FACTS AND FICTIONS IN MENTAL HEALTH

HAL ARKOWITZ AND SCOTT O. LILIENFELD

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To Lollie With Love
Hal Arkowitz

To My Students, From Whom I Continue to Learn So Much
Scott O. Lilienfeld

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Notes on Authors

Hal Arkowitz, Ph.D., is Emeritus Associate Professor at the University of Arizona. He received his bachelor's degree from New York University and his Ph.D. in Psychology (Clinical) from the University of Pennsylvania. His main research interests are in understanding how people change and why they don't. Dr. Arkowitz has published articles and books in the areas of anxiety, depression, psychotherapy, and motivational interviewing. For 10 years, he served as Editor of the *Journal of Psychotherapy Integration*. He also maintains an active clinical practice and has a strong interest in the integration of science and practice in clinical psychology.

Scott Lilienfeld, Ph.D., is Samuel Candler Dobbs Professor of Psychology at Emory University in Atlanta. He received his bachelor's degree from Cornell University in 1982 and his Ph.D. in Psychology (Clinical) from the University of Minnesota in 1990. Dr. Lilienfeld is Associate Editor of the *Journal of Abnormal Psychology*, and past President of the Society for a Science of Clinical Psychology President and the Society for the Scientific Study of Psychopathy. Dr. Lilienfeld has published over 300 manuscripts on personality disorders (especially psychopathy), dissociative disorders, psychiatric classification, pseudoscience in psychology, and evidence-based practices in clinical psychology.

In 1998, Dr. Lilienfeld received the David Shakow Award for Outstanding Early Career Contributions to Clinical Psychology from APA Division 12, and in 2012 he received the James McKeen Cattell Award for Distinguished Career Contributions to Applied Psychological Science from the Association for Psychological Science.

Preface

"Exercise great caution if you decide to change an answer (on a multiple choice test). Experience indicates that many students who change answers change to the wrong answer." This quote is taken from a highly influential book to help people prepare for the Graduate Record Examination, a test that is immensely important in gaining entry to graduate programs. This sounds like good advice except for one thing – it's wrong. Numerous studies have found that test-takers who stick with their first instinct in answering multiple choice items tend to do more poorly than if they had changed their answers more often.

Dr. Phil (Phil McGraw), the popular television "shrink," appears to create significant change in his guests' problems in 10–15 minutes. Yet, there is not one shred of evidence to suggest that this is the case. In fact, scientific evidence suggests that his and other approaches characterized by high confrontation and low empathy tend not only to be ineffective, but may increase resistance to change. His main messages are based on a philosophy of "Just do it!" Consider the following Dr. Phil quote: "A lot of people do have tragic childhoods. But you know what? Get over it." If change were this easy, the number of people with psychological problems would dwindle dramatically.

Both of these examples demonstrate how some of our firmly held beliefs are contradicted by findings from scientific research. In this book,

we use the word "myths" to describe these beliefs. Our goal is to present the scientific evidence that bears on these myths.

Often, these beliefs contain a grain of truth, but they become myths when stated in exaggerated and absolute ways. For example, many believe that sex offenders almost always repeat their crimes and can't be helped. Studies have found that only a relatively small number recidivate and those who receive treatment are much less likely to reoffend than those who do not. We have a long way to go to prevent recidivism among sexual offenders because even though it is lower than most people think, it is still too high. The myth does possess a kernel of truth, but as stated, it is contradicted by findings from research.

Some of the other myths we consider in this book are:

- Talking to suicidal persons about their wish to die increases the likelihood of suicide.
- Depression is due to a chemical imbalance in the brain.
- There is an epidemic of autism.
- Divorce always leads to serious problems in children.
- People can have multiple personalities.
- Marijuana is addictive.
- A full moon triggers strange behaviors.
- Herbal treatments have been demonstrated to be effective for anxiety and depression.
- Obesity is caused primarily by a lack of willpower.
- Electroconvulsive therapy is a hazardous procedure that often leaves people incoherent and zombie-like.

We learn myths from a variety of sources, including the media and the views voiced by untrained people. There are several reasons why we are prone to believing them. One of us (Scott Lilienfeld), along with his collaborators, has written extensively on this topic (e.g., in his book *50 Great Myths of Popular Psychology*). This discussion draws from this work.

First, myths make things simple so we don't have to deal with the complexities often present in reality. A good example of this is Dr. Phil's message that all we have to do to change problem behaviors is to "just do it." This message is simple, clear, and wrong. There are many reasons why problem behaviors are so hard to change (see Chapter 43, this

volume), as well as factors that need to be present for effective change to occur. It's easier just to accept Dr. Phil's simplified thesis.

Second, the reality that we experience is subjective, and influenced by selective perception and memory. In other words, we tend to perceive and remember what fits best with our preconceived notions. For example, if people perceive others with psychological problems as weak and fearful, they will be favorably inclined toward the belief that all others have to do is muster up the courage and make the needed changes.

The third reason is called "confirmation bias," which is the tendency to selectively attend to and remember information that confirms one's beliefs or hypotheses, and to neglect or distort information that doesn't. If we believe that most people with schizophrenia are violent, we will be more likely to attend to information consistent with previously held views and ignore or forget information inconsistent with them.

Fourth, people confuse correlation and causation. Just because two things are correlated or associated, doesn't mean that one causes the other. An example of this occurred in a state mental hospital where researchers noticed that there was a distinct odor in the ward of people with schizophrenia that was not present in other wards. The researchers formed the apparently reasonable hypothesis that the perspiration of those with schizophrenia may contain some chemicals that contribute to the development of this disorder. As they were conducting the study, a psychiatric aide came by and asked what they were studying. When the researchers told him, he laughed and said something like, "Oh yes, it does smell in there. The shower's been broken for a week now." The association between the body odor and schizophrenia was only correlational. The cause of both was the broken shower. In many instances, a correlation between two variables may be due to a third variable rather than to a causal connection between the two events.

Unfortunately, myths about mental health are widespread. Holding beliefs based on facts instead of fictions can reduce stigma and lead to more appropriate attitudes and behaviors toward people with mental illnesses. Our goal in this book is to supply precisely this corrective information.

Undergraduate and graduate students will find this book helpful in dispelling myths about mental health. This book can be used as a valuable adjunct to the main textbook in undergraduate classes in introductory, abnormal, and clinical psychology. It is also a good fit for graduate

courses in clinical psychology, counseling, social work, and psychiatry programs. Laypersons and journalists will also find a great deal of value in this book to further their understanding of mental illness.

Most of these chapters have previously been published in a bimonthly column entitled Facts and Fictions in Mental Health in the magazine *Scientific American Mind* and updated for this book. Three new chapters (on myths concerning suicide, bipolar disorder and creativity, and popular conceptions of psychotherapy) have been added.

We want to thank *Scientific American Mind* for generously granting us permission to publish the chapters in this book. In addition, we wish to express our deep appreciation to our two editors, Mariette DiChristina and Ingrid Wicklegren, for their invaluable feedback and suggestions on earlier drafts of the chapters. Their comments and suggestions significantly improved the liveliness and readability that we strived to achieve.

We also appreciate the help from others at *Scientific American Mind* who did outstanding work finding the illustrations for the chapters and helped in many other ways.

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Section 1
Anxiety-Related Disorders

Introduction

Most of us know at least one person who has been afflicted with an anxiety-related disorder. In many cases, it's the person staring back at us in the mirror. Approximately 3 out of every 10 people in the United States will suffer from one of these disorders at some point in their lives. Because these problems cause so much distress in so many people, it is imperative that we have a correct understanding of their nature and treatments.

Anxiety disorders are characterized by expectations that distressing or dangerous events may occur in certain situations, even when there is little or no chance they will. These expectations are often associated with pronounced physiological arousal and strong tendencies to avoid the feared situations. Anxiety is also part of the symptom picture of several anxiety-related disorders including posttraumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), and hoarding disorder.

The fifth edition of the American Psychiatric Association's diagnostic manual (*DSM-5*), published in 2013, lists several anxiety disorders including specific phobias; social phobia; panic disorder; agoraphobia; and generalized anxiety disorder.

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People with specific phobias usually experience anxiety about one particular situation (e.g., driving on freeways), object (e.g., needles), or living creatures (e.g., snakes). Often, phobias are given names derived from Greek. One of our favorites is hexakosioihexekontahexaphobia, which refers to a fear of the number 666, biblically associated with Satan. Try pronouncing that! Social anxiety disorder is an intense and often paralyzing fear of situations involving scrutiny by others, as in having a conversation or giving a speech in public. A diagnosis of panic disorder requires recurrent panic attacks with a fear of having more in the future. The name of this disorder also owes its origins to ancient Greece, in this case the mythical Greek god Pan, whose main diversion was scaring travelers in the forest, preferably at night. Apparently, Pan was good at his job. Panic attacks are terrifying experiences involving an abrupt surge of intense fear accompanied by physical symptoms that include accelerated heart rate, chest pain, shortness of breath, and trembling, as well as mental symptoms like a fear of losing control, going crazy, or dying. People diagnosed with agoraphobia become anxious in and avoid situations perceived as difficult to escape, embarrassing, or in which help would be unavailable in case of panic-like symptoms. Examples are crowded places, movie theaters, or being alone and away from home. Generalized anxiety disorder is characterized by excessive and pervasive worry, usually in several areas such as work, school, finances, and the safety of oneself or loved ones.

Several anxiety-related disorders appear in other sections of the *DSM*. These include PTSD, OCD, and hoarding disorder. In order to receive a diagnosis of PTSD, a person must experience exposure to traumas such as actual or threatened death, serious injury, or sexual violence. Exposure to trauma can be direct, as in the case of a victim of torture, or indirect, as in observing a fatal automobile crash. Common symptoms include trauma-related distressing and intrusive memories, flashbacks, or dreams; distress at exposure to cues relating to the trauma (e.g., media depictions of similar events); sleep disturbances; inability to experience positive emotions; and irritability and anger. Recently, researchers have found that this disorder is even more prevalent than previously thought, with rates of at least 7%.

A diagnosis of OCD requires the presence of either obsessions, which are persistent and intrusive thoughts, urges, or images recalled that cause

anxiety, or compulsions, which are maladaptive attempts to reduce that anxiety. In most cases, both obsessions and compulsions are present. A common example of OCD is when a person engages in excessive and frequent hand washing to reduce the anxiety caused by obsessions about dirt and contamination. In some cases, people with this disorder wash their hands so much that they rub off several layers of skin. A particularly good portrayal of a person with OCD was by Jack Nicholson in the 1997 movie *As Good as It Gets*. In contrast, people with hoarding disorder experience excessive anxiety about parting with possessions regardless of their value or utility. They retain them in an attempt to reduce anxiety. Some keep so much that it may be difficult for them to move around comfortably in their living quarters. A 2004 movie entitled *The Aviator* portrayed Howard Hughes, who was one of the wealthiest people in the world, and who developed a severe hoarding disorder.

There are a number of treatments that have been employed to treat anxiety. While the one that has shown the most success involves a number of methods that fall under the rubric of cognitive-behavior therapy, and to some extent psychoanalytically oriented psychotherapy. Others have also been used. They include anti-anxiety medication, herbal remedies, a form of meditation known as mindfulness, and a recently developed treatment known as eye movement desensitization and processing (EMDR). In the latter, the therapist asks clients to think of memories of anxiety-provoking events while tracing the therapist's back-and-forth finger movements with their eyes.

A number of questions have been raised about the nature and treatment of anxiety-related disorders. In this section, we will examine some of them, including:

- Do panic attacks come out of the blue?
- Do most people who experience trauma develop PTSD?
- Is trauma involving physical threat necessary to trigger PTSD?
- In *DSM-5*, is hoarding a symptom of obsessive-compulsive disorder?
- Are there any down sides to using anti-anxiety medications?
- How effective are herbal remedies, mindfulness meditation, and EMDR in the treatment of anxiety-related disorders?

1

Why Do We Panic?

"I was driving home after work," David reported. "Things had been very stressful there lately. I was tense but looking forward to getting home and relaxing. And then, all of a sudden – boom! My heart started racing, and I felt like I couldn't breathe. I was sweating and shaking. My thoughts were racing, and I was afraid that I was going crazy or having a heart attack. I pulled over and called my wife to take me to the emergency room."

David's fears turned out to be unjustified. An emergency room doctor told David, a composite of several therapy patients seen by one of us (Hal Arkowitz), that he was suffering from a panic attack.

The current edition of the *Diagnostic and Statistical Manual* (*DSM-5*) defines a panic attack as "An abrupt surge of intense fear or intense discomfort that reaches a peak within minutes." In addition, 4 out of a list of 13 symptoms must be present. Some of these symptoms are: trembling or shaking; sensation of shortness of breath or smothering chest pain or discomfort; feelings of unreality or detachment; and fears of dying or losing control and "going crazy." Most attacks occur without obvious provocation, making them even more terrifying. Some 8%–10% of the population experience an occasional attack, but only 5% develop panic

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disorder. Contrary to common misconception, these episodes aren't merely rushes of anxiety that most of us experience from time to time. Instead patients who have had a panic attack typically describe it as the most frightening event they have ever undergone.

Research has provided important leads to explain what causes a person's first panic attack – clues that can help ward off an attack in the first place. When stress builds up to a critical level, a very small additional amount of stress can trigger panic. As a result, the person may experience the event as coming out of the blue.

Some people may have a genetic predisposition toward panic, as psychologist Regina A. Shih, then at Johns Hopkins University, and her colleagues described in a review article. The disorder runs in families, and if one identical twin has panic disorder, the chance that the other one also has it is two to three times higher than for fraternal twins, who are genetically less similar. Although these findings do not rule out environmental factors, they do strongly suggest a genetic component.

Panic disorder imposes serious restrictions on patients' quality of life. They may be plagued by a persistent concern about the possibility of more attacks. Agoraphobia involves fear of specific situations in which escape might be difficult or help might not be available in the event of panic-like or other anxiety-related symptoms. The feared situations include using public transportation, being in enclosed places, and being outside of the home alone. In the most severe cases, sufferers may even become housebound.

From Normal Anxiety to Crippling Fear

What are the roots of these incapacitating panic attacks? Psychologist David H. Barlow of Boston University, who has conducted pioneering research on understanding and treating panic disorder and related disorders, and others believe that panic attacks result when our normal "fight-or-flight" response to imminent threats – including increased heart rate and rapid breathing – is triggered by "false alarms," situations in which real danger is absent. (In contrast, the same response in the face of a real danger is a "true alarm.")

When we experience true or false alarms, we tend to associate the biological and psychological reactions they elicit with cues that were

present at the time. These associations become "learned alarms" that can evoke further panic attacks.

Both external situations and internal bodily cues of arousal (such as increased breathing rate) can elicit a learned alarm. For example, some people experience panic attacks when they exercise because the physiological arousal leads to bodily sensations similar to those of a panic attack.

Why do some people experience only isolated attacks, whereas others develop full-blown panic disorder? Barlow has synthesized his research and that of others to develop an integrated theory of anxiety disorders, which states that certain predispositions are necessary to develop panic disorder:

- *a generalized biological vulnerability* toward anxiety, leading us to overreact to the events of daily life;
- *a generalized psychological vulnerability* to develop anxiety caused by early childhood learning (such as overprotection from our parents) that the world is a dangerous place and that stress is overwhelming and cannot be controlled;
- *a specific psychological vulnerability* in which we learn in childhood that some situations or objects are dangerous even if they are not.

Panic disorder develops when a person with these vulnerabilities experiences prolonged stress and a panic attack. The first attack activates the psychological vulnerabilities, creating a hypersensitivity to external and internal cues associated with the attack. As a result, even medication containing a mild stimulant can provoke an attack.

Still, there is good news. Two findings in particular can provide reassurance for those with panic disorder. The first is that all panic attacks are triggered by known events, even though the sufferer may be unaware of them. This knowledge can reduce the anxiety associated with the sense of unpredictability. Second, it can be reassuring to learn that a panic attack is a misfiring of the fight-or-flight response in the absence of danger.

Basic research not only has helped us understand panic disorder but also has led to effective treatments. In particular, Barlow and his associates developed panic-control treatment, described in their 2006 book *Mastery of Your Anxiety and Panic*. It involves education about panic

disorder and somewhat gradual exposure to the internal and external cues that trigger panic attacks, along with changing the catastrophic interpretations of bodily cues so that they no longer trigger the attacks. This treatment has in most instances surpassed drug therapies for the disorder over the long term.

Further Reading

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For a referral to a therapist in your area who uses panic-control treatment or similar treatments, contact the Center for Anxiety and Related Disorders at www.bu.edu/card or the Association for Behavioral and Cognitive Therapies at www.aabt.org.

2

Does Posttraumatic Stress Disorder Require Trauma?

Stress is an inevitable part of our life. Yet whether our daily hassles include the incessant gripes of a nasty boss or another hectoring letter from the Internal Revenue Service, we usually find some way of contending with them. In rare instances, though, terrifying events can overwhelm our coping capacities, leaving us psychologically paralyzed. In such cases, we may be at risk for posttraumatic stress disorder (PTSD).

PTSD is an anxiety disorder marked by flashbacks, nightmares, and other symptoms that impair everyday functioning. The disorder is widespread. At least in the United States, it is thought to affect about 8% of individuals at some point during their lifetime.

Although PTSD is one of the best known of all psychological disorders, it is also one of the most controversial. The intense psychological pain, even agony, experienced by sufferers is undeniably real. Yet the conditions under which PTSD occurs – in particular, the centrality of trauma as a trigger – have come increasingly into question. Mental health professionals have traditionally considered PTSD a typical, at times even ubiquitous, response to trauma. They have also regarded the disorder as distinct from other forms of anxiety spawned by life's slings and arrows. Still, recent data fuel doubts about both assumptions.

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