dimensional rather than categorical entities. Additional discussion also focuses on contributors to the development of personality disorders, particularly antisocial and borderline personality disorder.

CHAPTER 11. Development-Related Disorders

In light of significant recent advances in the understanding and treatment of attention-deficit/hyperactivity disorder, this chapter has been substantially revised. An expanded discussion of ADHD in adults is now included, with particular attention to differential symptom presentation between adults and children. An expanded discussion of interventions, both pharmacological and psychological, is included and contains specific techniques for addressing the symptoms of this condition.

CHAPTER 12. Aging-Related and Cognitive Disorders

In this edition, a new condition, traumatic brain injury (TBI), has been added to the discussion. TBI is of particular relevance in light of the increasing number of people developing brain-related disorders as a result of injuries received as the result of war and terrorist acts. The chapter also includes expanded coverage of contemporary theories about the etiology of Alzheimer's disease (e.g., Caspase theory).

CHAPTER 13. Substance-Related Disorders

In addition to incorporating the most recent data about the extent to which substances are being used and abused, the chapter also adds discussion of substances that have become especially problematic in recent years (e.g., methamphetamine and OxyContin). There is also expanded discussion of etiological factors associated with the development of substance dependence and the most effective treatment interventions.

CHAPTER 14. Eating Disorders and Impulse-Control Disorders

This chapter expands upon discussion of biological and sociocultural contributors to the development of eating disorders. In addition, the chapter contains a new section on Internet addiction.

CHAPTER 15. Ethical and Legal Issues

This chapter includes discussion of legal issues that have been affected by recent legislative and judicial decisions (e.g., mandated reporting of self-neglecting elders; duty to warn statutes pertaining to the clinician's responsibility in situations not involving a specific identifiable victim). The chapter also introduces Guidelines for Practice with Older Adults, and considers several recent cases that are relevant to legal and ethical issues.

A Brief Note to the Instructor

Like us, most instructors have students like Katya, Chung, and Jason and are aware of the challenge that this heterogeneity of students presents. We want to excite aspiring researchers like Katya to pursue their goals and become immersed in this fascinating and rapidly changing field of abnormal psychology. However, even those of you who are extremely research oriented realize the importance of including ample clinical material in order to make the scientific material understandable. For students like Chung who come to the course with broader interests, we want to capture for them the fascinating and multifarious aspects of abnormal behavior. This includes highlighting interesting clinical phenomena and incorporating them with ideas derived from empirically supported research. Our goal is to infuse teaching with credible and validated scholarship. Students like Jason present the greatest teaching challenge because their concerns are of such a personal nature. As instructors, we need to keep in mind the importance of not creating a therapy context in the classroom. At the same time, we must recognize that emotionally provocative information can be discussed in a way that is informative and responsive to individual needs.

In writing this textbook, we speak to these various types of students in a manner that is informative, scholarly, and engaging. The scientist-practitioner framework is geared toward emphasizing current empirically supported research while conveying the compelling personal problems and serious psychological disorders of real people through case studies. The pedagogy is developed to communicate this framework as well. We believe that, by carefully blending scientific findings with clinical material, we have created a textbook that will serve the needs of a diverse student body as well as the instructors who teach them.

Ancillaries

The following ancillaries are available to accompany *Abnormal Psychology,* Fifth Edition. Please contact your McGraw-Hill sales representative for details concerning policies, prices, and availability, as some restrictions may apply.

For the Instructor

Classroom Performance System Guide and CD-ROM allows instructors to immediately determine what students are learning during lectures. With this Classroom Performance System (CPS) from **eInstruction,** instructors can ask questions, take polls, host classroom demonstrations, and get instant feedback. In addition, CPS makes it easy to take attendance, give and grade pop quizzes, or give formal paper-based class tests with multiple versions of the tests using CPS for immediate grading. For instructors who want to use CPS in the classroom, we offer a guide containing strategies for implementing the system, specific multiple-choice questions designed for in-class use, and classroom demonstrations for use with this system. For a quick, easy demonstration of CPS, go to www.mhhe.com/wmg/cps/psychology.

The *Instructor's Manual* by Michele Catone-Maitino of Hudson Valley Community College provides many tools useful for teaching the fifth edition. For each chapter, the *Instructor's Manual* includes an overview of the chapter, teaching objectives, suggestions and resources for lecture topics, classroom activities, and essay questions designed to help students develop ideas for independent projects and papers. The *Instructor's Manual* is available on the Instructor's Resource CD-ROM and on the password-protected instructor's side of the Online Learning Center (www.mhhe.com/halgin5).

The *Test Bank* by Timothy P. Tomczak of Genesee Community College contains over 2,000 testing items. All testing items are classified as conceptual or applies, and referenced to the appropriate learning objective. The questions are available on the Instructor's Resource CD-ROM both as Word files and in computerized format.

The **Computerized Test Bank** runs on both Macintosh and Windows computers and includes an editing feature that enables instructors to import their own questions, scramble items, and modify questions to create their own tests.

The **Instructor's Resource CD-ROM** contains all the key resources available to instructors in one flexible format. This CD includes the Instructor's Manual, the Test Bank, the Computerized Test Bank, an Image Bank, and a PowerPoint presentation prepared by Travis Langley of Henderson State University.

The **Overhead Transparencies** set contains key illustrations, graphs, and tables to complement the fifth edition of *Abnormal Psychology* for instructors to use during their lectures.

The **Online Learning Center** for instructors by Kim Dielman of the University of Central Arkansas houses downloadable versions of the Instructor's Manual and PowerPoint presentation slides, a sample chapter, and a variety of other text-specific instructor resources, including a bank of 145 images and access to our acclaimed customized website creation tool, **PageOut!**

PageOut! makes it possible for you to build your own course website in less than an hour. You do not have to be a computer whiz to create a website with this exclusive McGraw-Hill product. It requires no prior knowledge of HTML, no long hours of coding, and no design skills. For more information, visit the **PageOut!** website at www.pageout.net.

For the Student

MindMAP plus Student CD-ROM brings to life many fascinating aspects of abnormal psychology. It contains two types of multimedia enhancements to the book's content: (1) interactive exercises that give students firsthand exposure to key concepts and (2) video segments from interviews with clients as well as relevant clips from Discovery Channel. Students are cued into

each multimedia unit with a MindMAP icon. For the instructor, a Media Resources Guide summarizes these activities and film segments and provides related discussion and test questions.

Student Study Guide, by Barbara Bowman of Washburn University, includes the learning objectives from the book, detailed chapter outlines, guided reviews of the major concepts covered in the chapter, and multiple-choice practice tests. Answers to the practice tests are provided.

The Online Learning Center (www.mhhe.com/halgin5) is the official website for the fifth edition of *Abnormal Psychology.* It contains chapter outlines, practice quizzes, interactive exercises, virtual flashcards, links to relevant psychology sites, an Internet primer, a career appendix, and a statistics primer.

Faces Interactive, created by Arthur J. Kohn of Portland State University, is a unique web based learning environment that provides students with an opportunity to observe real patients through a series of case studies on twelve different psychological disorders. The disorders studied in *Faces Interactive* include Attention Deficit Hyperactivity Disorder, Bipolar Disorder, Borderline Personality Disorder, Bulimia Nervosa, Dysthymic Disorder, Major Depression, Obsessive Compulsive Disorder, Panic Disorder with Agoraphobia, Paranoid Schizophrenia, Post Traumatic Stress Disorder, Tourette's Syndrome, and Substance Abuse. Each case study takes students through five stages of a patient's experience: the diagnosis, case history, an interview, treatment, and assessment. Students are able to explore diagnostic processes, improve their understanding of clinical practice, and gain experience documenting their findings in a case study report project. After using *Faces Interactive,* students will have a wealth of information about, and a humanistic outlook on, these disorders. This product is available at the Online Learning Center (www.mhhe.com/halgin5).

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A great book can't come together without a great publishing team. We'd like to thank our editorial team, all of whom worked with us through various stages of the publishing process. Special gratitude goes to Dawn Groundwater, Director of Development, Psychology. We are also indebted to Melissa Caughlin, Marketing Director, who possesses a sophisticated understanding of the needs of instructors and students. With thoughtfulness and good humor, Melissa provided us with recommendations that enhance the text in many important ways. Other members of the McGraw-Hill team also deserving an expression of our appreciation are Mary Lee Harms, Freelance Developmental Editor; Leslie LaDow, Production Editor; and Srdjan Savanovic, Designer.

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On a personal note, we want to thank each other for a wonderful collaborative relationship. Even the fifth edition of a textbook requires countless discussions and compromises, all of which were managed in a friendly and collegial manner. We are thrilled to see how successful our efforts have been for more than a decade.


CHAPTER 5

Anxiety Disorders

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Case Report
Barbara Wilder

Before I left my office to meet Barbara Wilder for the first time, the clinic receptionist, Marie, pulled me aside in the hallway to warn me about the situation in the waiting room. Marie explained that Barbara's friend, who had come along for support, offered the reassuring words that Barbara was fine and that she commonly had these kinds of "attacks." Even with her warning, the scene would leave a lasting mark in my memory—in a distant corner of the otherwise empty waiting room, Barbara was writhing on the floor in what appeared to be a convulsion. Her friend knelt next to her, offering soothing words that had a powerful impact on helping Barbara regain control of herself.

As I walked across the waiting room, I sorted through a number of options about how I would enter this very dramatic situation. I momentarily wondered if I should return to my office and wait until Barbara had calmed down, but I felt it might appear as though I was intimidated by Barbara's behavior. Instead, I reached out my hands to Barbara and, in a reassuring voice, introduced myself and helped her rise from the floor and take a seat in a nearby chair. For a moment, Barbara continued to gasp for breath but gradually recovered as she sat between her friend and me. She seemed like a frightened child whose fears were contained by the presence of caregivers sitting beside her. I sat there for 5 minutes and offered calming words in an effort to offer her further comfort. Barbara then looked into my eyes and said, "I'm really sorry for all this drama. I hope you'll understand that this condition is beyond my control." I told Barbara that I realized this and that I also recognized how disturbing and frightening such reactions could be. I asked her to come with me to my office. At first, she asked if her friend could join us but quickly reconsidered and stated, "Actually, I think I should try to do this on my own."

As Barbara walked alongside me, my occasional glances caused me to wonder about whether I had correctly recalled her age. How could this woman be only 22 years old? The way she carried her body and shuffled her feet, along with the look of worry on her face, caused me to think that she must be at least in her midthirties. I wondered whether she was suffering from a medical problem, such as arthritis, that caused her to walk and move her body with such rigidity. The more we talked, the more I realized that her badly tension was telling the story of inner turmoil rather than physical impairment. Barbara began her story by telling me how the preceding 6 months had been "pure hell." It all began one evening when she was waiting in a crowded airport lounge to fly home to visit her parents, her first visit since starting her new job. She suddenly felt incredibly dizzy, and the words on the page of her paperback novel began to dance in front of her eyes. She felt a roaring sound in her ears and a sudden stabbing pain in her chest. Her heart pounded wildly, and she broke out into a cold sweat. Her hands trembled uncontrollably. Just that day, Barbara had heard about the sudden death of a young woman due to a rare heart condition. Struggling to overcome the choking sensation in her throat, she was convinced that she was about to die.

In what seemed to Barbara to be an absolute miracle, the woman next to her saw what was happening and summoned paramedics. Neither they nor the physicians who examined Barbara could find anything physically wrong. The doctor told Barbara that she was probably exhausted and that the airport lounge must have been too stuffy. She spent the night at the hospital and was released the next morning.

Barbara had to cancel her visit to her parents, but her alarm about the incident gradually subsided. Two weeks later, though, the same thing happened again. She was shopping at the mall for a present for her roommate, who was to be married in a few days. Once again, a medical exam showed no physical abnormalities. Barbara began to suspect that the physicians were hiding something from her about the seriousness of her condition. Over the next several months, Barbara went from physician to physician, searching in vain for someone who could diagnose her illness and put her on a proper course of therapy. All they did, though, was advise her to get some rest. One physician prescribed a mild tranquilizer, but it offered no relief from her attacks, which became even more intense, occurring once every 2 weeks.

Little by little, Barbara found herself staying away from situations in which she would be trapped if she were to have an attack. She quit her job, because she was terrified that she would have an attack in the elevator while riding up to her office on the 28th floor. Eventually, Barbara became virtually a total recluse. She could not even walk out of her front door without feeling an overwhelming sense of dread. The only time she left the house was when her former roommate, who was now married, took her to the grocery store or for a walk. At this friend's suggestion, Barbara sought help at the mental health clinic. This young woman appeared to others, for much of her early years, to be an individual who functioned quite well. They did not realize, however, that within Barbara's hidden emotional life she was tremendously insecure and felt intensely dependent on others. When confronted with the challenging life transitions of her first job, she became caught up in overwhelming anxiety.

Sarah Tobin, PhD

Case Report

Opening each chapter is a case report from the files of Dr. Sarah Tobin. The cases detail the history of patients who are dealing with mental health issues covered in the chapters. The clinical perspective and descriptions of real people's experiences provide a window into how chapter material is observed and applied in practice.

Chapter Outline

Each chapter begins with an outline of the heading levels, setting the stage for and serving as an overview of the chapter.

Mini Case

GENERALIZED ANXIETY DISORDER

Gina is a 32-year-old single mother of two children seeking professional help for her long-standing feelings of anxiety. Despite the fact that her life is relatively stable in terms of financial and interpersonal matters, she worries most of the time that she will develop financial problems, that her children will become ill, and that the political situation in the country will make life for her and her children more difficult. Although she tries to dismiss these concerns as excessive, she finds it virtually impossible to control her worrying. Most of the time, she feels uncomfortable and tense, and sometimes her tension becomes so extreme that she begins to tremble and sweat. She finds it difficult to sleep at night. During the day she is restless, keyed up, and tense. She has consulted a variety of medical specialists, each of whom has been unable to diagnose a physical problem.

Diagnostic Features

- This diagnosis is assigned to people who experience excessive anxiety and worry occurring more days than not for at least 6 months, pertaining to a number of events or activities, such as work or school.
- Their anxiety, worry, or related physical symptoms cause significant distress or impairment.
- They find it difficult to control their worry.
- Their anxiety and worry are associated with at least three of the following:
  - Restlessness
  - Being easily fatigued
  - Concentration difficulty
  - Irritability
  - Muscle tension
  - Sleep disturbance

Characteristics of Obsessive-Compulsive Disorder

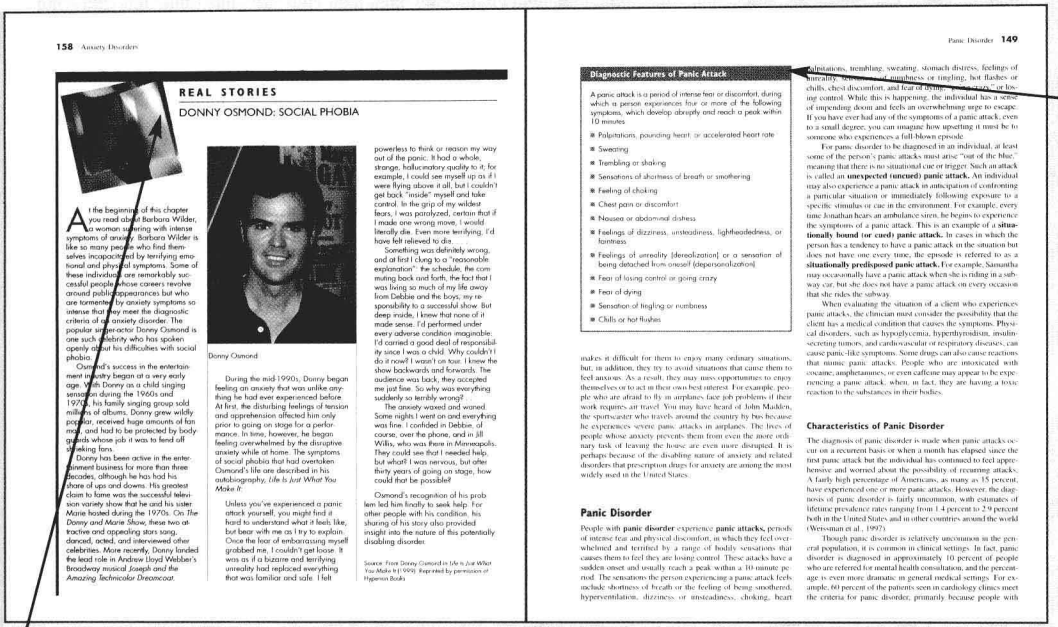
The obsessions and compulsions that characterize OCD greatly interfere with life and trap the individual in a cycle of distressing, anxiety-provoking thought and behavior. The symptoms of OCD are time-consuming, irrational, and distracting, and the individual may desperately wish to stop them. You can imagine how distressing it is for people whose thoughts are filled with concerns about contamination (e.g., germs), doubts (e.g., leaving the gas on), or aggression (e.g., fear of harming another person).

The most common compulsions involve the repetition of a specific behavior, such as washing and cleaning, counting, putting items in order, checking, or requesting assurance. Another compulsion that has caught the attention of experts in this area involves hoarding (Steketee & Frost, 2003), in which an individual stores useless items such as outdated newspapers, mail, shopping bags, and empty food containers. When other people urge them to discard any of the items, they respond with concern that the item may be needed later for some reason. Of particular concern to public health officials are those individuals who compulsively hoard live animals in their homes, such as cats, dogs, farm animals, wild animals, or birds. Dozens, or even as many as 100 animals, are sometimes kept in the most unhygienic of conditions by these individuals.


In the movie *As Good as It Gets*, Jack Nicholson plays a man with obsessive-compulsive disorder. Even expressing affection to a pet is complicated by his need to wear protective gloves.

Mini Case

This boxed feature, often found several times in each chapter, presents a brief hypothetical case study, accompanied by an outline of the *DSM-IV-IR* criteria that relates to the case. This combination helps readers to recognize a disorder's symptoms and offers them a window into what psychology professionals look for when they make diagnoses.



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REAL STORIES

DONNY OSMOND: SOCIAL PHOBIA

At the beginning of this chapter you read about Barbara Wilder, a woman suffering with intense symptoms of anxiety. Barbara Wilder is like so many people who find themselves incapacitated by terrifying emotional and physical symptoms. Some of these individuals are remarkably successful people whose careers revolve around public appearances but who are tormented by anxiety symptoms so intense that they meet the diagnostic criteria of an anxiety disorder. The popular singer-actor Donny Osmond is one such celebrity who has spoken openly about his difficulties with social phobia.

Osmond's success in the entertainment industry began at a very early age. With Donny as a child singing sensation during the 1960s and 1970s, his family singing group sold millions of albums, Donny grew wildly popular, received huge amounts of fan mail, and had to be protected by body guards whose job it was to fend off adoring fans.

Donny has been active in the entertainment business for more than three decades, although he has had his share of ups and downs. His greatest claim to fame was the successful television variety show that he and his sister Marie hosted during the 1970s. On *The Donny and Marie Show*, these two attractive and appealing stars sang, danced, acted, and interviewed other celebrities. More recently, Donny landed the lead role in Andrew Lloyd Webber's Broadway musical *Joseph and the Amazing Technicolor Dreamcoat*.

Donny Osmond

During the mid-1990s, Donny began feeling an anxiety that was unlike anything he had ever experienced before. At first, the disturbing feelings of tension and apprehension affected him only prior to going on stage for a performance. In time, however, he began feeling overwhelmed by the disruptive anxiety while at home. The symptoms of social phobia that had overtaken Osmond's life are described in his autobiography, *Life Is Just What You Make It*:

> Unless you've experienced a panic attack yourself, you might find it hard to understand what it feels like, but bear with me as I try to explain. Once the fear of embarrassing myself grabbed me, I couldn't get loose. It was as if a bizarre and terrifying unreality had replaced everything that was familiar and safe. I felt powerless to think or reason my way out of the panic. It had a whole, strange, hallucinatory quality to it; for example, I could see myself up as if I were flying above it all, but I couldn't get back "inside" myself and take control. In the grip of my wildest fears, I was paralyzed, certain that if I made one wrong move, I would literally die. Even more terrifying, I'd have felt relieved to die.
>
> Something was definitely wrong, and at first I clung to a "reasonable explanation": the schedule, the commuting back and forth, the fact that I was living so much of my life away from Debbie and the boys; my responsibility to a successful show. But deep inside, I knew that none of it made sense. I'd performed under every adverse condition imaginable. I'd carried a good deal of responsibility since I was a child. Why couldn't I do it now? I wasn't on tour. I knew the show backwards and forwards. The audience was back, they accepted me just fine. So why was everything suddenly so terribly wrong?
>
> At first, the anxiety waxed and waned. Some nights I went on and everything was fine. I confided in Debbie, of course, over the phone, and in Jill Willis, who was there in Minneapolis. They could see that I needed help, but what? I was nervous, but after thirty years of going on stage, how could that be possible?
>
> Osmond's recognition of his problem led him finally to seek help. For other people with his condition, his sharing of his story also provided insight into the nature of this potentially disabling disorder.

Source: From Donny Osmond in *Life Is Just What You Make It* (1999). Reprinted by permission of Hyperion Books.

Panic Disorder 149

Diagnostic Features of Panic Attack

A panic attack is a period of intense fear or discomfort, during which a person experiences four or more of the following symptoms, which develop abruptly and reach a peak within 10 minutes

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feeling of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feelings of dizziness, unsteadiness, lightheadedness, or faintness
- Feelings of unreality (derealization) or a sensation of being detached from oneself (depersonalization)
- Fear of losing control or going crazy
- Fear of dying
- Sensation of tingling or numbness
- Chills or hot flashes

palpitations, trembling, sweating, stomach distress, feelings of unreality, dizziness, numbness or tingling, hot flashes or chills, chest discomfort, and fear of losing control, or losing control. While this is happening, the individual has a sense of impending doom and feels an overwhelming urge to escape. If you have ever had any of the symptoms of a panic attack, even to a small degree, you can imagine how upsetting it must be to someone who experiences a full-blown episode.

For panic disorder to be diagnosed in an individual, at least some of the person's panic attacks must arise "out of the blue," meaning that there is no situational cue or trigger. Such an attack is called an **unexpected (uncued) panic attack.** An individual may also experience a panic attack in anticipation of confronting a particular situation or immediately following exposure to a specific stimulus or cue in the environment. For example, every time Jonathan hears an ambulance siren, he begins to experience the symptoms of a panic attack. This is an example of a **situationally bound (or cued) panic attack.** In cases in which the person has a tendency to have a panic attack in the situation but does not have one every time, the episode is referred to as a **situationally predisposed panic attack.** For example, Samantha may occasionally have a panic attack when she is riding in a subway car, but she does not have a panic attack on every occasion that she rides the subway.

When evaluating the situation of a client who experiences panic attacks, the clinician must consider the possibility that the client has a medical condition that causes the symptoms. Physical disorders, such as hypoglycemia, hyperthyroidism, insulin-secreting tumors, and cardiovascular or respiratory diseases, can cause panic-like symptoms. Some drugs can also cause reactions that mimic panic attacks. People who are intoxicated with cocaine, amphetamines, or even caffeine may appear to be experiencing a panic attack, when, in fact, they are having a toxic reaction to the substances in their bodies.

makes it difficult for them to enjoy many ordinary situations; but, in addition, they try to avoid situations that cause them to feel anxious. As a result, they may miss opportunities to enjoy themselves or to act in their own best interest. For example, people who are afraid to fly in airplanes face job problems if their work requires air travel. You may have heard of John Madden, the sportscaster who travels around the country by bus because he experiences severe panic attacks in airplanes. The lives of people whose anxiety prevents them from even the more ordinary task of leaving the house are even more disrupted. It is perhaps because of the disabling nature of anxiety and related disorders that prescription drugs for anxiety are among the most widely used in the United States.

Panic Disorder

People with **panic disorder** experience **panic attacks,** periods of intense fear and physical discomfort, in which they feel overwhelmed and terrified by a range of bodily sensations that causes them to feel they are losing control. These attacks have a sudden onset and usually reach a peak within a 10-minute period. The sensations the person experiencing a panic attack feels include shortness of breath or the feeling of being smothered, hyperventilation, dizziness or unsteadiness, choking, heart

Characteristics of Panic Disorder

The diagnosis of panic disorder is made when panic attacks occur on a recurrent basis or when a month has elapsed since the first panic attack but the individual has continued to feel apprehensive and worried about the possibility of recurring attacks. A fairly high percentage of Americans, as many as 15 percent, have experienced one or more panic attacks. However, the diagnosis of panic disorder is fairly uncommon, with estimates of lifetime prevalence rates ranging from 1.4 percent to 2.9 percent both in the United States and in other countries around the world (Weissman et al., 1997).

Though panic disorder is relatively uncommon in the general population, it is common in clinical settings. In fact, panic disorder is diagnosed in approximately 10 percent of people who are referred for mental health consultation, and the percentage is even more dramatic in general medical settings. For example, 60 percent of the patients seen in cardiology clinics meet the criteria for panic disorder, primarily because people with

Diagnostic Features

This boxed feature offers a broader approach to diagnosis, outlining examples of symptoms that could relate to a category of disorders as opposed to a specific disorder.

Real Stories

For every chapter, a "Real Stories" box highlights an individual's own account of what it is like to have a disorder. These people, many of them well-known public figures, openly share their personal thoughts and feelings and, in doing so, help bridge the gap between the stigma of mental illness and empathetic understanding.

Nothing to Hide: Mental Illness in the Family

Nothing to Hide: Mental Illness in the Family introduces families whose lives have been changed by mental illness. These families are from diverse racial, ethnic, religious, and socioeconomic backgrounds. They live in areas both urban and rural, from Los Angeles to a small town in Tennessee. Clearly mental illness knows no boundaries.

"When a debilitating illness, either physical or mental, strikes a child, an adolescent, or an adult, it has an impact on the entire family. A diagnosis of mental illness, however, carries with it an additional challenge: the pervasive and destructive burden of stigma. Stigma gives rise to myths, stereotypes, and misunderstandings about people who have psychiatric disorders and their family members. The primary goal of Nothing to Hide is to dispel common misconceptions about mental illness in order to decrease stigma."

—Jean J. Beard and Peggy Gillespie, Amherst, Massachusetts

"People sometimes ask, "Why are these people smiling?" I can't answer that question. But I know the question betrays a notion that most of us have about mental illness: that those who have it are different from us. Slowly, we think, they don't feel what we feel; they don't express it in the same way. Now, please take another look."

—Gigi Kaeser (photographer)

Armond discusses being a single mother with depression and comments on the frustration of misdiagnosis and poverty

NOTHING TO HIDE

THE MARGOSIAN FAMILY

Everything was falling out from underneath me. I was overwhelmed, and I started to feel very bad about myself. I was all alone with two young children and I had no one to turn to for support. Although I have had depression most of my life, this time it was far more profound. I decided to go to the local mental health clinic, where I requested therapy for both my daughter and myself. Alex was only three years old, but she had observed the beatings I had sustained by her father. I felt we had been through so much that I wanted to make sure she was okay emotionally. The staff at the mental health center told me that Alex didn't need therapy. As for me, they said that I had accomplished so much during the past nine months, why would I need any therapy? They couldn't understand why I was so depressed, and I couldn't really explain it. Those of us who are poor and mentally ill can get treated pretty shabbily by the mental health system.

• • • •

I finally got permission from the clinic staff to see a therapist there. After seeing him for a few weeks, I wasn't feeling any better. One day, I told my therapist that I was afraid to leave his office because I wanted to attempt suicide. He didn't believe me! He said, "Well, you've survived so far. You'll survive another week." When I left the session, I bought over-the-counter sleeping pills and then went home. I cooked dinner, bathed the children, and read them a bedtime story. After they were asleep, I took out some photographs of them

Alexandra, Arsinee, and Abrahäni

and thought, "These are the most perfect and beautiful children. Anybody would want to take them in after I'm gone." I wrote them a long letter saying goodbye, and I took the pills.

I ended up in the ICU. From there, I admitted myself into the psychiatric unit. While I was there, I kept asking the doctors for antidepressants. They said I didn't need them, and that I had my intellect to fall back on! They thought that my depression was only situational.

• • • •

A few months later, I found a psychiatrist at a different mental health center. She realized that I needed medication to stabilize my condition. In fact, she couldn't believe what I had gone through. She knew that I was a good mother and that I needed some help to get better. The medication she put me on helped to save my life.

• • • •

Given everything that we've been through together, I'm amazed that my children are thriving. Although I'm on state assistance and we live in poverty, I've managed to have the children attend an excellent private school. In the end, it was my children who saved my life. They are my true heroes. They've taught me what is really important in life.

Sometimes my children say things like, "Mommy, I don't see why you have to go to therapy. You don't need therapy! You're fine the way you are." And I always say, "I'm fine because I go to therapy!"

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Hurricane Katrina, the most devastating natural disaster in American history, ravaged several southern states in 2005, traumatizing thousands of people who will contend with the emotional aftereffects of this trauma for years to come.

in treating the symptoms of numbing, intrusion, and social withdrawal (Lindburg et al., 2001; Seedat et al., 2001).

Even though medications can provide some symptom relief, it would be naive to think that medication alone is sufficient for ameliorating the distressing psychological and interpersonal problems that burden those with PTSD. Consequently, clinicians recommend ongoing psychotherapy, not only to deal with emotional issues but also to monitor the individual's reactions to medical treatments (Davidson, Stein, Shalev, & Yehuda, 2004). The most effective psychological treatments for PTSD involve a combination of "covering" and "uncovering" techniques. "Covering" techniques, such as supportive therapy and stress management, help the client seal over the pain of the trauma. They may also help the client reduce stress more effectively and, in the process, eliminate some of the secondary problems that the symptoms cause. For example, PTSD victims who isolate themselves from friends and family are cutting themselves off from social support, which is an important therapeutic agent. By learning alternate coping methods, clients can become better able to seek out this kind of support.

"Uncovering" techniques, which involve a reliving of the trauma, include the behavioral treatments of imaginal flooding and systematic desensitization. Exposing the person with PTSD to cues that bring back memories of the event in a graded fashion, or in a situation in which the individual is taught simultaneously to relax, can eventually break the conditioned anxiety reaction. Other treatments, such as psychodrama, can also be useful in bringing to conscious awareness, under a controlled setting, repressed memories of the traumatic event.

In an analysis of the results of 26 studies on the treatment of PTSD, researchers compared the efficacy of the major forms of psychotherapy on more than 1,500 patients. They concluded that the majority of patients treated with psychotherapy for PTSD recover or improve, although many patients continue to have substantial residual symptoms that persist long after treatment (Bradley et al., 2005). Clearly, although treatment can be effective, continued follow-up is necessary to help these clients maintain their treatment gains over the long term.

PTSD victims can also learn to reduce stress by approaching their situations more rationally and by breaking down their problems into manageable units. They can work toward achieving a better balance between self-blame and avoidance. Individuals who feel excessively guilty for their role in the traumatic incident can learn to see that their responsibility was not as great as imagined. Conversely, those who feel they have no control over what happens to them and, therefore, avoid confronting problems can learn to feel a greater sense of mastery over the course of their lives (Hobfall et al., 1991).

Donald Meichenbaum (1998) describes a six-step cognitive-behavioral therapy plan that incorporates strategies he has found beneficial for clients suffering from PTSD:

1. Establish a good working relationship with clients, characterized by nurturance and compassion.
2. Encourage clients to view their symptoms in a more positive light. For example, numbing can be viewed as a way of slowing the pace in order to deal with intense levels of distress.
3. Help clients translate global problem descriptions into specific, problem-solving terms.
4. Take behavioral steps, such as confronting the feared situation, in thought and in real settings.
5. Confront barriers in the form of feelings (e.g., fears, guilt, depression) and distorted beliefs (e.g., negative self-views) that get in the way of implementing change and mastering fears.
6. Help clients anticipate possible lapses (e.g., a recurrence of flashbacks, bouts of anxiety or depression).

Anxiety Disorders: The Biopsychosocial Perspective

As you can see, anxiety disorders cover a broad spectrum of problems, ranging from very specific, seemingly idiosyncratic responses to diffuse and undifferentiated feelings of dread. These disorders involve an intriguing intertwining of biological, psychological, and sociocultural phenomena. Fortunately, relatively straightforward behaviorally based treatments are available that can successfully alleviate the symptoms of anxiety for many people who suffer from these disorders. Furthermore, a number of other strategies involving cognitive, insight-oriented, and psychopharmacological interventions can enhance the effectiveness of behavioral techniques. Knowledge gained from research on the causes and treatment of anxiety disorders can also have some practical benefits for managing lesser difficulties.

The Biopsychosocial Perspective

Found at the end of the chapter, this section of the text underscores the perspectives, treatment strategies, and options.

Return to the Case

This end-of-chapter feature revisits the case report presented at the beginning of the chapter. After learning about the disorder in more detail from studying the chapter, the reader can then fully appreciate the in-depth coverage of the patient's history and Dr. Tobin's official assessment, diagnosis, case formulation, treatment plan, and clinical conclusions.

Case Report
Barbara Wilder

RETURN TO THE CASE

Barbara's History

As Barbara shared her life history with me, the flow of her speech frequently was interrupted by sobs and pleas that I be patient with her. As Barbara's story unfolded, I came to understand how the emotional scars left by growing up in a dysfunctional family plagued her throughout childhood and adolescence.

Barbara was raised almost exclusively by her mother. Her father spent very little time at home, because he worked as a sales representative for a company that had branch offices spread across a three-state area. When he was home, he was almost always inebriated. Barbara's mother was very protective of her, restricting almost all social and after-school activities. Barbara remembers feeling somewhat resentful of her mother's strong control over her, but she justified her mother's behavior, because "after all, she couldn't count on my father to help her, and, besides, I was a pretty difficult kid and she didn't want me getting into trouble."

Barbara's father was known to have out-of-town affairs with women, and everyone regarded him as a failure in his job. However, no one discussed these problems openly. Barbara remembers being frightened of her father because, when he was drinking, he became furious over even her slightest failure to respond instantly to his instructions. Usually, he gave unclear or contradictory instructions, so she could not predict when he would yell at her and when he would be satisfied with her response. When she tried to apologize, he criticized her even more. Barbara learned that the best way to deal with him was to stay out of his way.

Barbara explained to me that it was not only her father who struggled with psychological impairment. Her mother had, for most of her adult years, an intense fear of leaving the house alone, and she experienced deep depression related to her unhappy marriage. Going back a generation, Barbara's grandmother was considered by most people to be particular. She insisted on living the life of a recluse and acted toward her husband in ways that others considered domineering, bordering on sadistic. Barbara's maternal grandfather put up with the abuse, never complaining, always appearing to others as a quiet, accommodating "gentleman." It was quite a shock to the whole community when, at the age of 62, he asphyxiated himself and left a note filled with rage about his "miserable marriage."

In her senior year of high school, Barbara began to write away to a number of colleges for applications. It never occurred to her that her parents would object to her going to college, as long as she realized that she would have to support herself. Since Barbara's grades were excellent, she felt quite certain that she would earn some kind of financial aid. One day, her mother stopped Barbara as she was leaving the house to mail a stack of envelopes and asked Barbara what she was doing. When Barbara explained, her mother burst into tears. She told Barbara that it was time for them to have a talk. They sat down in the kitchen, and Barbara's mother poured forth an amazing "confession." Ever since Barbara was a child, it had been very important for her mother to have Barbara with her at home. That was why she found it so hard to let Barbara go out with her friends and do things after school. She said that Barbara's father had been so impossible that she was unhappy almost all the time. She couldn't even leave the house to run a simple errand unless she had Barbara with her. She begged Barbara not to go away to school, saying that she could not bear the thought of her leaving. Barbara was stunned. She did not realize how much she meant to her mother. There was no way she could even consider going away to school under these circumstances. Barbara threw away all her letters and applied to the community college located 10 miles away from home.

After college, Barbara took a job in an insurance company, where she became a top-notch typist and receptionist. When her boss was transferred to another city, he told Barbara that he wanted her to move also. She could enroll in the university and take courses there to complete her bachelor's degree, all at company expense. According to her boss, Barbara had a lot of potential to advance in a career if she had the proper training. Concerned about leaving her mother, Barbara asked her what she should do. Barbara's mother assured her that she would "manage somehow." Barbara made the move, and all seemed to be going well. She felt particularly lucky to have found a roommate with whom she shared many common interests, ideas, and feelings. They soon became inseparable. Unfortunately, however, things did not remain so serene for Barbara; the ghosts of unresolved conflicts and pain reappeared and took the form of her current emotional crisis.

Assessment

Although I had some reasonable hypotheses about the nature of Barbara's disorder, important gaps needed to be filled in. Of particular concern was the possibility that Barbara might be suffering from a medical problem. It is not uncommon for people with certain medical problems, such as hypoglycemia, hyperthyroidism, or insulin-secreting tumors, to have symptoms that are strikingly similar to those found in anxiety disorders. However, the physician who conducted the physical examination found no physiological basis for Barbara's problems. Drugs and alcohol were ruled out as well. Barbara had never abused drugs, and she only occasionally

death-related phobias, which appear closer in time to the onset of panic disorder.

Theories and Treatment of Specific Phobias

As you have just seen, there are many types of specific phobias, ranging from the common to the relatively obscure. However, the fact that they are grouped together suggests that there is a common theme or element that underlies their cause and potentially their treatment. As is true for panic disorder, the primary explanations of specific phobias rely on biological and psychological perspectives. Nevertheless, as is also true for panic disorder, the existence of a specific phobia in an individual can have a significant impact on those who are close to that person. Consequently, treatment sometimes involves partners and family members.

The primary biological perspective on specific phobias involves the notion that humans are essentially preprogrammed to fear certain situations or stimuli that could threaten our survival (Lang, Davis, & Öhman, 2000). According to this view, there is an evolutionary advantage to the fear of death, disaster, or injury. This "biological preparedness" theory is based on the assumption that there might be a biological "wiring" that causes people to react with fear to threatening situations (Seligman, 1971). Such a biological propensity might explain how people can so rapidly acquire irrational fears that are so resistant to extinction. Adding support to the hypothesis that biology plays a determining role in the development of specific phobias is research that has been conducted with male twins. Using personal interviews, Kendler and his colleagues (2001) assessed 1,198 male-male twin pairs and reported genetic contributions ranging from 25 to 37 percent in the etiology of phobias and the irrational fears associated with phobias. Furthermore, it has been found that family members seem to share similar phobias; for example, first-degree biological relatives of people with animal phobias share this kind of phobia, although not necessarily to the same kind of animal. Similarly, individuals with blood-injury phobias or those with situational phobias are likely to have biological relatives who share similar specific phobias (American Psychiatric Association, 2000).

Speculation about the psychological causes of phobias goes back at least as far as the time of Freud. Although Freud did not initially consider phobias to be psychologically based, his later writings reflect his notion of phobias as psychological symptoms that defend the ego against anxiety. Around the time that Freud was writing on the topic, behavioral psychologists, such as Watson, were demonstrating in the laboratory that animals and humans alike could acquire phobic behavior through conditioning, which led to the conclusion that phobias resulted from maladaptive learning. Current conceptualizations add to this behavioral model the notion that the individual's thoughts also play a role in acquiring and maintaining specific phobias. Many people with phobias report that they had an aversive experience during childhood that has remained with them, or whose parents, and even grandparents, displayed phobic behavior when confronted with the feared object (Fredrikson, Annas, & Wik, 1997; Merkelbach & Muris, 1997).

Cognitive-behavioral theorists (Beck, Emery, & Greenberg, 1985) view anxiety disorders, such as specific phobias, as rooted in and maintained by the client's cognitive styles. According to this view, phobic individuals have overactive "alarm systems" to danger, and they perceive things as dangerous because they misinterpret stimuli. Their perceptions are based on faulty inferences and overgeneralizations. Consider the case of Roberto, a 30-year-old man who experiences a fear of dying that is triggered by unexpected physical sensations. He interprets the physical sensations as a sign of a physical disease and becomes anxious; in this way, a chain reaction is set up. Roberto then generalizes in such a way that everything looks dangerous. His attention becomes "stuck" on potentially dangerous stimuli, leaving him with less ability to think rationally. Roberto begins to think that he is losing his mind, and this makes matters worse.

Some people have feelings or beliefs about a stimulus that set the stage for developing a phobia. For example, the perception of an object or a situation as uncontrollable, unpredictable, dangerous, or disgusting is correlated with feelings of vulnerability. These attributions might explain the common phobia of spiders, an insect about which people have many misconceptions and apprehensions (Armfield & Mattiske, 1996). In another common phobia, that of blood-injury-injection, disgust and fear of contamination play a prominent role (Sawchuk et al., 2000). People with phobias also tend to overestimate the likelihood of a dangerous outcome after exposure to the feared stimulus (de Jong & Merckelbach, 2000). As you can see, in addition to being associated with prior aversive experiences, specific phobias can also arise from a person's thoughts and perceptions, which heighten the individual's feelings of vulnerability.

Behavioral therapy is highly effective because symptoms are relatively easy to identify and the stimuli are limited to specific situations or objects. Systematic desensitization, described in Chapter 4, rests on the premise that an individual can best overcome maladaptive anxiety by approaching feared stimuli gradually, while in a relaxed state. A therapist might decide, though, that systematic desensitization is either too time consuming, impractical, or unnecessary. Consider the case of Florence, a medical student who sees a therapist in desperation one week before she starts an anatomy course. She has fainted on past occasions when watching videotapes of surgical procedures and is sure that she will make a fool of herself in anatomy class. One week is not enough time to go through the systematic desensitization procedure. Furthermore, Florence's anxiety is not so severe as to be terrifying. Her therapist, therefore, decides to use a behavioral technique called **flooding,** in which the client is

MindMAP Segment 5.2: Systematic Desensitization

Interactivity

An icon guides the reader to an interactivity related to a specific topic discussed in the text. The interactivity can be found on the MindMAP Plus CD-ROM that is included with each new textbook.

Video Segment

A photo from each video segment on the MindMAP Plus CD-ROM provides a visual cue to launch the CD-ROM and view the video.

In MindMAP Segment 5.4, Carl talks about the problems he faced after returning home from his tours of duty in Vietnam.

Especially profound in the experience of PTSD are symptoms that wreak havoc in the life of the traumatized individual.

intervene with survivors in an effort to reduce the debilitating effects of exposure to widespread trauma. The 2004 tsunami in Southeast Asia, one of the most devastating natural disasters in recorded history, resulted in the development of very serious psychological problems. Again, though, learning from previous disasters, relief workers were trained in methods of helping people cope with the psychological toll of devastation.

Theories and Treatment

Biological Perspectives Although by definition PTSD has its origins in life experiences, researchers have increasingly been turning up evidence linking its symptoms to biological abnormalities. Researchers have formulated the theory that, once a traumatic experience has occurred, parts of the individual's nervous system become primed or hypersensitive to possible danger in the future. Subcortical pathways in the central nervous system, as well as structures in the sympathetic nervous system, are permanently on "alert" for signs of impending harm; people who develop PTSD following exposure to trauma are more likely to have had a predisposition in the form of exaggerated "startle" responses (eyeblinks and skin conductance) (Guthrie & Bryant, 2005). Altered neurotransmitter functioning would play a role in this scenario. For some individuals with PTSD, alterations seem to occur in the norepinephrine pathways, while in others abnormalities in the serotonin pathways are more likely (Southwick et al., 1997). Dopamine, particularly in neurons in the prefrontal area that are sensitive to stress, may also be involved in the symptoms of PTSD (Horger & Roth, 1996).

It seems that even the structure of the brain can change as a result of trauma; for example, researchers have noted that these changes in the hippocampus may result from hyperarousal of the amygdala, a limbic system structure that mediates emotional responses (Villarreal & King, 2001). Finally, genetic predisposition may also play a role in the development of PTSD. In one study of more than 4,000 twin pairs who fought in Vietnam, genetic factors seemed to play an important role in their susceptibility to the development of reexperiencing, avoidance, and arousal symptoms (True et al., 1993). Evidence has also emerged that people with first-degree relatives with a history of depression have an increased vulnerability to developing PTSD in response to traumatic life events (American Psychiatric Association, 2000).

Psychological Perspectives It is clear that psychological factors play a central role in the development of PTSD. Theorists have discussed and studied human responses to trauma for many decades. Freud described symptoms such as those in the disorder currently labeled PTSD as representing a flooding of the ego's defenses, with uncontrollable anxiety originating from the intense and threatening experiences. The experiences themselves may be traumatic enough to cause this reaction, or they may trigger painful memories of earlier unresolved unconscious conflicts and may cause anxiety to overflow as a result of an inability to keep these memories repressed. For example, the experience of killing another person in battle may stimulate the emergence of previously repressed aggressive impulses. Anxiety over the expression of these impulses could trigger the stress reaction.

According to classical behavioral approaches, it is assumed that the person with PTSD has acquired a conditioned fear to the stimuli that were present at the time of the trauma. Because of a learned association, the individual experiences anxiety when these or similar stimuli are present, even in the absence of the traumatizing experience. Presumably, such reactions lead to avoidance. To escape, at least in fantasy, from the traumatic event becomes reinforcing for the individual, and this reinforcement then strengthens the withdrawal reaction seen in PTSD victims.

Cognitive-behavioral theorists (Foa, Steketee, & Rothbaum, 1989) have incorporated the concept of how people's beliefs about a traumatic event influence how they cope with it. Thoughts that are likely to have a detrimental effect, and can ultimately lead to PTSD, include excessive self-blame for events that are beyond personal control, as well as guilt over the outcome of these events (Kubany, 1994; Ramsay, Gorst-Unsworth, & Turner, 1993). The individual's unsuccessful attempts to reduce the stress experienced in the aftermath of the event can also increase the risk for PTSD. Some of these problematic coping methods include avoidance of problems for long periods of time, blaming and lashing out at other people, adopting a cynical and pessimistic view of life, catastrophizing or exaggerating the extent of current difficulties, isolating oneself socially, and abusing drugs and alcohol (Holtfalt et al., 1991).

Clearly, not everyone exposed to traumatic experiences, combat-related or otherwise, suffers from PTSD. What are the factors that increase the likelihood that a particular individual

Concept Map

This visual guide presents a quick, "at-a-glance" view of the chapter.

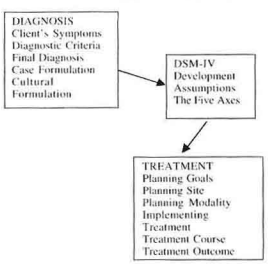
Guided Review

This is a fill-in-the-blank summarizing exercise that appears in each chapter.

CHAPTER 2

CLASSIFICATION, TREATMENT PLANS, ETHICS, AND LEGAL ISSUES

CLASSIFICATION AND TREATMENT



LEARNING OBJECTIVES

1.0 Psychological Disorder: Experiences of Client and Clinician (pp. 87-92)
- 1.1 Distinguish the concept of a client from that of a patient as the individual who is the focus of psychological treatment. (p. 88)
- 1.2 Describe the prevalence of psychological disorders in the United States. (pp. 89-90)
- 1.3 Describe the types of clinicians who provide psychological treatment. (p. 91)

2.0 The Diagnostic and Statistical Manual of Mental Disorders (pp. 92-108)
- 2.1 Outline the history of the development of DSM-IV. (pp. 93-96)
- 2.2 Define the term mental disorder as it is used in DSM-IV. (pp. 97-99)
- 2.3 Explain the assumptions underlying the DSM-IV, including the medical model, a theoretical orientation, categorical approach, and multiaxial system. (pp. 99-103)
- 2.4 Define the five axes of DSM-IV: (pp. 103-108)
  - Axis I: Clinical Disorders (pp. 103-104)
  - Axis II: Personality Disorders and Mental Retardation (pp. 104-105)
  - Axis III: General Medical Conditions (pp. 105-106)
  - Axis IV: Psychosocial and Environmental Problems (pp. 106-107)
  - Axis V: Global Assessment of Functioning (pp. 107-108)

3.0 The Diagnostic Process (pp. 108-117)
- 3.1 Explain how the clinician obtains the client's reported symptoms. (p. 109)
- 3.2 Indicate how the diagnostic criteria of DSM-IV are used in identifying a possible diagnosis, including the role of the decision tree. (pp. 109-111)

REVIEW AT A GLANCE

Nearly (1)_____ the population is afflicted with a diagnosable psychological disorder at some time in life. Approximately (2)_____ percent of these people seek professional help from clinicians, (3) ____ percent from other processional sources. The remainder turn to informal sources of support or go without help. Clinicians are found within several professions such as (4)_____, (5)_____, (6)_____, (7)_____, and (8)_____ counseling.

Clinicians and researchers use the (9)_____, which contains descriptions of all psychological disorders. In recent editions the authors have tried to meet the criterion of (10)_____ so that a given diagnosis will be consistently applied to anyone showing a particular set of symptoms. Researchers have also worked to ensure the (11)_____ of the classification system that that the various diagnoses represent real and distinct clinical phenomenon. The DSM-IV is based on a (12)_____ model orientation in which disorders are viewed as (13)_____. Diagnoses are categorized in terms of relevant areas of functioning called (14)_____. Axis I includes (15)_____; Axis II, (16)_____; Axis III, (17)_____, Axis IV, (18)_____, and Axis V contains the (19)_____ scale.

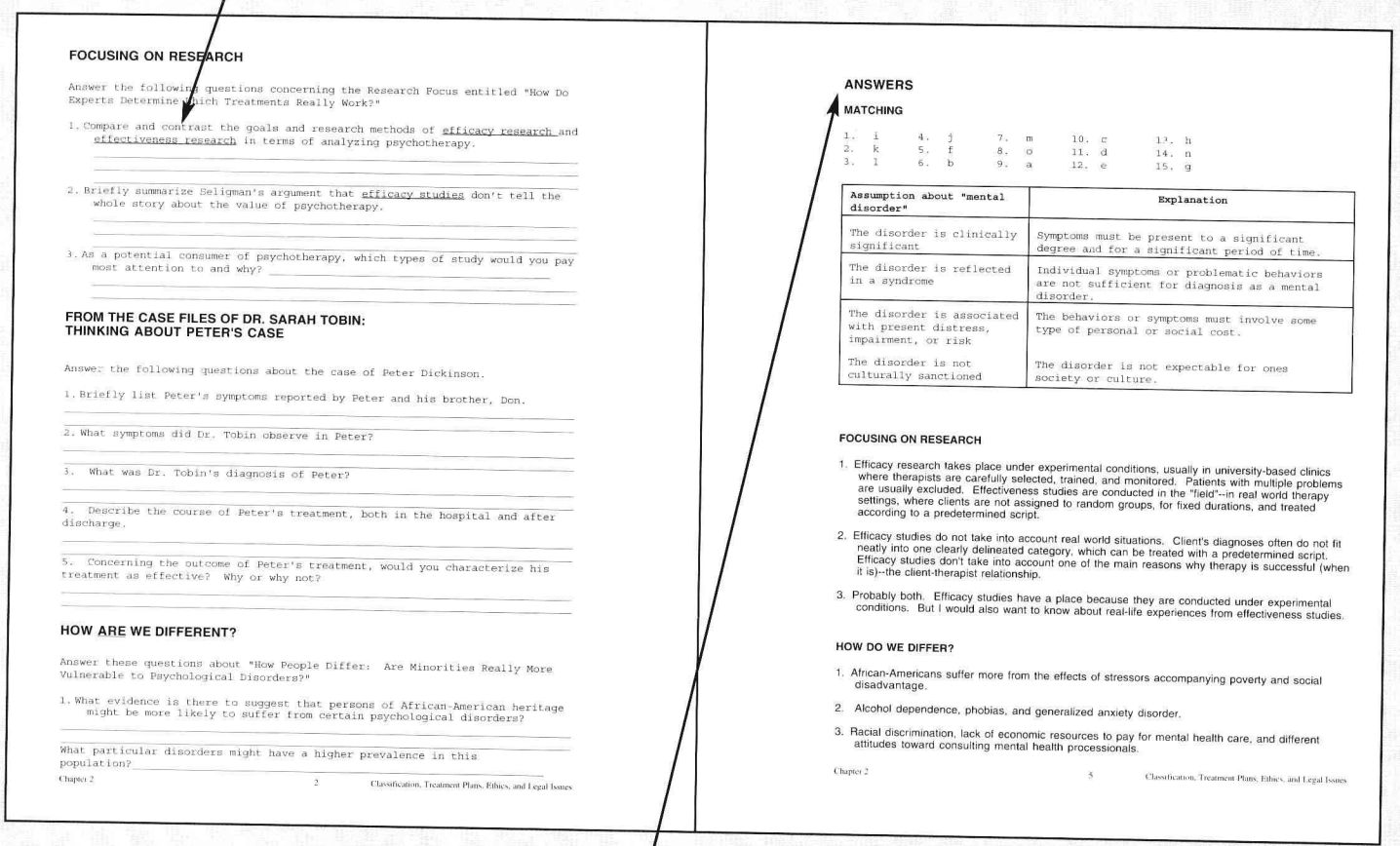
The diagnostic process involves using all relevant information to arrive at a label that characterizes a client's disorder. After attending to a client's reported and observable symptoms, the clinician uses the DSM-IV criteria and a strategy known as a (20)_____. The clinician rules out (21)_____ and tries to assign a (22)_____. After the diagnostic process, clinicians develop a (23)_____, in an effort to understand the processes and factors that might have influenced the client's current psychological status. Once diagnosis is determined, a (24)_____ plan is developed, which includes issues pertaining to (25)_____, (26)_____, and (27)_____. A (28)_____ is recommended. Possibilities include a (29)_____, (30)_____, (31)_____, (32)_____ or other appropriate setting. The treatment (33)_____ is specified, and may involve (34)_____, (35)_____, (36)_____, or (37)_____therapy. After a plan is developed, clinicians implement treatment with particular attention to the fact that the (38)_____ is a crucial determinant of whether therapy will succeed.

Learning Objectives

These goals help students focus their studying efforts on the key information in each chapter.

Exercises

In addition to matching, identifications, and applicable games, each chapter contains critical thinking questions that relate back to the Dr. Sarah Tobin Case Reports in each chapter.



FOCUSING ON RESEARCH

Answer the following questions concerning the Research Focus entitled "How Do Experts Determine Which Treatments Really Work?"

1. Compare and contrast the goals and research methods of efficacy research and effectiveness research in terms of analyzing psychotherapy.

2. Briefly summarize Seligman's argument that efficacy studies don't tell the whole story about the value of psychotherapy.

3. As a potential consumer of psychotherapy, which types of study would you pay most attention to and why?

FROM THE CASE FILES OF DR. SARAH TOBIN: THINKING ABOUT PETER'S CASE

Answer the following questions about the case of Peter Dickinson.

1. Briefly list Peter's symptoms reported by Peter and his brother, Don.

2. What symptoms did Dr. Tobin observe in Peter?

3. What was Dr. Tobin's diagnosis of Peter?

4. Describe the course of Peter's treatment, both in the hospital and after discharge.

5. Concerning the outcome of Peter's treatment, would you characterize his treatment as effective? Why or why not?

HOW ARE WE DIFFERENT?

Answer these questions about "How People Differ: Are Minorities Really More Vulnerable to Psychological Disorders?"

1. What evidence is there to suggest that persons of African-American heritage might be more likely to suffer from certain psychological disorders?

What particular disorders might have a higher prevalence in this population?

Chapter 2 2 Classification, Treatment Plans, Ethics, and Legal Issues

ANSWERS

MATCHING

1. i	4. j	7. m	10. c	13. h
2. k	5. f	8. o	11. d	14. n
3. l	6. b	9. a	12. e	15. g

Assumption about "mental disorder"	Explanation
The disorder is clinically significant	Symptoms must be present to a significant degree and for a significant period of time.
The disorder is reflected in a syndrome	Individual symptoms or problematic behaviors are not sufficient for diagnosis as a mental disorder.
The disorder is associated with present distress, impairment, or risk	The behaviors or symptoms must involve some type of personal or social cost.
The disorder is not culturally sanctioned	The disorder is not expectable for ones society or culture.

FOCUSING ON RESEARCH

1. Efficacy research takes place under experimental conditions, usually in university-based clinics where therapists are carefully selected, trained, and monitored. Patients with multiple problems are usually excluded. Effectiveness studies are conducted in the "field"--in real world therapy settings, where clients are not assigned to random groups, for fixed durations, and treated according to a predetermined script.

2. Efficacy studies do not take into account real world situations. Client's diagnoses often do not fit neatly into one clearly delineated category, which can be treated with a predetermined script. Efficacy studies don't take into account one of the main reasons why therapy is successful (when it is)--the client-therapist relationship.

3. Probably both. Efficacy studies have a place because they are conducted under experimental conditions. But I would also want to know about real-life experiences from effectiveness studies.

HOW DO WE DIFFER?

1. African-Americans suffer more from the effects of stressors accompanying poverty and social disadvantage.

2. Alcohol dependence, phobias, and generalized anxiety disorder.

3. Racial discrimination, lack of economic resources to pay for mental health care, and different attitudes toward consulting mental health processionals.

Chapter 2 5 Classification, Treatment Plans, Ethics, and Legal Issues

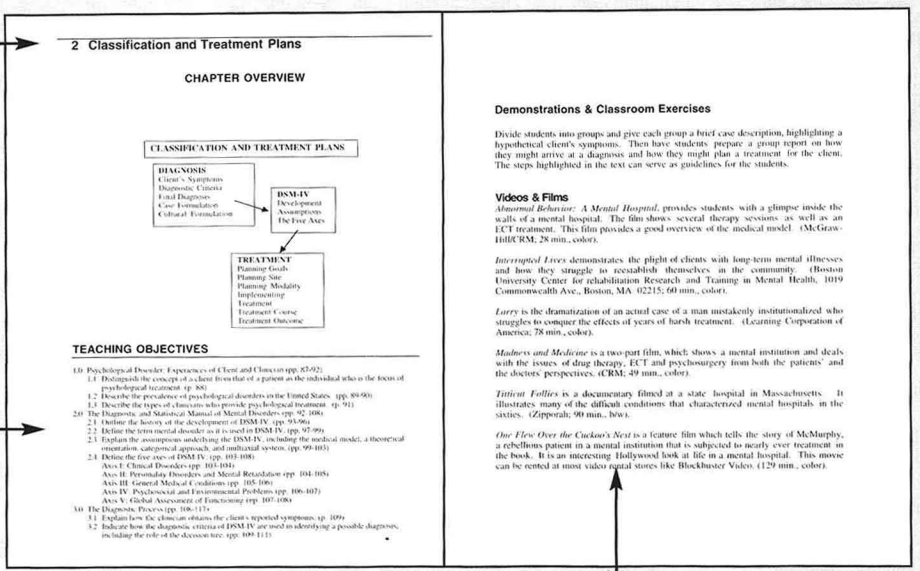
Answer Keys

At the end of each chapter, full explanations are provided for each of the multiple-choice items. Possible answers are supplied for the case-through, essay, and short-answer items, and the answers to the matching, identification, review at a glance, and games are also provided.

Instructor's Manual

Chapter Overview

This visual guide presents the chapter outline as a concept map. Each section is self-contained and includes a topic summary and related learning objectives.



2 Classification and Treatment Plans

CHAPTER OVERVIEW

CLASSIFICATION AND TREATMENT PLANS

DIAGNOSIS
Client's Symptoms
Diagnostic Criteria
Final Diagnosis
Case Formulation
Cultural Formulation

DSM-IV
Development
Assumptions
The Five Axes

TREATMENT
Planning Goals
Planning Site
Planning Modality
Implementing
Treatment
Treatment Course
Treatment Outcome

TEACHING OBJECTIVES

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Demonstrations & Classroom Exercises

Divide students into groups and give each group a brief case description, highlighting a hypothetical client's symptoms. Then have students prepare a group report on how they might arrive at a diagnosis and how they might plan a treatment for the client. The steps highlighted in the text can serve as guidelines for the students.

Videos & Films

Abnormal Behavior: A Mental Hospital, provides students with a glimpse inside the walls of a mental hospital. The film shows several therapy sessions as well as an ECT treatment. This film provides a good overview of the medical model. (McGraw-Hill/CRM; 28 min., color).

Interrupted Lives demonstrates the plight of clients with long-term mental illnesses and how they struggle to reestablish themselves in the community. (Boston University Center for rehabilitation Research and Training in Mental Health, 1019 Commonwealth Ave., Boston, MA 02215; 60 min., color).

Larry is the dramatization of an actual case of a man mistakenly institutionalized who struggles to conquer the effects of years of harsh treatment. (Learning Corporation of America; 78 min., color).

Madness and Medicine is a two-part film, which shows a mental institution and deals with the issues of drug therapy, ECT and psychosurgery from both the patients' and the doctors' perspectives. (CRM; 49 min., color).

Titticut Follies is a documentary filmed at a state hospital in Massachusetts. It illustrates many of the difficult conditions that characterized mental hospitals in the sixties. (Zipporah; 90 min., b/w).

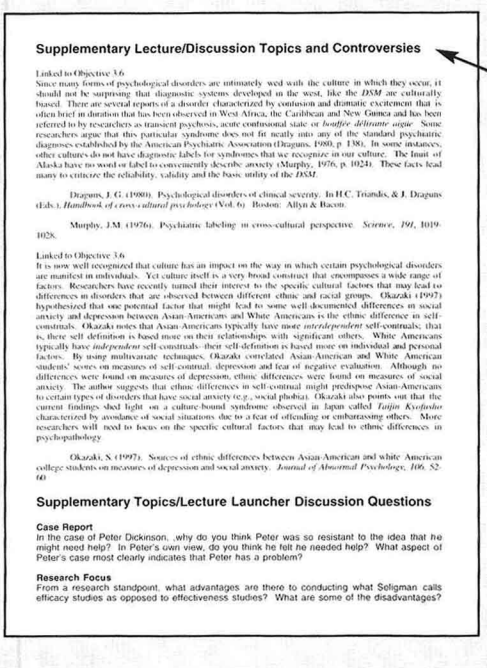
One Flew Over the Cuckoo's Nest is a feature film which tells the story of McMurphy, a rebellious patient in a mental institution that is subjected to nearly ever treatment in the book. It is an interesting Hollywood look at life in a mental hospital. This movie can be rented at most video rental stores like Blockbuster Video. (129 min., color).

Teaching Objectives

Identical to the learning objectives that appear in the student study guide, these objectives are meant to guide instructors' chapter syllabi.

Demonstrations and Classroom Exercises & Video and Films

Includes various demonstrations and exercises to be used in class as well as a list of videos related to chapter content.



Supplementary Lecture/Discussion Topics and Controversies

Linked to Objective 3.6
Since many forms of psychological disorders are intimately wed with the culture in which they occur, it should not be surprising that diagnostic systems developed in the west, like the *DSM* are culturally biased. There are several reports of a disorder characterized by confusion and dramatic excitement that is often brief in duration that has been observed in West Africa, the Caribbean and New Guinea and has been referred to by researchers as transient psychosis, acute confusional state or *bouffée délirante aigue*. Some researchers argue that this particular syndrome does not fit neatly into any of the standard psychiatric diagnoses established by the American Psychiatric Association (Draguns, 1980, p. 130). In some instances, other cultures do not have diagnostic labels for syndromes that we recognize in our culture. The Inuit of Alaska have no word or label to conveniently describe anxiety (Murphy, 1976, p. 1024). These facts lead many to criticize the reliability, validity and the basic utility of the *DSM*.

Draguns, J. G. (1980). Psychological disorders of clinical severity. In H.C. Triandis, & J. Draguns (Eds.), *Handbook of cross-cultural psychology* (Vol. 6). Boston: Allyn & Bacon.

Murphy, J.M. (1976). Psychiatric labeling in cross-cultural perspective. *Science, 191*, 1019-1028.

Linked to Objective 3.6
It is now well recognized that culture has an impact on the way in which certain psychological disorders are manifest in individuals. Yet culture itself is a very broad construct that encompasses a wide range of factors. Researchers have recently turned their interest to the specific cultural factors that may lead to differences in disorders that are observed between different ethnic and racial groups. Okazaki (1997) hypothesized that one potential factor that might lead to some well-documented differences in social anxiety and depression between Asian-Americans and White Americans is the ethnic difference in self-construals. Okazaki notes that Asian-Americans typically have more *interdependent* self-construals; that is, there self definition is based more on their relationships with significant others. White Americans typically have *independent* self-construals -their self-definition is based more on individual and personal factors. By using multivariate techniques, Okazaki correlated Asian-American and White American students' scores on measures of self-construal, depression and fear of negative evaluation. Although no differences were found on measures of depression, ethnic differences were found on measures of social anxiety. The author suggests that ethnic differences in self-construal might predispose Asian-Americans to certain types of disorders that have social anxiety (e.g., social phobia). Okazaki also points out that the current findings shed light on a culture-bound syndrome observed in Japan called *Taijin Kyofusho* characterized by avoidance of social situations due to a fear of offending or embarrassing others. More researchers will need to focus on the specific cultural factors that may lead to ethnic differences in psychopathology.

Okazaki, S. (1997). Sources of ethnic differences between Asian-American and white American college students on measures of depression and social anxiety. *Journal of Abnormal Psychology, 106*, 52-60.

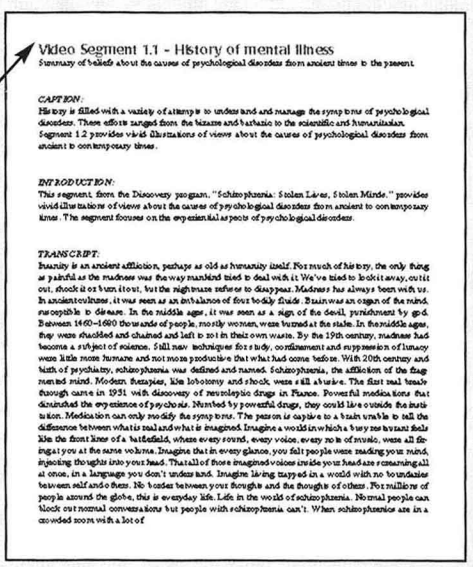
Supplementary Topics/Lecture Launcher Discussion Questions

Case Report
In the case of Peter Dickinson, why do you think Peter was so resistant to the idea that he might need help? In Peter's own view, do you think he felt *he* needed help? What aspect of Peter's case most clearly indicates that Peter has a problem?

Research Focus
From a research standpoint, what advantages are there to conducting what Seligman calls efficacy studies as opposed to effectiveness studies? What are some of the disadvantages?

Supplementary Lecture/Discussion Topics and Controversies

Includes additional lecture topics and discussion questions linked to learning objectives. These also reflect back to the main text case features.



Video Segment 1.1 - History of mental illness
Summary of beliefs about the causes of psychological disorders from ancient times to the present

CAPTION:
History is filled with a variety of attempts to understand and manage the symptoms of psychological disorders. These efforts ranged from the bizarre and barbaric to the scientific and humanitarian. Segment 1.2 provides vivid illustrations of views about the causes of psychological disorders from ancient to contemporary times.

INTRODUCTION:
This segment, from the Discovery program, "Schizophrenia: Stolen Lives, Stolen Minds," provides vivid illustrations of views about the causes of psychological disorders from ancient to contemporary times. The segment focuses on the experiential aspects of psychological disorders.

TRANSCRIPT:
Insanity is an ancient affliction, perhaps as old as humanity itself. For much of history, the only thing as painful as the madness was the way mankind tried to deal with it. We've tried to lock it away, cut it out, shock it or burn it out, but the nightmare refuses to disappear. Madness has always been with us. In ancient civilizations, it was seen as an imbalance of four bodily fluids. Brain was an organ of the mind, susceptible to disease. In the middle ages, it was seen as a sign of the devil, punishment by god. Between 1400–1600 thousands of people, mostly women, were burned at the stake. In the middle ages, they were shackled and chained and left to rot in their own waste. By the 19th century, madness had become a subject of science. Still new techniques for study, confinement and suppression of lunacy were little more humane and not more productive that what had come before. With 20th century and birth of psychiatry, schizophrenia was defined and named. Schizophrenia, the affliction of the fragmented mind. Modern therapies, like lobotomy and shock, were still abusive. The first real breakthrough came in 1951 with discovery of neuroleptic drugs in France. Powerful medications that disturbed the experiences of psychosis. Numbed by powerful drugs, they could live outside the institution. Medication can only modify the symptoms. The person is captive to a brain unable to tell the difference between what is real and what is imagined. Imagine a world in which a busy person feels like the front lines of a battlefield, where every sound, every voice, every note of music, were all ringing you at the same volume. Imagine that in every glance, you felt people were reading your mind, injecting thoughts into your head. That all of those imagined voices inside your head are screaming all at once, in a language you don't understand. Imagine living trapped in a world with no boundaries between self and others. No border between your thoughts and the thoughts of others. For millions of people around the globe, this is everyday life. Life in the world of schizophrenia. Normal people can block out normal conversations but people with schizophrenia can't. When schizophrenics are in a crowded room with a lot of

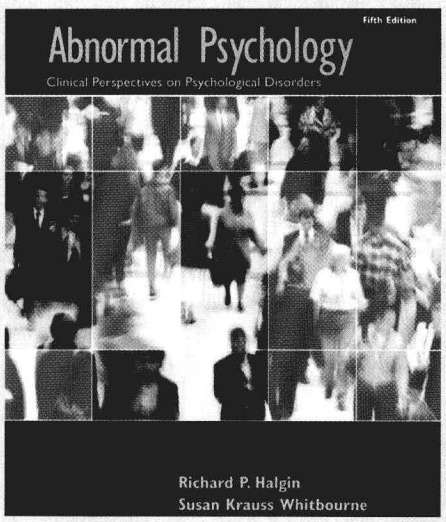
Guide to Video Segments on MindMAP Plus Student CD-ROM

For each video segment, the Instructor's Manual includes an introduction to the segment, a transcript, teaching notes, and discussion questions to engage students in the subject of the video.

ONLINE LEARNING CENTER

http://www.mhhe.com/halgin5

Welcome to the
Halgin/Whitbourne
Abnormal Psychology
Updated 5e website!



About the Book

- **Overview**
  Provides a quick synopsis of the edition and the material covered.
- **Table of Contents**
  Lists the entire ToC.
- **What's New**
  Introduces the new features of the textbook.
- **Supplements**
  Includes title and ISBN information for all accompanying student and instructor supplements.
- **Faces of Abnormal Psychology Video**
  Links to a downloadable demo of McGraw-Hill's latest abnormal psychology video containing new segments on real people with real disorders. FACES is free to adopters.

About the Authors

Meet the Authors

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Student Resources

- **Online Learning Center**
  Links to every text chapter containing learning objectives, quizzes, flashcards, Internet exercises, and more!
- **Internet Primer**
  Links to the McGraw-Hill Internet Guide providing students with valuable information on Internet navigation.
- **Careers in Psychology**
  Links to a list of resources for students interested in a career in psychology.
- **Statistics Primer**
  Provides a quick overview of statistics.
- **Web Resources**
  Links to interesting and useful psychology sites.

Instructor's Resources

- **Online Learning Center**
  CLICK HERE to see a web version of the Instructor's Manual and downloadable PowerPoint slide presentations for each chapter. This area is password protected. Please contact your McGraw-Hill representative for the password.
- **PageOut**
  FREE to adopters, PageOut is designed for the professor just beginning to explore website options. In just a few minutes, even the novice computer user can have a course website up and running.
- **Psych in the News**
  Links to issues of the Psychwatch: Newsletter.