

The relevance of maintaining and worsening processes in psychopathology

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Abstract: The states called “psychopathology” are very diverse, but Lane et al.’s single-process explanation does little to account for this diversity. Moreover, some other crucial phenomena of psychopathology do not fit this theory: the role of negative evaluations of conscious emotions, and the role of emotions without physiological correlates. And it does not consider the processes maintaining disorders.

The target article proposes a unifying theory of psychopathology based on two hypotheses, one concerning the genesis of psychological disorders and the other concerning the psychotherapeutic process leading to change. We focus on the first hypothesis: Psychopathology depends on poor processing of emotions related to traumatic experiences. Four crucial phenomena do not fit this single-process explanation. First, the states called “psychopathology” are very diverse, but Lane et al.’s theory does little to account for this diversity. Indeed, how can a common cause yield a diversity of psychological illnesses? For example, if all psychopathologies are ascribable to the same sequence – trauma → no mentalization of the concomitant emotion → psychopathology – how can different psychological disorders occur? And why does one patient become borderline whereas another patient becomes agoraphobic?

Second, how does patients’ awareness of traumatic emotions contribute to psychopathological suffering? Many patients can be aware of traumatic emotions and even evaluate them negatively. This evaluation, not a lack of awareness, exacerbates their suffering. Anxious patients, for example, evaluate their fear as a proof of their weakness. Patients are depressed, for example, not only because they judge their retirement as a sign of uselessness, but also because they consider their lack of interest and energy as a further evidence of uselessness. Such ruminations about depressive symptoms are a key risk factor in clinical depression (Nolen-Hoeksema 1991; 2000). Patients are often disturbed about their disturbances (Ellis 1980) and unintentionally give themselves two problems for the price of one (Clark & Beck 2010; Dryden 2000).

Third, how does psychopathology arise from explicit components of emotions? In some cases, an awareness of an emotion and the safety-seeking behaviors that are elicited, such as avoidance of the feared object, can occur without any physiological correlates of the emotion itself (Mauss et al. 2003). This lack of correspondence between subjective reports of anxiety and physiological arousal in anxious patients is supported in a number of studies, showing a dissociation between state anxiety and physiological arousal (heart rate, blood pressure, noradrenaline, cortisol response), with the former being stronger compared with the latter (Alpers et al. 2003; Van Duinen et al. 2010).

Fourth, the theory in the target article fails to account for the persistence of psychological disorders. It does not consider research suggesting the existence of two classes of processes that maintain and worsen psychological disorders: those linked to cognitive processes (e.g., Harvey et al. 2004) and

those linked to interpersonal ones (e.g., Alden & Taylor 2004). Regarding cognitive processes, together with Johnson-Laird we have argued that psychological illnesses arise from pathological emotions, and different emotions lead to characteristic pathologies. Cognitive processes, such as reasoning, strive to reduce the impairments giving rise to the hyper emotions, but they often serve to maintain or exacerbate the illness (Johnson-Laird et al. 2006). A hypochondriac patient, for example, focuses on a danger, such as a bodily feeling, which leads to an unconscious transition to a great anxiety that he or she is seriously ill. The anxiety drives cognitive processes in a prudential way: The patient is more likely than others to attend to information related to the illness (see Owens et al. 2004), to identify harmless physical sensations as signs of serious illness (see Haenen et al. 1997), and to be biased toward confirming its occurrence (see de Jong et al. 1998; Gilbert 1998). The processes aimed at preventing harm have the opposite effect. They strengthen patients' beliefs that they are ill and help to maintain or increase the hypochondria. Likewise, patients suffering from anxiety, OCD, or depression use their emotions as a source of evaluations. If they feel anxious about something, they overestimate the danger (Arntz et al. 1995). This mechanism is common to those with a tendency to obsessive compulsions (Davey et al. 2003; Gangemi et al. 2007), and those suffering from depression (Kanary et al. 1997). This process too implies vicious circles that strengthen negative emotions, appraisal, and beliefs that cause these psychological disorders.

For the interpersonal processes, several studies have demonstrated that anxious people behave in ways that lead to negative reactions from other people, thus establishing dysfunctional interpersonal cycles between themselves and others (Clark 2001). These interpersonal cycles could be responsible for the maintenance of the disorders. For example, people with social anxiety and with social phobia display distinctive and less-functional social behavior (i.e., anger, criticism, dependency) than people without those conditions (Alden & Taylor 2004). They also fail to reciprocate others' self-disclosures, a strategy that led others to perceive targets as dissimilar and uninterested in them, factors that weigh heavily in relationship formation (Alden & Bieling 1998; Papsdorf & Alden 1998). Depression is also associated with negative social responses (Alden et al. 1995). Segrin (2001) found for example, a relationship between social skills deficits and interpersonal connections as maintaining factors of depression.

In sum, the sequence of events following traumas, including inadequate emotional reactions, may lead to certain psychological illnesses. But, other factors matter too. They include the nature of the emotions themselves, which tend to characterize different illnesses; the subjective experience of emotions, which, even in the absence of physiological reactions, can contribute to illnesses; the differences in how individuals react to emotions; the interplay between their emotions and cognitions; and interpersonal processes in maintaining illnesses.