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PSY 300 Abnormal Psychology

PSY 300 Abnormal Psychology

Exploring the Continuum of Mental
Health

Jorden A. Cummings and Stephanie
Weigel

Stephanie Weigel; Herkimer
Community College; Alexis Bridley &
Lee W. Daffin Jr.; and Bill Pelz



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Abnormal Psychology

This textbook was created using open source materials for the use in PSY 300 Abnormal Psychology at Fort Hays State University.

STEPHANIE WEIGEL

About the Book

JORDEN A. CUMMINGS

OVERVIEW

Abnormal Psychology, by Jorden A. Cummings (Associate Professor, Department of Psychology, University of Saskatchewan), has been created from a combination of original content and materials compiled and adapted from several **open educational resources (OERs)**, including Source Chapters from:

- *Essentials of Abnormal Psychology – 1st edition*, by Bridley & Daffin, edited by Carrie Cuttler, available at <https://opentext.wsu.edu/abnormalpsychology/> and licensed under a [Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License](#).

- *Psychology: Open Stax*, by Spielman, R. M., Dumper, K., Jenkins, W., Lacombe, A., Lovett, M., & Perlmutter, M. (2019), available at <https://opentextbc.ca/psychologyopenstax/> and licensed under a [Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License](https://creativecommons.org/licenses/by-nc-sa/4.0/).
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The *Self-Tests* provided with each chapter are a new addition for this book; these were created using the [H5P plugin for WordPress](#), and are available for others to download and use in their own instances of WordPress or Pressbooks.

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COVER ATTRIBUTION

Cover image by [Steve Johnson](#) on [Unsplash](#). Cover design by Rob Butz

Source OER Attributions

JORDEN A. CUMMINGS

Authors are indicated within each section throughout this book, but are also listed here, along with links to the original source OER. Edits to the ported content, where they have taken place, are indicated on the list shown here. General formatting edits and renumbering of headings, figures, and tables have also been done throughout the book.

The chapter *Introductions*, *Summaries*, and *Self-Tests* have been created from a combination of original content and edits to / rearrangements of the source OERs used within that chapter.

Chapter 1:

- 1.1 Defining Psychopathology
 - Based upon: “Understanding Abnormal Behavior.” Bridley, A. and Daffin, L. W.

Abnormal Psychology

Jr. (2018). In Carrie Cuttler (Ed),
Essentials of Abnormal Psychology.
Washington State University. Retrieved
from [https://opentext.wsu.edu/
abnormalpsychology/](https://opentext.wsu.edu/abnormalpsychology/).

- Edited by Jorden Cummings & Jessica Campoli (removed Types of Mental Health Professionals; added Canadian content).
- 1.2 Cultural Expectations
 - Taken from: “What Are Psychological Disorders?” In Spielman, R. M., Dumper, K., Jenkins, W., Lacombe, A., Lovett, M., & Perlmutter, M. (2019).
Psychology. Open Stax. Retrieved from
[https://opentextbc.ca/
psychologyopenstax/](https://opentextbc.ca/psychologyopenstax/)
- 1.3 Clinical Assessment
 - Taken from: “Clinical Assessment.”
Bridley, A. and Daffin, L. W. Jr. (2018).
In Carrie Cuttler (Ed), *Essentials of
Abnormal Psychology*. Washington State
University. Retrieved from
[https://opentext.wsu.edu/
abnormalpsychology/](https://opentext.wsu.edu/abnormalpsychology/)
- 1.4 Diagnosing and Classifying Abnormal

Behaviour

- Based upon: “Diagnosing and Classifying Abnormal Behaviour.” Bridley, A. and Daffin, L. W. Jr. (2018). In Carrie Cuttler (Ed), *Essentials of Abnormal Psychology*. Washington State University. Retrieved from <https://opentext.wsu.edu/abnormalpsychology/>.
- Edited by Jordan Cummings (updated information regarding ICD-11).

Chapter 2:

- 2.1 Historical Perspectives on Mental Illness
 - Based upon: “Historical Perspectives on Mental Illness.” Bridley, A. and Daffin, L. W. Jr. (2018). In Carrie Cuttler (Ed), *Essentials of Abnormal Psychology*. Washington State University. Retrieved from <https://opentext.wsu.edu/abnormalpsychology/>.
 - Edited by Jordan Cummings (removed material from section 1.3.6).
- 2.2 Therapeutic Orientations
 - Based upon: “Therapeutic Orientations.” Boettcher, H., Hofmann, S. G., & Wu, Q. J. (2020). In R. Biswas-Diener & E.

Diener (Eds), *Noba textbook series: Psychology*. Champaign, IL: DEF publishers. Retrieved from <http://noba.to/ftnpwsk>

- Based upon: “The Behavioural Model” and “The Cognitive Model.” Bridley, A. and Daffin, L. W. Jr. (2018). In Carrie Cuttler (Ed), *Essentials of Abnormal Psychology*. Washington State University. Retrieved from <https://opentext.wsu.edu/abnormalpsychology/>
- Edited by Jordan Cummings.
- 2.3 The Biological Model.
 - Taken from: “The Biological Model.” Bridley, A. and Daffin, L. W. Jr. (2018). In Carrie Cuttler (Ed), *Essentials of Abnormal Psychology*. Washington State University. Retrieved from <https://opentext.wsu.edu/abnormalpsychology/>
- 2.4 Psychopharmacology.
 - Taken from: “Psychopharmacology.” Barron, S. (2020). In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology*. Champaign, IL: DEF publishers. Retrieved from <http://noba.to/>

[umx6f2t8](#)

- 2.5 Evidence-Based Practice & Empirically Supported Treatments.
 - Original content by Cailey Strauss and Jordan A. Cummings.

Chapter 3:

- 3.1 Mood Disorders
 - Based upon: “Mood Disorders.” Gershon, A. & Thompson, R. (2020). In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology*. Champaign, IL: DEF publishers. Retrieved from <http://noba.to/aqy9rsxe>
 - Edited by Jordan Cummings (added Canadian content).

Chapter 4:

- 4.1 Anxiety and Related Disorders.
 - Based upon: “Anxiety and Related Disorders.” Barlow, D. H. & Ellard, K. K. (2020). In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology*. Champaign, IL: DEF publishers. Retrieved from <http://noba.to/xms3nq2c>.

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- Edited by Jorden Cummings, Kendal Deleurme, and Jessica Campoli (PTSD section removed; added Canadian content).
- 4.2 Body Dysmorphic Disorder.
 - Taken from: “Body Dysmorphic Disorder.” Bridley, A. and Daffin, L. W. Jr. (2018). In Carrie Cuttler (Ed), *Essentials of Abnormal Psychology*. Washington State University. Retrieved from <https://opentext.wsu.edu/abnormalpsychology/>

Chapter 5:

- 5.1 Schizophrenia Spectrum Disorders.
 - Based upon: “Schizophrenia Spectrum Disorders.” Barch, D. M. (2020). Schizophrenia spectrum disorders. In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology*. Champaign, IL: DEF publishers. Retrieved from <http://noba.to/5d98nsy4>
 - Edited by Jorden Cummings (added Canadian content).

Chapter 6:

- Original content, written by Jordan Cummings, Jessica Campoli, Kelsi Toews, and Whitney Willcott-Benoit.

Chapter 7:

- 7.1 ADHD and Behavior Disorders in Children
 - Based upon: “ADHD and Behavior Disorders in Children.” Milich, R. & Roberts, W. (2020). In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology*. Champaign, IL: DEF publishers. Retrieved from <http://noba.to/cpxg6b27>
 - Edited by Jordan Cummings and Jessica Campoli (added Canadian content).

Chapter 8:

- 8.1 Autism: Insights from the Study of the Social Brain
 - Based upon: “Autism: Insights from the Study of the Social Brain.” Pelphrey, K. A. (2020). In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology*. Champaign, IL: DEF publishers. Retrieved from <http://noba.to/yqdepwgt>

- Edited by Jessica Campoli (added Canadian content).

Chapter 9:

- 9.1 Personality Disorders
 - Based upon: “Personality Disorders.” Crego, C. & Widiger, T. (2020). In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology*. Champaign, IL: DEF publishers. Retrieved from <http://noba.to/67mvg5r2>
 - Edited by Jordan Cummings & Cailey Strauss (added DSM-5 descriptions of Clusters and symptoms of each personality disorder).

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JORDEN A. CUMMINGS

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-Jordan A. Cummings (June 15, 2020)

STEPHANIE WEIGEL

PART I

Chapter 1: Defining
& Classifying
Abnormal
Behaviour

STEPHANIE WEIGEL

Chapter 1 Introduction

JORDEN A. CUMMINGS

Welcome to Abnormal Psychology! As you'll read more about in this chapter, abnormal psychology refers to the scientific study of people who are exhibiting behaviour that seems atypical or unusual, with the intent to be able to reliably predict, explain, diagnose, identify the causes of, and treat maladaptive behavior. Abnormal psychology is one of the largest sub-fields in psychology, representing a great deal of research and applied work trying to understand and cure mental disorders. As you will see from the first part of this chapter, and as you learn more in this book, the costs of mental illness are substantial.

This chapter will introduce you broadly to important

concepts, definitions, and terminology in abnormal psychology that will frame the rest of your learning. It reviews how to define mental disorder as well as the strengths and limitations of our current diagnostic approaches. You'll read, as well, about how culture and cultural expectations influence our views on abnormality. We cannot examine abnormality without taking cultural norms into account.

In this chapter you will also learn about how mental health professionals assess individuals who might be experiencing a mental disorder, some important concepts for measurement like validity and reliability, and read an overview of some of the many different tools these professionals use to conduct their assessments. Last, you'll learn how these professionals diagnose and classify abnormal behaviour.

1.1 Defining Psychopathology

ALEXIS BRIDLEY & LEE W. DAFFIN JR.;
CARRIE CUTTLER; JESSICA CAMPOLI; AND
JORDEN A. CUMMINGS

Section Learning Objectives

- Know the cost of mental illness to society.
- Define abnormal psychology, psychopathology, and psychological disorders.
- Explain the concept of dysfunction as it relates to mental illness.
- Explain the concept of distress as it relates to mental illness.
- Explain the concept of deviance as it relates to mental illness.

- Explain the concept of dangerousness as it relates to mental illness.

WHAT IS THE COST OF MENTAL ILLNESS TO SOCIETY?

Mental illness has significant social and economic costs in Canada. People with mental illness are more likely to experience social and economic marginalization, including social isolation, inability to work, and lower educational attainment and income, compared to Canadians who do not have a mental illness (Burczycka, 2018). People with mental illness also have a higher risk of being victimized. One in ten people with mental health-related disabilities in Canada report experiencing violence over the past year, a rate that is double that found in the general population (Burczycka, 2018). Moreover, mental illness can significantly impact people's ability to work. It is estimated that 2 out of 9 workers suffer from a mental illness that affects their work performance, and this amounts to an annual wage loss of over \$6.3 billion (Smetanin et al., 2011).

Each year, the economic burnout of mental illness in Canada is estimated at \$51 billion (Smetanin et al., 2011). Mental illness significantly impacts the health care system directly and indirectly. Directly, there are costs of about \$21.3 billion due to hospitalizations, medical visits, and support

staff (Smetanin et al., 2011). There are also indirect costs to the justice system, social service and education systems, and other costs due to losses in quality of life. The personal and economic costs of mental illness will further increase due to greater numbers of Canadians expected to be impacted by mental health problems, combined with our aging population and growth of the Canadian population over the next 30 years (Smetanin et al., 2011). By 2041, annual costs of mental illness are expected to be \$307 billion (Mental Health Commission of Canada, 2010).

In terms of worldwide impact, the World Economic Forum used 2010 data to estimate \$2.5 trillion in global costs of mental illness in 2010 and projected costs of \$6 trillion by 2030. The costs for mental illness are greater than the combined costs of cancer, diabetes, and respiratory disorders (Whiteford et al., 2013).

Though there is no one behavior that we can use to classify people as abnormal, most clinical practitioners agree that any behavior that strays from what is considered the norm or is unexpected within the confines of one's culture, that causes dysfunction in cognition, emotion, and/or behavior, and that causes distress and/or impairment in functioning, is abnormal behavior. Armed with this understanding, let's discuss what mental disorders are.

DEFINITION OF ABNORMAL PSYCHOLOGY AND PSYCHOPATHOLOGY

The term **abnormal psychology** refers to the scientific study

of people who are atypical or unusual, with the intent to be able to reliably predict, explain, diagnose, identify the causes of, and treat maladaptive behavior. A more sensitive and less stigmatizing term that is used to refer to the scientific study of psychological disorders is **psychopathology**. These definitions beg the questions of, what is considered abnormal and what is a psychological or mental disorder?

DEFINING PSYCHOLOGICAL DISORDERS

It may be surprising to you, but the concept of mental or psychological disorders has proven very difficult to define and even the American Psychiatric Association (APA), in its publication, the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5 for short), states that though “no definition can capture all aspects of all disorders in the range contained in the DSM-5” certain aspects are required. While the concept of mental or psychological disorders is difficult to define, and no definition will ever be perfect, it is recognized as an extremely important concept and therefore **psychological disorders** (aka **mental disorders**) have been defined as a psychological dysfunction which causes distress or impaired functioning and deviates from typical or expected behavior according to societal or cultural standards. This definition includes three components (3 Ds). Let’s break these down now:

- **Dysfunction** – includes “clinically significant disturbance in an individual’s cognition, emotion

regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning” (pg. 20). In other words, dysfunction refers to a breakdown in **cognition, emotion, and/or behavior**. For instance, an individual experiencing delusions that he is an omnipotent deity would have a breakdown in cognition because his thought processes are not consistent with reality. An individual who is unable to experience pleasure would have a breakdown in emotion. Finally, an individual who is unable to leave her home and attend work due to fear of having a panic attack would be exhibiting a breakdown in behavior. Abnormal behavior has the capacity to make our well-being difficult to obtain and can be assessed by looking at an individual’s current performance and comparing it to what is expected in general or how the person has performed in the past.

- **Distress or Impairment** – **Distress** can take the form of psychological or physical pain, or both concurrently. Simply put, distress refers to suffering. Alone though, distress is not sufficient enough to describe behavior as abnormal. Why is that? The loss of a loved one would cause even the most “normally” functioning individual pain and suffering. An athlete who experiences a career-ending injury would display distress as well.

Suffering is part of life and cannot be avoided. And some people who display abnormal behavior are generally positive while doing so. Typically, if distress is absent then impairment must be present to deem behavior abnormal. **Impairment** refers to when the person experiences a disabling condition “in social, occupational, or other important activities” (pg. 20). In other words, impairment refers to when a person loses the capacity to function normally in daily life (e.g., can no longer maintain minimum standards of hygiene, pay bills, attend social functions, or go to work). Once again typically distress and/or impairment in functioning are required to consider behavior abnormal and to diagnose a psychological disorder.

- **Deviance** – A closer examination of the word abnormal shows that it indicates a move away from what is normal, typical, or average. Our **culture** – or the totality of socially transmitted behaviors, customs, values, technology, attitudes, beliefs, art, and other products that are particular to a group – determines what is normal and so a person is said to be deviant when he or she fails to follow the stated and unstated rules of society, called **social norms**. What is considered “normal” by society can change over time due to shifts in accepted values and expectations. For instance, just a few decades ago homosexuality was considered taboo

in the U.S. and it was included as a mental disorder in the first edition of the DSM; but today, it is generally accepted. Likewise, PDAs, or public displays of affection, do not cause a second look by most people unlike the past when these outward expressions of love were restricted to the privacy of one's own house or bedroom. In the U.S., crying is generally seen as a weakness for males but if the behavior occurs in the context of a tragedy such as the Vegas mass shooting on October 1, 2017, in which 58 people were killed and about 500 were wounded, then it is appropriate and understandable. Finally, consider that statistically deviant behavior is not necessarily negative. Genius is an example of behavior that is not the norm, but it is generally considered a positive attribute rather than a negative one.

Though not part of the DSM 5's conceptualization of what abnormal behavior is, many clinicians add a 4th D – dangerousness to this list. **Dangerousness** refers to when behavior represents a threat to the safety of the person or others. Individuals expressing suicidal intent, those experiencing acute paranoid ideation combined with aggressive impulses (e.g., wanting to harm people who are perceived as “being out to get them”), and many individuals with antisocial personality disorder may be considered dangerous. Mental health professionals (and many other professionals including researchers) have a duty to report to

law enforcement when an individual expresses an intent to harm themselves or others. Nevertheless, individuals with depression, anxiety, and obsessive-compulsive disorder are typically no more a threat to others than individuals without these disorders. As such, it is important to note that having a mental disorder does not automatically deem one to be dangerous and most dangerous individuals are not mentally ill. Indeed, a review of the literature (Matthias & Angermeyer, 2002) found that only a small proportion of crimes are committed by individuals with severe mental disorders, that strangers are at a lower risk of being attacked by a person with a severe mental disorder than by someone who is mentally healthy, and that elevated risks to behave violently are limited to a small number of symptom constellations. Similarly, Hiday and Burns (2010) showed that dangerousness is more the exception than the rule.

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1.2 Cultural Expectations

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Section Learning Objectives

- Understand the cultural problems inherent in defining the concept of psychological disorder

CULTURAL EXPECTATIONS

Violating cultural expectations is not, in and of itself, a satisfactory means of identifying the presence of a psychological disorder. Since behavior varies from one

culture to another, what may be expected and considered appropriate in one culture may not be viewed as such in other cultures. For example, returning a stranger's smile is expected in the United States because a pervasive social norm dictates that we reciprocate friendly gestures. A person who refuses to acknowledge such gestures might be considered socially awkward—perhaps even disordered—for violating this expectation. However, such expectations are not universally shared. Cultural expectations in Japan involve showing reserve, restraint, and a concern for maintaining privacy around strangers. Japanese people are generally unresponsive to smiles from strangers (Patterson et al., 2007). Eye contact provides another example. In the United States and Europe, eye contact with others typically signifies honesty and attention. However, most Latin-American, Asian, and African cultures interpret direct eye contact as rude, confrontational, and aggressive (Pazain, 2010). Thus, someone who makes eye contact with you could be considered appropriate and respectful or brazen and offensive, depending on your culture.



Eye contact is one of many social gestures that vary from culture to culture. (credit: Joi Ito)

Hallucinations (seeing or hearing things that are not physically present) in Western societies is a violation of cultural expectations, and a person who reports such inner experiences is readily labeled as psychologically disordered. In other cultures, visions that, for example, pertain to future events may be regarded as normal experiences that are positively valued (Bourguignon, 1970). Finally, it is important to recognize that cultural norms change over time: what might be considered typical in a society at one time may no longer be viewed this way later, similar to how fashion trends from one era may elicit quizzical looks decades later—imagine how a headband, legwarmers, and the big hair of the 1980s would go over on your campus today.

The Myth of Mental Illness

In the 1950s and 1960s, the concept of mental illness was widely criticized. One of the major criticisms focused on the notion that mental illness was a “myth that justifies psychiatric intervention in socially disapproved behavior” (Wakefield, 1992). Thomas Szasz (1960), a noted psychiatrist, was perhaps the biggest proponent of this view. Szasz argued that the notion of mental illness was invented by society (and the mental health establishment) to stigmatize and subjugate people whose behavior violates accepted social and legal norms. Indeed, Szasz suggested that what appear to be symptoms of mental illness are more appropriately characterized as “problems in living” (Szasz, 1960).

In his 1961 book, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, Szasz expressed his disdain for the concept of mental illness and for the field of psychiatry in general (Oliver, 2006). The basis for Szasz’s attack was his contention that detectable abnormalities in bodily structures and functions (e.g., infections and organ damage or dysfunction) represent the defining features of genuine illness or disease, and because symptoms of purported mental illness

are not accompanied by such detectable abnormalities, so-called psychological disorders are not disorders at all. Szasz (1961/2010) proclaimed that “disease or illness can only affect the body; hence, there can be no mental illness” (p. 267).

Today, we recognize the extreme level of psychological suffering experienced by people with psychological disorders: the painful thoughts and feelings they experience, the disordered behavior they demonstrate, and the levels of distress and impairment they exhibit. This makes it very difficult to deny the reality of mental illness.

However controversial Szasz’s views and those of his supporters might have been, they have influenced the mental health community and society in several ways. First, lay people, politicians, and professionals now often refer to mental illness as mental health “problems,” implicitly acknowledging the “problems in living” perspective Szasz described (Buchanan-Barker & Barker, 2009). Also influential was Szasz’s view of homosexuality. Szasz was perhaps the first psychiatrist to openly challenge the idea that homosexuality represented a form of mental illness or disease (Szasz, 1965). By challenging the idea that homosexuality represented a form a mental illness, Szasz helped pave the way for the social and civil rights that gay and lesbian people now have (Barker, 2010). His work also inspired legal changes that protect the rights of people in psychiatric institutions and allow such individuals a greater degree of influence and responsibility over their lives (Buchanan-Barker & Barker, 2009).

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1.3 Clinical Assessment

ALEXIS BRIDLEY & LEE W. DAFFIN JR. AND
CARRIE CUTTLER

Section Learning Objectives

- Define clinical assessment.
- Clarify why clinical assessment is an ongoing process.
- Define and exemplify reliability.
- Define and exemplify validity.
- Define standardization.
- List and describe six methods of assessment.

WHAT IS CLINICAL ASSESSMENT?

In order for a mental health professional to be able to effectively treat a client and know that the selected treatment actually worked (or is working), he/she first must engage in the clinical assessment of the client. **Clinical assessment** refers to collecting information and drawing conclusions through the use of observation, psychological tests, neurological tests, and interviews to determine what the person's problem is and what symptoms he/she is presenting with. This collection of information involves learning about the client's skills, abilities, personality characteristics, cognitive and emotional functioning, social context (e.g., environmental stressors), and cultural factors particular to them such as their language or ethnicity. Clinical assessment is not just conducted at the beginning of the process of seeking help but all throughout the process. Why is that?

Consider this. First, we need to determine if a treatment is even needed. By having a clear accounting of the person's symptoms and how they affect daily functioning we can determine to what extent the individual is adversely affected. Assuming treatment is needed, our second reason to engage in clinical assessment is to determine what treatment will work best. As you will see later in this chapter, there are numerous approaches to treatment. These include Behavior Therapy, Cognitive Therapy, Cognitive-Behavioral Therapy (CBT), Humanistic-Experiential Therapies, Psychodynamic Therapies, Couples and Family Therapy, and biological treatments (e.g., psychopharmacology). Of course, for any

mental disorder, some of the aforementioned therapies will have greater efficacy than others. Even if several can work well, it does not mean a particular therapy will work well for that specific client. Assessment can help the clinician figure this out. Finally, we need to know if the treatment worked. This will involve measuring symptoms and behavior before any treatment is used and then measuring symptoms and behavior while the treatment is in place. We will even want to measure symptoms and behavior after the treatment ends to make sure symptoms do not return. Knowing what the person's baselines are for different aspects of psychological functioning will help us to see when improvement occurs. In recap, obtaining the baselines happens in the beginning, implementing the treatment plan happens more so in the middle, and then making sure the treatment produces the desired outcome occurs at the end. It should be clear from this discussion that clinical assessment is an *ongoing* process.

KEY CONCEPTS IN ASSESSMENT

Important to the assessment process are three critical concepts – reliability, validity, and standardization. Actually, these three are important to science in general. First, we want assessment to be **reliable** or consistent. Outside of clinical assessment, when our car has an issue and we take it to the mechanic, we want to make sure that what one mechanic says is wrong with our car is the same as what another says or even two others. If not, the measurement tools they use to assess cars are flawed. The same is true of a patient

who is experiencing a mental disorder. If one mental health professional says the person has major depressive disorder and another says the issue is borderline personality disorder, then there is an issue with the assessment tool being used. Ensuring that two different raters (e.g., mechanics, mental health professionals) are consistent in their assessments is called *interrater reliability*. Another type of reliability occurs when a person takes a test one day, and then the same test on another day. We would expect the person's answers to be consistent with one another, which is called *test-retest reliability*. An example is if the person takes the Minnesota Multiphasic Personality Inventory (MMPI) on Tuesday and then the same test on Friday, then unless something miraculous or tragic happened over the two days in between tests, the scores on the MMPI should be nearly identical to one another. In other words, the two scores (test and retest) should be correlated with one another. If the test is reliable, the correlation should be very high (remember, a correlation goes from -1.00 to +1.00 and positive means as one score goes up, so does the other, so the correlation for the two tests should be high on the positive side).

In addition to reliability, we want to make sure the test measures what it says it measures. This is called **validity**. Let's say a new test is developed to measure symptoms of depression. It is compared against an existing, and proven test, such as the Beck Depression Inventory (BDI). If the new test measures depression, then the scores on it should be highly correlated with the ones obtained by the BDI. This

is called *concurrent* or *descriptive validity*. We might even ask if an assessment tool looks valid. If we answer yes, then it has *face* validity, though it should be noted that this is not based on any statistical or evidence-based method of assessing validity. An example would be a personality test that asks about how people behave in certain situations. It, therefore, seems to measure personality or we have an overall feeling that it measures what we expect it to measure.

A tool should also be able to accurately predict what will happen in the future, called *predictive validity*. Let's say we want to tell if a high school student will do well in college. We might create a national exam to test needed skills and call it something like the Scholastic Aptitude Test (SAT). We would have high school students take it by their senior year and then wait until they are in college for a few years and see how they are doing. If they did well on the SAT, we would expect that at that point, they should be doing well in college. If so, then the SAT accurately predicts college success. The same would be true of a test such as the Graduate Record Exam (GRE) and its ability to predict graduate school performance.

Finally, we want to make sure that the experience one patient has when taking a test or being assessed is the same as another patient taking the test the same day or on a different day, and with either the same tester or another tester. This is accomplished with the use of clearly laid out rules, norms, and/or procedures, and is called **standardization**. Equally important is that mental health professionals interpret the

results of the testing in the same way or otherwise it will be unclear what the meaning of a specific score is.

METHODS OF ASSESSMENT

So how do we assess patients in our care? We will discuss psychological tests, neurological tests, the clinical interview, behavioral assessment, and a few others in this section.

THE CLINICAL INTERVIEW

A clinical interview is a face-to-face encounter between a mental health professional and a patient in which the former observes the latter and gathers data about the person's behavior, attitudes, current situation, personality, and life history. The interview may be *unstructured* in which open-ended questions are asked, *structured* in which a specific set of questions according to an interview schedule are asked, or *semi-structured*, in which there is a pre-set list of questions but clinicians are able to follow up on specific issues that catch their attention.

A **mental status examination** is used to organize the information collected during the interview and to systematically evaluate the client through a series of observations and questions assessing appearance and behavior (e.g., grooming and body language), thought processes and content (e.g., disorganized speech or thought and false beliefs), mood and affect (e.g., hopelessness or elation), intellectual functioning (e.g., speech and memory), and

awareness of surroundings (e.g., does the client know where he/she is, when it is, and who he/she is?). The exam covers areas not normally part of the interview and allows the mental health professional to determine which areas need to be examined further. The limitation of the interview is that it lacks reliability, especially in the case of the unstructured interview.

PSYCHOLOGICAL TESTS AND INVENTORIES

Psychological tests are used to assess the client's personality, social skills, cognitive abilities, emotions, behavioral responses, or interests and can be administered either individually or to groups. **Projective tests** consist of simple ambiguous stimuli that can elicit an unlimited number of responses. They include the Rorschach test or inkblot test and the **Thematic Apperception Test** which requires the individual to write a complete story about each of 20 cards shown to them and give details about what led up to the scene depicted, what the characters are thinking, what they are doing, and what the outcome will be. From these responses, the clinician gains perspective on the patient's worries, needs, emotions, conflicts. Another projective test is the *sentence completion test* and asks individuals to finish an incomplete sentence. Examples include 'My mother' or 'I hope.'

Personality inventories ask clients to state whether each item in a long list of statements applies to them, and could ask about feelings, behaviors, or beliefs. Examples include the MMPI or Minnesota Multiphasic Personality Inventory

and the NEO-PI-R which is a concise measure of the five major domains of personality – Neuroticism, Extroversion, Openness, Agreeableness, and Conscientiousness. Six facets define each of the five domains and the measure assesses emotional, interpersonal, experimental, attitudinal, and motivational styles (Costa & McCrae, 1992). These inventories have the advantage of being easy to administer by either a professional or the individual taking it, are standardized, objectively scored, and are completed either on the computer or through paper and pencil. That said, personality cannot be directly assessed and so you can never completely know the individual on the basis of these inventories.

NEUROLOGICAL TESTS

Neurological tests are also used to diagnose cognitive impairments caused by brain damage due to tumors, infections, or head injury; or changes in brain activity. *Positron Emission Tomography or PET* is used to study the brain's functioning and begins by injecting the patient with a radionuclide which collects in the brain. Patients then lie on a scanning table while a ring-shaped machine is positioned over their head. Images are produced that yield information about the functioning of the brain. *Magnetic Resonance Imaging or MRI* produces 3D images of the brain or other body structures using magnetic fields and computers. They are used to detect structural abnormalities such as brain and spinal cord tumors or nervous system disorders such as

multiple sclerosis. Finally, *computed tomography* or the *CT scan* involves taking X-rays of the brain at different angles that are then combined. They are used to detect structural abnormalities such as brain tumors and brain damage caused by head injuries.

PHYSICAL EXAMINATION

Many mental health professionals recommend the patient see their family physician for a physical examination which is much like a check-up. Why is that? Some organic conditions, such as hyperthyroidism or hormonal irregularities, manifest behavioral symptoms that are similar to mental disorders and so ruling such conditions out can save costly therapy or surgery.

BEHAVIORAL ASSESSMENT

Within the realm of behavior modification and applied behavior analysis, is **behavioral assessment** which is simply the measurement of a target behavior. The **target behavior** is whatever behavior we want to change and it can be in excess (needing to be reduced), or in a deficit state (needing to be increased). During behavioral assessment we assess the ABCs of behavior:

- **Antecedents** are the environmental events or stimuli that trigger a behavior
- **Behaviors** are what the person does, says, thinks/feels; and

- **Consequences** are the outcome of a behavior that either encourages it to be made again in the future or discourages its future occurrence.

Though we might try to change another person's behavior using behavior modification, we can also change our own behavior using **self-monitoring** which refers to measuring and recording one's own ABCs. In the context of psychopathology, behavior modification can be useful in treating phobias, reducing habit disorders, and ridding the person of maladaptive cognitions.

A limitation of this method is that the process of observing and/or recording a behavior can cause the behavior to change, called **reactivity**. Have you ever noticed someone staring at you while you sat and ate your lunch? If you have, what did you do? Did you change your behavior? Did you become self-conscious? Likely yes and this is an example of reactivity. Another issue is that the behavior that is made in one situation may not be made in other situations, such as your significant other only acting out at their favorite team's football game and not at home. This form of validity that is impacted by situational variation is called **cross-sectional validity**.

INTELLIGENCE TESTS

Intelligence testing is occasionally used to determine the client's level of cognitive functioning. Intelligence testing consists of a series of tasks asking the patient to use both

verbal and nonverbal skills. An example is the Stanford-Binet Intelligence test which is used to assess fluid reasoning, knowledge, quantitative reasoning, visual-spatial processing and working memory. These tests are rather time-consuming and require specialized training to administer. As such, they are typically only used in cases where there is a suspected cognitive disorder or intellectual disability. Intelligence tests have been criticized for not predicting future behaviors such as achievement and reflecting social or cultural factors/biases and not actual intelligence.

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1.4 Diagnosing and Classifying Abnormal Behavior

ALEXIS BRIDLEY & LEE W. DAFFIN JR.;
CARRIE CUTTLER; AND JORDEN A. CUMMINGS

Section Learning Objectives

- Explain what it means to make a clinical diagnosis.
- Define syndrome.
- Clarify and exemplify what a classification system does.
- Identify the two most used classification systems.
- Outline the history of the DSM.
- Identify and explain the elements of a diagnosis.

- Outline the major disorder categories of the DSM-5.
- Describe the ICD-11.
- Clarify why the DSM-5 and ICD-11 need to be harmonized.

CLINICAL DIAGNOSIS AND CLASSIFICATION SYSTEMS

To begin any type of treatment, the client/patient must be clearly diagnosed with a mental disorder. **Clinical diagnosis** is the process of using assessment data to determine if the pattern of symptoms the person presents with is consistent with the diagnostic criteria for a specific mental disorder set forth in an established classification system such as the DSM-5 or ICD-10 (both will be described shortly). Any diagnosis should have clinical utility, meaning it aids the mental health professional in determining the prognosis, the treatment plan, and possible outcomes of treatment (APA, 2013). Receiving a diagnosis does not necessarily mean the person requires treatment. This decision is made based upon how severe the symptoms are, the level of distress caused by the symptoms, symptom salience such as expressing suicidal ideation, risks and benefits of treatment, disability, and other factors (APA,

2013). Likewise, a patient may not meet full criteria for a diagnosis but require treatment nonetheless.

Symptoms that cluster together on a regular basis are called a **syndrome**. If they also follow the same, predictable course, we say that they are characteristic of a *specific disorder*. **Classification systems** for mental disorders provide mental health professionals with an agreed upon list of disorders falling in distinct categories for which there are clear descriptions and criteria for making a diagnosis. Distinct is the key word here. People experiencing delusions, hallucinations, disorganized speech, catatonia, and/or negative symptoms are different from people presenting with a primary clinical deficit in cognitive functioning that is not developmental in nature but has been acquired (i.e. they have shown a decline in cognitive functioning over time). The former would likely be diagnosed with a schizophrenia spectrum disorder while the latter likely has a neurocognitive disorder (NCD). The latter can be further distinguished from neurodevelopmental disorders which manifest early in development and involve developmental deficits that cause impairments in social, academic, or occupational functioning (APA, 2013). These three disorder groups or categories can be clearly distinguished from one another. Classification systems also permit the gathering of statistics for the purpose of determining incidence and prevalence rates, they facilitate research on the etiology and treatment of disorders, and they conform to the requirements of insurance companies for the payment of claims.

The most widely used classification system in the United States and Canada is the *Diagnostic and Statistical Manual of Mental Disorders* currently in its 5th edition and produced by the American Psychiatric Association (APA, 2013). Alternatively, the World Health Organization (WHO) produces the *International Statistical Classification of Diseases and Related Health Problems (ICD)* currently in its 10th edition with an 11th edition expected to be published in 2018. We will begin by discussing the DSM and then move to the ICD.

THE DSM CLASSIFICATION SYSTEM

A BRIEF HISTORY OF THE DSM

The DSM 5 was published in 2013 and took the place of the DSM IV-TR (TR means Text Revision; published in 2000) but the history of the DSM goes back to 1844 when the American Psychiatric Association published a predecessor of the DSM which was a “statistical classification of institutionalized mental patients” and “...was designed to improve communication about the types of patients cared for in these hospitals” (APA, 2013, p. 6). However, the first official version of the DSM was not published until 1952. The DSM evolved through four subsequent editions after World War II into a diagnostic classification system to be used by psychiatrists and physicians, but also other mental health professionals. The Herculean task of revising the DSM IV-TR began in 1999 when the APA embarked upon an evaluation of the strengths and weaknesses of the DSM in

coordination with the World Health Organization (WHO) Division of Mental Health, the World Psychiatric Association, and the National Institute of Mental Health (NIMH). This resulted in the publication of a monograph in 2002 called, *A Research Agenda for DSM-V*. From 2003 to 2008, the APA, WHO, NIMH, the National Institute on Drug Abuse (NIDA), and the National Institute on Alcoholism and Alcohol Abuse (NIAAA) convened 13 international DSM-5 research planning conferences, “to review the world literature in specific diagnostic areas to prepare for revisions in developing both DSM-5 and the International Classification of Disease, 11th Revision (ICD-11)” (APA, 2013).

After the naming of a DSM-5 Task Force Chair and Vice-Chair in 2006, task force members were selected and approved by 2007 and workgroup members were approved in 2008. What resulted from this was an intensive process of “conducting literature reviews and secondary analyses, publishing research reports in scientific journals, developing draft diagnostic criteria, posting preliminary drafts on the DSM-5 Web site for public comment, presenting preliminary findings at professional meetings, performing field trials, and revisiting criteria and text”(APA, 2013).

What resulted was a “common language for communication between clinicians about the diagnosis of disorders” along with a realization that the criteria and disorders contained within were based on current research and may undergo modification with new evidence gathered

(APA, 2013). Additionally, some disorders were not included within the main body of the document because they did not have the scientific evidence to support their widespread clinical use, but were included in Section III under “Conditions for Further Study” to “highlight the evolution and direction of scientific advances in these areas to stimulate further research” (APA, 2013).

ELEMENTS OF A DIAGNOSIS

The DSM 5 states that the following make up the key elements of a diagnosis (APA, 2013):

- **Diagnostic Criteria and Descriptors** – Diagnostic criteria are the guidelines for making a diagnosis. When the full criteria are met, mental health professionals can add severity and course specifiers to indicate the patient’s current presentation. If the full criteria are not met, designators such as “other specified” or “unspecified” can be used. If applicable, an indication of severity (mild, moderate, severe, or extreme), descriptive features, and course (type of remission – partial or full – or recurrent) can be provided with the diagnosis. The final diagnosis is based on the clinical interview, text descriptions, criteria, and clinical judgment.
- **Subtypes and Specifiers** – Since the same disorder can be manifested in different ways in different

individuals the DSM uses subtypes and specifiers to better characterize an individual's disorder. *Subtypes* denote “mutually exclusive and jointly exhaustive phenomenological subgroupings within a diagnosis” (APA, 2013). For example, non-rapid eye movement sleep arousal disorders can have either a sleepwalking or sleep terror type. Enuresis is nocturnal only, diurnal only, or both. *Specifiers* are not mutually exclusive or jointly exhaustive and so more than one specifier can be given. For instance, binge eating disorder has remission and severity specifiers. Major depressive disorder has a wide range of specifiers that can be used to characterize the severity, course, or symptom clusters. Again the fundamental distinction between subtypes and specifiers is that there can be only one subtype but multiple specifiers.

- **Principle Diagnosis** – A *principal diagnosis* is used when more than one diagnosis is given for an individual (when an individual has *comorbid disorders*). The principal diagnosis is the reason for the admission in an inpatient setting or the reason for a visit resulting in ambulatory care medical services in outpatient settings. The principal diagnosis is generally the main focus of treatment.
- **Provisional Diagnosis** – If not enough information is available for a mental health

professional to make a definitive diagnosis, but there is a strong presumption that the full criteria will be met with additional information or time, then the *provisional* specifier can be used.

DSM-5 DISORDER CATEGORIES

The DSM-5 includes the following categories of disorders:

Table 1.1. DSM-5 Classification System of Mental Disorders

Disorder Category	Short Description
Neurodevelopmental Disorders	A group of conditions that arise in the developmental period and include intellectual disability, communication disorders, autism spectrum disorder, motor disorders, and ADHD
Schizophrenia Spectrum and Other Psychotic Disorders	Disorders characterized by one or more of the following: delusions, hallucinations, disorganized thinking and speech, disorganized motor behavior, and negative symptoms
Bipolar and Related Disorders	Characterized by mania or hypomania and possibly depressed mood; includes Bipolar I and II, cyclothymic disorder
Depressive Disorders	Characterized by sad, empty, or irritable mood, as well as somatic and cognitive changes that affect functioning; includes major depressive and persistent depressive disorders
Anxiety Disorders	Characterized by excessive fear and anxiety and related behavioral disturbances; Includes phobias, separation anxiety, panic attack, generalized anxiety disorder
Obsessive-Compulsive and Related Disorders	Characterized by obsessions and compulsions and includes OCD, hoarding, and body dysmorphic disorders
Trauma- and Stressor-Related Disorders	Characterized by exposure to a traumatic or stressful event; PTSD, acute stress disorder, and adjustment disorders
Dissociative Disorders	Characterized by a disruption or disturbance in memory, identity, emotion, perception, or behavior; dissociative identity disorder, dissociative amnesia, and depersonalization/derealization disorder
Somatic Symptom and Related Disorders	Characterized by prominent somatic symptoms. Includes illness anxiety disorder, somatic symptom disorder, and conversion disorder
Feeding and Eating Disorders	Characterized by a persistent disturbance of eating or eating-related behavior to include bingeing and purging
Elimination Disorders	Characterized by the inappropriate elimination of urine or feces; usually first diagnosed in childhood or adolescence

Abnormal Psychology

Sleep-Wake Disorders	Characterized by sleep-wake complaints about the quality, timing, and amount of sleep; includes insomnia, sleep terrors, narcolepsy, and sleep apnea
Sexual Dysfunctions	Characterized by sexual difficulties and include premature ejaculation, female orgasmic disorder, and erectile disorder
Gender Dysphoria	Characterized by distress associated with the incongruity between one's experienced or expressed gender and the gender assigned at birth
Disruptive, Impulse-Control, and Conduct Disorders	Characterized by problems in self-control of emotions and behavior and involve the violation of the rights of others and cause the individual to be in violation of societal norms; Includes oppositional defiant disorder, antisocial personality disorder, kleptomania, etc.
Substance-Related and Addictive Disorders	Characterized by the continued use of a substance despite significant problems related to its use
Neurocognitive Disorders	Characterized by a decline in cognitive functioning over time and the NCD has not been present since birth or early in life
Personality Disorders	Characterized by a pattern of stable traits which are inflexible, pervasive, and leads to distress or impairment
Paraphilic Disorders	Characterized by recurrent and intense sexual fantasies that can cause harm to the individual or others; includes exhibitionism, voyeurism, and sexual sadism

THE ICD-11

In 1893, the International Statistical Institute adopted the International List of Causes of Death which was the first edition of the ICD. The World Health Organization was entrusted with the development of the ICD in 1948 and published the 6th version (ICD-6), which was the first version to include mental disorders. The ICD-11 was

published in June 2018 and adopted by member states of WHO in June 2019. The WHO states:

ICD is the foundation for the identification of health trends and statistics globally, and the international standard for reporting diseases and health conditions. It is the diagnostic classification standard for all clinical and research purposes. ICD defines the universe of diseases, disorders, injuries and other related health conditions, listed in a comprehensive, hierarchical fashion that allows for:

- easy storage, retrieval and analysis of health information for evidence-based decision-making;
- sharing and comparing health information between hospitals, regions, settings, and countries;
- and data comparisons in the same location across different time periods.

Source: <http://www.who.int/classifications/icd/en/>

The ICD lists many types of diseases and disorders and includes Chapter V: Mental and Behavioral Disorders. The list of mental disorders is broken down as follows:

- Organic, including symptomatic, mental disorders
- Mental and behavioral disorders due to psychoactive substance use
- Schizophrenia, schizotypal and delusional disorders
- Mood (affective) disorders

- Neurotic, stress-related and somatoform disorders
- Behavioral syndromes associated with physiological disturbances and physical factors
- Disorders of adult personality and behavior
- Mental retardation
- Disorders of psychological development
- Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
- Unspecified mental disorder

HARMONIZATION OF DSM-5 AND ICD-11

According to the DSM-5, there is an effort to harmonize the two classification systems so that there can be a more accurate collection of national health statistics and design of clinical trials, increased ability to replicate scientific findings across national boundaries and to rectify the lack of agreement between the DSM-IV and ICD-10 diagnoses. (APA, 2013). At time of publication of this text, however, this had not yet occurred.

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Summary and Self-Test: Defining & Classifying Abnormal Behaviour

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SUMMARY

Mental illness has a significant social and economic cost on society, both directly and indirectly through costs like victimization, lost ability to work, burnout, hospitalizations, and medical visits. Abnormal psychology is a field of

psychology that studies people who are atypical or unusual. The intention of this study is to predict, explain, diagnose, identify the causes of, and treat mental disorders.

Mental disorders are hard to define. Most definitions include the “3 Ds”: Dysfunction, distress (or impairment), and deviance. Meaning that disorders disturb an individual’s cognition, emotion regulation or behaviour, that this causes distress for the individual, and that this behaviour is a move away from what our culture determines is normal, typical, or average.

It is important to consider culture when evaluating abnormal behaviour. Violating cultural expectations is not, in and of itself, a satisfactory means of identifying the presence of a psychological disorder. Behaviour varies from culture to culture, so what may be expected and appropriate in one culture may not be viewed as such in others.

In order for a mental health professional to effectively treat a client (and know if the treatment is working), they must first know what a client’s presenting problem is. Clinical assessment refers to collecting information about this and drawing conclusions through the use of observation, psychological tests, neurological tests, and interviews to determine what the symptoms the client is presenting with. The concepts of reliability, validity, and standardization are key to the assessment process.

After the assessment is complete, a professional can consider if the person meets criteria for a clinical diagnosis. Diagnosis is the process of using assessment data to determine

if the pattern of symptoms the person presents with is consistent with the diagnostic criteria for a specific mental health disorder, set forth in an established classification system like the DSM-5 or ICD-10. Symptoms that cluster together on a regular basis are called a syndrome.

Classification systems for mental disorders provide health professionals with an agreed-upon list of disorders, for which there are clear descriptions and criteria for making a diagnosis. The most widely used classification system in North America is the Diagnostic and Statistical Manual of Mental Disorders, currently in its 5th edition. It is published by the American Psychiatric Association. The first edition of the DSM was published in 1952 and the current edition was published in 2013 after almost 40 years of research! The World Health Organization (WHO) also publishes the International Classification of Diseases (ICD), an alternative classification system.

The DSM also states the key elements of diagnosis, which include diagnostic criteria and descriptors, which are guidelines for making a diagnosis. A second key element are subtypes and specifiers, used to better characterize an individual's disorder since the same disorder can manifest in different ways for different people. Last, principle diagnoses are given when more than one diagnosis is applicable for one individual and provisional diagnoses are given when not enough information is available to make a definitive diagnosis.



An interactive H5P element has been excluded from this version of the text. You can view it online

here:

<https://fhsu.pressbooks.pub/abnormalpsych/?p=44#h5p-1>

Link: https://openpress.usask.ca/abnormalpsychology/wp-admin/admin-ajax.php?action=h5p_embed&id=6

PART II

Chapter 2:
Perspectives on
Abnormal
Behaviour

STEPHANIE WEIGEL

Chapter 2 Introduction

JORDEN A. CUMMINGS

Abnormal psychology is a broad and diverse topic of study that, as you will see in this chapter, has fascinated humans for centuries. There are many different lenses through which we can view abnormal behaviour. In this chapter we will discuss many of those lenses, illustrating and comparing how they conceptualize psychopathology. In the first part of this chapter, you'll read about historical perspectives on abnormality, all the way from prehistoric beliefs through to the 18th and 19th centuries. As you will see, views on abnormality have always been influenced by the broader culture and historical context that they exist in.

You will then learn about the modern therapeutic

orientations, beginning with the birth of abnormal psychology as a discipline: Sigmund Freud's psychoanalysis. These orientations are used to explain abnormal behaviour and tell clinicians how to treat it. This section also covers humanistic and person-centred approaches, the behavioural and cognitive models as well as cognitive-behavioural therapy (which combine the two), acceptance and mindfulness-based approaches, and some emerging views on abnormality. Each of these orientations views abnormal behaviour slightly differently, although many of their ideas overlap and many orientations have informed one another. This chapter will also discuss the biological model of mental illness and psychopharmacology as a treatment option.

Another modern development, beginning in the 1990s, was the rise of evidence-based practice in clinical psychology and the development of criteria for evaluating the research evidence for various psychotherapies, in order to develop the distinction of "empirically supported treatment." In the final part of this chapter, you will learn what evidence-based practice and empirically supported treatments involve, and also learn about characteristics for identifying the opposite: treatments that harm.

2.1 Historical Perspectives on Mental Illness

ALEXIS BRIDLEY & LEE W. DAFFIN JR.;
CARRIE CUTTLER; AND JORDEN A. CUMMINGS

Section Learning Objectives

- Describe prehistoric and ancient beliefs about mental illness.
- Describe Greco-Roman thought on mental illness.
- Describe thoughts on mental illness during the Middle Ages.
- Describe thoughts on mental illness during the Renaissance.

- Describe thoughts on mental illness during the 18th and 19th centuries

As we have seen so far, what is considered abnormal behavior is often dictated by the culture/society a person lives in, and unfortunately, the past has not treated the afflicted very well. In this section, we will examine how past societies viewed and dealt with mental illness.

PREHISTORIC AND ANCIENT BELIEFS

Prehistoric cultures often held a supernatural view of abnormal behavior and saw it as the work of evil spirits, demons, gods, or witches who took control of the person. This form of demonic possession was believed to occur when the person engaged in behavior contrary to the religious teachings of the time. Treatment by cave dwellers included a technique called **trephination**, in which a stone instrument known as a *trephine* was used to remove part of the skull, creating an opening. They believed that evil spirits could escape through the hole in the skull, thereby ending the person's mental affliction and returning them to normal behavior. Early Greek, Hebrew, Egyptian, and Chinese cultures used a treatment method called **exorcism** in which evil spirits were cast out through prayer, magic, flogging,

starvation, noise-making, or having the person ingest horrible tasting drinks.

GRECO-ROMAN THOUGHT

Rejecting the idea of demonic possession, Greek physician, Hippocrates (460-377 B.C.), said that mental disorders were akin to physical disorders and had natural causes. Specifically, he suggested that they arose from brain pathology, or head trauma/brain dysfunction or disease, and were also affected by heredity. Hippocrates classified mental disorders into three main categories – melancholia, mania, and phrenitis (brain fever) and gave detailed clinical descriptions of each. He also described four main fluids or **humors** that directed normal functioning and personality – *blood* which arose in the heart, *black bile* arising in the spleen, *yellow bile* or *cholera* from the liver, and *phlegm* from the brain. Mental disorders occurred when the humors were in a state of imbalance such as an excess of yellow bile causing frenzy/mania and too much black bile causing melancholia/depression. Hippocrates believed mental illnesses could be treated as any other disorder and focused on the underlying pathology.

Also important was Greek philosopher, Plato (429-347 B.C.), who said that the mentally ill were not responsible for their own actions and so should not be punished. He emphasized the role of social environment and early learning in the development of mental disorders and believed it was the responsibility of the community and their families to care for them in a humane manner using rational discussions.

Greek physician, Galen (A.D. 129–199) said mental disorders had either physical or mental causes that included fear, shock, alcoholism, head injuries, adolescence, and changes in menstruation.

In Rome, physician Asclepiades (124–40 BC) and philosopher Cicero (106–43 BC) rejected Hippocrates' idea of the four humors and instead stated that melancholy arises from grief, fear, and rage; not excess black bile. Roman physicians treated mental disorders with massage and warm baths, with the hope that their patients be as comfortable as possible. They practiced the concept of "*contrariis contrarius*", meaning opposite by opposite, and introduced contrasting stimuli to bring about balance in the physical and mental domains. An example would be consuming a cold drink while in a warm bath.

THE MIDDLE AGES – 500 AD TO 1500 AD

The progress made during the time of the Greeks and Romans was quickly reversed during the Middle Ages with the increase in power of the Church and the fall of the Roman Empire. Mental illness was yet again explained as possession by the Devil and methods such as exorcism, flogging, prayer, the touching of relics, chanting, visiting holy sites, and holy water were used to rid the person of the Devil's influence. In extreme cases, the afflicted were confined, beat, and even executed. Scientific and medical explanations, such as those proposed by Hippocrates, were discarded at this time.

Group hysteria, or **mass madness**, was also seen in which

large numbers of people displayed similar symptoms and false beliefs. This included the belief that one was possessed by wolves or other animals and imitated their behavior, called **lycanthropy**, and a mania in which large numbers of people had an uncontrollable desire to dance and jump, called **tarantism**. The latter was believed to have been caused by the bite of the wolf spider, now called the tarantula, and spread quickly from Italy to Germany and other parts of Europe where it was called **Saint Vitus's dance**.

Perhaps the return to supernatural explanations during the Middle Ages makes sense given events of the time. The Black Death or Bubonic Plague had killed up to a third, and according to other estimates almost half, of the population. Famine, war, social oppression, and pestilence were also factors. Death was ever present which led to an epidemic of depression and fear. Nevertheless, near the end of the Middle Ages, mystical explanations for mental illness began to lose favor and government officials regained some of their lost power over nonreligious activities. Science and medicine were once again called upon to explain mental disorders.

THE RENAISSANCE – 14TH TO 16TH CENTURIES

The most noteworthy development in the realm of philosophy during the Renaissance was the rise of **humanism**, or the worldview that emphasizes human welfare and the uniqueness of the individual. This helped continue the decline of supernatural views of mental illness.

In the mid to late 1500s, Johann Weyer (1515-1588), a German physician, published his book, *On the Deceits of the Demons*, that rebutted the Church's witch-hunting handbook, the *Malleus Maleficarum*, and argued that many accused of being witches and subsequently imprisoned, tortured, hung, and/or burned at the stake, were mentally disturbed and not possessed by demons or the Devil himself. He believed that like the body, the mind was susceptible to illness. Not surprisingly, the book was met with vehement protest and even banned from the church. It should be noted that these types of acts occurred not only in Europe but also in the United States. The most famous example was the Salem Witch Trials of 1692 in which more than 200 people were accused of practicing witchcraft and 20 were killed.

The number of **asylums**, or places of refuge for the mentally ill where they could receive care, began to rise during the 16th century as the government realized there were far too many people afflicted with mental illness to be left in private homes. Hospitals and monasteries were converted into asylums. Though the intent was benign in the beginning, as they began to overflow patients came to be treated more like animals than people. In 1547, the Bethlem Hospital opened in London with the sole purpose of confining those with mental disorders. Patients were chained up, placed on public display, and often heard crying out in pain. The asylum became a tourist attraction, with sightseers paying a penny to view the more violent patients, and soon was called "Bedlam" by local people; a term that today means

“a state of uproar and confusion” (<https://www.merriam-webster.com/dictionary/bedlam>).

REFORM MOVEMENT – 18TH TO 19TH CENTURIES

The rise of the **moral treatment movement** occurred in Europe in the late 18th century and then in the United States in the early 19th century. Its earliest proponent was Phillipe Pinel (1745-1826) who was assigned as the superintendent of la Bicetre, a hospital for mentally ill men in Paris. He emphasized the importance of affording the mentally ill respect, moral guidance, and humane treatment, all while considering their individual, social, and occupational needs. Arguing that the mentally ill were sick people, Pinel ordered that chains be removed, outside exercise be allowed, sunny and well-ventilated rooms replace dungeons, and patients be extended kindness and support. This approach led to considerable improvement for many of the patients, so much so, that several were released.

Following Pinel’s lead in England, William Tuke (1732-1822), a Quaker tea merchant, established a pleasant rural estate called the York Retreat. The Quakers believed that all people should be accepted for who they were and treated kindly. At the retreat, patients could work, rest, talk out their problems, and pray (Raad & Makari, 2010). The work of Tuke and others led to the passage of the County Asylums Act of 1845 which required that every county in England and Wales provide asylum to the mentally ill. This

was even extended to English colonies such as Canada, India, Australia, and the West Indies as word of the maltreatment of patients at a facility in Kingston, Jamaica spread, leading to an audit of colonial facilities and their policies.

Reform in the United States started with the figure largely considered to be the father of American psychiatry, Benjamin Rush (1745-1813). Rush advocated for the humane treatment of the mentally ill, showing them respect, and even giving them small gifts from time to time. Despite this, his practice included treatments such as bloodletting and purgatives, the invention of the “tranquilizing chair,” and a reliance on astrology, showing that even he could not escape from the beliefs of the time.

Due to the rise of the moral treatment movement in both Europe and the United States, asylums became habitable places where those afflicted with mental illness could recover. However, it is often said that the moral treatment movement was a victim of its own success. The number of mental hospitals greatly increased leading to staffing shortages and a lack of funds to support them. Though treating patients humanely was a noble endeavor, it did not work for some and other treatments were needed, though they had not been developed yet. It was also recognized that the approach worked best when the facility had 200 or fewer patients. However, waves of immigrants arriving in the U.S. after the Civil War were overwhelming the facilities, with patient counts soaring to 1,000 or more. Prejudice against the new arrivals led to discriminatory practices in which immigrants

were not afforded moral treatments provided to native citizens, even when the resources were available to treat them.

Another leader in the moral treatment movement was Dorothea Dix (1802-1887), a New Englander who observed the deplorable conditions suffered by the mentally ill while teaching Sunday school to female prisoners. She instigated the **mental hygiene movement**, which focused on the physical well-being of patients. Over the span of 40 years, from 1841 to 1881, she motivated people and state legislators to do something about this injustice and raised millions of dollars to build over 30 more appropriate mental hospitals and improve others. Her efforts even extended beyond the U.S. to Canada and Scotland.

Finally, in 1908 Clifford Beers (1876-1943) published his book, *A Mind that Found Itself*, in which he described his personal struggle with bipolar disorder and the “cruel and inhumane treatment people with mental illnesses received. He witnessed and experienced horrific abuse at the hands of his caretakers. At one point during his institutionalization, he was placed in a straightjacket for 21 consecutive nights.” (<http://www.mentalhealthamerica.net/our-history>). His story aroused sympathy in the public and led him to found the National Committee for Mental Hygiene, known today as Mental Health America, which provides education about mental illness and the need to treat these people with dignity. Today, MHA has over 200 affiliates in 41 states and employs 6,500 affiliate staff and over 10,000 volunteers.

For more information on MHA, please visit:
<http://www.mentalhealthamerica.net/>

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2.2 Therapeutic Orientations

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Section Learning Objectives

- Describe the similarities and differences between theoretical orientations and therapeutic orientations
- Explain how the following orientations view abnormality and suggest we treat it: Psychodynamic/psychoanalytic, person-centered,

behavioural, cognitive, cognitive behavioural, acceptance-based, and mindfulness-based

- Discuss emerging treatment strategies

WHAT ARE THEORETICAL ORIENTATIONS?

Although all psychologists share a common goal of seeking to understand human behaviour, psychology is a diverse discipline, in which many different ways of viewing human behaviour have developed. Those views are impacted by the cultural and historical context they exist within, as we have previously discussed in earlier sections of this book.

The purpose of a theoretical orientation is to present a framework through which to understand, organize, and predict human behaviour. Theoretical orientations explain, from that orientation's perspective, why humans act the way they do. Applied to mental health, they are often referred to as *therapeutic* orientations and serve to also provide a framework for how to treat psychopathology. You can think of each orientation as a different pair of coloured glasses through which we view human behaviour. Each orientation will see human behaviour slightly differently, and thus have a different explanation for why people act the way they do. When applied to treatment, this means that each orientation

might recommend different types of interventions for the same disorder.

Practicing mental health workers, like clinical psychologists, generally adopt a theoretical orientation that they feel best explains human behaviour and thus helps them treat their clients and patients. For example, as you will see below, a psychodynamic therapist will have a very different explanation for a client's presenting problem than a behaviour therapist would, and as such each would choose different techniques to treat that presenting problem. In this section we'll discuss some of the major theoretical/therapeutic orientations, how they view human behaviour and treatment, and what techniques they might use.

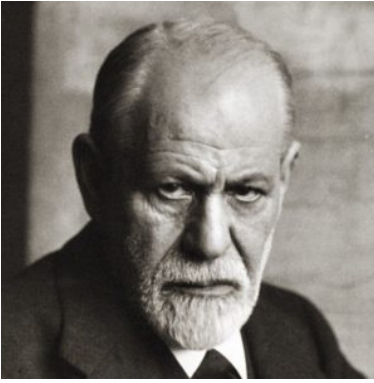
PSYCHOANALYSIS AND PSYCHODYNAMIC THERAPY

The earliest organized therapy for mental disorders was psychoanalysis. Made famous in the early 20th century by one of the best-known clinicians of all time, Sigmund Freud, this approach sees mental health problems as rooted in unconscious conflicts and desires. In order to resolve the mental illness, then, these unconscious struggles must be identified and addressed. Psychoanalysis often does this through exploring one's early childhood experiences that may have continuing repercussions on one's mental health in the present and later in life. Psychoanalysis is an intensive, long-term approach in which patients and therapists may meet multiple times per week, often for many years.

Freud suggested more generally that psychiatric problems are the result of tension between different parts of the mind: the id, the superego, and the ego. In Freud's *structural model*, the id represents pleasure-driven unconscious urges (e.g., our animalistic desires for sex and aggression), while the superego is the semi-conscious part of the mind where morals and societal judgment are internalized (e.g., the part of you that automatically knows how society expects you to behave). The ego—also partly conscious—mediates between the id and superego. Freud believed that bringing unconscious struggles like these (where the id demands one thing and the superego another) into conscious awareness would relieve the stress of the conflict (Freud, 1920/1955)—which became the goal of **psychoanalytic therapy**.

Although psychoanalysis is still practiced today, it has largely been replaced by the more broadly defined **psychodynamic therapy**. This latter approach has the same basic tenets as psychoanalysis, but is briefer, makes more of an effort to put clients in their social and interpersonal context, and focuses more on relieving psychological distress than on changing the person.

TECHNIQUES IN PSYCHOANALYSIS



Building on the work of Josef Breuer and others, Sigmund Freud developed psychotherapeutic theories and techniques that became widely known as psychoanalysis or psychoanalytic therapy. [Image: CC0 Public Domain, <https://goo.gl/m25gce>]

Psychoanalysts and psychodynamic therapists employ several techniques to explore patients' unconscious mind. One common technique is called **free association**. Here, the patient shares any and all thoughts that come to mind, without attempting to organize or censor them in any way. For example, if you took a pen and paper and just wrote down whatever came into your head, letting one thought lead to the next without allowing conscious

criticism to shape what you were writing, you would be doing free association. The analyst then uses his or her expertise to discern patterns or underlying meaning in the patient's thoughts.

Sometimes, free association exercises are applied specifically to childhood recollections. That is, psychoanalysts believe a person's childhood relationships with caregivers often determine the way that person relates to others, and predicts later psychiatric difficulties. Thus, exploring these

childhood memories, through free association or otherwise, can provide therapists with insights into a patient's psychological makeup.

Because we don't always have the ability to consciously recall these deep memories, psychoanalysts also discuss their patients' dreams. In Freudian theory, dreams contain not only *manifest* (or literal) content, but also *latent* (or symbolic) content (Freud, 1900; 1955). For example, someone may have a dream that his/her teeth are falling out—the manifest or actual content of the dream. However, dreaming that one's teeth are falling out could be a reflection of the person's unconscious concern about losing his or her physical attractiveness—the latent or metaphorical content of the dream. It is the therapist's job to help discover the latent content underlying one's manifest content through dream analysis.

In psychoanalytic and psychodynamic therapy, the therapist plays a receptive role—interpreting the patient's thoughts and behavior based on clinical experience and psychoanalytic theory. For example, if during therapy a patient begins to express unjustified anger toward the therapist, the therapist may recognize this as an act of *transference*. That is, the patient may be displacing feelings for people in his or her life (e.g., anger toward a parent) onto the therapist. At the same time, though, the therapist has to be aware of his or her own thoughts and emotions, for, in a related process, called *countertransference*, the therapist may displace his/her own emotions onto the patient.

The key to psychoanalytic theory is to have patients uncover the buried, conflicting content of their mind, and therapists use various tactics—such as seating patients to face away from them—to promote a freer self-disclosure. And, as a therapist spends more time with a patient, the therapist can come to view his or her relationship with the patient as another reflection of the patient’s mind.

ADVANTAGES AND DISADVANTAGES OF PSYCHOANALYTIC THERAPY

Psychoanalysis was once the only type of psychotherapy available, but presently the number of therapists practicing this approach is decreasing around the world. Psychoanalysis is not appropriate for some types of patients, including those with severe psychopathology or intellectual disability. Further, psychoanalysis is often expensive because treatment usually lasts many years. Still, some patients and therapists find the prolonged and detailed analysis very rewarding.

Perhaps the greatest disadvantage of psychoanalysis and related approaches is the lack of empirical support for their effectiveness. The limited research that has been conducted on these treatments suggests that they do not reliably lead to better mental health outcomes (e.g., Driessen et al., 2010). And, although there are some reviews that seem to indicate that long-term psychodynamic therapies might be beneficial (e.g., Leichsenring & Rabung, 2008), other researchers have questioned the validity of these reviews. Nevertheless, psychoanalytic theory was history’s first attempt at formal

treatment of mental illness, setting the stage for the more modern approaches used today.

HUMANISTIC AND PERSON-CENTERED THERAPY

One of the next developments in therapy for mental illness, which arrived in the mid-20th century, is called humanistic or **person-centered therapy (PCT)**. Here, the belief is that mental health problems result from an inconsistency between patients' behavior and their true personal identity. Thus, the goal of PCT is to create conditions under which patients can discover their self-worth, feel comfortable exploring their own identity, and alter their behavior to better reflect this identity.

PCT was developed by a psychologist named Carl Rogers, during a time of significant growth in the movements of humanistic theory and human potential.

These perspectives were based on the idea that humans have an inherent drive to realize and express their own capabilities and creativity.

Rogers, in particular,

believed that all people have the potential to change and



The quality of the relationship between therapist and patient is of great importance in person-centered therapy. [Image: CC0 Public Domain, <https://goo.gl/m25gce>]

improve, and that the role of therapists is to foster self-understanding in an environment where adaptive change is most likely to occur (Rogers, 1951). Rogers suggested that the therapist and patient must engage in a genuine, egalitarian relationship in which the therapist is nonjudgmental and empathetic. In PCT, the patient should experience both a vulnerability to anxiety, which motivates the desire to change, and an appreciation for the therapist's support.

TECHNIQUES IN PERSON-CENTERED THERAPY

Humanistic and person-centered therapy, like psychoanalysis, involves a largely unstructured conversation between the therapist and the patient. Unlike psychoanalysis, though, a therapist using PCT takes a passive role, guiding the patient toward his or her own self-discovery. Rogers's original name for PCT was *non-directive therapy*, and this notion is reflected in the flexibility found in PCT. Therapists do not try to change patients' thoughts or behaviors directly. Rather, their role is to provide the therapeutic relationship as a platform for personal growth. In these kinds of sessions, the therapist tends only to ask questions and doesn't provide any judgment or interpretation of what the patient says. Instead, the therapist is present to provide a safe and encouraging environment for the person to explore these issues for him- or herself.

An important aspect of the PCT relationship is the therapist's **unconditional positive regard** for the patient's

feelings and behaviors. That is, the therapist is never to condemn or criticize the patient for what s/he has done or thought; the therapist is only to express warmth and empathy. This creates an environment free of approval or disapproval, where patients come to appreciate their value and to behave in ways that are congruent with their own identity.

ADVANTAGES AND DISADVANTAGES OF PERSON-CENTERED THERAPY

One key advantage of person-centered therapy is that it is highly acceptable to patients. In other words, people tend to find the supportive, flexible environment of this approach very rewarding. Furthermore, some of the themes of PCT translate well to other therapeutic approaches. For example, most therapists of any orientation find that clients respond well to being treated with nonjudgmental empathy. The main disadvantage to PCT, however, is that findings about its effectiveness are mixed. One possibility for this could be that the treatment is primarily based on *unspecific treatment factors*. That is, rather than using therapeutic techniques that are specific to the patient and the mental problem (i.e., *specific treatment factors*), the therapy focuses on techniques that can be applied to anyone (e.g., establishing a good relationship with the patient) (Cuijpers et al., 2012; Friedli, King, Lloyd, & Horder, 1997). Similar to how “one-size-fits-all” doesn’t really fit every person, PCT uses the same practices for everyone, which may work for some people but not others. Further research is necessary to evaluate its utility as a

therapeutic approach. It is important to note, however, that many practitioners incorporate Rogerian concepts, like unconditional positive regard, into their work even if they primarily practice from a different theoretical orientation.

THE BEHAVIOURAL MODEL

The Behaviourists believed that how we act is learned – we continue to act in the ways that we are reinforced and we avoid acting in ways that result in us being punished. Likewise, they believed that abnormal behaviour resulted from learning and could be treated by learning via new reinforcements and punishments. Early behaviourists identified a number of ways of learning: First, **conditioning**, a type of associative learning, occurs which two events are linked and has two forms – classical conditioning, or linking together two types of stimuli, and operant conditioning, or linking together a response with its consequence. Second, **observational learning** occurs when we learn by observing the world around us.

We should also note the existence of non-associative learning or when there is no linking of information or observing the actions of others around you. Types include **habituation**, or when we simply *stop responding* to repetitive and harmless stimuli in our environment such as a fan running in your laptop as you work on a paper, and **sensitization**, or when our reactions are *increased* due to a strong stimulus, such as an individual who experienced a

mugging and now experiences panic when someone walks up behind him/her on the street.

One of the most famous studies in psychology was conducted by Watson and Rayner (1920). Essentially, they wanted to explore the possibility of conditioning emotional responses. The researchers ran a 9-month-old child, known as Little Albert, through a series of trials in which he was exposed to a white rat. At first, he showed no response except curiosity. Then the researchers began to make a loud sound (UCS) whenever the rat was presented. Little Albert exhibited the normal fear response to this sound. After several conditioning trials like these, Albert responded with fear to the mere presence of the white rat.

As fears can be learned, so too they can be unlearned. Considered the follow-up to Watson and Rayner (1920), Jones (1924) wanted to see if a child (named Peter) who learned to be afraid of white rabbits could be conditioned to become unafraid of them. Simply, she placed Peter in one end of a room and then brought in the rabbit. The rabbit was far enough away so as to not cause distress. Then, Jones gave Peter some pleasant food (i.e., something sweet such as cookies; remember the response to the food is unlearned). She continued this procedure with the rabbit being brought in a bit closer each time until eventually, Peter did not respond with distress to the rabbit. This process is called **counterconditioning** or **extinction**, or the reversal of previous learning.

Operant conditioning, is more directly relevant to

therapeutic work. **Operant conditioning** is a type of associate learning which focuses on consequences that follow a response or behavior that we make (anything we do, say, or think/feel) and whether it makes a behavior more or less likely to occur. Skinner talked about **contingencies** or when one thing occurs due to another. Think of it as an If-Then statement. If I do X then Y will happen. For operant conditioning, this means that if I make a behavior, then a specific consequence will follow. The events (response and consequence) are linked in time.

What form do these consequences take? There are two main ways they can present themselves.

- **Reinforcement** – Due to the consequence, a behavior/response is more likely to occur in the future. It is strengthened.
- **Punishment** – Due to the consequence, a behavior/response is less likely to occur in the future. It is weakened.

Reinforcement and punishment can occur as two types – positive and negative. These words have no affective connotation to them meaning they do not imply good or bad. *Positive* means that you are giving something – good or bad. *Negative* means that something is being taken away – good or bad. Check out the figure below for how these contingencies are arranged.

Figure 2.1. Contingencies in Operant Conditioning

	Some “ Bad ” Thing	Some “ Good ” Thing
Giving	Positive Punishment	Positive Reinforcement
Taking Away	Negative Reinforcement	Negative Punishment

Let’s go through each:

- **Positive Punishment (PP)** – If something bad or aversive is given or added, then the behavior is less likely to occur in the future. If you talk back to your mother and she slaps your mouth, this is a PP. Your response of talking back led to the consequence of the aversive slap being delivered or given to your face. Ouch!!!
- **Positive Reinforcement (PR)** – If something good is given or added, then the behavior is more likely to occur in the future. If you study hard and earn an A on your exam, you will be more likely to study hard in the future. Similarly, your parents may give you money for your stellar performance. Cha Ching!!!
- **Negative Reinforcement (NR)** – This is a tough

one for students to comprehend because the terms don't seem to go together and are counterintuitive. But it is really simple and you experience NR all the time. This is when you are more likely to engage in a behavior that has resulted in the removal of something aversive in the past. For instance, what do you do if you have a headache? You likely answered take Tylenol. If you do this and the headache goes away, you will take Tylenol in the future when you have a headache. Another example is continually smoking marijuana because it temporarily decreases feelings of anxiety. The behavior of smoking marijuana is being reinforced because it reduces a negative state.

- **Negative Punishment (NP)** – This is when something good is taken away or subtracted making a behavior less likely in the future. If you are late to class and your professor deducts 5 points from your final grade (the points are something good and the loss is negative), you will hopefully be on time in all subsequent classes. Another example is taking away a child's allowance when he misbehaves.

TECHNIQUES IN BEHAVIOUR THERAPY

Within the context of abnormal behavior or psychopathology, the behavioral perspective is useful because it suggests that maladaptive behavior occurs when learning

goes awry. As you will see throughout this book, a large number of treatment techniques have been developed from the behavioural model and proven to be effective over the years. For example, desensitization (Wolpe, 1997) teaches clients to respond calmly to fear-producing stimuli. It begins with the individual learning a relaxation technique such as diaphragmatic breathing. Next, a fear hierarchy, or list of feared objects and situations, is constructed in which the individual moves from least to most feared. Finally, the individual either imagines (systematic) or experiences in real life (in-vivo) each object or scenario from the hierarchy and uses the relaxation technique while doing so. This represents individual pairings of feared object or situation and relaxation and so if there are 10 objects/situations in the list, the client will experience ten such pairings and eventually be able to face each without fear. Outside of phobias, desensitization has been shown to be effective in the treatment of Obsessive Compulsive Disorder symptoms (Hakimian and D'Souza, 2016) and limitedly with the treatment of depression that is co-morbid with OCD (Masoumeh and Lancy, 2016).

Critics of the behavioral perspective point out that it oversimplifies behavior and often ignores inner determinants of behavior. Behaviorism has also been accused of being mechanistic and seeing people as machines. Watson and Skinner defined behavior as what we do or say, but later, behaviorists added what we think or feel. In terms of the latter, cognitive behavior modification procedures arose after the 1960s along with the rise of cognitive psychology. This

led to a cognitive-behavioral perspective which combines concepts from the behavioral and cognitive models. After reviewing the basics of the cognitive model, we'll discuss the cognitive-behavioural model in more detail.

THE COGNITIVE MODEL

Behaviorism said psychology was to be the study of observable behavior, and any reference to cognitive processes was dismissed as this was not overt, but covert according to Watson and later Skinner. Of course, removing cognition from the study of psychology ignored an important part of what makes us human and separates us from the rest of the animal kingdom. Fortunately, the work of George Miller, Albert Ellis, Aaron Beck, and Ulrich Neisser demonstrated the importance of cognitive abilities in understanding thoughts, behaviors, and emotions, and in the case of psychopathology, they helped to show that people can create their own problems by how they come to interpret events experienced in the world around them. How so? According to the cognitive model, irrational or dysfunctional thought patterns can be the basis of psychopathology. Throughout this book, we will discuss several treatment strategies that are used to change unwanted, maladaptive cognitions, whether they are present as an *excess* such as with paranoia, suicidal ideation, or feelings of worthlessness; or as a *deficit* such as with self-confidence and self-efficacy. More specifically, cognitive distortions/maladaptive cognitions can take the following forms:

- Overgeneralizing – You see a larger pattern of negatives based on one event.
- What if? – Asking yourself what if something happens without being satisfied by any of the answers.
- Blaming – Focusing on someone else as the source of your negative feelings and not taking any responsibility for changing yourself.
- Personalizing – Blaming yourself for negative events rather than seeing the role that others play.
- Inability to disconfirm – Ignoring any evidence that may contradict your maladaptive cognition.
- Regret orientation – Focusing on what you could have done better in the past rather than on making an improvement now.
- Dichotomous thinking – Viewing people or events in all-or-nothing terms.

For more on cognitive distortions, check out this website: <http://www.goodtherapy.org/blog/20-cognitive-distortions-and-how-they-affect-your-life-0407154>

COGNITIVE BEHAVIORAL THERAPY

Although the behavioural and cognitive models have separate origins, **cognitive-behavioral therapy (CBT)**, which combines elements of both, has gained more widespread support and practice. CBT refers to a family of therapeutic

approaches whose goal is to alleviate psychological symptoms by changing their underlying cognitions and behaviors. The premise of CBT is that thoughts, behaviors, and emotions interact and contribute to various mental disorders. For example, let's consider how a CBT therapist would view a patient who compulsively washes her hands for hours every day. First, the therapist would identify the patient's maladaptive thought: "If I don't wash my hands like this, I will get a disease and die." The therapist then identifies how this maladaptive *thought* leads to a maladaptive *emotion*: the feeling of anxiety when her hands aren't being washed. And finally, this maladaptive emotion leads to the maladaptive behavior: the patient washing her hands for hours every day.

CBT is a present-focused therapy (i.e., focused on the "now" rather than causes from the past, such as childhood relationships) that uses behavioral goals to improve one's mental illness. Often, these behavioral goals involve between-session homework assignments. For example, the therapist may give the hand-washing patient a worksheet to take home; on this worksheet, the woman is to write down every time she feels the urge to wash her hands, how she deals with the urge, and what behavior she replaces that urge with. When the patient has her next therapy session, she and the therapist review her "homework" together. CBT is a relatively brief intervention of 12 to 16 weekly sessions, closely tailored to the nature of the psychopathology and treatment of the specific mental disorder. And, as the empirical data shows, CBT has proven to be highly

efficacious for virtually all psychiatric illnesses (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012).

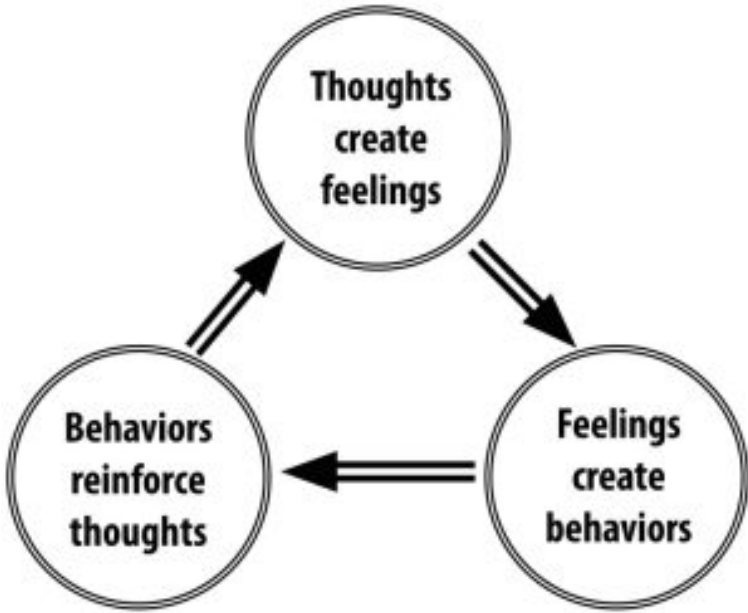


Figure 2.2. Pattern of thoughts, feelings, and behaviors addressed through cognitive-behavioral therapy.

HISTORY OF COGNITIVE BEHAVIORAL THERAPY

CBT developed from clinical work conducted in the mid-20th century by Dr. Aaron T. Beck, a psychiatrist, and Albert Ellis, a psychologist. Beck used the term **automatic thoughts** to refer to the thoughts depressed patients report experiencing spontaneously. He observed that these thoughts arise from three belief systems, or **schemas**: beliefs about the self, beliefs about the world, and beliefs about the future. In

treatment, therapy initially focuses on identifying automatic thoughts (e.g., “If I don’t wash my hands constantly, I’ll get a disease”), testing their validity, and replacing maladaptive thoughts with more adaptive thoughts (e.g., “Washing my hands three times a day is sufficient to prevent a disease”). In later stages of treatment, the patient’s maladaptive schemas are examined and modified. Ellis (1957) took a comparable approach, in what he called rational-emotive-behavioral therapy (REBT), which also encourages patients to evaluate their own thoughts about situations.

TECHNIQUES IN CBT

Beck and Ellis strove to help patients identify maladaptive appraisals, or the untrue judgments and evaluations of certain thoughts. For example, if it’s your first time meeting new people, you may have the automatic thought, “These people won’t like me because I have nothing interesting to share.” That thought itself is not what’s troublesome; the appraisal (or evaluation) that it might have merit is what’s troublesome. The goal of CBT is to help people make adaptive, instead of maladaptive, appraisals (e.g., “I do know interesting things!”). This technique of **reappraisal**, or **cognitive restructuring**, is a fundamental aspect of CBT. With cognitive restructuring, it is the therapist’s job to help point out when a person has an inaccurate or maladaptive thought, so that the patient can either eliminate it or modify it to be more adaptive.

In addition to *thoughts*, though, another important treatment target of CBT is maladaptive *behavior*. Every time a

person engages in maladaptive behavior (e.g., never speaking to someone in new situations), he or she reinforces the validity of the maladaptive thought, thus maintaining or perpetuating the psychological illness. In treatment, the therapist and patient work together to develop healthy behavioral habits (often tracked with worksheet-like homework), so that the patient can break this cycle of maladaptive thoughts and behaviors.

For many mental health problems, especially anxiety disorders, CBT incorporates what is known as **exposure therapy**. During exposure therapy, a patient confronts a problematic situation and fully engages in the experience instead of avoiding it. For example, imagine a man who is terrified of spiders. Whenever he encounters one, he immediately screams and panics. In exposure therapy, the man would be forced to confront and interact with spiders, rather than simply avoiding them as he usually does. The goal is to reduce the fear associated with the situation through *extinction learning*, a neurobiological and cognitive process by which the patient “unlearns” the irrational fear. For example, exposure therapy for someone terrified of spiders might begin with him looking at a cartoon of a spider, followed by him looking at pictures of real spiders, and later, him handling a plastic spider. After weeks of this incremental exposure, the patient may even be able to hold a live spider. After repeated exposure (starting small and building one’s way up), the patient experiences less physiological fear and

maladaptive thoughts about spiders, breaking his tendency for anxiety and subsequent avoidance.

ADVANTAGES AND DISADVANTAGES OF CBT

CBT interventions tend to be relatively brief, making them cost-effective for the average consumer. In addition, CBT is an intuitive treatment that makes logical sense to patients. It can also be adapted to suit the needs of many different populations. One disadvantage, however, is that CBT does involve significant effort on the patient's part, because the patient is an active participant in treatment. Therapists often assign "homework" (e.g., worksheets for recording one's thoughts and behaviors) between sessions to maintain the cognitive and behavioral habits the patient is working on. The greatest strength of CBT is the abundance of empirical support for its effectiveness. Studies have consistently found CBT to be equally or more effective than other forms of treatment, including medication and other therapies (Butler, Chapman, Forman, & Beck, 2006; Hofmann et al., 2012). For this reason, CBT is considered a first-line treatment for many mental disorders.

Focus: Topic: Pioneers of CBT

The central notion of CBT is the idea that a person's behavioral and emotional responses are causally influenced by

one's thinking. The stoic Greek philosopher Epictetus is quoted as saying, "men are not moved by things, but by the view they take of them." Meaning, it is not the event per se, but rather one's assumptions (including interpretations and perceptions) of the event that are responsible for one's emotional response to it. Beck calls these assumptions about events and situations automatic thoughts (Beck, 1979), whereas Ellis (1962) refers to these assumptions as self-statements. The cognitive model assumes that these cognitive processes cause the emotional and behavioral responses to events or stimuli. This causal chain is illustrated in Ellis's ABC model, in which A stands for the antecedent event, B stands for belief, and C stands for consequence. During CBT, the person is encouraged to carefully observe the sequence of events and the response to them, and then explore the validity of the underlying beliefs through behavioral experiments and reasoning, much like a detective or scientist.

ACCEPTANCE AND MINDFULNESS-BASED APPROACHES

Unlike the preceding therapies, which were developed in the 20th century, this next one was born out of age-old Buddhist and yoga practices. **Mindfulness**, or a process that tries to cultivate a nonjudgmental, yet attentive, mental state, is a therapy that focuses on one's awareness of bodily sensations, thoughts, and the outside environment. Whereas other therapies work to modify or eliminate these sensations and thoughts, mindfulness focuses on nonjudgmentally accepting

them (Kabat-Zinn, 2003; Baer, 2003). For example, whereas CBT may actively confront and work to change a maladaptive thought, mindfulness therapy works to acknowledge and accept the thought, understanding that the thought is spontaneous and not what the person truly believes. There are two important components of mindfulness: (1) self-regulation of attention, and (2) orientation toward the present moment (Bishop et al., 2004). Mindfulness is thought to improve mental health because it draws attention away from past and future stressors, encourages acceptance of troubling thoughts and feelings, and promotes physical relaxation.

TECHNIQUES IN MINDFULNESS-BASED THERAPY

Psychologists have adapted the practice of mindfulness as a form of psychotherapy, generally called **mindfulness-based therapy (MBT)**. Several types of MBT have become popular in recent years, including *mindfulness-based stress reduction* (MBSR) (e.g., Kabat-Zinn, 1982) and *mindfulness-based cognitive therapy* (MBCT) (e.g., Segal, Williams, & Teasdale, 2002).



One of the most important advantages of mindfulness based therapy is its level of accessibility to patients. [Image: Wayne MacPhail, <https://goo.gl/aSZanf>, CC BY-NC SA 2.0, <https://goo.gl/Toc0ZF>]

MBSR uses meditation, yoga, and attention to physical experiences to reduce stress. The hope is that reducing a person's overall stress will allow that person to more objectively evaluate his or her thoughts. In MBCT, rather than reducing one's general stress to address a specific problem, attention is focused on one's thoughts and their associated emotions. For example, MBCT helps prevent

relapses in depression by encouraging patients to evaluate their own thoughts objectively and without value judgment (Baer, 2003). Although cognitive behavioral therapy (CBT) may seem similar to this, it focuses on "pushing out" the maladaptive thought, whereas mindfulness-based cognitive therapy focuses on "not getting caught up" in it. The treatments used in MBCT have been used to address a wide range of illnesses, including depression, anxiety, chronic pain, coronary artery disease, and fibromyalgia (Hofmann, Sawyer, Witt & Oh, 2010).

Mindfulness and acceptance—in addition to being therapies in their own right—have also been used as "tools"

in other cognitive-behavioral therapies, particularly in **dialectical behavior therapy (DBT)** (e.g., Linehan, Amstrong, Suarez, Allmon, & Heard, 1991). DBT, often used in the treatment of borderline personality disorder, focuses on skills training. That is, it often employs mindfulness and cognitive behavioral therapy practices, but it also works to teach its patients “skills” they can use to correct maladaptive tendencies. For example, one skill DBT teaches patients is called *distress tolerance*—or, ways to cope with maladaptive thoughts and emotions in the moment. For example, people who feel an urge to cut themselves may be taught to snap their arm with a rubber band instead. The primary difference between DBT and CBT is that DBT employs techniques that address the symptoms of the problem (e.g., cutting oneself) rather than the problem itself (e.g., understanding the psychological motivation to cut oneself). CBT does not teach such skills training because of the concern that the skills—even though they may help in the short-term—may be harmful in the long-term, by maintaining maladaptive thoughts and behaviors.

DBT is founded on the perspective of a **dialectical worldview**. That is, rather than thinking of the world as “black and white,” or “only good and only bad,” it focuses on accepting that some things can have characteristics of both “good” and “bad.” So, in a case involving maladaptive thoughts, instead of teaching that a thought is entirely bad, DBT tries to help patients be less judgmental of their thoughts (as with mindfulness-based therapy) and encourages

change through therapeutic progress, using cognitive-behavioral techniques as well as mindfulness exercises.

Another form of treatment that also uses mindfulness techniques is **acceptance and commitment therapy (ACT)** (Hayes, Strosahl, & Wilson, 1999). In this treatment, patients are taught to observe their thoughts from a detached perspective (Hayes et al., 1999). ACT encourages patients *not* to attempt to change or avoid thoughts and emotions they observe in themselves, but to recognize which are beneficial and which are harmful. However, the differences among ACT, CBT, and other mindfulness-based treatments are a topic of controversy in the current literature.

ADVANTAGES AND DISADVANTAGES OF MINDFULNESS-BASED THERAPY

Two key advantages of mindfulness-based therapies are their acceptability and accessibility to patients. Because yoga and meditation are already widely known in popular culture, consumers of mental healthcare are often interested in trying related psychological therapies. Currently, psychologists have not come to a consensus on the efficacy of MBT, though growing evidence supports its effectiveness for treating mood and anxiety disorders. For example, one review of MBT studies for anxiety and depression found that mindfulness-based interventions generally led to moderate symptom improvement (Hofmann et al., 2010).

EMERGING TREATMENT STRATEGIES



Recent improvements in video chat technology along with the proliferation of mobile devices like smartphones and tablets has made online delivery of therapy more commonplace. [Image: Noba, CC BY 2.0, <https://goo.gl/BRvSA7>]

With growth in research and technology, psychologists have been able to develop new treatment strategies in recent years. Often, these approaches focus on enhancing existing treatments, such as cognitive-behavioral therapies, through the use of technological advances. For

example, *internet- and mobile-delivered therapies* make psychological treatments more available, through smartphones and online access. Clinician-supervised online CBT modules allow patients to access treatment from home on their own schedule—an opportunity particularly important for patients with less geographic or socioeconomic access to traditional treatments. Furthermore, smartphones help extend therapy to patients' daily lives, allowing for symptom tracking, homework reminders, and more frequent therapist contact.

Another benefit of technology is **cognitive bias modification**. Here, patients are given exercises, often

through the use of video games, aimed at changing their problematic thought processes. For example, researchers might use a mobile app to train alcohol abusers to avoid stimuli related to alcohol. One version of this game flashes four pictures on the screen—three alcohol cues (e.g., a can of beer, the front of a bar) and one health-related image (e.g., someone drinking water). The goal is for the patient to tap the healthy picture as fast as s/he can. Games like these aim to target patients' automatic, subconscious thoughts that may be difficult to direct through conscious effort. That is, by repeatedly tapping the healthy image, the patient learns to “ignore” the alcohol cues, so when those cues are encountered in the environment, they will be less likely to trigger the urge to drink. Approaches like these are promising because of their accessibility, however they require further research to establish their effectiveness.

Yet another emerging treatment employs *CBT-enhancing pharmaceutical agents*. These are drugs used to improve the effects of therapeutic interventions. Based on research from animal experiments, researchers have found that certain drugs influence the biological processes known to be involved in learning. Thus, if people take these drugs while going through psychotherapy, they are better able to “learn” the techniques for improvement. For example, the antibiotic d-cycloserine improves treatment for anxiety disorders by facilitating the learning processes that occur during exposure therapy. Ongoing research in this exciting area may prove to be quite fruitful.

CONCLUSION

Throughout human history we have had to deal with mental illness in one form or another. Over time, several schools of thought have emerged for treating these problems. Although various therapies have been shown to work for specific individuals, cognitive behavioral therapy is currently the treatment most widely supported by empirical research. Still, practices like psychodynamic therapies, person-centered therapy, mindfulness-based treatments, and acceptance and commitment therapy have also shown success. And, with recent advances in research and technology, clinicians are able to enhance these and other therapies to treat more patients more effectively than ever before. However, what is important in the end is that people actually seek out mental health specialists to help them with their problems. One of the biggest deterrents to doing so is that people don't understand what psychotherapy really entails. Through understanding how current practices work, not only can we better educate people about how to get the help they need, but we can continue to advance our treatments to be more effective in the future.

Outside Resources

Article: A personal account of the benefits of mindfulness-based therapy <https://www.theguardian.com/lifeandstyle/2014/jan/11/julie-myerson-mindfulness-based-cognitive-therapy>

Article: The Effect of Mindfulness-Based Therapy on Anxiety and Depression: A Meta-Analytic Review <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2848393/>

Video: An example of a person-centered therapy session.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=58#oembed-1>

Video: Carl Rogers, the founder of the humanistic, person-centered approach to psychology, discusses the position of the therapist in PCT.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=58#oembed-2>

Video: CBT (cognitive behavioral therapy) is one of the most common treatments for a range of mental health problems, from anxiety, depression, bipolar, OCD or schizophrenia. This animation explains the basics and how you can decide whether it's best for you or not.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=58#oembed-3>

Web: An overview of the purpose and practice of cognitive behavioral therapy (CBT) <http://psychcentral.com/lib/in-depth-cognitive-behavioral-therapy/>

Web: The history and development of psychoanalysis <http://www.freudfile.org/psychoanalysis/history.html>

Discussion Questions

1. Psychoanalytic theory is no longer the dominant therapeutic approach, because it lacks empirical support. Yet many consumers continue to seek psychoanalytic or psychodynamic treatments. Do

you think psychoanalysis still has a place in mental health treatment? If so, why?

2. What might be some advantages and disadvantages of technological advances in psychological treatment? What will psychotherapy look like 100 years from now?
3. Some people have argued that all therapies are about equally effective, and that they all affect change through common factors such as the involvement of a supportive therapist. Does this claim sound reasonable to you? Why or why not?
4. When choosing a psychological treatment for a specific patient, what factors besides the treatment's demonstrated efficacy should be taken into account?

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2.3 The Biological Model

ALEXIS BRIDLEY & LEE W. DAFFIN JR. AND
CARRIE CUTTLER

Section Learning Objectives

- Describe how communication in the nervous system occurs.
- List the parts of the nervous system.
- Describe the structure of the neuron and all key parts.
- Outline how neural transmission occurs.
- Identify and define important neurotransmitters.
- List the major structures of the brain.
- Clarify how specific areas of the brain are

involved in mental illness.

- Describe the role of genes in mental illness.
- Describe the role of hormonal imbalances in mental illness.
- Describe commonly used treatments for mental illness.
- Evaluate the usefulness of the biological model.

Proponents of the biological model view mental illness as being a result of a malfunction in the body to include issues with brain anatomy or chemistry. As such, we will need to establish a foundation for how communication in the nervous system occurs, what the parts of the nervous system are, what a neuron is and its structure, how neural transmission occurs, and what the parts of the brain are. While doing this, we will identify areas of concern for psychologists focused on the treatment of mental disorders.

BRAIN STRUCTURE AND CHEMISTRY

COMMUNICATION IN THE NERVOUS SYSTEM

To really understand brain structure and chemistry, it is a good idea to understand how communication occurs within the nervous system. Simply:

1. Receptor cells in each of the five sensory systems

detect energy.

2. This information is passed to the nervous system due to the process of transduction and through sensory or afferent neurons, which are part of the peripheral nervous system.
3. The information is received by brain structures (central nervous system) and perception occurs.
4. Once the information has been interpreted, commands are sent out, telling the body how to respond, also via the peripheral nervous system.

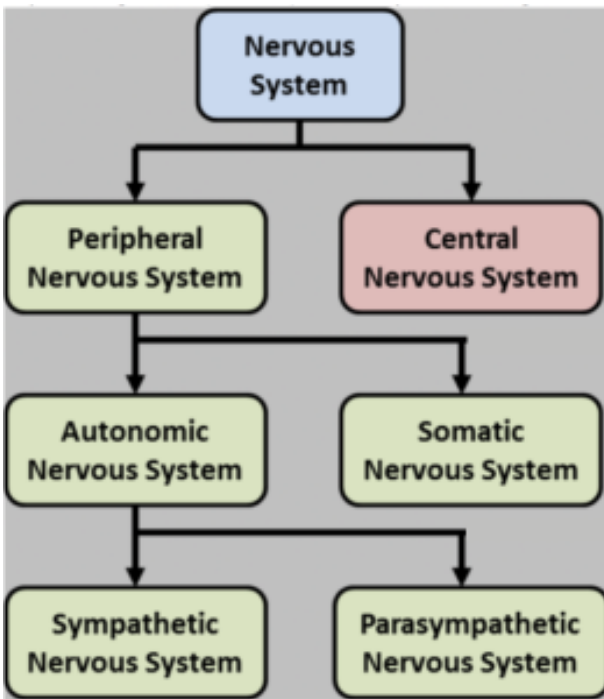
Please note that we will not cover this process in full, but just the parts relevant to our topic of psychopathology.

THE NERVOUS SYSTEM

The nervous system consists of two main parts – the central and peripheral nervous systems. The **central nervous system (CNS)** is the control center for the nervous system which receives, processes, interprets, and stores incoming sensory information. It consists of the brain and spinal cord. The **peripheral nervous system** consists of everything outside the brain and spinal cord. It handles the CNS's input and output and divides into the somatic and autonomic nervous systems. The **somatic nervous system** allows for voluntary movement by controlling the skeletal muscles and it carries sensory information to the CNS. The **autonomic nervous system** regulates the functioning of blood vessels,

glands, and internal organs such as the bladder, stomach, and heart. It consists of sympathetic and parasympathetic nervous systems. The **sympathetic nervous system** is involved when a person is intensely aroused. It provides the strength to fight back or to flee (fight-or-flight response). Eventually, the response brought about by the sympathetic nervous system must end so the **parasympathetic nervous system** kicks in to calm the body.

Figure 2.3. The Structure of the Nervous System



THE NEURON

The fundamental unit of the nervous system is the neuron,

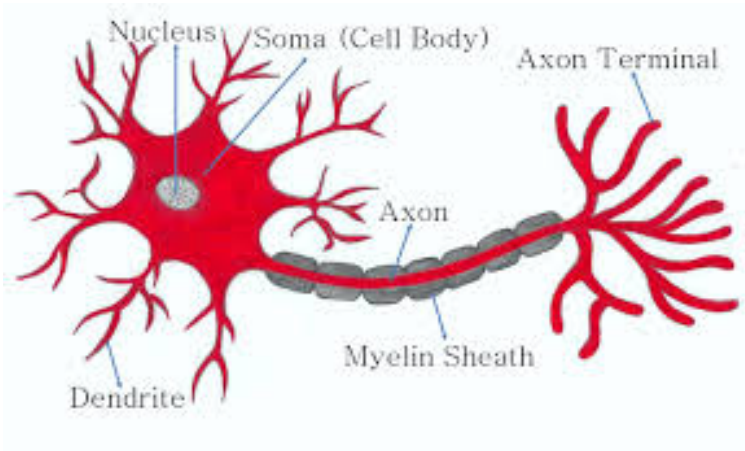
or nerve cell (See Figure 2.4). It has several structures in common with all cells in the body. The **nucleus** is the control center of the body and the **soma** is the cell body. In terms of structures that make it different, these focus on the ability of a neuron to send and receive information. The **axon** sends signals/information through the neuron while the **dendrites** receive information from neighboring neurons and look like little trees. Notice the *s* on the end of dendrite and that axon has no such letter. In other words, there are lots of dendrites but only one axon. Also of importance to the neuron is the **myelin sheath** or the white, fatty covering which: 1) provides insulation so that signals from adjacent neurons do not affect one another and, 2) increases the speed at which signals are transmitted. The **axon terminals** are the end of the axon where the electrical impulse becomes a chemical message and is released into the **synaptic cleft** which is the space between neurons.

Though not neurons, **glial cells** play an important part in helping the nervous system to be the efficient machine that it is. Glial cells are support cells in the nervous system that serve five main functions.

1. They act as a glue and hold the neuron in place.
2. They form the myelin sheath.
3. They provide nourishment for the cell.
4. They remove waste products.
5. They protect the neuron from harmful substances.

Finally, **nerves** are a group of axons bundled together like wires in an electrical cable.

Figure 2.4. The Structure of the Neuron



NEURAL TRANSMISSION

Transducers or receptor cells in the major organs of our five sensory systems – vision (the eyes), hearing (the ears), smell (the nose), touch (the skin), and taste (the tongue) – convert the physical energy that they detect or sense, and send it to the brain via the neural impulse. How so? We will cover this process in three parts.

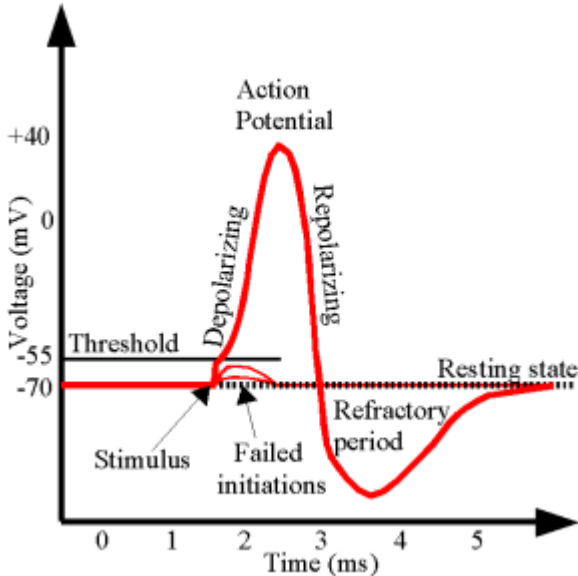
Part 1. The Neural Impulse

- Step 1 – Neurons waiting to fire are said to be in **resting potential** and to be **polarized** (meaning they have a negative charge inside the neuron and a positive charge outside).

- Step 2 – If adequately stimulated, the neuron experiences an **action potential** and becomes **depolarized**. When this occurs, ion gated channels open allowing positively charged Sodium (Na) ions to enter. This shifts the polarity to positive on the inside and negative outside.
- Step 3 – Once the action potential passes from one segment of the axon to the next, the previous segment begins to **repolarize**. This occurs because the Na channels close and Potassium (K) channels open. K has a positive charge and so the neuron becomes negative again on the inside and positive on the outside.
- Step 4 – After the neuron fires, it will not fire again no matter how much stimulation it receives. This is called the **absolute refractory period**.
- Step 5 – After a short period of time, the neuron can fire again, but needs greater than normal levels of stimulation to do so. This is called the **relative refractory period**.
- Step 6 – Please note that the process is cyclical. Once the relative refractory period has passed the neuron returns to its resting potential.

Part 2. The Action Potential

Let's look at the electrical portion of the process in another way and add some detail.

Figure 2.5. *The Action Potential*

- Recall that a neuron is normally at resting potential and polarized. The charge inside is -70mV at rest.
- If it receives sufficient stimulation meaning that the polarity inside the neuron rises from -70 mV to -55mV defined as the **threshold of excitation**, the neuron will **fire** or send an electrical impulse down the length of the axon (the action potential or depolarization). It should be noted that it either hits -55mV and fires or it does not. This is the **all-or-nothing principle**. The threshold must be reached.
- Once the electrical impulse has passed from one

segment of the axon to the next, the neuron begins the process of resetting called repolarization.

- During repolarization, the neuron will not fire no matter how much stimulation it receives. This is called absolute refractory period.
- The neuron next moves into relative refractory period meaning it can fire, but needs greater than normal levels of stimulation. Notice how the line has dropped below -70mV . Hence, to reach -55mV and fire, it will need more than the normal gain of $+15\text{mV}$ (-70 to -55 mV).
- And then it returns to resting potential, as you saw in Figure 2.3

Ions are charged particles found both inside and outside the neuron. It is positively charged Sodium (Na) ions that cause the neuron to depolarize and fire and positively charged Potassium (K) ions that exit and return the neuron to a polarized state.

Part 3. The Synapse

The electrical portion of the neural impulse is just the start. The actual code passes from one neuron to another in a chemical form called a **neurotransmitter**. The point where this occurs is called the **synapse**. The synapse consists of three parts – the axon *terminals* of the sending neuron (presynaptic neuron); the *space* in between called the **synaptic cleft**, **space**, or **gap**; and the *dendrite* of the receiving neuron

(postsynaptic neuron). Once the electrical impulse reaches the end of the axon, called the **axon terminal**, it stimulates synaptic vesicles or neurotransmitter sacs to release the neurotransmitter. Neurotransmitters will only bind to their specific **receptor sites**, much like a key will only fit into the lock it was designed for. You might say neurotransmitters are part of a lock-and-key system. What happens to the neurotransmitters that do not bind to a receptor site? They might go through **reuptake** which is a process in which the presynaptic neuron takes back excess neurotransmitters in the synaptic space for future use or **enzymatic degradation** when enzymes destroy excess neurotransmitters in the synaptic space.

NEUROTRANSMITTERS

What exactly are some of the neurotransmitters which are so critical for neural transmission, and are important to our discussion of psychopathology?

- **Dopamine** – controls voluntary movements and is associated with the reward mechanism in the brain
- **Serotonin** – controls pain, sleep cycle, and digestion; leads to a stable mood and so low levels leads to depression
- **Norepinephrine** – increases the heart rate and blood pressure and regulates mood
- **GABA** – an inhibitory neurotransmitter

responsible for blocking the signals of excitatory neurotransmitters responsible for anxiety and panic.

- **Glutamate** – an excitatory neurotransmitter associated with learning and memory

The critical thing to understand here is that there is a belief in the realm of mental health that chemical imbalances are responsible for many mental disorders. Chief among these are neurotransmitter imbalances. For instance, people with Seasonal Affective Disorder (SAD) have difficulty regulating serotonin. More on this throughout the book as we discuss each disorder.

THE BRAIN

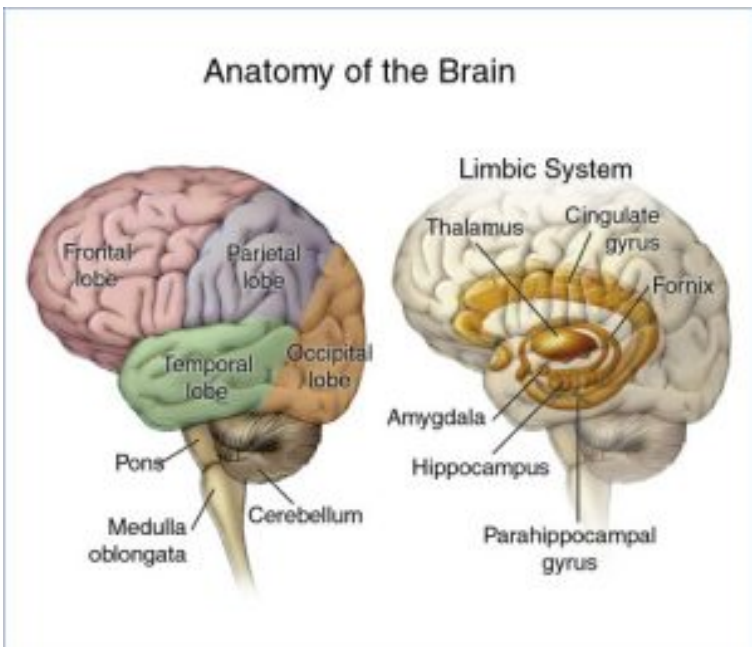
The central nervous system consists of the brain and spinal cord; the former we will discuss briefly and in terms of key structures which include:

- **Medulla** – regulates breathing, heart rate, and blood pressure
- **Pons** – acts as a bridge connecting the cerebellum and medulla and helps to transfer messages between different parts of the brain and spinal cord.
- **Reticular formation** – responsible for alertness and attention

- **Cerebellum** – involved in our sense of balance and for coordinating the body’s muscles so that movement is smooth and precise. Involved in the learning of certain kinds of simple responses and acquired reflexes.
- **Thalamus** – major sensory relay center for all senses except smell.
- **Hypothalamus** – involved in drives associated with the survival of both the individual and the species. It regulates temperature by triggering sweating or shivering and controls the complex operations of the autonomic nervous system
- **Amygdala** – responsible for evaluating sensory information and quickly determining its emotional importance
- **Hippocampus** – our “gateway” to memory. Allows us to form spatial memories so that we can accurately navigate through our environment and helps us to form new memories (involved in memory consolidation)
- The **cerebrum** has four distinct regions in each cerebral hemisphere. First, the **frontal lobe** contains the motor cortex which issues orders to the muscles of the body that produce voluntary movement. The frontal lobe is also involved in emotion and in the ability to make plans, think

creatively, and take initiative. The **parietal lobe** contains the somatosensory cortex and receives information about pressure, pain, touch, and temperature from sense receptors in the skin, muscles, joints, internal organs, and taste buds. The occipital lobe contains the **visual** cortex and receives and processes visual information. Finally, the temporal lobe is involved in memory, perception, and emotion. It contains the **auditory** cortex which processes sound.

Figure 2.6. Anatomy of the Brain



Of course, this is not an exhaustive list of structures found

in the brain but gives you a pretty good idea of function and which structures help to support those functions. What is important to mental health professionals is that for some disorders, specific areas of the brain are involved. For instance, individuals with borderline personality disorder have been shown to have structural and functional changes in brain areas associated with impulse control and emotional regulation while imaging studies reveal differences in the frontal cortex and subcortical structures of individuals with OCD.

Exercises

Check out the following from Harvard Health for more on depression and the brain as a cause:
<https://www.health.harvard.edu/mind-and-mood/what-causes-depression>

GENES, HORMONAL IMBALANCES, AND VIRAL INFECTIONS

GENETIC ISSUES AND EXPLANATIONS

DNA, or deoxyribonucleic acid, is our heredity material and is found in the nucleus of each cell packaged in threadlike structures known as *chromosomes*. Most of us have 23 pairs of chromosomes or 46 total. Twenty-two of these pairs are the same in both sexes, but the 23rd pair is called the sex chromosome and differs between males and females. Males

have X and Y chromosomes while females have two Xs. According to the Genetics Home Reference website as part of NIH's National Library of Medicine, a *gene* is "the basic physical and functional unit of heredity" (<https://ghr.nlm.nih.gov/primer/basics/gene>). They act as the instructions to make proteins and it is estimated by the Human Genome Project that we have between 20,000 and 25,000 genes. We all have two copies of each gene and one is inherited from our mother and one from our father.

Recent research has discovered that autism, ADHD, bipolar disorder, major depression, and schizophrenia all share genetic roots. They "were more likely to have suspect genetic variation at the same four chromosomal sites. These included risk versions of two genes that regulate the flow of calcium into cells." For more on this development, please check out the article at: <https://www.nih.gov/news-events/nih-research-matters/common-genetic-factors-found-5-mental-disorders>. Likewise, twin and family studies have shown that people with first-degree relatives with OCD are at higher risk of developing the disorder themselves. The same is true of most mental disorders. Indeed, it is presently believed that genetic factors contribute to all mental disorders but typically account for less than half of the explanation. Moreover, most mental disorders are linked to abnormalities in many genes, rather than just one; that is, most are **polygenetic**.

Moreover, there are important gene-environment interactions that are unique for every person (even twins) which help to explain why some people with a genetic

predisposition toward a certain disorder develop that disorder and others do not (e.g., why one identical twin may develop schizophrenia but the other does not). The **diathesis-stress model** posits that people can inherit tendencies or vulnerabilities to express certain traits, behaviors, or disorders, which may then be activated under certain environmental conditions like stress (e.g., abuse, traumatic events). However, it is also important to note that certain protective factors (like being raised in a consistent, loving, supportive environment) may modify the response to stress and thereby help to protect individuals against mental disorders.

Exercises

For more on the role of genes in the development of mental illness, check out this article from Psychology Today:

<https://www.psychologytoday.com/blog/saving-normal/201604/what-you-need-know-about-the-genetics-mental-disorders>

HORMONAL IMBALANCES

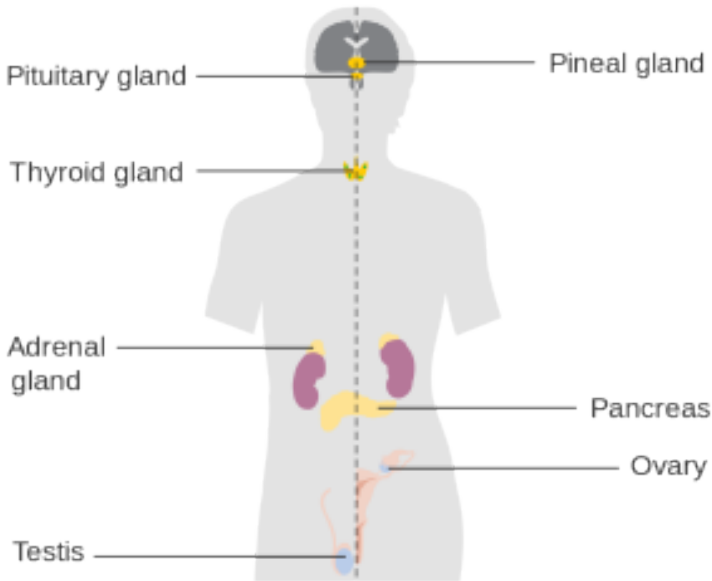
The body has two coordinating and integrating systems in the body. The nervous system is one and the endocrine system is the second. The main difference between these two systems is in terms of the speed with which they act. The nervous system moves quickly with nerve impulses moving in a few hundredths of a second. The endocrine system

moves slowly with hormones, released by endocrine glands, taking seconds, or even minutes, to reach their target. Hormones are important to psychologists because they organize the nervous system and body tissues at certain stages of development and activate behaviors such as alertness or sleepiness, sexual behavior, concentration, aggressiveness, reaction to stress, a desire for companionship.

The **pituitary gland** is the “master gland” which regulates other endocrine glands. It influences blood pressure, thirst, contractions of the uterus during childbirth, milk production, sexual behavior and interest, body growth, the amount of water in the body’s cells, and other functions as well. The **pineal gland** produces melatonin which helps regulate the sleep-wake cycle and other circadian rhythms. Overproduction of the hormone melatonin can lead to Seasonal Affective Disorder (a specific type of Major Depressive Disorder). The **thyroid gland** produces thyroxin which facilitates energy, metabolism, and growth. Hypothyroidism is a condition in which the thyroid glands become underactive and this condition can produce symptoms of depression. In contrast, hyperthyroidism is a condition in which the thyroid glands become overactive and this condition can produce symptoms of mania. Therefore it is important for individuals experiencing these symptoms to have their thyroid checked, because conventional treatments for depression and mania will not correct the problem with the thyroid, and will therefore not resolve the symptoms. Rather, individuals with these conditions need to be treated

with thyroid medications. Also of key importance to mental health professionals are the **adrenal glands** which are located on top of the kidneys, and release *cortisol* which helps the body deal with stress. However, chronically, elevated levels of cortisol can lead to increased weight gain, interfere with learning and memory, decrease the immune response, reduce bone density, increase cholesterol, and increase the risk of depression.

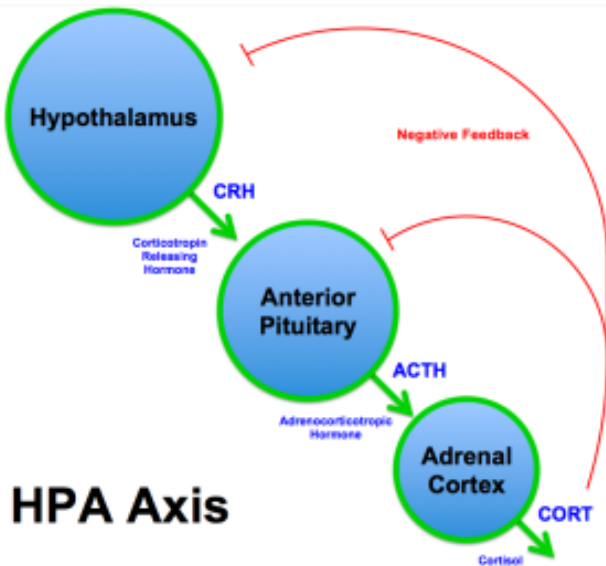
Figure 2.7. Hormone Systems



The **Hypothalamic-Pituitary-Adrenal-Cortical Axis (HPA Axis)** is the connection between the hypothalamus, pituitary glands, and adrenal glands. Specifically, the hypothalamus releases corticotropin-releasing factor (CRF)

which stimulates the anterior pituitary to release adrenocorticotrophic hormone (ACTH), which in turn stimulates the adrenal cortex to release cortisol (see Figure 2.4). Malfunctioning of this system is implicated in a wide range of mental disorders including, depression, anxiety, and post-traumatic stress disorder. Exposure to chronic, unpredictable stress during early development can sensitive this system, making it over-responsive to stress (meaning it activates too readily and does not shut down appropriately). Sensitization of the HPA axis leads to an overproduction of cortisol which once again can damage the body and brain when it remains at chronically high levels.

Figure 2.8. The HPA Axis



For more on the link between cortisol and depression, check out this article:

<https://www.psychologytoday.com/blog/the-athletes-way/201301/cortisol-why-the-stress-hormone-is-public-enemy-no-1>

VIRAL INFECTIONS

Infections can cause brain damage and lead to the development of mental illness or an exacerbation of symptoms. For example, evidence suggests that contracting strep infection can lead to the development of OCD, Tourette's syndrome, and tic disorder in children (Mell, Davis, & Owens, 2005; Giedd et al., 2000; Allen et al., 1995; <https://www.psychologytoday.com/blog/the-perfectionists-handbook/201202/can-infections-result-in-mental-illness>).

Influenza epidemics have also been linked to schizophrenia (Brown et al., 2004; McGrath and Castle, 1995; McGrath et al., 1994; O'Callaghan et al., 1991) though more recent research suggests this evidence is weak at best (Selten & Termorshuizen, 2017; Ebert & Kotler, 2005).

TREATMENTS

PSYCHOPHARMACOLOGY AND PSYCHOTROPIC DRUGS

One option to treat severe mental illness is psychotropic medications. These medications fall into five major categories. In this section we will broadly discuss these categories, and in the next we will cover them in more detail.

Antidepressants are used to treat depression, but also anxiety, insomnia, or pain. The most common types of antidepressants are selective serotonin reuptake inhibitors (SSRIs) and include Citalopram (Celexa), Paroxetine, and Fluoxetine (Prozac). They can often take 2-6 weeks to take effect. Possible side effects include weight gain, sleepiness, nausea and vomiting, panic attacks, or thoughts about suicide or dying.

Anti-anxiety medications help with the symptoms of anxiety and include the benzodiazepines such as Diazepam (Valium), Alprazolam (Xanax), and Lorazepam (Ativan). These medications are effective in reducing anxiety in the short-term and take less time to take effect than antidepressants which are also commonly prescribed for anxiety. However, benzodiazepines are rather addictive. As such, tolerance to these drugs can develop quickly and individuals may experience withdrawal symptoms (e.g., anxiety, panic, insomnia) when they cease taking the drugs. For this reason, benzodiazepines should not be used in the long-term. Side

effects include drowsiness, dizziness, nausea, difficulty urinating, and irregular heartbeat, to name a few.

Stimulants increase one's alertness and attention and are frequently used to treat ADHD. They include Lisdexamfetamine, the combination of dextroamphetamine and amphetamine, and Methylphenidate (Ritalin). Stimulants are generally effective and produce a calming effect. Possible side effects include loss of appetite, headache, motor tics or verbal tics, and personality changes such as appearing emotionless.

Antipsychotics are used to treat psychosis (i.e., hallucinations and delusions). They can also be used to treat eating disorders, severe depression, PTSD, OCD, ADHD, and Generalized Anxiety Disorder. Common antipsychotics include Chlorpromazine, Perphenazine, Quetiapine, and Lurasidone. Side effects include nausea, vomiting, blurred vision, weight gain, restlessness, tremors, and rigidity.

Mood stabilizers are used to treat bipolar disorder and at times depression, schizoaffective disorder, and disorders of impulse control. A common example is Lithium and side effects include loss of coordination, hallucinations, seizures, and frequent urination.

For more information on psychotropic medications,
please visit:

<https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml>

The use of these drugs has been generally beneficial to patients. Most report that their symptoms decline, leading them to feel better and improve their functioning. Also, long-term hospitalizations are less likely to occur as a result, though the medications do not benefit the individual in terms of improved living skills.

ELECTROCONVULSIVE THERAPY

According to Mental Health America, “Electroconvulsive therapy (ECT) is a procedure in which a brief application of electric stimulus is used to produce a generalized seizure.” Patients are placed on a padded bed and administered a muscle relaxant to avoid injury during the seizures. Annually, approximately 100,000 are treated using ECT for conditions including severe depression, acute mania, and suicidality. The procedure is still the most controversial available to mental health professionals due to “its effectiveness vs. the side effects, the objectivity of ECT experts, and the recent increase in ECT as a quick and easy solution, instead of long-term psychotherapy or hospitalization”

(<http://www.mentalhealthamerica.net/ect>). Its popularity has declined since the 1940s and 1950s.

PSYCHOSURGERY

Another option to treat mental disorders is to perform brain surgeries. In the past, we have conducted trephining and lobotomies, neither of which are used today. Today's techniques are much more sophisticated and have been used to treat schizophrenia, depression, and obsessive-compulsive disorder, though critics cite obvious ethical issues with conducting such surgeries as well as scientific issues. Due to these issues, psychosurgery is only used as a radical last resort when all other treatment options have failed to resolve a serious mental illness.

For more on psychosurgery, check out this article from Psychology Today:

<https://www.psychologytoday.com/articles/199203/psychosurgery>

EVALUATION OF THE MODEL

The biological model is generally well respected today but suffers a few key issues. First, consider the list of side effects given for the psychotropic medications. You might make the case that some of the side effects are worse than the

condition they are treating. Second, the viewpoint that all human behavior is explainable in biological terms, and therefore, when issues arise they can be treated using biological methods, overlooks factors that are not biological in nature. More on that over the next two sections.

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2.4 Psychopharmacology

SUSAN BARRON

Section Learning Objectives

- How do the majority of psychoactive drugs work in the brain?
- How does the route of administration affect how rewarding a drug might be?
- Why is grapefruit dangerous to consume with many psychotropic medications?

- Why might individualized drug doses based on genetic screening be helpful for treating conditions like depression?
- Why is there controversy regarding pharmacotherapy for children, adolescents, and the elderly?

Psychopharmacology is the study of how drugs affect behavior. If a drug changes your perception, or the way you feel or think, the drug exerts effects on your brain and nervous system. We call drugs that change the way you think or feel psychoactive or psychotropic drugs, and almost everyone has used a psychoactive drug at some point (yes, caffeine counts). Understanding some of the basics about psychopharmacology can help us better understand a wide range of things that interest psychologists and others. For example, the pharmacological treatment of certain neurodegenerative diseases such as Parkinson's disease tells us something about the disease itself. The pharmacological treatments used to treat psychiatric conditions such as schizophrenia or depression have undergone amazing development since the 1950s, and the drugs used to treat these disorders tell us something about what is happening in the brain of individuals with these conditions. Finally, understanding something about the actions of drugs of abuse and their routes of administration can help us understand why some psychoactive drugs are so addictive. In this module,

we will provide an overview of some of these topics as well as discuss some current controversial areas in the field of psychopharmacology.

INTRODUCTION

Psychopharmacology, the study of how drugs affect the brain and behavior, is a relatively new science, although people have probably been taking drugs to change how they feel from early in human history (consider the of eating fermented fruit, ancient beer recipes, chewing on the leaves of the cocaine plant for stimulant properties as just some examples). The word *psychopharmacology* itself tells us that this is a field that bridges our understanding of behavior (and brain) and pharmacology, and the range of topics included within this field is extremely broad.

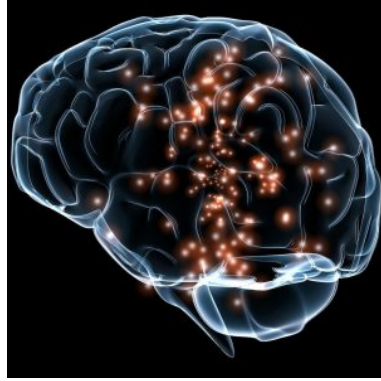
Virtually any drug that changes the way you feel does this by altering how neurons communicate with each other. Neurons (more than 100 billion in your nervous system) communicate with each other by releasing a chemical

(**neurotransmitter**) across a tiny space between two neurons (the **synapse**).

When the neurotransmitter crosses the synapse, it binds to a postsynaptic receptor

(protein) on the receiving neuron and the message may then be transmitted onward. Obviously, neurotransmission is far more complicated than this – links at the end of this module can provide some useful background if you want more detail – but the first step is understanding that virtually all **psychoactive drugs** interfere with or alter how neurons communicate with each other.

There are many neurotransmitters. Some of the most important in terms of psychopharmacological treatment and drugs of abuse are outlined in Table 1. The neurons that release these neurotransmitters, for the most part, are localized within specific circuits of the brain that mediate these



Drugs that alter our feelings and behavior do so by affecting the communication between neurons in the brain. [Image: <https://goo.gl/oQCafL>, CC0 Public Domain, <https://goo.gl/m25gce>]

behaviors. Psychoactive drugs can either increase activity at the synapse (these are called **agonists**) or reduce activity at the synapse (**antagonists**). Different drugs do this by different mechanisms, and some examples of agonists and antagonists are presented in Table 2. For each example, the drug's trade name, which is the name of the drug provided by the drug company, and generic name (in parentheses) are provided.

Neurotransmitter	Abbreviation	Behaviors or Diseases Related to These Neurotransmitter
Acetylcholine	ACh	Learning and memory; Alzheimer's disease; muscle movement in the peripheral nervous system
Dopamine	DA	Reward circuits; Motor circuits involved in Parkinson's disease; Schizophrenia
Norepinephrine	NE	Arousal; Depression
Serotonin	5HT	Depression; Aggression; Schizophrenia
Glutamate	GLU	Learning; Major excitatory neurotransmitter in the brain
GABA	GABA	Anxiety disorders; Epilepsy; Major inhibitory neurotransmitter in the brain
Endogenous Opioids	Endorphins, Enkephalins	Pain; Analgesia; Reward

Table 2.1 Neurotransmitters and associated behaviours or diseases

A very useful link at the end of this module shows the various steps involved in neurotransmission and some ways drugs can alter this.

Table 2 provides examples of drugs and their primary

mechanism of action, but it is very important to realize that drugs also have effects on other neurotransmitters. This contributes to the kinds of side effects that are observed when someone takes a particular drug. The reality is that no drugs currently available work only exactly where we would like in the brain or only on a specific neurotransmitter. In many cases, individuals are sometimes prescribed one **psychotropic drug** but then may also have to take additional drugs to reduce the side effects caused by the initial drug. Sometimes individuals stop taking medication because the side effects can be so profound.

Drug	Mechanism	Use	Agonist/Antagonist
L-dopa	Increase synthesis of DA	Parkinson's disease	Agonist for DA
Adderall (mixed salts amphetamine)	Increase release of DA, NE	ADHD	Agonist for DA, NE
Ritalin (methylphenidate)	Blocks removal of DA, NE, and lesser (SHT) from synapse	ADHD	Agonist for DA, NE mostly
Aricept (donepezil)	Blocks removal of ACh from synapse	Alzheimer's disease	Agonist for ACh
Prozac (fluoxetine)	Blocks removal of SHT from synapse	Depression, obsessive compulsive disorder	Agonist SHT
Seroquel (quetiapine)	Blocks DA and SHT receptors	Schizophrenia, bipolar disorder	Antagonist for DA, SHT
Revia (naltrexone)	Blocks opioid post-synaptic receptors	Alcoholism, opioid addiction	Antagonist (for opioids)

Table 2.2 Examples of drugs and their primary mechanism of action

PHARMACOKINETICS: WHAT IS IT – WHY IS IT IMPORTANT?

While this section may sound more like pharmacology, it is important to realize how important pharmacokinetics can be when considering psychoactive

drugs. **Pharmacokinetics** refers to how the body handles a drug that we take. As mentioned earlier, psychoactive drugs exert their effects on behavior by altering neuronal communication in the brain, and the majority of drugs reach the brain by traveling in the blood. The acronym ADME is often used with A standing for absorption (how the drug gets into the blood), Distribution (how the drug gets to the organ of interest – in this module, that is the brain), Metabolism (how the drug is broken down so it no longer exerts its psychoactive effects), and Excretion (how the drug leaves the body). We will talk about a couple of these to show their importance for considering psychoactive drugs.

DRUG ADMINISTRATION



A drug delivered by IV reaches the brain more quickly than if the drug is taken orally. While rapid delivery has advantages, there are also risks involved with IV administration.

[Image: Calleamanecer, <https://goo.gl/OX6Yj5>, CC BY-SA 3.0, <https://goo.gl/eLCn2O>]

There are many ways to take drugs, and these routes of drug administration can have a significant impact on how quickly that drug reaches brain. The most common route of administration is oral administration, which is relatively slow and – perhaps surprisingly – often the most variable and complex route of administration. Drugs enter the stomach and then get absorbed by the blood supply and capillaries that line the small intestine. The

rate of absorption can be affected by a variety of factors including the quantity and the type of food in the stomach (e.g., fats vs. proteins). This is why the medicine label for some drugs (like antibiotics) may specifically state foods that you should or should NOT consume within an hour of taking the drug because they can affect the rate of absorption. Two of the most rapid routes of administration include inhalation (i.e., smoking or gaseous anesthesia) and intravenous (IV) in which the drug is injected directly into

the vein and hence the blood supply. Both of these routes of administration can get the drug to brain in less than 10 seconds. IV administration also has the distinction of being the most dangerous because if there is an adverse drug reaction, there is very little time to administer any antidote, as in the case of an IV heroin overdose.

Why might how quickly a drug gets to the brain be important? If a drug activates the reward circuits in the brain AND it reaches the brain very quickly, the drug has a high risk for abuse and addiction. Psychostimulants like amphetamine or cocaine are examples of drugs that have high risk for abuse because they are agonists at DA neurons involved in reward AND because these drugs exist in forms that can be either smoked or injected intravenously. Some argue that cigarette smoking is one of the hardest addictions to quit, and although part of the reason for this may be that smoking gets the nicotine into the brain very quickly (and indirectly acts on DA neurons), it is a more complicated story. For drugs that reach the brain very quickly, not only is the drug very addictive, but so are the cues associated with the drug (see Rohsenow, Niaura, Childress, Abrams, & Monti, 1990). For a crack user, this could be the pipe that they use to smoke the drug. For a cigarette smoker, however, it could be something as normal as finishing dinner or waking up in the morning (if that is when the smoker usually has a cigarette). For both the crack user and the cigarette smoker, the cues associated with the drug may actually cause craving that is alleviated by (you guessed it) – lighting a cigarette or using

crack (i.e., relapse). This is one of the reasons individuals that enroll in drug treatment programs, especially out-of-town programs, are at significant risk of relapse if they later find themselves in proximity to old haunts, friends, etc. But this is much *more* difficult for a cigarette smoker. How can someone avoid eating? Or avoid waking up in the morning, etc. These examples help you begin to understand how important the route of administration can be for psychoactive drugs.

DRUG METABOLISM

Metabolism involves the breakdown of psychoactive drugs, and this occurs primarily in the liver. The liver produces **enzymes** (proteins that speed up a chemical reaction), and these enzymes help catalyze a chemical reaction that breaks down psychoactive drugs. Enzymes exist in “families,” and many psychoactive drugs are broken down by the same family of enzymes, the cytochrome P450 superfamily. There is not a unique enzyme for each drug; rather, certain enzymes can break down a wide variety of drugs. Tolerance to the effects of many drugs can occur with repeated exposure; that is, the drug produces less of an effect over time, so more of the drug is needed to get the same effect. This is particularly true for sedative drugs like alcohol or opiate-based painkillers. *Metabolic tolerance* is one kind of tolerance and it takes place in the liver. Some drugs (like alcohol) cause **enzyme induction** – an increase in the enzymes produced by the liver. For example, chronic drinking results in alcohol being broken down more quickly,

so the alcoholic needs to drink more to get the same effect – of course, until so much alcohol is consumed that it damages the liver (alcohol can cause fatty liver or cirrhosis).

RECENT ISSUES RELATED TO PSYCHOTROPIC DRUGS AND METABOLISM

GRAPEFRUIT JUICE AND METABOLISM



Grapefruit can interfere with enzymes in the liver that help the body to process certain drugs.

[Image: CC0 Public Domain, <https://goo.gl/m25gce>]

Certain types of food in the stomach can alter the rate of drug absorption, and other foods can also alter the rate of drug metabolism. The most well known is grapefruit juice. Grapefruit juice suppresses cytochrome P450 enzymes in the liver, and these liver enzymes normally break down a large variety of drugs (including some of the psychotropic drugs). If the enzymes are suppressed, drug levels can build up to

potentially toxic levels. In this case, the effects can persist for extended periods of time after the consumption of grapefruit juice. As of 2013, there are at least 85 drugs shown to adversely interact with grapefruit juice (Bailey, Dresser, & Arnold, 2013). Some psychotropic drugs that are likely to

interact with grapefruit juice include carbamazepine (Tegretol), prescribed for bipolar disorder; diazepam (Valium), used to treat anxiety, alcohol withdrawal, and muscle spasms; and fluvoxamine (Luvox), used to treat obsessive compulsive disorder and depression. A link at the end of this module gives the latest list of drugs reported to have this unusual interaction.

INDIVIDUALIZED THERAPY, METABOLIC
DIFFERENCES, AND POTENTIAL PRESCRIBING
APPROACHES FOR THE FUTURE

Mental illnesses contribute to more disability in western countries than all other illnesses including cancer and heart disease. Depression alone is predicted to be the second largest contributor to disease burden by 2020 (World Health Organization, 2004). The numbers of people affected by mental health issues are pretty astonishing, with estimates that 25% of adults experience a mental health issue in any given year, and this affects not only the individual but their friends and family. One in 17 adults experiences a serious mental illness (Kessler, Chiu, Demler, & Walters, 2005). Newer antidepressants are probably the most frequently prescribed drugs for treating mental health issues, although there is no “magic bullet” for treating depression or other conditions. Pharmacotherapy with psychological therapy may be the most beneficial treatment approach for many psychiatric conditions, but there are still many unanswered questions. For example, why does one antidepressant help one

individual yet have no effect for another? Antidepressants can take 4 to 6 weeks to start improving depressive symptoms, and we don't really understand why. Many people do not respond to the first antidepressant prescribed and may have to try different drugs before finding something that works for them. Other people just do not improve with antidepressants (Ioannidis, 2008). As we better understand why individuals differ, the easier and more rapidly we will be able to help people in distress.

One area that has received interest recently has to do with an individualized treatment approach. We now know that there are genetic differences in some of the cytochrome P450 enzymes and their ability to break down drugs. The general population falls into the following 4 categories: 1) *ultra-extensive metabolizers* break down certain drugs (like some of the current antidepressants) very, very quickly, 2) *extensive metabolizers* are also able to break down drugs fairly quickly, 3) *intermediate metabolizers* break down drugs more slowly than either of the two above groups, and finally 4) *poor metabolizers* break down drugs much more slowly than all of the other groups. Now consider someone receiving a prescription for an antidepressant – what would the consequences be if they were either an ultra-extensive metabolizer or a poor metabolizer? The ultra-extensive metabolizer would be given antidepressants and told it will probably take 4 to 6 weeks to begin working (this is true), but they metabolize the medication so quickly that it will never be effective for them. In contrast, the poor metabolizer given

the same daily dose of the same antidepressant may build up such high levels in their blood (because they are not breaking the drug down), that they will have a wide range of side effects and feel really badly – also not a positive outcome. What if – instead – prior to prescribing an antidepressant, the doctor could take a blood sample and determine which type of metabolizer a patient actually was? They could then make a much more informed decision about the best dose to prescribe. There are new genetic tests now available to better individualize treatment in just this way. A blood sample can determine (at least for some drugs) which category an individual fits into, but we need data to determine if this actually is effective for treating depression or other mental illnesses (Zhou, 2009). Currently, this genetic test is expensive and not many health insurance plans cover this screen, but this may be an important component in the future of psychopharmacology.

OTHER CONTROVERSIAL ISSUES

JUVENILES AND PSYCHOPHARMACOLOGY

A recent Centers for Disease Control (CDC) report has suggested that as many as 1 in 5 children between the ages of 5 and 17 may have some type of mental disorder (e.g., ADHD, autism, anxiety, depression) (CDC, 2013). The incidence of bipolar disorder in children and adolescents has also increased 40 times in the past decade (Moreno, Laje, Blanco, Jiang, Schmidt, & Olfson, 2007), and it is now estimated that 1 in 88 children have been diagnosed with an

autism spectrum disorder (CDC, 2011). Why has there been such an increase in these numbers? There is no single answer to this important question. Some believe that greater public awareness has contributed to increased teacher and parent referrals. Others argue that the increase stems from changes in criterion currently used for diagnosing. Still others suggest environmental factors, either prenatally or postnatally, have contributed to this upsurge.

We do not have an answer, but the question does bring up an additional controversy related to how we should treat this population of children and adolescents.

Many psychotropic drugs used for treating psychiatric disorders have been tested in adults, but few have been tested for safety or efficacy with children or adolescents. The most well-established psychotropics prescribed for children and



There are concerns about both the safety and efficacy of drugs like Prozac for children and teens. [Image: zaza_bj, CC BY-NC-SA 2.0, <https://goo.gl/Toc0ZF>]

adolescents are the psychostimulant drugs used for treating attention deficit hyperactivity disorder (ADHD), and there are clinical data on how effective these drugs are. However, we know far less about the safety and efficacy in young

populations of the drugs typically prescribed for treating anxiety, depression, or other psychiatric disorders. The young brain continues to mature until probably well after age 20, so some scientists are concerned that drugs that alter neuronal activity in the developing brain could have significant consequences. There is an obvious need for clinical trials in children and adolescents to test the safety and effectiveness of many of these drugs, which also brings up a variety of ethical questions about who decides what children and adolescents will participate in these clinical trials, who can give consent, who receives reimbursements, etc.

THE ELDERLY AND PSYCHOPHARMACOLOGY

Another population that has not typically been included in clinical trials to determine the safety or effectiveness of psychotropic drugs is the elderly. Currently, there is very little high-quality evidence to guide prescribing for older people – clinical trials often exclude people with multiple comorbidities (other diseases, conditions, etc.), which are typical for elderly populations (see Hilmer and Gnjidict, 2008; Pollock, Forsyth, & Bies, 2008). This is a serious issue because the elderly consume a disproportionate number of the prescription meds prescribed. The term **polypharmacy** refers to the use of multiple drugs, which is very common in elderly populations in the United States. As our population ages, some estimate that the proportion of people 65 or older will reach 20% of the U.S. population by 2030, with this group consuming 40% of the

prescribed medications. As shown in Table 3 (from Schwartz and Abernethy, 2008), it is quite clear why the typical clinical trial that looks at the safety and effectiveness of psychotropic drugs can be problematic if we try to interpret these results for an elderly population.

Clinical Trial Subjects	Aged Patients Who Receive Drug Therapies
One drug	Drug of interest and medications
Single doses	Chronic administration
No disease	Multiple diseases
No alcohol, tobacco, OTC* drugs, nutraceuticals	OTC* drugs, nutraceuticals, alcohol, tobacco, and other
20-40 years (vs 60-75 years)	65-100+ years
Caucasians	Caucasians and minorities
Selection bias	All comers/socioeconomic basis

*OTC = Over the counter

Table 2.3 Comparison of clinical trial subjects and aged patients receiving drug therapies

Metabolism of drugs is often slowed considerably for elderly populations, so less drug can produce the same effect (or all too often, too much drug can result in a variety of side effects). One of the greatest risk factors for elderly populations is falling (and breaking bones), which can happen if the elderly person gets dizzy from too much of a drug. There is also evidence that psychotropic medications can reduce bone density (thus worsening the consequences if someone

falls) (Brown & Mezuk, 2012). Although we are gaining an awareness about some of the issues facing pharmacotherapy in older populations, this is a very complex area with many medical and ethical questions.

This module provided an introduction of some of the important areas in the field of psychopharmacology. It should be apparent that this module just touched on a number of topics included in this field. It should also be apparent that understanding more about psychopharmacology is important to anyone interested in understanding behavior and that our understanding of issues in this field has important implications for society.

Outside Resources

Video: Neurotransmission



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=75#oembed-1>

Web: Description of how some drugs work and the brain

areas involved – 1 <http://www.drugabuse.gov/news-events/nida-notes/2007/10/impacts-drugs-neurotransmission>

Web: Description of how some drugs work and the brain areas involved – 2 <http://learn.genetics.utah.edu/content/addiction/mouse/>

Web: Information about how neurons communicate and the reward pathways <http://learn.genetics.utah.edu/content/addiction/rewardbehavior/>

Web: National Institute of Alcohol Abuse and Alcoholism <http://www.niaaa.nih.gov/>

Web: National Institute of Drug Abuse <http://www.drugabuse.gov/>

Web: National Institute of Mental Health <http://www.nimh.nih.gov/index.shtml>

Web: Neurotransmission https://science.education.nih.gov/supplements/nih2/Addiction/activities/lesson2_neurotransmission.html

Web: Report of the Working Group on Psychotropic Medications for Children and Adolescents: Psychopharmacological, Psychosocial, and Combined Interventions for Childhood Disorders: Evidence Base, Contextual Factors, and Future Directions (2008): <http://www.apa.org/pi/families/resources/child-medications.pdf>

Web: Ways drugs can alter neurotransmission http://thebrain.mcgill.ca/flash/d/d_03/d_03_m/d_03_m_par/d_03_m_par.html

Discussion Questions

1. What are some of the issues surrounding prescribing medications for children and adolescents? How might this be improved?
2. What are some of the factors that can affect relapse to an addictive drug?
3. How might prescribing medications for depression be improved in the future to increase the likelihood that a drug would work and minimize side effects?

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2.5 Evidence Based Practice & Empirically Supported Treatments

CAILEY STRAUSS AND JORDEN A. CUMMINGS

Section Learning Objectives

- Describe the key components of evidence-based practice
- Explain how a treatment is deemed empirically-supported
- Define treatments that harm and explain why they should be of concern for mental health

providers

EVIDENCE-BASED PRACTICE

Evidence-based practice (EBP) is defined by the Canadian Psychological Association (2012) as the intentional and careful use of the best research evidence available at the time, in order to guide each clinical decision and delivered service. To practice in an evidence-based way, a clinician must make themselves aware of the best available research and utilize it while considering specific client preferences, personality traits, and cultural contexts. Selecting a treatment approach that has been shown to be effective for the specific problem is important, as well as tailoring it to fit the individual client (referred to as client specificity). Delivering treatment is therefore a more intentional process than simply learning one treatment modality and applying it indiscriminately to every client.

Given that research is constantly evolving and new studies are frequently added to the existing body of literature, evidence-based practice requires that a clinician maintain a commitment to being and staying informed. Clinicians must also not just consume empirical research, but thoughtfully evaluate it for validity. Every study has limitations, and understanding these limitations is integral to the critical

consumption of research. Then, a clinician is charged with the difficult task of deciding how to translate the empirical research into every decision made in clinical practice. Lastly, there must always be open and honest communication between the clinician and client, in an environment where the client feels comfortable and safe expressing their needs.

Although EBP requires a great amount of work on the part of the service provider, it is necessary in order to protect the public from intentional or inadvertent harm. It also maximizes the chances for successful treatment. Evidence-based practice also encourages the view of Psychology as a legitimate, ethical and scientific field of study and practice.

EMPIRICALLY-SUPPORTED TREATMENTS

Born out of an increasing focus on accountability, cost effectiveness, and protecting Psychology's reputation as a credible health service, task forces were mobilized in the 1990s to investigate the available treatments and services. By endorsing only those modalities that met certain criteria, the task forces created lists of empirically supported treatments. In order to be on the list, the therapy approach had to have been shown to be effective in controlled research settings. This means that the therapy was better than placebo in a statistically significant way, or was found to be at least as effective as an already empirically supported treatment. There was also a move towards standardized and manualized treatment. Treatments that could be easily described (and therefore taught) through a clear step-by-step set of rules

were prioritized over those that could not. Clinicians were urged to utilize only those treatments that were found to be empirically supported, in an effort to be fully evidence based in practice (Hunsley, Dobson, Johnston, & Mikhail, 1999).

The advantages of using empirically supported treatments are numerous. Subjecting each therapy to in-depth scrutiny helps to prevent ineffective or harmful approaches from being used. It therefore protects the public from adverse effects that range from paying for an ineffective treatment, to sustaining psychological damage. Focusing on empirically supported treatments serves as a quality control system for the field of Psychology, and protects it from becoming “watered down” by treatment approaches that lack efficacy. By using this system it also becomes less likely that one will make ethical missteps. When a clinician commits to evidence based practice using only empirically supported treatments, the public can be confident that they will receive therapy that is cost effective and has been shown to have a high likelihood of helping them.

However, any big change within a field is likely to have negative consequences no matter how beneficial it may be. There have been several arguments made against a system that strictly adheres to empirically supported treatments. Some took issue with the notion that “validity” is objective and can ever be achieved. They argued that validity is an ever-changing process and that judgments of validity are only as good as the studies that investigate each treatment approach (some of which are plagued with small sample sizes

and subpar research conditions). Other critics suggested that many legitimate therapies do not lend themselves to manualized approaches and that strict adherence to a manual does not allow the flexibility required for client specificity. Yet another argument against the list of empirically supported treatments is that it is easily misinterpreted and used as a tool of elitism. Third-party payers may decide to fund only those approaches that are on the list and exclude all others, which is not how the list was intended to be used. Also, therapy approaches for use with certain psychological disorders (notably the personality disorders) are underrepresented on the list of empirically supported treatments, leaving a large subset of clients without appropriate services. As with most issues, the concept of empirically supported treatments is therefore likely best used as a flexible guideline rather than a rigid prescription for practice.

TREATMENTS THAT HARM

In 2007 Scott Lilienfeld wrote an important article about psychological treatments that cause harm. He argued that the potential for psychology treatments to be harmful had been largely ignored. Despite an increased interest in the negative side effects of psychiatric medications, the field of psychology had been allowed to “fly under the radar.” Lilienfeld posited that this oversight carried with it serious risk to both the field of psychology and the public at large. He researched potentially harmful therapies (PHTs) and broke them down

into two categories: Level I (probably harmful) and Level II (possibly harmful). It was noted that the distinction between these two categories likely requires further research, as the therapies listed under Level II may actually be moved to Level I with further information gathered.

According to Lilienfeld, there are two reasons why clinicians need to be concerned about potentially harmful therapies. First, clinicians are bound by an ethical duty to avoid harming their clients. Ignorance is not a valid defense for causing harm, no matter how unintentional. Second, investigating the sometimes negative effects of therapy can shed light on potential causes of client deterioration. Learning about situations in which clients do not get better is as important as the cases in which they do – failure presents an opportunity for growth and increased knowledge. In his article Lilienfeld describes potential harm as including several possibilities: a worsening of symptoms or emergence of new ones, increased distress about existing symptoms, unhealthy dependency on the therapist, reluctance to seek future treatment when needed, and in extreme cases physical harm. Harm can even be done to family and friends of the client, as in the case of false abuse accusations. A therapy is considered a PHT if (1) it causes harmful psychological or physical effects in clients or their relatives, (2) the harmful effects are enduring and are not simply a short-term worsening of symptoms during treatment (as in the case of some PTSD treatments), and (3) the harm has been replicated by independent study. Treatments that harm are concerning

because they contribute to client attrition (i.e., clients prematurely leaving therapy), long-term deterioration (i.e., a worsening of client functioning), and a general degradation of psychology's reputation as a discipline.

In Lilienfeld's opinion, the topic of treatments that harm requires further investigation. His suggestions for future research include the extent to which harmful therapies are being administered, reasons for the continued popularity of harmful therapies, therapist or client variables that may increase or decrease the likelihood of harm, as well as any mediating variables. He also posits that the antidote to PHTs may include using standardized questionnaires at every session to track client outcomes.

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Summary and Self-Test: Perspectives on Abnormal Behaviour

ALEXIS BRIDLEY & LEE W. DAFFIN JR.;
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BARRON; CAILEY STRAUSS; AND JORDEN A.
CUMMINGS

SUMMARY

What is considered abnormal behaviour is often dictated by the culture/society a person lives in, as well as the historical context of the time.

Prehistoric cultures often held supernatural views of abnormal behaviour, seeing abnormal behaviour as demonic

possession that occurred when a person engaged in behaviour contrary to the religious teachings of the time. Treatment included trephination and exorcism.

Greco-Roman thought on abnormal behaviour rejected the idea of demonic possession. Hippocrates proposed that mental disorders are similar to physical disorders and had natural causes. He also proposed that mental disorders resulted when our humors were imbalanced. Plato further proposed that the mentally ill were not responsible for their actions and so should not be punished.

Progress made by the Greeks and Romans was reversed during the Middle Ages, when mental illness was yet again seen as the result of demonic possession. Exorcism, flogging, prayer, visiting holy sites, and holy water were all used as treatments. At the time, group hysteria was also seen in large numbers.

The Renaissance saw the rise in humanism, which emphasized human welfare and the uniqueness of the individual. The number of asylums began to rise as the government took more responsibility for people's care.

The moral treatment movement began in the late 18th century in Europe and then rose in the United States in the early 19th century. This movement emphasized respect for the mentally ill, moral guidance, and humane treatment.

Theoretical orientations present a framework through which to understand, organize, and predict human behaviour. When used to treat people with mental illness they are referred to as therapeutic orientations.

The earliest orientation was psychoanalysis, developed by Freud. This model suggests that psychiatric problems are the result of tension between the id, superego, and ego. Although psychoanalysis is still practiced today it has largely been replaced by psychodynamic theory, which uses the same underlying principles of psychoanalysis but is briefer, more present-focused, and sometimes manualized.

Person-centered therapy is referred to as a humanistic therapy, and it is based on the belief that mental health problems arise when our innate human tendency for self-actualization gets blocked somehow. Person-centered therapy believes that providing clients with unconditional positive regard and a place of support will allow them to grow and change. In this sense, it is an unstructured therapy.

The behavioural model of psychopathology believes that how we act is learned, including dysfunctional, abnormal behaviour. It relies upon principles of operant conditioning. Behavioural therapies are popular choices for a wide range of mental illness, especially anxiety disorders. Overall, they focus on learning new behaviour.

The cognitive model arose in direct response to the behavioural model; cognitive theorists believe that by overlooking thoughts, behaviourism was missing an important component of mental illness. According to the cognitive model our thoughts, especially about how we interpret events, influence mental disorder.

Cognitive behavioural therapy (CBT) combines aspects of both behavioural therapy and cognitive therapy. It is one of

the most popular therapies, internationally, and it works for a wide variety of diagnoses and presenting problems.

Newer forms of therapy include the acceptance- and mindfulness-based approaches. Mindfulness is a process that cultivates a non-judgmental state of attention. These types of therapies work by altering people's *relationships* with their thoughts, behaviours, and emotions, whereas previously developed therapies try to change this content directly.

Emerging treatment strategies include the use of internet-delivered therapies, cognitive bias modification via gamification, and CBT-enhancing pharmaceutical agents

The biological model explains how mental illness develops from a medical perspective. The neuron is the fundamental unit of communication of the nervous system. Neurotransmitters like dopamine and serotonin play a key role in our mental health.

Genetic issues, hormonal imbalances, and viral infections can also influence mental illness.

There are five major categories of psychotropic medication: Antidepressants, anti-anxiety medications, stimulants, antipsychotics, and mood stabilizers. Electroconvulsive therapy and psychosurgery are also sometimes used to treat cases of mental illness that do not respond well to medication.

Pharmacokinetics refers to how the body handles drugs that we take, including different drug administrations and drug metabolism.

Controversial issues in psychopharmacology include the use of medications by juveniles and the elderly.

Evidence-based practice is the intentional and careful use of the best available research evidence combined with clinical experience and specific client preferences. Empirically-supported treatments are those that meet certain research criteria in order to be labeled as scientifically supported. Last, treatments that harm are those that cause damage to either clients or their families.

SELF-TEST



An interactive H5P element has been excluded from this version of the text. You can view it online

here:

<https://fhsu.pressbooks.pub/abnormalpsych/?p=79#h5p-2>

Link: https://openpress.usask.ca/abnormalpsychology/wp-admin/admin-ajax.php?action=h5p_embed&id=10

PART III

Chapter 4: Anxiety
Disorders

STEPHANIE WEIGEL

Chapter 4 Introduction

DAVID H. BARLOW; KRISTEN K. ELLARD; AND
JORDEN A. CUMMINGS

Anxiety is a natural part of life and, at normal levels, helps us to function at our best. However, for people with anxiety disorders, anxiety is overwhelming and hard to control. Anxiety disorders develop out of a blend of biological (genetic) and psychological factors that, when combined with stress, may lead to the development of ailments. Primary anxiety-related diagnoses include generalized anxiety disorder, panic disorder, specific phobia, social anxiety disorder (social phobia), post-traumatic stress disorder (PTSD), and obsessive-compulsive disorder. In this module, we summarize the main clinical features of each of these

disorders and discuss their similarities and differences with everyday experiences of anxiety. We will also briefly discuss how the anxiety disorders are treated. Note that we will not focus on PTSD in this chapter, as we will be discussing it in more detail in a later module.

4.1 Anxiety and Related Disorders

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AND JESSICA CAMPOLI

Section Learning Objectives

- Understand the relationship between anxiety and anxiety disorders.
- Identify key vulnerabilities for developing anxiety and related disorders.
- Identify main diagnostic features of specific anxiety-related disorders.

- Differentiate between disordered and non-disordered functioning.
- Describe treatments for anxiety disorders

WHAT IS ANXIETY?

What is anxiety? Most of us feel some anxiety almost every day of our lives. Maybe you have an important test coming up for school. Or maybe there's that big game next Saturday, or that first date with someone new you are hoping to impress. **Anxiety** can be defined as a negative mood state that is accompanied by bodily symptoms such as increased heart rate, muscle tension, a sense of unease, and apprehension about the future (APA, 2013; Barlow, 2002).

Anxiety is what motivates us to plan for the future, and in this sense, anxiety is actually a good thing. It's that nagging feeling that motivates us to study for that test, practice harder for that game, or be at our very best on that date. But some people experience anxiety so intensely that it is no longer helpful or useful. They may become so overwhelmed and distracted by anxiety that they actually fail their test, fumble the ball, or spend the whole date fidgeting and avoiding eye contact. If anxiety begins to interfere in the person's life in a significant way, it is considered a disorder.

VULNERABILITIES TO ANXIETY

Anxiety and closely related disorders emerge from “triple vulnerabilities,” a

combination of biological, psychological, and specific factors that increase our risk for developing a disorder (Barlow, 2002; Suárez, Bennett, Goldstein, & Barlow, 2009). **Biological vulnerabilities** refer to specific genetic and neurobiological factors that might predispose someone to develop anxiety disorders. No single gene directly causes anxiety or panic, but our genes may

make us more susceptible to anxiety and influence how our brains react to stress (Drabant et al., 2012; Gelernter & Stein, 2009; Smoller, Block, & Young, 2009). **Psychological vulnerabilities** refer to the influences that our early experiences have on how we view the world. If we were confronted with unpredictable stressors or traumatic experiences at younger ages, we may come to view the world as unpredictable and uncontrollable, even dangerous



While everyone may experience some level of anxiety at one time or another, those with anxiety disorders experience it consistently and so intensely that it has a significantly negative impact on their quality of life. [Image: Bada Bing, <https://goo.gl/aawyLi>, CC BY-NC-SA 2.0, <https://goo.gl/Toc0ZF>].

(Chorpita & Barlow, 1998; Gunnar & Fisher, 2006). **Specific vulnerabilities** refer to how our experiences lead us to focus and channel our anxiety (Suárez et al., 2009). If we learned that physical illness is dangerous, maybe through witnessing our family's reaction whenever anyone got sick, we may focus our anxiety on physical sensations. If we learned that disapproval from others has negative, even dangerous consequences, such as being yelled at or severely punished for even the slightest offense, we might focus our anxiety on social evaluation. If we learn that the "other shoe might drop" at any moment, we may focus our anxiety on worries about the future. None of these vulnerabilities directly causes anxiety disorders on its own—instead, when all of these vulnerabilities are present, and we experience some triggering life stress, an anxiety disorder may be the result (Barlow, 2002; Suárez et al., 2009). In the next sections, we will briefly explore each of the major anxiety-based disorders, found in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (APA, 2013).

GENERALIZED ANXIETY DISORDER

Most of us worry some of the time, and this worry can actually be useful in helping us to plan for the future or make sure we remember to do something important. Most of us can set aside our worries when we need to focus on other things or stop worrying altogether whenever a problem has passed. However, for someone with **generalized anxiety disorder (GAD)**, these worries become difficult, or even impossible,

to turn off. They may find themselves worrying excessively about a number of different things, both minor and catastrophic. Their worries also come with a host of other symptoms such as muscle tension, fatigue, agitation or restlessness, irritability, difficulties with sleep (either falling asleep, staying asleep, or both), or difficulty concentrating. The *DSM-5* criteria specify that at least six months of excessive anxiety and worry of this type must be ongoing, happening more days than not for a good proportion of the day, to receive a diagnosis of GAD.

About 5.7% of the population has met criteria for GAD at some point during their lifetime (Kessler, Berglund, et al., 2005), making it one of the most common anxiety disorders (see Table 1). Data from the 2012 Canadian Community Health Survey found that the 12-month and lifetime prevalence rate of GAD for Canadians aged 15 or older was 2.6% and 8.7%, respectively (Statistics Canada, 2016). GAD has been found more commonly among women and in urban geographical areas (Pelletier, O'Donnell, McRae, & Grenier, 2017).

Disorder	1-Year Prevalence Rates ¹	Lifetime Prevalence Rates ²	Prevalence by Gender	Median Age of Onset
Generalized Anxiety Disorder	3.1%	5.7%	67% female	31 yrs.
DCD	1%	1.6%	55% female	19 yrs.
Panic Disorder	2.7%	4.7%	67% female	24 yrs.
PTSD	3.5%	6.8%	52% female ³	23 yrs.
Social Anxiety	6.8%	12.1%	50% female	13 yrs.
Specific Phobia	8.7%	12.5%	60% - 90% female ⁴	7-9 yrs.

Table 4.1: Prevalence rates for major anxiety disorders. [1] Kessler et al. (2005), [2]Kessler, Chiu, Demler, Merikangas, & Walters (2005), [3]Kessler, Sonnega, Bromet, Hughes, & Nelson (1995), [4]Craske et al. (1996). *Note: PTSD is discussed in a separate chapter.*

What makes a person with GAD worry more than the average person? Research shows that individuals with GAD are more sensitive and vigilant toward possible threats than people who are not anxious (Aikins & Craske, 2001; Barlow, 2002; Bradley, Mogg, White, Groom, & de Bono, 1999). This may be related to early stressful experiences, which can lead to a view of the world as an unpredictable, uncontrollable, and even dangerous place. Some have suggested that people with GAD worry as a way to gain some control over these otherwise uncontrollable or unpredictable experiences and against uncertain outcomes (Dugas, Gagnon, Ladouceur, & Freeston, 1998). By repeatedly going through all of the possible “What if?” scenarios in their mind, the person might feel like they are less vulnerable to an unexpected outcome, giving them the sense that they have *some* control over the situation (Wells, 2002). Others have suggested people with GAD worry as a way to avoid

feeling distressed (Borkovec, Alcaine, & Behar, 2004). For example, Borkovec and Hu (1990) found that those who worried when confronted with a stressful situation had less physiological arousal than those who didn't worry, maybe because the worry "distracted" them in some way.

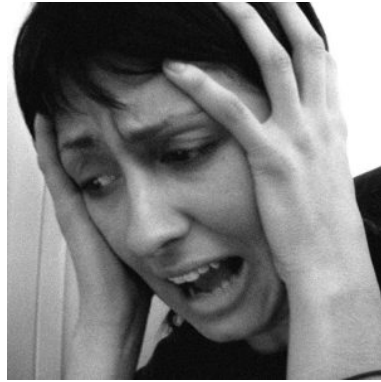
The problem is, all of this "what if?"-ing doesn't get the person any closer to a solution or an answer and, in fact, might take them away from important things they should be paying attention to in the moment, such as finishing an important project. Many of the catastrophic outcomes people with GAD worry about are very unlikely to happen, so when the catastrophic event doesn't materialize, the act of worrying gets **reinforced** (Borkovec, Hazlett-Stevens, & Diaz, 1999). For example, if a mother spends all night worrying about whether her teenage daughter will get home safe from a night out and the daughter returns home without incident, the mother could easily attribute her daughter's safe return to her successful "vigil." What the mother hasn't learned is that her daughter would have returned home just as safe if she had been focusing on the movie she was watching with her husband, rather than being preoccupied with worries. In this way, the cycle of worry is perpetuated, and, subsequently, people with GAD often miss out on many otherwise enjoyable events in their lives.

PANIC DISORDER AND AGORAPHOBIA

Have you ever gotten into a near-accident or been taken by surprise in some way? You may have felt a flood of physical

sensations, such as a racing heart, shortness of breath, or tingling sensations. This alarm reaction is called the “**fight or flight**” response (Cannon, 1929) and is your body’s natural reaction to fear, preparing you to either fight or escape in response to threat or danger. It’s likely you weren’t too concerned with these sensations, because you knew what was causing them. But imagine if this alarm reaction came “out of the blue,” for no apparent reason, or in a situation in which you didn’t expect to be anxious or fearful. This is called an “unexpected” panic attack or a false alarm. Because there is no apparent reason or cue for the alarm reaction, you might react to the sensations with intense fear, maybe thinking you are having a heart attack, or going crazy, or even dying. You might begin to associate the physical sensations you felt during this attack with this fear and may start to go out of your way to avoid having those sensations again.

Unexpected panic attacks such as these are at the heart of **panic disorder (PD)**. However, to receive a diagnosis of PD, the person must not only have unexpected panic attacks but also must experience continued intense anxiety and avoidance related to the attack for at least one month, causing significant distress or interference in their lives. People with panic disorder tend to interpret even normal physical sensations in a catastrophic way, which triggers more anxiety and, ironically, more physical sensations, creating a vicious cycle of panic (Clark, 1986, 1996). The person may begin to avoid a number of situations or activities that produce the same physiological arousal that was present during the beginnings of a panic attack. For example, someone who experienced a racing heart during a panic attack might avoid exercise or caffeine. Someone who experienced choking sensations might avoid wearing high-necked sweaters or necklaces. Avoidance of these **internal bodily or somatic cues** for



Panic disorder is a debilitating condition that leaves sufferers with acute anxiety that persists long after a specific panic attack has subsided. When this anxiety leads to deliberate avoidance of particular places and situations a person may be given a diagnosis of agoraphobia. [Image: Nate Steiner, <https://goo.gl/dUYWDF>, Public Domain]

panic has been termed **interoceptive avoidance** (Barlow & Craske, 2007; Brown, White, & Barlow, 2005; Craske & Barlow, 2008; Shear et al., 1997).

The individual may also have experienced an overwhelming urge to escape during the unexpected panic attack. This can lead to a sense that certain places or situations—particularly situations where escape might not be possible—are not “safe.” These situations become **external cues** for panic. If the person begins to avoid several places or situations, or still endures these situations but does so with a significant amount of apprehension and anxiety, then the person also has **agoraphobia** (Barlow, 2002; Craske & Barlow, 1988; Craske & Barlow, 2008). Agoraphobia can cause significant disruption to a person’s life, causing them to go out of their way to avoid situations, such as adding hours to a commute to avoid taking the train or only ordering take-out to avoid having to enter a grocery store. In one tragic case seen by our clinic, a woman suffering from agoraphobia had not left her apartment for 20 years and had spent the past 10 years confined to one small area of her apartment, away from the view of the outside. In some cases, agoraphobia develops in the absence of panic attacks and therefore is a separate disorder in DSM-5. But agoraphobia often accompanies panic disorder.

One third of adults in Canada experience a panic attack each year; however, only 1-2% of Canadians that same year are diagnosed with panic disorder (Canadian Mental Health Association’s BC Division, 2013). About 4.7% of the

population has met criteria for PD or agoraphobia over their lifetime, according to both American (Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Kessler et al., 2006) (see Table 4.1) and Canadian data (Canadian Mental Health Association's BC Division, 2013). In all of these cases of panic disorder, what was once an adaptive natural alarm reaction now becomes a learned, and much feared, false alarm. Data from the 2002 Canadian Community Health Survey found that the prevalence of agoraphobia was 0.78% for people aged 15–54 years and 0.61% for adults aged 55 years or older (McCabe, Cairney, Veldhuizen, Herrmann, & Streiner, 2006). In that paper, agoraphobia was reported to be more common in women, younger age groups, and people who were widowed or divorced (McCabe et al., 2006).

SPECIFIC PHOBIA

The majority of us might have certain things we fear, such as bees, or needles, or heights (Myers et al., 1984). But what if this fear is so consuming that you can't go out on a summer's day, or get vaccines needed to go on a special trip, or visit your doctor in her new office on the 26th floor? To meet criteria for a diagnosis of specific phobia, there must be an irrational fear of a specific object or situation that substantially interferes with the person's ability to function. For example, a patient at our clinic turned down a prestigious and coveted artist residency because it required spending time near a wooded area, bound to have insects. Another patient purposely left her house two hours early each morning so she

could walk past her neighbor's fenced yard before they let their dog out in the morning. Specific phobias affect about 1 in every 10 Canadians (Canadian Psychological Association, 2015).

The list of possible phobias is staggering, but four major subtypes of specific phobia are recognized: blood-injury-injection (BII) type, situational type (such as planes, elevators, or enclosed places), natural environment type for events one may encounter in nature (for example, heights, storms, and water), and animal type.



Elevators can be a trigger for sufferers of claustrophobia or agoraphobia.

[Image: srgpicker, CC BY-NC-SA 2.0, <https://goo.gl/Toc0ZF>]

A fifth category “other” includes phobias that do not fit any of the four major subtypes (for example, fears of choking, vomiting, or contracting an illness). Most phobic reactions cause a surge of activity in the sympathetic nervous system and increased heart rate and blood pressure, maybe even a panic attack. However, people with BII type

phobias usually experience a marked *drop* in heart rate and blood pressure and may even faint. In this way, those with BII phobias almost always differ in their physiological reaction from people with other types of phobia (Barlow & Liebowitz, 1995; Craske, Antony, & Barlow,

2006; Hofmann, Alpers, & Pauli, 2009; Ost, 1992). BII phobia also runs in families more strongly than any phobic disorder we know (Antony & Barlow, 2002; Page & Martin, 1998). Specific phobia is one of the most common psychological disorders in the United States, with 12.5% of the population reporting a lifetime history of fears significant enough to be considered a “phobia” (Arrindell et al., 2003; Kessler, Berglund, et al., 2005) (see Table 1). Most people who suffer from specific phobia tend to have multiple phobias of several types (Hofmann, Lehman, & Barlow, 1997).

SOCIAL ANXIETY DISORDER (SOCIAL PHOBIA)

Many people consider themselves shy, and most people find social evaluation uncomfortable at best, or giving a speech somewhat mortifying. Yet, only a small proportion of the population fear these types of situations significantly enough to merit a diagnosis of **social anxiety disorder (SAD)** (APA, 2013). SAD is more than exaggerated shyness (Bogels et al., 2010; Schneier et al., 1996). To receive a diagnosis of SAD, the fear and anxiety associated with social situations must be so strong that the person avoids them entirely, or if avoidance is not possible, the person endures them with a great deal of distress. Further, the fear and avoidance of social situations must get in the way of the person’s daily life, or seriously limit their academic or occupational functioning. For example, a patient at our clinic compromised her perfect 4.0 grade point average because she could not complete a required oral presentation in one of her classes, causing her

to fail the course. Fears of negative evaluation might make someone repeatedly turn down invitations to social events or avoid having conversations with people, leading to greater and greater isolation.

The specific social situations that trigger anxiety and fear range from one-on-one interactions, such as starting or maintaining a conversation; to performance-based situations, such as giving a speech or performing on stage; to assertiveness, such as asking someone to change disruptive or undesirable behaviors. Fear of social evaluation might even extend to such things as using public restrooms, eating in a restaurant, filling out forms in a public place, or even reading on a train. Any type of situation that could potentially draw attention to the person can become a feared social situation. For example, one patient of ours went out of her way to avoid any situation in which she might have to use a public restroom for fear that someone would hear her in the bathroom stall and think she was disgusting. If the fear is limited to performance-based situations, such as public speaking, a diagnosis of **SAD performance only** is assigned.

What causes someone to fear social situations to such a large extent? The person may have learned growing up that social evaluation in particular can be dangerous, creating a specific psychological vulnerability to develop social anxiety (Bruch & Heimberg, 1994; Lieb et al., 2000; Rapee & Melville, 1997). For example, the person's caregivers may have harshly criticized and punished them for even the smallest mistake, maybe even punishing them physically.

Or, someone might have experienced a social trauma that had lasting effects, such as being bullied or humiliated. Interestingly, one group of researchers found that 92% of adults in their study sample with social phobia experienced severe teasing and bullying in childhood, compared with only 35% to 50% among people with other anxiety disorders (McCabe, Antony, Summerfeldt, Liss,



Social trauma in childhood may have long-lasting effects. [Image: ihtatho, <https://goo.gl/dTzrdj>, CC BY-NC 2.0, <https://goo.gl/VnKlK8>]

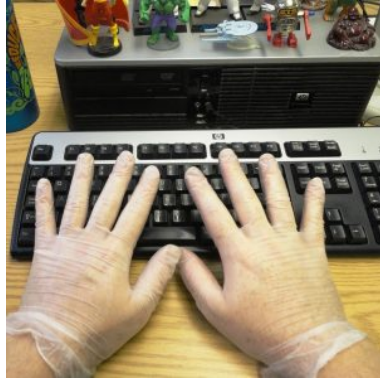
& Swinson, 2003). Someone else might react so strongly to the anxiety provoked by a social situation that they have an unexpected panic attack. This panic attack then becomes associated (**conditioned response**) with the social situation, causing the person to fear they will panic the next time they are in that situation. This is not considered PD, however, because the person's fear is more focused on social evaluation than having unexpected panic attacks, and the fear of having an attack is limited to social situations. According to American studies, as many as 12.1% of the general population suffer from social phobia at some point in their lives (Kessler, Berglund, et al., 2005), making it one of the most common anxiety disorders, second only to specific phobia (see Table

1). In a survey of residents (aged 15–64) from Ontario, Canada, the 12-month and lifetime prevalence of social anxiety was 6.7% and 13%, respectively (Stein & Kean, 2000). Social anxiety disorder is more common among females and younger age groups (Stein & Kean, 2000).

OBSESSIVE-COMPULSIVE DISORDER

Have you ever had a strange thought pop into your mind, such as picturing the stranger next to you naked? Or maybe you walked past a crooked picture on the wall and couldn't resist straightening it. Most people have occasional strange thoughts and may even engage in some "compulsive" behaviors, especially when they are stressed (Boyer & Liénard, 2008; Fullana et al., 2009). But for most people, these thoughts are nothing more than a passing oddity, and the behaviors are done (or not done) without a second thought. For someone with **obsessive-compulsive disorder (OCD)**, however, these thoughts and compulsive behaviors don't just come and go. Instead, strange or unusual thoughts are taken to mean something much more important and real, maybe even something dangerous or frightening. The urge to engage in some behavior, such as straightening a picture, can become so intense that it is nearly impossible *not* to carry it out, or causes significant anxiety if it can't be carried out. Further, someone with OCD might become preoccupied with the possibility that the behavior wasn't carried out to completion and feel compelled to repeat the behavior again and again, maybe several times before they are "satisfied."

To receive a diagnosis of OCD, a person must experience obsessive thoughts and/or compulsions that seem irrational or nonsensical, but that keep coming into their mind. Some examples of obsessions include doubting thoughts (such as doubting a door is locked or an appliance is turned off), thoughts of contamination (such as thinking that touching almost anything might give you cancer), or aggressive thoughts or images that are unprovoked or nonsensical. Compulsions may be carried out in an attempt to neutralize some of these thoughts, providing temporary relief from the anxiety the obsessions cause, or they may be nonsensical in and of themselves. Either way, compulsions are distinct in that they must be repetitive or excessive, the person feels “driven” to carry out the behavior, and the person feels a great deal of distress if they can’t engage in the behavior. Some examples of compulsive behaviors are repetitive washing (often in response to contamination obsessions), repetitive checking (locks, door handles, appliances often in response to doubting obsessions), ordering and arranging



People suffering from OCD may have an irrational fear of germs and “becoming contaminated”. [Image: benchilada, <https://goo.gl/qemgDm>, CC BY-NC-SA 2.0, <https://goo.gl/Toc0ZF>]

things to ensure symmetry, or doing things according to a specific ritual or sequence (such as getting dressed or ready for bed in a specific order). To meet diagnostic criteria for OCD, engaging in obsessions and/or compulsions must take up a significant amount of the person's time, at least an hour per day, and must cause significant distress or impairment in functioning.

According to large American samples, 1.6% of the population has met criteria for OCD over the course of a lifetime (Kessler, Berglund, et al., 2005) (see Table 1). Data from the 2012 Canadian Community Health Survey estimated the prevalence of OCD at 0.93%, and found that it was more common among females, younger adults, and those with lower incomes (Osland, Arnold, & Pringsheim, 2018). Although people with OCD, compared to people without OCD, are significantly more likely to report needing help for mental health, they are more likely to not actually receive help (Osland et al., 2018). There may be a potential gap between the needs of people with OCD symptoms and existing services. Whereas OCD was previously categorized as an Anxiety Disorder, in the most recent version of the DSM (DSM-5; APA, 2013) it has been reclassified under the more specific category of Obsessive-Compulsive and Related Disorders.

People with OCD often confuse having an intrusive thought with their potential for carrying out the thought. Whereas most people when they have a strange or frightening thought are able to let it go, a person with OCD

may become “stuck” on the thought and be intensely afraid that they might somehow lose control and act on it. Or worse, they believe that having the thought is just as bad as doing it. This is called **thought-action fusion**. For example, one patient of ours was plagued by thoughts that she would cause harm to her young daughter. She experienced intrusive images of throwing hot coffee in her daughter’s face or pushing her face underwater when she was giving her a bath. These images were so terrifying to the patient that she would no longer allow herself any physical contact with her daughter and would leave her daughter in the care of a babysitter if her husband or another family was not available to “supervise” her. In reality, the last thing she wanted to do was harm her daughter, and she had no intention or desire to act on the aggressive thoughts and images, nor does anybody with OCD act on these thoughts, but these thoughts were so horrifying to her that she made every attempt to prevent herself from the potential of carrying them out, even if it meant not being able to hold, cradle, or cuddle her daughter. These are the types of struggles people with OCD face every day.

What is Eco-Anxiety?

An assessment conducted by the Government of Canada in 2019 analyzed climate data from 1948 to 2016, which confirmed what many expected but feared – a steady, linear

progression of climate warming that is projected to amplify. Further, risks of extreme weather and climate-related natural disasters are increasingly widespread and are having serious consequences (Government of Canada, 2019). For Canadians, this includes increased exposure to wildfires (Jain et al., 2017), heatwaves (Hartmann et al., 2013), droughts (Girardin & Wotton, 2009), floods (Burn & Whitfield, 2015), snow and ice cover durations, freshwater availability, and changes in surrounding ocean activity in the coming years (as cited in Government of Canada, 2019). You may even recall some relatively recent disasters, such as the 2013 Southern Alberta flood and the 2016 Fort McMurray wildfire.

Historically, discussions and research on the impact of climate change primarily focused on physical health, such as increased risk of asthma and cardiovascular disease (Centers for Disease Control and Prevention & National Center for Environmental Health, 2014). However, as Canadians continue to be affected by widespread climate change, interest in the effects of climate change on mental health has significantly increased (APA, 2017). For example, with exposure to climate change comes increased emotional responding, which can be debilitating (APA, 2017). Heightened emotional responses can disrupt individuals' information processing and decision making, interfering with daily functioning (APA, 2017). Further, extreme weather and climate-related natural disasters can be traumatic, regardless if individuals experience them directly, further impairing mental health (APA, 2017). Researchers have demonstrated positive correlations between climate change and several mental health issues, including depression and substance use (Neria & Shultz, 2012), as well as

posttraumatic stress (Bryant et al., 2014). Concerningly, climate change also appears to relate to increased aggression and interpersonal violence (Anderson, 2001; Ranson, 2012).

Have you ever found yourself worrying about these issues and the potential consequences for not only our current living, but also future generations? If so, you are not alone. Individuals of all ages are becoming increasingly worried and fearful about environmental damage and potential future disaster – this is something we refer to as *eco-anxiety* (Albrecht, 2011; American Psychological Association [APA], 2017). However, you may have heard other variations of this term, including ‘climate anxiety,’ ‘climate grief,’ and ‘environmental doom.’ Eco-anxiety is largely founded on the current state of the environment and its uncertain future. Additionally, given current evidence demonstrating the direct impact of humans on climate change (see Government of Canada, 2019, for a detailed review), those struggling with eco-anxiety are often primarily concerned about the role of human activities (APA, 2017). While data indicating the exact prevalence of eco-anxiety is limited, research based in Australia suggests that ~96% of young people consider climate change to be a serious issue and ~89% report being concerned about the long-term consequences (Chiw & Ling, 2019). Moreover, researchers have begun investigating the presence of eco-anxiety among undergraduate students, with the vast majority appearing to have high levels of eco-anxiety and stress over the earth’s state (Kelly, 2017).

Unfortunately, it is proposed that common psychological responses to eco-related distress – such as perceived lack of

control, feelings of helplessness, and avoidant behaviours – hinder individuals’ ability to contribute to climate-change solutions (APA, 2017). On the contrary, when individuals personally relate the state of the climate to their own well-being, their motivation to engage in positive solutions increases (Sawitri, Hadiyanto, & Hadi, 2015, as cited in Government of Canada, 2019). If you thought about the effects of climate change on humans prior to reading this section, did mental health ever come to mind? What have your experiences with eco-anxiety been, if at all?

TREATMENTS FOR ANXIETY AND RELATED DISORDERS

Many successful treatments for anxiety and related disorders have been developed over the years. Medications (anti-anxiety drugs and antidepressants) have been found to be beneficial for disorders other than specific phobia, but relapse rates are high once medications are stopped (Heimberg et al., 1998; Hollon et al., 2005), and some classes of medications (minor tranquilizers or benzodiazepines) can be habit forming.



Exposure-based CBT aims to help patients recognize and change problematic thoughts and behaviors in real-life situations. A person with a fear of elevators would be encouraged to practice exposure exercises that might involve approaching or riding elevators to attempt to overcome their anxiety. [Image: Mag3737, <https://goo.gl/j9L5AQ>, CC BY-NC-SA 2.0, <https://goo.gl/Toc0ZF>]

Exposure-based cognitive behavioral therapies (CBT) are effective psychosocial treatments for anxiety disorders, and many show greater treatment effects than medication in the long term (Barlow, Allen, & Basden, 2007; Barlow, Gorman, Shear, & Woods, 2000). In CBT, patients are taught skills to help identify and change problematic thought processes, beliefs, and behaviors that tend to worsen symptoms of anxiety, and practice applying these skills to real-life situations through exposure exercises. Patients learn how the automatic

“appraisals” or thoughts they have about a situation affect both how they feel and how they behave. Similarly, patients learn how engaging in certain behaviors, such as avoiding situations, tends to strengthen the belief that the situation is something to be feared. A key aspect of CBT is exposure exercises, in which the patient learns to gradually approach situations they find fearful or distressing, in order to challenge

their beliefs and learn new, less fearful associations about these situations.

Typically 50% to 80% of patients receiving drugs or CBT will show a good initial response, with the effect of CBT more durable. Newer developments in the treatment of anxiety disorders are focusing on novel interventions, such as the use of certain medications to enhance learning during CBT (Otto et al., 2010), and transdiagnostic treatments targeting core, underlying vulnerabilities (Barlow et al., 2011). As we advance our understanding of anxiety and related disorders, so too will our treatments advance, with the hopes that for the many people suffering from these disorders, anxiety can once again become something useful and adaptive, rather than something debilitating.

Outside Resources

American Psychological Association (APA)
<http://www.apa.org/topics/anxiety/index.aspx>

National Institutes of Mental Health (NIMH)
<http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml>

Web: Anxiety and Depression Association of America (ADAA) <http://www.adaa.org/>

Web: Center for Anxiety and Related Disorders (CARD)
<http://www.bu.edu/card/>

Discussion Questions

1. Name and describe the three main vulnerabilities contributing to the development of anxiety and related disorders. Do you think these disorders could develop out of biological factors alone? Could these disorders develop out of learning experiences alone?
2. Many of the symptoms in anxiety and related disorders overlap with experiences most people have. What features differentiate someone with a disorder versus someone without?
3. What is an “alarm reaction?” If someone experiences an alarm reaction when they are about to give a speech in front of a room full of people, would you consider this a “true alarm” or a “false alarm?”
4. Many people are shy. What differentiates someone who is shy from someone with social anxiety disorder? Do you think shyness should be considered an anxiety disorder?
5. Is anxiety ever helpful? What about worry?

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4.2 Body Dysmorphic Disorder

ALEXIS BRIDLEY & LEE W. DAFFIN JR. AND
CARRIE CUTTLER

Section Learning Objectives

- Describe how body dysmorphic disorder presents itself.
- Describe the epidemiology of body dysmorphic.
- Indicate which disorders are commonly comorbid with body dysmorphic.
- Describe the theories for the etiology of body dysmorphic disorder.
- Describe the treatment for body dysmorphic disorder.

CLINICAL DESCRIPTION

Body Dysmorphic Disorder (BDD) is another obsessive-compulsive disorder, however, the focus of these obsessions are with a perceived defect or flaw in physical appearance. A key feature of these obsessions with defects or flaws are that they are *not* observable to others. An individual who has a congenital facial defect or a burn victim who is concerned about scars are *not* examples of an individual with BDD. The obsessions related to one's appearance can run the spectrum from feeling "unattractive" to "looking hideous." While any part of the body can be a concern for an individual with BDD, the most commonly reported areas are skin (e.g., acne, wrinkles, skin color), hair (e.g., thinning hair or excessive body hair), or nose (e.g., size, shape).

The distressing nature of the obsessions regarding one's body, often drive individuals with BDD to engage in compulsive behaviors that take up a considerable amount of time. For example, an individual may repeatedly compare her body to other people's bodies in the general public; repeatedly look at herself in the mirror; engage in excessive grooming which includes using make-up to modify her appearance. Some individuals with BDD will go as far as having numerous plastic surgeries in attempts to obtain the "perfect" appearance. The problem is plastic surgery does not usually resolve the issue. After all, the physical defect or flaw is not observable to others. While most of us are guilty of engaging

in some of these behaviors, to meet criteria for BDD, one must spend a considerable amount of time preoccupied with his/her appearance (i.e., on average 3-8 hours a day), as well as display significant impairment in social, occupational, or other areas of functioning.

MUSCLE DYSMORPHIA

While muscle dysmorphia is not a formal diagnosis, it is a common type of BDD, particularly within the male population. Muscle dysmorphia refers to the belief that one's body is too small, or lacks appropriate amount of muscle definition (Ahmed, Cook, Genen & Schwartz, 2014). While severity of BDD between individuals with and without muscle dysmorphia appears to be the same, some studies have found a higher use of substance abuse (i.e. steroid use), poorer quality of life, and an increased reports of suicide attempts in those with muscle dysmorphia (Pope, Pope, Menard, Fay Olivardia, & Philips, 2005).

EPIDEMIOLOGY

The point prevalence rate for BDD among U.S. adults is 2.4% (APA, 2013). Internationally, this rate drops to 1.7% –1.8% (APA, 2013). Despite the difference between the national and international prevalence rates, the symptoms across races and cultures are similar.

Gender-based prevalence rates indicate a fairly balanced sex ratio (2.5% females; 2.2% males; APA, 2013). While the diagnosis rates may be different, general symptoms of BDD

appear to be the same across genders with one exception: males tend to report genital preoccupations, while females are more likely to present with a comorbid eating disorder.

COMORBIDITY

While research on BDD is still in its infancy, initial studies suggest that major depressive disorder is the most common comorbid psychological disorder (APA, 2013). Major depressive disorder typically occurs after the onset of BDD. Additionally, there are some reports of social anxiety, OCD, and substance-related disorders (likely related to muscle enhancement; APA, 2013).

ETIOLOGY

Initial studies exploring genetic factors for BDD indicate a hereditary influence as the prevalence of BDD is elevated in first degree relatives of people with BDD. Interestingly, the prevalence of BDD is also heightened in first degree relatives of individuals with OCD (suggesting a shared genetic influence to these disorders).

However, environmental factors appear to play a larger role in the development of BDD than OCD (Ahmed, et al., 2014; Lervolino et al., 2009). Specifically, it is believed that negative life experiences such as teasing in childhood, negative social evaluations about one's body, and even childhood neglect and abuse may contribute to BDD. Cognitive research has further discovered that people with BDD tend to have an attentional bias towards beauty and

attractiveness, selectively attending to words related to beauty and attractiveness. Cognitive theories have also proposed that individuals with BDD have dysfunctional beliefs that their worth is inherently tied to their attractiveness and hold attractiveness as one of their primary core values. These beliefs are further reinforced by our society, which overly values and emphasizes beauty.

TREATMENT

Seeing as though there are strong similarities between OCD and BDD, it should not come as a surprise that the only two effective treatments for BDD are those that are effective in OCD. Exposure and response prevention has been successful in treating symptoms of BDD, as clients are repeatedly exposed to their body imperfections/obsessions and prevented from engaging in compulsions used to reduce their anxiety (Veale, Gournay, et al., 1996; Wilhelm, Otto, Lohr, & Deckersbach, 1999).

The other treatment option, psychopharmacology, has also been shown to reduce symptoms in individuals diagnosed with BDD. Similar to OCD, medications such as clomipramine and other SSRIs are generally prescribed. While these are effective in reducing BDD symptoms, once the medication is discontinued, symptoms resume nearly immediately, suggesting this is not an effective long-term treatment option for those with BDD.

Treatment of BDD appears to be difficult, with one study finding that only 9% of clients had full remission at a 1-year

follow-up, and 21% reported partial remission (Phillips, Pagano, Menard & Stout, 2006). A more recent finding reported more promising findings with 76% of participants reporting full remission over an 8-year period (Bjornsson, Dyck, et al., 2011).

PLASTIC SURGERY AND MEDICAL TREATMENTS

It should not come as a surprise that many individuals with BDD seek out plastic surgery to attempt to correct their perceived defects. Phillips and colleagues (2001) evaluated treatments of clients with BDD and found that 76.4% reported some form of plastic surgery or medical treatment, with dermatology treatment the most reported (45%) followed by plastic surgery (23%). The problem with this type of treatment is that the individual is rarely satisfied with the outcome of the procedure, thus leading them to seek out additional surgeries on the same defect (Phillips, et al., 2001). Therefore, it is important that medical professionals thoroughly screen patients for BDD before completing any type of medical treatment.

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Summary and Self-Test: Anxiety Disorders

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SUMMARY

Anxiety is a negative mood state that is accompanied by bodily symptoms such as increased heart rate, muscle tension, a sense of unease, and apprehension about the future. Anxiety is a normal human experience, but when it becomes extreme and impairs someone's functioning, it enters the realm of possible mental illness.

A combination of biological, psychological, and specific

vulnerabilities increase a person's likelihood of developing an anxiety disorder.

Generalized anxiety disorder (GAD) is marked by excessive worry that is difficult or even impossible to turn off. This worry is accompanied by muscle tension, fatigue, agitation or restlessness, irritability, difficulties with sleep, or difficulties concentrating.

Unexpected panic attacks are core to panic disorder. In addition to the panic attacks, the person must also experience continued intense anxiety and avoidance related to the attack for at least one month, causing significant distress or interference in their lives. Sometimes people with panic disorder also develop agoraphobia, which is when they begin to avoid several places or situations, or still endures the situations but with a significant amount of anxiety.

Specific phobia occurs when someone has an irrational fear of a specific object or situation that substantially interferes with their ability to function. Four major subtypes of specific phobia are recognized: blood-injury-injection type, situational type, natural environment type, and animal type.

Social anxiety disorder involves severe anxiety in social situations where one can be evaluated. This anxiety must get in the way of the person's daily life or otherwise severely impact their functioning. If the fear is specific to performance-based situations, this subtype of social anxiety can be diagnosed.

Obsessive-Compulsive Disorder (OCD) occurs when obsessive thoughts (intrusive thoughts that are unusual) and

compulsions (activities that must be done) are present and they interfere with someone's functioning. Less than 1% of Canadians have OCD. People with OCD often suffer from thought-action fusion or the idea that having a thought is directly linked with their potential for carrying out the thought.

Anxiety disorders are sometimes treated with anti-anxiety medications or antidepressants. Exposure-based cognitive behavioural therapies are very effective ways of treating anxiety disorders psychotherapeutically.

Body-dysmorphic disorder (BDD) is seen as a type of OCD focused on perceived defects or flaws in physical appearance. A key feature of these perceived defects or flaws is that they are not observable to others. It is common for individuals with BDD to also experience major depression.

BDD seems to be predicted by a combination of hereditary factors and environmental factors like teasing in childhood, negative social evaluations about one's body, and childhood trauma.

Like OCD, BDD is treated with a specific type of CBT called exposure and response prevention.



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here:

<https://fhsu.pressbooks.pub/abnormalpsych/?p=109#h5p-4>

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STEPHANIE WEIGEL

PART IV

Chapter 3: Mood
Disorders

STEPHANIE WEIGEL

Chapter 3 Introduction

JORDEN A. CUMMINGS

Sadness and euphoria are two very human experiences. We have all felt down, blue, sad, or maybe even deep grief before. Likewise, all of us have been at one time or another elated, joyful, thrilled and excited. But as intense as these experiences might feel, they are very different from clinical mood disorders. In this chapter you'll learn about both depression and mania, and the variety of mood disorders that are marked by these experiences. Although "depressed" is a phrase that gets used often, feeling down is not the same as being diagnosed with depression. In addition, the mood disorders consist of many more symptoms than just feeling down or elated.

In this chapter we'll discuss all of the symptoms of depressed, manic, and hypomanic episodes as well as the diagnostic criteria for both the unipolar and bipolar mood disorders. We'll also review the rates and vulnerabilities for both and the etiologies hypothesized to underly them. Last, we're going to discuss how mood disorders are treated with both biological and psychological interventions.

3.1 Mood Disorders

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Section Learning Objectives

- Describe the diagnostic criteria for mood disorders.
- Understand age, gender, and ethnic differences in prevalence rates of mood disorders.
- Identify common risk factors for mood disorders.
- Know effective treatments of mood disorders.



Perinatal depression following child birth afflicts about 5% of all mothers. An unfortunate social stigma regarding this form of depression compounds the problem for the women who suffer its effects. [Image: CC0 Public Domain]

Everyone feels down or euphoric from time to time, but this is different from having a mood disorder such as major depressive disorder or bipolar disorder. Mood disorders are extended periods of depressed, euphoric, or irritable moods that in combination with other symptoms cause the person significant distress and interfere with his or her daily life, often resulting in social and occupational difficulties. In this module,

we describe major mood disorders, including their symptom presentations, general prevalence rates, and how and why the rates of these disorders tend to vary by age, gender, and race. In addition, biological and environmental risk factors that have been implicated in the development and course of mood disorders, such as heritability and stressful life events, are reviewed. Finally, we provide an overview of treatments for mood disorders, covering treatments with demonstrated effectiveness, as well as new treatment options showing promise.

The actress Brooke Shields published a memoir titled *Down*

Came the Rain: My Journey through Postpartum Depression in which she described her struggles with depression following the birth of her daughter. Despite the fact that about one in 20 women experience depression after the birth of a baby (American Psychiatric Association [APA], 2013), postpartum depression—recently renamed “perinatal depression”—continues to be veiled by stigma, owing in part to a widely held expectation that motherhood should be a time of great joy. In an opinion piece in the *New York Times*, Shields revealed that entering motherhood was a profoundly overwhelming experience for her. She vividly describes experiencing a sense of “doom” and “dread” in response to her newborn baby. Because motherhood is conventionally thought of as a joyous event and not associated with sadness and hopelessness, responding to a newborn baby in this way can be shocking to the new mother as well as those close to her. It may also involve a great deal of shame for the mother, making her reluctant to divulge her experience to others, including her doctors and family.

Feelings of shame are not unique to perinatal depression. Stigma applies to other types of depressive and bipolar disorders and contributes to people not always receiving the necessary support and treatment for these disorders. In fact, the World Health Organization ranks both major depressive disorder (MDD) and bipolar disorder (BD) among the top 10 leading causes of disability worldwide. Further, MDD and BD carry a high risk of suicide. It is estimated that 25%–50%

of people diagnosed with BD will attempt suicide at least once in their lifetimes (Goodwin & Jamison, 2007).

WHAT ARE MOOD DISORDERS?

MOOD EPISODES

Everyone experiences brief periods of sadness, irritability, or euphoria. This is different than having a mood disorder, such as MDD or BD, which are characterized by a constellation of symptoms that causes people significant distress or impairs their everyday functioning.

Major Depressive Episode

A major depressive episode (MDE) refers to symptoms that co-occur for at least two weeks and cause significant distress or impairment in functioning, such as interfering with work, school, or relationships. Core symptoms include feeling down or depressed or experiencing **anhedonia**—loss of interest or pleasure in things that one typically enjoys. According to the fifth edition of the *Diagnostic and Statistical Manual (DSM-5; APA, 2013)*, the criteria for an MDE require five or more of the following nine symptoms, including one or both of the first two symptoms, for most of the day, nearly every day:

1. depressed mood
2. diminished interest or pleasure in almost all activities

3. significant weight loss or gain or an increase or decrease in appetite
4. insomnia or **hypersomnia**
5. **psychomotor agitation** or **retardation**
6. fatigue or loss of energy
7. feeling worthless or excessive or inappropriate guilt
8. diminished ability to concentrate or indecisiveness
9. recurrent thoughts of death, **suicidal ideation**, or a suicide attempt

These symptoms cannot be caused by physiological effects of a substance or a general medical condition (e.g., hypothyroidism).

Manic or Hypomanic Episode

The core criterion for a manic or hypomanic episode is a distinct period of abnormally and persistently euphoric, expansive, or irritable mood and persistently increased goal-directed activity or energy. The mood disturbance must be present for one week or longer in mania (unless hospitalization is required) or four days or longer in hypomania. Concurrently, at least three of the following symptoms must be present in the context of euphoric mood (or at least four in the context of irritable mood):

1. inflated self-esteem or **grandiosity**

2. increased goal-directed activity or psychomotor agitation
3. reduced need for sleep
4. racing thoughts or flight of ideas
5. distractibility
6. increased talkativeness
7. excessive involvement in risky behaviors

Manic episodes are distinguished from hypomanic episodes by their duration and associated impairment; whereas manic episodes must last one week and are defined by a significant impairment in functioning, hypomanic episodes are shorter and not necessarily accompanied by impairment in functioning.

MOOD DISORDERS

Unipolar Mood Disorders

Two major types of unipolar disorders described by the *DSM-5* (APA, 2013) are major depressive disorder and persistent depressive disorder (PDD; dysthymia). MDD is defined by one or more MDEs, but no history of manic or hypomanic episodes. Criteria for PDD are feeling depressed most of the day for more days than not, for at least two years. At least two of the following symptoms are also required to meet criteria for PDD:

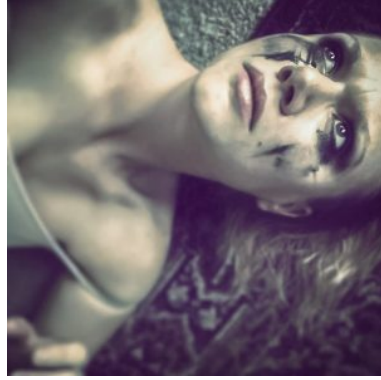
1. poor appetite or overeating

2. insomnia or hypersomnia
3. low energy or fatigue
4. low self-esteem
5. poor concentration or difficulty making decisions
6. feelings of hopelessness

Like MDD, these symptoms need to cause significant distress or impairment and cannot be due to the effects of a substance or a general medical condition. To meet criteria for PDD, a person cannot be without symptoms for more than two months at a time. PDD has overlapping symptoms with MDD. If someone meets criteria for an MDE during a PDD episode, the person will receive diagnoses of PDD and MDD.

Bipolar Mood Disorders

Three major types of BDs are described by the *DSM-5* (APA, 2013). Bipolar I Disorder (BD I), which was previously known as manic-depression, is characterized by a single (or recurrent) manic episode. A depressive episode is not necessary but commonly present for the diagnosis of BD I. Bipolar II Disorder is characterized by single (or recurrent) hypomanic episodes and



depressive episodes. Another type of BD is cyclothymic disorder, characterized by numerous and alternating periods of hypomania and depression, lasting at least two years. To qualify for cyclothymic disorder, the periods of depression cannot meet full diagnostic criteria for an MDE; the person must experience symptoms at least half the time with no more than two consecutive symptom-free months; and the symptoms must cause significant distress or impairment.

It is important to note that the *DSM-5* was published in 2013, and findings based on the updated manual will be forthcoming. Consequently, the research presented below was largely based on a similar, but not identical,

Bipolar disorders are characterized by cycles of high energy and depression. [Image: Brett Whaley, <https://goo.gl/k4HTR7>, CC BY-NC 2.0, <https://goo.gl/VnKlK8>]

conceptualization of mood disorders drawn from the *DSM-IV* (APA, 2000).

Box 1. Specifiers

Both MDEs and manic episodes can be further described using standardized tags based on the timing of, or other symptoms that are occurring during, the mood episode, to increase diagnostic specificity and inform treatment. Psychotic features is specified when the episodes are accompanied by delusions (rigidly held beliefs that are false) or hallucinations (perceptual disturbances that are not based in reality). Seasonal pattern is specified when a mood episode occurs at the same time of the year for two consecutive years — most commonly occurring in the fall and winter. Peripartum onset is specified when a mood episode has an onset during pregnancy or within four weeks of the birth of a child. Approximately 3%–6% of women who have a child experience an MDE with peripartum onset (APA, 2013). This is less frequent and different from the baby blues or when women feel transient mood symptoms usually within 10 days of giving birth, which are experienced by most women (Nolen-Hoeksema & Hilt, 2009).

HOW COMMON ARE MOOD DISORDERS? WHO DEVELOPS MOOD DISORDERS?

DEPRESSIVE DISORDERS

In a nationally representative sample of Americans, lifetime prevalence rate for MDD was 16.6% (Kessler, Berglund,

Demler, Jin, Merikangas, & Walters, 2005). This means that nearly one in five Americans will meet the criteria for MDD during their lifetime. Lifetime prevalence rates in Canada have been estimated at 11.2% (Knoll & MacLennan, 2017). The 12-month prevalence—the proportion of people who meet criteria for a disorder during a 12-month period—of MDD in Canada is 4.7% (Knoll & MacLennan, 2017).

Although the onset of MDD can occur at any time throughout the lifespan, the average age of onset is mid-20s, with the age of onset decreasing with people born more recently (APA, 2000). Prevalence of MDD among older adults is much lower than it is for younger cohorts (Kessler, Birnbaum, Bromet, Hwang, Sampson, & Shahly, 2010). The duration of MDEs varies widely. Recovery begins within three months for 40% of people with MDD and within 12 months for 80% (APA, 2013). MDD tends to be a recurrent disorder with about 40%–50% of those who experience one MDE experiencing a second MDE (Monroe & Harkness, 2011). An earlier age of onset predicts a worse course. About 5%–10% of people who experience an MDE will later experience a manic episode (APA, 2000), thus no longer meeting criteria for MDD but instead meeting them for BD I. Diagnoses of other disorders across the lifetime are common for people with MDD: 59% experience an anxiety disorder; 32% experience an impulse control disorder, and 24% experience a substance use disorder (Kessler, Merikangas, & Wang, 2007).

Women experience two to three times higher rates of

MDD than do men (Nolen-Hoeksema & Hilt, 2009). This gender difference emerges during puberty (Conley & Rudolph, 2009). Before puberty, boys exhibit similar or higher prevalence rates of MDD than do girls (Twenge & Nolen-Hoeksema, 2002). MDD is inversely correlated with **socioeconomic status (SES)**, a person's economic and social position based on income, education, and occupation. Higher prevalence rates of MDD are associated with lower SES (Lorant, Deliege, Eaton, Robert, Philippot, & Ansseau, 2003), particularly for adults over 65 years old (Kessler et al., 2010). Independent of SES, results from a nationally representative sample found that European Americans had a higher prevalence rate of MDD than did African Americans and Hispanic Americans, whose rates were similar (Breslau, Aguilar-Gaxiola, Kendler, Su, Williams, & Kessler, 2006). The course of MDD for African Americans is often more severe and less often treated than it is for European Americans, however (Williams et al., 2007). American research indicates that Native Americans (a designation still used in the United States) have a higher prevalence rate than do European Americans, African Americans, or Hispanic Americans (Hasin, Goodwin, Stinson & Grant, 2005). Depression is not limited to industrialized or western cultures; it is found in all countries that have been examined, although the symptom presentation as well as prevalence rates vary across cultures (Chentsova-Dutton & Tsai, 2009).

It is important to note that sexual minorities, including non-gender binary individuals tend to experience higher

rates of depression than the general population. For example, a recent Canadian study estimated the lifetime prevalence rates of depression as 67.7% for sexual minorities and 72% for gender liminal individuals living in Ontario (Williams et al., 2017). In another study conducted in Ontario, 66.4% of transgender participants reported experiencing current depression (Rotondi, Bauer, Scanlon, Kaay, Travers, & Travers, 2011).

BIPOLAR DISORDERS



Adolescents experience a higher incidence of bipolar spectrum disorders than do adults. Making matters worse, those who are diagnosed with BD at a younger age seem to suffer symptoms more intensely than those with adult onset. [Image: CC0 Public Domain]

The lifetime prevalence rate of bipolar spectrum disorders in the general U.S. population is estimated at approximately 4.4%, with BD I constituting about 1% of this rate (Merikangas et al., 2007). In Canadian samples, the lifetime prevalence rate for bipolar disorder has been estimated at 2.6% (Statistics Canada, 2013) and the 12-month prevalence rate as 1.5% (Statistics Canada, 2013). More recent data shows the lifetime prevalence rate of

Bipolar I and II in Canada at 0.87% and 0.57%, respectively (McDonald et al., 2015).

Prevalence estimates, however, are highly dependent on the diagnostic procedures used (e.g., interviews vs. self-report) and whether or not sub-threshold forms of the disorder are included in the estimate. BD often co-occurs with other psychiatric disorders. Approximately 65% of people with BD meet diagnostic criteria for at least one additional psychiatric disorder, most commonly anxiety disorders and substance use disorders (McElroy et al., 2001). The co-occurrence of BD with other psychiatric disorders is associated with poorer illness course, including higher rates of suicidality (Leverich et al., 2003). A recent cross-national study sample of more than 60,000 adults from 11 countries, estimated the worldwide prevalence of BD at 2.4%, with BD I constituting 0.6% of this rate (Merikangas et al., 2011). In this study, the prevalence of BD varied somewhat by country. Whereas the United States had the highest lifetime prevalence (4.4%), India had the lowest (0.1%). Variation in prevalence rates was not necessarily related to SES, as in the case of Japan, a high-income country with a very low prevalence rate of BD (0.7%).

With regard to ethnicity, data from studies not confounded by SES or inaccuracies in diagnosis are limited, but available reports suggest rates of BD among European Americans are similar to those found among African Americans (Blazer et al., 1985) and Hispanic Americans (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005). Another large

community-based study found that although prevalence rates of mood disorders were similar across ethnic groups, Hispanic Americans and African Americans with a mood disorder were more likely to remain persistently ill than European Americans (Breslau et al., 2005). Compared with European Americans with BD, African Americans tend to be underdiagnosed for BD (and over-diagnosed for schizophrenia) (Kilbourne, Haas, Mulsant, Bauer, & Pincus, 2004; Minsky, Vega, Miskimen, Gara, & Escobar, 2003), and Hispanic Americans with BD have been shown to receive fewer psychiatric medication prescriptions and specialty treatment visits (Gonzalez et al., 2007). Misdiagnosis of BD can result in the underutilization of treatment or the utilization of inappropriate treatment, and thus profoundly impact the course of illness.

As with MDD, adolescence is known to be a significant risk period for BD; mood symptoms start by adolescence in roughly half of BD cases (Leverich et al., 2007; Perlis et al., 2004). Longitudinal studies show that those diagnosed with BD prior to adulthood experience a more pernicious course of illness relative to those with adult onset, including more episode recurrence, higher rates of suicidality, and profound social, occupational, and economic repercussions (e.g., Lewinsohn, Seeley, Buckley, & Klein, 2002). The prevalence of BD is substantially lower in older adults compared with younger adults (1% vs. 4%) (Merikangas et al., 2007).

WHAT ARE SOME OF THE FACTORS

IMPLICATED IN THE DEVELOPMENT AND COURSE OF MOOD DISORDERS?

Mood disorders are complex disorders resulting from multiple factors. Causal explanations can be attempted at various levels, including biological and psychosocial levels. Below are several of the key factors that contribute to onset and course of mood disorders are highlighted.

DEPRESSIVE DISORDERS

Research across family and twin studies has provided support that genetic factors are implicated in the development of MDD. Twin studies suggest that familial influence on MDD is mostly due to genetic effects and that individual-specific environmental effects (e.g., romantic relationships) play an important role, too. By contrast, the contribution of shared environmental effect by siblings is negligible (Sullivan, Neale & Kendler, 2000). The mode of inheritance is not fully understood although no single genetic variation has been found to increase the risk of MDD significantly. Instead,



Romantic relationships can affect mood as in the case of divorce or the death of a spouse. [Image: CC0 Public Domain]

several genetic variants and environmental factors most likely contribute to the risk for MDD (Lohoff, 2010).

One environmental stressor that has received much support in relation to MDD is stressful life events. In particular, severe stressful life events—those that have long-term consequences and involve loss of a significant relationship (e.g., divorce) or economic stability (e.g., unemployment) are strongly related to depression (Brown & Harris, 1989; Monroe et al., 2009). Stressful life events are more likely to predict the first MDE than subsequent episodes (Lewinsohn, Allen, Seeley, & Gotlib, 1999). In contrast, minor events may play a larger role in subsequent episodes than the initial episodes (Monroe & Harkness, 2005).

Depression research has not been limited to examining reactivity to stressful life events. Much research, particularly brain imaging research using functional magnetic resonance imaging (fMRI), has centered on examining neural circuitry—the interconnections that allow multiple brain regions to perceive, generate, and encode information in concert. A meta-analysis of neuroimaging studies showed that when viewing negative stimuli (e.g., picture of an angry face, picture of a car accident), compared with healthy control participants, participants with MDD have greater activation in brain regions involved in stress response and reduced activation of brain regions involved in positively motivated behaviors (Hamilton, Etkin, Furman, Lemus, Johnson, & Gotlib, 2012).

Other environmental factors related to increased risk for

MDD include experiencing **early adversity** (e.g., childhood abuse or neglect; Widom, DuMont, & Czaja, 2007), **chronic stress** (e.g., poverty) and interpersonal factors. For example, marital dissatisfaction predicts increases in depressive symptoms in both men and women. On the other hand, depressive symptoms also predict increases in marital dissatisfaction (Whisman & Uebelacker, 2009). Research has found that people with MDD generate some of their interpersonal stress (Hammen, 2005). People with MDD whose relatives or spouses can be described as critical and emotionally overinvolved have higher relapse rates than do those living with people who are less critical and emotionally overinvolved (Butzlaff & Hooley, 1998).

People's **attributional styles** or their general ways of thinking, interpreting, and recalling information have also been examined in the etiology of MDD (Gotlib & Joormann, 2010). People with a pessimistic attributional style tend to make internal (versus external), global (versus specific), and stable (versus unstable) attributions to negative events, serving as a vulnerability to developing MDD. For example, someone who when he fails an exam thinks that it was his fault (internal), that he is stupid (global), and that he will always do poorly (stable) has a pessimistic attribution style. Several influential theories of depression incorporate attributional styles (Abramson, Metalsky, & Alloy, 1989; Abramson Seligman, & Teasdale, 1978).

BIPOLAR DISORDERS

Although there have been important advances in research on the etiology, course, and treatment of BD, there remains a need to understand the mechanisms that contribute to episode onset and relapse. There is compelling evidence for biological causes of BD, which is known to be highly heritable (McGuffin, Rijdsdijk, Andrew, Sham, Katz, & Cardno, 2003). It may be argued that a high rate of heritability demonstrates that BD is fundamentally a biological phenomenon. However, there is much variability in the course of BD both within a person across time and across people (Johnson, 2005). The triggers that determine how and when this genetic vulnerability is expressed are not yet understood; however, there is evidence to suggest that psychosocial triggers may play an important role in BD risk (e.g., Johnson et al., 2008; Malkoff-Schwartz et al., 1998).

In addition to the genetic contribution, biological explanations of BD have also focused on brain function. Many of the studies using fMRI techniques to characterize BD have focused on the processing of emotional stimuli based on the idea that BD is fundamentally a disorder of emotion (APA, 2000). Findings show that regions of the brain thought to be involved in emotional processing and regulation are activated differently in people with BD relative to healthy controls (e.g., Altshuler et al., 2008; Hassel et al., 2008; Lennox, Jacob, Calder, Lupson, & Bullmore, 2004).

However, there is little consensus as to whether a particular brain region becomes more or less active in response to an

emotional stimulus among people with BD compared with healthy controls. Mixed findings are in part due to samples consisting of participants who are at various phases of illness at the time of testing (manic, depressed, inter-episode). Sample sizes tend to be relatively small, making comparisons between subgroups difficult. Additionally, the use of a standardized stimulus (e.g., facial expression of anger) may not elicit a sufficiently strong response. Personally engaging stimuli, such as recalling a memory, may be more effective in inducing strong emotions (Isacowitz, Gershon, Allard, & Johnson, 2013).

Within the psychosocial level, research has focused on the environmental contributors to BD. A series of studies show that environmental stressors, particularly severe stressors (e.g., loss of a significant relationship), can adversely impact the course of BD. People with BD have substantially increased risk of relapse (Ellicott, Hammen, Gitlin, Brown, & Jamison, 1990) and suffer more depressive symptoms (Johnson, Winett, Meyer, Greenhouse, & Miller, 1999) following a severe life stressor. Interestingly, positive life events can also adversely impact the course of BD. People with BD suffer more manic symptoms after life events involving attainment of a desired goal (Johnson et al., 2008). Such findings suggest that people with BD may have a hypersensitivity to rewards.

Evidence from the life stress literature has also suggested that people with mood disorders may have a circadian vulnerability that renders them sensitive to stressors that disrupt their sleep or rhythms. According to **social**

zeitgeber theory (Ehlers, Frank, & Kupfer, 1988; Frank et al., 1994), stressors that disrupt sleep, or that disrupt the daily routines that entrain the biological clock (e.g., meal times) can trigger episode relapse. Consistent with this theory, studies have shown that life events that involve a disruption in sleep and daily routines, such as overnight travel, can increase bipolar symptoms in people with BD (Malkoff-Schwartz et al., 1998).

WHAT ARE SOME OF THE WELL-SUPPORTED TREATMENTS FOR MOOD DISORDERS?

DEPRESSIVE DISORDERS



A number of medications are effective in treating mood disorders.

Meditation, exercise, counseling and other therapies also show effectiveness for some disorders. [Image: CC0 Public Domain]

There are many treatment options available for people with MDD. First, a number of antidepressant medications are available, all of which target one or more of the neurotransmitters implicated in depression. The earliest antidepressant medications were monoamine oxidase inhibitors (MAOIs). MAOIs inhibit monoamine oxidase, an enzyme involved in deactivating dopamine, norepinephrine, and

serotonin. Although effective in treating depression, MAOIs can have serious side effects. Patients taking MAOIs may develop dangerously high blood pressure if they take certain drugs (e.g., antihistamines) or eat foods containing tyramine, an amino acid commonly found in foods such as aged cheeses, wine, and soy sauce. Tricyclics, the second-oldest class of antidepressant medications, block the reabsorption of norepinephrine, serotonin, or dopamine at synapses, resulting in their increased availability. Tricyclics are most effective for treating vegetative and somatic symptoms of depression. Like MAOIs, they have serious side effects, the most concerning of which is being cardiotoxic. Selective serotonin reuptake inhibitors (SSRIs; e.g., Fluoxetine) and serotonin and norepinephrine reuptake inhibitors (SNRIs; e.g., Duloxetine) are the most recently introduced antidepressant medications. SSRIs, the most commonly prescribed antidepressant medication, block the reabsorption of serotonin, whereas SNRIs block the reabsorption of serotonin and norepinephrine. SSRIs and SNRIs have fewer serious side effects than do MAOIs and tricyclics. In particular, they are less cardiotoxic, less lethal in overdose, and produce fewer cognitive impairments. They are not, however, without their own side effects, which include but are not limited to difficulty having orgasms, gastrointestinal issues, and insomnia. It should be noted that anti-depressant medication may not work equally for all people. This approach to treatment often involves experimentation with several

medications and dosages, and may be more effective when paired with physical exercise and psychotherapy.

Other biological treatments for people with depression include electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), and deep brain stimulation. ECT involves inducing a seizure after a patient takes muscle relaxants and is under general anesthesia. ECT is viable treatment for patients with severe depression or who show resistance to antidepressants although the mechanisms through which it works remain unknown. A common side effect is confusion and memory loss, usually short-term (Schulze-Rauschenbach, Harms, Schlaepfer, Maier, Falkai, & Wagner, 2005). Repetitive TMS is a noninvasive technique administered while a patient is awake. Brief pulsating magnetic fields are delivered to the cortex, inducing electrical activity. TMS has fewer side effects than ECT (Schulze-Rauschenbach et al., 2005), and while outcome studies are mixed, there is evidence that TMS is a promising treatment for patients with MDD who have shown resistance to other treatments (Rosa et al., 2006). Most recently, deep brain stimulation is being examined as a treatment option for patients who did not respond to more traditional treatments like those already described. Deep brain stimulation involves implanting an electrode in the brain. The electrode is connected to an implanted neurostimulator, which electrically stimulates that particular brain region. Although there is some evidence of its effectiveness (Mayberg et al., 2005), additional research is needed.

Several psychosocial treatments have received strong empirical support, meaning that independent investigations have achieved similarly positive results—a high threshold for examining treatment outcomes. These treatments include but are not limited to behavior therapy, cognitive therapy, and interpersonal therapy. Behavior therapies focus on increasing the frequency and quality of experiences that are pleasant or help the patient achieve mastery. Cognitive therapies primarily focus on helping patients identify and change distorted automatic thoughts and assumptions (e.g., Beck, 1967). Cognitive-behavioral therapies are based on the rationale that thoughts, behaviors, and emotions affect and are affected by each other. Interpersonal Therapy for Depression focuses largely on improving interpersonal relationships by targeting problem areas, specifically unresolved grief, interpersonal role disputes, role transitions, and interpersonal deficits. The overall response rate for cognitive behavioral therapy for depression, based on international samples, has ranged from 34% to 71% (Beard, Stein, Hearon, Lee, Hsu, & Bjorgvinsson, 2016; Santoft, Axelsson, Ost, Hedman-Lagerlof, Fust, & Hedman-Lagerlof, 2019). Finally, there is also some support for the effectiveness of Short-Term Psychodynamic Therapy for Depression (Leichsenring, 2001). The short-term treatment focuses on a limited number of important issues, and the therapist tends to be more actively involved than in more traditional psychodynamic therapy.

BIPOLAR DISORDERS

Patients with BD are typically treated with pharmacotherapy. Antidepressants such as SSRIs and SNRIs are the primary choice of treatment for depression, whereas for BD, lithium is the first line treatment choice. This is because SSRIs and SNRIs have the potential to induce mania or hypomania in patients with BD. Lithium acts on several neurotransmitter systems in the brain through complex mechanisms, including reduction of excitatory (dopamine and glutamate) neurotransmission, and increasing of inhibitory (GABA) neurotransmission (Lenox & Hahn, 2000). Lithium has strong efficacy for the treatment of BD (Geddes, Burgess, Hawton, Jamison, & Goodwin, 2004). However, a number of side effects can make lithium treatment difficult for patients to tolerate. Side effects include impaired cognitive function (Wingo, Wingo, Harvey, & Baldessarini, 2009), as well as physical symptoms such as nausea, tremor, weight gain, and fatigue (Dunner, 2000). Some of these side effects can improve with continued use; however, medication noncompliance remains an ongoing concern in the treatment of patients with BD. Anticonvulsant medications (e.g., carbamazepine, valproate) are also commonly used to treat patients with BD, either alone or in conjunction with lithium.

There are several adjunctive treatment options for people with BD. Interpersonal and social rhythm therapy (IPSRT; Frank et al., 1994) is a psychosocial intervention focused on addressing the mechanism of action posited in

social *zeitgeber* theory to predispose patients who have BD to relapse, namely sleep disruption. A growing body of literature provides support for the central role of sleep dysregulation in BD (Harvey, 2008). Consistent with this literature, IPSRT aims to increase rhythmicity of patients' lives and encourage vigilance in maintaining a stable rhythm. The therapist and patient work to develop and maintain a healthy balance of activity and stimulation such that the patient does not become overly active (e.g., by taking on too many projects) or inactive (e.g., by avoiding social contact). The efficacy of IPSRT has been demonstrated in that patients who received this treatment show reduced risk of episode recurrence and are more likely to remain well (Frank et al., 2005).

CONCLUSION

Everyone feels down or euphoric from time to time. For some people, these feelings can last for long periods of time and can also co-occur with other symptoms that, in combination, interfere with their everyday lives. When people experience an MDE or a manic episode, they see the world differently. During an MDE, people often feel hopeless about the future, and may even experience suicidal thoughts. During a manic episode, people often behave in ways that are risky or place them in danger. They may spend money excessively or have unprotected sex, often expressing deep shame over these decisions after the episode. MDD and BD cause significant problems for people at school, at work, and

in their relationships and affect people regardless of gender, age, nationality, race, religion, or sexual orientation. If you or someone you know is suffering from a mood disorder, it is important to seek help. Effective treatments are available and continually improving. If you have an interest in mood disorders, there are many ways to contribute to their understanding, prevention, and treatment, whether by engaging in research or clinical work.

Outside Resources

Books: Recommended memoirs include *A Memoir of Madness* by William Styron (MDD); *Noonday Demon: An Atlas of Depression* by Andrew Solomon (MDD); and *An Unquiet Mind: A Memoir of Moods and Madness* by Kay Redfield (BD).

Web: Visit the Association for Behavioral and Cognitive Therapies to find a list of the recommended therapists and evidence-based treatments. <http://www.abct.org>

Web: Visit the Depression and Bipolar Support Alliance for educational information and social support options. <http://www.dbsalliance.org/>

Discussion Questions

1. What factors might explain the large gender difference in the prevalence rates of MDD?
2. Why might American ethnic minority groups experience more persistent BD than European Americans?
3. Why might the age of onset for MDD be decreasing over time?
4. Why might overnight travel constitute a potential risk for a person with BD?
5. What are some reasons positive life events may precede the occurrence of manic episode?

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Summary and Self-Test: Mood Disorders

ANDA GERSHON; RENEE THOMPSON; AND
JORDEN A. CUMMINGS

SUMMARY

Everyone feels down or euphoric from time to time, but this is different from having a mood disorder like major depressive disorder or bipolar disorder. Mood disorders are extended periods of depressed, euphoric, or irritable moods that in combination with other symptoms cause the person distress and interfere with their life.

Mood episodes are shortened periods of mood disruption. A major depressive episode refers to symptoms that last for at

least two weeks and cause significant distress or impairment in functioning. Core symptoms include low mood and anhedonia.

Manic and hypomanic episodes are periods of abnormally and persistently euphoric, expansive, or irritable mood and persistently increased goal-directed activity or energy. For mania this must be present for one week or longer, or four days for hypomania.

There are two major types of unipolar mood disorders: major depressive disorder, which is defined by one or more major depressive episodes, and persistent depressive disorder, which is feeling depressed most days for at least two years.

Bipolar I disorder is characterized by a single or recurrent manic episode whereas Bipolar II is characterized by a single or recurrent hypomanic episode. Cyclothymic disorder is characterized by numerous and alternating periods of hypomania and depression, lasting at least two years.

The lifetime prevalence rate for major depression in Canada is 11.2%. The average age of onset for depression is in the mid-20s, and an earlier age of onset predicts a worse course. About 5-10% of people who experience a major depressive episode will later experience mania.

Women experience 2-3 times higher rates of major depression than men do, although before puberty rates of childhood depression are equal for boys and girls. Major depression is inversely related to socioeconomic status. Unfortunately, sexual minorities experience much higher rates of depression than the general population.

The lifetime prevalence rate for bipolar disorder is 2.6% in Canada. The majority of people with bipolar disorder also meet criteria for another disorder. Adolescence is a significant risk period for bipolar disorder.

Multiple variables are implicated in the development of depressive disorders including genetic factors, stressful life events, early adversity, chronic stress, and attributional styles.

Bipolar disorder is highly heritable and might fundamentally be a biological phenomenon. However, as each person experiences the course of their bipolar disorder differently, environmental variables still impact it including stress and social rhythms.

There are many treatment options for depression including antidepressant medication, electroconvulsive therapy, transcranial magnetic stimulation, deep brain stimulation, cognitive-behavioural therapy, interpersonal therapy, psychodynamic therapy, and mindfulness-based cognitive therapy.

Patients with bipolar disorder are typically treated with lithium, Interpersonal and social rhythm therapy is also effective for bipolar disorder.



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STEPHANIE WEIGEL

PART V

Chapter 5:
Schizophrenia &
Related Psychotic
Disorders

STEPHANIE WEIGEL

Chapter 5 Introduction

DEANNA M. BARCH AND JORDEN A. CUMMINGS

Schizophrenia and the other psychotic disorders are some of the most impairing forms of psychopathology, frequently associated with a profound negative effect on the individual's educational, occupational, and social function. Up to 3% of Canadians will experience psychosis at some point in their lives (Canadian Mental Health Association, 2013; Schizophrenia Society of Canada 2017-2018). Schizophrenia affects 1% of the Canadian population (about 1 in 100 persons), with the most affected being people aged 16 to 30 years (Hafner & an der Heiden, 1997).

Sadly, these disorders often manifest right at time of the transition from adolescence to adulthood, just as young

people should be evolving into independent young adults. The spectrum of psychotic disorders includes schizophrenia, schizoaffective disorder, delusional disorder, schizotypal personality disorder, schizophreniform disorder, brief psychotic disorder, as well as psychosis associated with substance use or medical conditions. In this module, we summarize the primary clinical features of these disorders, describe the known cognitive and neurobiological changes associated with schizophrenia, describe potential risk factors and/or causes for the development of schizophrenia, and describe currently available treatments for schizophrenia.

5.1 Schizophrenia & Related Psychotic Disorders

DEANNA M. BARCH AND JORDEN A. CUMMINGS

Section Learning Objectives

- Describe the signs and symptoms of schizophrenia and related psychotic disorders.
- Describe the most well-replicated cognitive and neurobiological changes associated with schizophrenia.
- Describe the potential risk factors for the

development of schizophrenia.

- Describe the controversies associated with “clinical high risk” approaches to identifying individuals at risk for the development of schizophrenia.
- Describe the treatments that work for some of the symptoms of schizophrenia.

THE PHENOMENOLOGY OF SCHIZOPHRENIA AND RELATED PSYCHOTIC DISORDERS

Most of you have probably had the experience of walking down the street in a city and seeing a person you thought was acting oddly. They may have been dressed in an unusual way, perhaps disheveled or wearing an unusual collection of clothes, makeup, or jewelry that did not seem to fit any particular group or subculture. They may have been talking to themselves or yelling at someone you could not see. If you tried to speak to them, they may have been difficult to follow or understand, or they may have acted paranoid or started telling a bizarre story about the people who were plotting against them. If so, chances are that you have encountered an individual with schizophrenia or another type of psychotic disorder. If you have watched the movie *A Beautiful Mind* or *The Fisher King*, you have also seen a portrayal of someone thought to have schizophrenia. Sadly, a few of the individuals who have committed some of the recently highly

publicized mass murders may have had schizophrenia, though most people who commit such crimes do not have schizophrenia and the vast majority of people with schizophrenia are not dangerous. It is also likely that you have met people with schizophrenia without ever knowing it, as they may suffer in silence or stay isolated to protect themselves from the horrors they see, hear, or believe are operating in the outside world. As these examples begin to illustrate, psychotic disorders involve many different types of symptoms, including delusions, hallucinations, disorganized speech and behavior, abnormal motor behavior (including **catatonia**), and negative symptoms such **anhedonia/ amotivation** and blunted affect/reduced speech.

Delusions are false beliefs that are often fixed, hard to change even when the person is presented with conflicting information, and are often culturally influenced in their content (e.g., delusions involving Jesus in Judeo-Christian cultures, delusions involving Allah in Muslim cultures). They can be terrifying for the person, who may remain convinced that they are true even when loved ones and friends present them with clear information that they cannot be true. There are many different types or themes to delusions.



Under Surveillance: Abstract groups like the police or the government are commonly the focus of a schizophrenic's persecutory delusions. [Image: Thomas Hawk, <https://goo.gl/qsrqiR>, CC BY-NC 2.0, <https://goo.gl/VnKlK8>]

The most common delusions are persecutory and involve the belief that individuals or groups are trying to hurt, harm, or plot against the person in some way. These can be people that the person knows (people at work, the neighbors, family members), or more abstract groups (the FBI, the CIA, aliens, etc.). Other types of delusions include grandiose delusions, where the person believes that they have some special power or ability (e.g., I am the new Buddha, I am a rock star); referential delusions, where the person believes that events or objects in the environment have special meaning for them (e.g., that song on the radio is being played *specifically* for me); or other types of delusions where the person may believe that others are controlling their thoughts and actions, their thoughts are being broadcast aloud, or that others can read their mind (or they can read other people's minds).

When you see a person on the street talking to themselves or shouting at other people, they are experiencing **hallucinations**. These are perceptual

experiences that occur even when there is no stimulus in the outside world generating the experiences. They can be auditory, visual, olfactory (smell), gustatory (taste), or somatic (touch). The most common hallucinations in psychosis (at least in adults) are auditory, and can involve one or more voices talking about the person, commenting on the person's behavior, or giving them orders. The content of the hallucinations is frequently negative ("you are a loser," "that drawing is stupid," "you should go kill yourself") and can be the voice of someone the person knows or a complete stranger. Sometimes the voices sound as if they are coming from outside the person's head. Other times the voices seem to be coming from inside the person's head, but are not experienced the same as the person's inner thoughts or inner speech.

Talking to someone with schizophrenia is sometimes difficult, as their speech may be difficult to follow, either because their answers do not clearly flow from your questions, or because one sentence does not logically follow from another. This is referred to as **disorganized speech**, and it can be present even when the person is



People who suffer from schizophrenia may see the world differently. This can include hallucinations, delusions, and disorganized thinking. [Image: Noba Project CCBYNC-SA 4.0 <https://tinyurl.com/y3k6qoz4>]

writing. **Disorganized**

behavior can include odd dress, odd makeup (e.g., lipstick outlining a mouth for 1 inch), or unusual rituals (e.g., repetitive hand gestures). Abnormal motor behavior can include catatonia, which refers to a variety of behaviors that seem to reflect a reduction in responsiveness to the external environment. This can include holding unusual postures for long periods of time, failing to respond to verbal or motor prompts from another person, or excessive and seemingly purposeless motor activity.

Some of the most debilitating symptoms of schizophrenia are difficult for others to see. These include what people refer to as “negative symptoms” or the absence of certain things we typically expect most people to have. For example, anhedonia or amotivation reflect a lack of apparent interest in or drive

to engage in social or recreational activities. These symptoms can manifest as a great amount of time spent in physical immobility. Importantly, anhedonia and amotivation do not seem to reflect a lack of enjoyment in pleasurable activities or events (Cohen & Minor, 2010; Kring & Moran, 2008; Llerena, Strauss, & Cohen, 2012) but rather a reduced drive or ability to take the steps necessary to obtain the potentially positive outcomes (Barch & Dowd, 2010). **Flat affect** and reduced speech (**alogia**) reflect a lack of showing emotions through facial expressions, gestures, and speech intonation, as well as a reduced amount of speech and increased pause frequency and duration.

In many ways, the types of symptoms associated with psychosis are the most difficult for us to understand, as they may seem far outside the range of our normal experiences. Unlike depression or anxiety, many of us may not have had experiences that we think of as on the same continuum as psychosis. However, just like many of the other forms of **psychopathology** described in this book, the types of psychotic symptoms that characterize disorders like schizophrenia are on a continuum with “normal” mental experiences. For example, work by Jim van Os in the Netherlands has shown that a surprisingly large percentage of the general population (10%+) experience psychotic-like symptoms, though many fewer have multiple experiences and most will not continue to experience these symptoms in the long run (Verdoux & van Os, 2002). Similarly, work in a general population of adolescents and young adults in Kenya

has also shown that a relatively high percentage of individuals experience one or more psychotic-like experiences (~19%) at some point in their lives (Mamah et al., 2012; Ndetei et al., 2012), though again most will not go on to develop a full-blown psychotic disorder.

Schizophrenia is the primary disorder that comes to mind when we discuss “psychotic” disorders (see Table 1 for **diagnostic criteria**), though there are a number of other disorders that share one or more features with schizophrenia. In the remainder of this module, we will use the terms “psychosis” and “schizophrenia” somewhat interchangeably, given that most of the research has focused on schizophrenia. In addition to schizophrenia (see Table 1), other psychotic disorders include schizophreniform disorder (a briefer version of schizophrenia), schizoaffective disorder (a mixture of psychosis and depression/mania symptoms), delusional disorder (the experience of only delusions), and brief psychotic disorder (psychotic symptoms that last only a few days or weeks).

<p>Schizophrenia (Lifetime prevalence about 0.3% to 0.7% [APA, 2013])</p> <ul style="list-style-type: none"> - Two or more of the following for at least 1 month: hallucinations, delusions, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms. - Impairment in one or more areas of function (social, occupational, educational self-care) for a significant period of time since the onset of the illness. - Continuous signs of the illness for at least 6 months (this can include prodromal or residual symptoms, which are attenuated forms of the symptoms described above).
<p>Schizophreniform Disorder (Lifetime prevalence similar to Schizophrenia [APA, 2013])</p> <ul style="list-style-type: none"> - The same symptoms of schizophrenia described above that are present for at least 1 month but less than 6 months.
<p>Schizoaffective Disorder (Lifetime prevalence about 0.3% [APA, 2013])</p> <ul style="list-style-type: none"> - A period of illness where the person has both the psychotic symptoms necessary to meet criteria for schizophrenia and either a major depression or manic episode. - The person experiences either delusions or hallucinations for at least 2 weeks when they are not having a depressive or manic episode. - The symptoms that meet criteria for depressive or manic episodes are present for over half of the illness duration.
<p>Delusional Disorder (Lifetime prevalence about 0.2% [APA, 2013])</p> <ul style="list-style-type: none"> - The presence of at least one delusion for at least a month. - The person has never met criteria for schizophrenia. - The person's function is not impaired outside the specific impact of the delusion. - The duration of any depressive or manic episodes have been brief relative to the duration of the delusion(s).
<p>Brief Psychotic Disorder (Lifetime prevalence unclear [APA, 2013])</p> <ul style="list-style-type: none"> - One or more of the following symptoms present for at least 1 day but less than 1 month: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior.
<p>Attenuated Psychotic Disorder (In Section III of the [APA, 2013]-V, Lifetime presence unclear [APA, 2013])</p> <ul style="list-style-type: none"> - One or more of the following symptoms in an "attenuated" form: delusions, hallucinations, or disorganized speech. - The symptoms must have occurred at least once a week for the past month and must have started or gotten worse in the past year. - The symptoms must be severe enough to distress or disable the individual or to suggest to others that the person needs clinical help. - The person has never met the diagnostic criteria for a psychotic disorder, and the symptoms are not better attributed to another disorder, to substance use, or to a medical condition.

Table 5.1: Types of Psychotic Disorders (Simplified from the Diagnostic and Statistical Manual – 5th Edition (DSM-5) (APA, 2013)

THE COGNITIVE NEUROSCIENCE OF SCHIZOPHRENIA

As described above, when we think of the core symptoms of psychotic disorders such as schizophrenia, we think of people who hear voices, see visions, and have false beliefs about reality (i.e., delusions). However, problems in cognitive function are also a critical aspect of psychotic disorders and of schizophrenia in particular. This emphasis on cognition in

schizophrenia is in part due to the growing body of research suggesting that cognitive problems in schizophrenia are a major source of disability and loss of **functional capacity** (Green, 2006; Nuechterlein et al., 2011). The cognitive deficits that are present in schizophrenia are widespread and can include problems with **episodic memory** (the ability to learn and retrieve new information or episodes in one's life), **working memory** (the ability to maintain information over a short period of time, such as 30 seconds), and other tasks that require one to "control" or regulate one's behavior (Barch & Ceaser, 2012; Bora, Yucel, & Pantelis, 2009a; Fioravanti, Carlone, Vitale, Cinti, & Clare, 2005; Forbes, Carrick, McIntosh, & Lawrie, 2009; Mesholam-Gately, Giuliano, Goff, Faraone, & Seidman, 2009). Individuals with schizophrenia also have difficulty with what is referred to as "**processing speed**" and are frequently slower than healthy individuals on almost all tasks. Importantly, these cognitive deficits are present prior to the onset of the illness (Fusar-Poli et al., 2007) and are also present, albeit in a milder form, in the first-degree relatives of people with schizophrenia (Snitz, Macdonald, & Carter, 2006). This suggests that cognitive impairments in schizophrenia reflect part of the risk for the development of psychosis, rather than being an outcome of developing psychosis. Further, people with schizophrenia who have more severe cognitive problems also tend to have more severe negative symptoms and more disorganized speech and behavior (Barch, Carter, & Cohen, 2003; Barch et al.,

1999; Dominguez Mde, Viechtbauer, Simons, van Os, & Krabbendam, 2009; Ventura, Helleman, Thames, Koellner, & Nuechterlein, 2009; Ventura, Thames, Wood, Guzik, & Helleman, 2010). In addition, people with more cognitive problems have worse function in everyday life (Bowie et al., 2008; Bowie, Reichenberg, Patterson, Heaton, & Harvey, 2006; Fett et al., 2011).



Some with schizophrenia suffer from difficulty with social cognition. They may not be able to detect the meaning of facial expressions or other subtle cues that most other people rely on to navigate the social world.

[Image: Ralph Buckley, <https://goo.gl/KuBzsD>, CC BY-SA 2.0, <https://goo.gl/i4GXf5>]

Some people with schizophrenia also show deficits in what is referred to as social cognition, though it is not clear whether such problems are separate from the cognitive problems described above or the result of them (Hoe, Nakagami, Green, & Brekke, 2012; Kerr & Neale, 1993; van Hooren et al., 2008). This includes problems with the recognition of emotional expressions on the faces of other individuals (Kohler, Walker, Martin, Healey, & Moberg, 2010) and

problems inferring the intentions of other people (theory of mind) (Bora, Yucel, & Pantelis, 2009b). Individuals with

schizophrenia who have more problems with social cognition also tend to have more negative and disorganized symptoms (Ventura, Wood, & Helleman, 2011), as well as worse community function (Fett et al., 2011).

The advent of neuroimaging techniques such as structural and functional **magnetic resonance imaging** and **positron emission tomography** opened up the ability to try to understand the brain mechanisms of the symptoms of schizophrenia as well as the cognitive impairments found in psychosis. For example, a number of studies have suggested that delusions in psychosis may be associated with problems in “salience” detection mechanisms supported by the ventral striatum (Jensen & Kapur, 2009; Jensen et al., 2008; Kapur, 2003; Kapur, Mizrahi, & Li, 2005; Murray et al., 2008) and the anterior prefrontal cortex (Corlett et al., 2006; Corlett, Honey, & Fletcher, 2007; Corlett, Murray, et al., 2007a, 2007b). These are regions of the brain that normally increase their activity when something important (aka “salient”) happens in the environment. If these brain regions misfire, it may lead individuals with psychosis to mistakenly attribute importance to irrelevant or unconnected events. Further, there is good evidence that problems in working memory and cognitive control in schizophrenia are related to problems in the function of a region of the brain called the dorsolateral prefrontal cortex (DLPFC) (Minzenberg, Laird, Thelen, Carter, & Glahn, 2009; Ragland et al., 2009). These problems include changes in how the DLPFC works when people are doing working-memory or cognitive-control

tasks, and problems with how this brain region is connected to other brain regions important for working memory and cognitive control, including the posterior parietal cortex (e.g., Karlsgodt et al., 2008; Kim et al., 2003; Schlosser et al., 2003), the anterior cingulate (Repovs & Barch, 2012), and temporal cortex (e.g., Fletcher et al., 1995; Meyer-Lindenberg et al., 2001). In terms of understanding episodic memory problems in schizophrenia, many researchers have focused on medial temporal lobe deficits, with a specific focus on the hippocampus (e.g., Heckers & Konradi, 2010). This is because there is much data from humans and animals showing that the hippocampus is important for the creation of new memories (Squire, 1992). However, it has become increasingly clear that problems with the DLPFC also make important contributions to episodic memory deficits in schizophrenia (Ragland et al., 2009), probably because this part of the brain is important for controlling our use of memory.

In addition to problems with regions such as the DLPFC and medial temporal lobes in schizophrenia described above, magnetic resonance neuroimaging studies have also identified changes in cellular architecture, white matter connectivity, and gray matter volume in a variety of regions that include the prefrontal and temporal cortices (Bora et al., 2011). People with schizophrenia also show reduced overall brain volume, and reductions in brain volume as people get older may be larger in those with schizophrenia than in healthy people (Olabi et al., 2011). Taking antipsychotic

medications or taking drugs such as marijuana, alcohol, and tobacco may cause some of these structural changes. However, these structural changes are not completely explained by medications or substance use alone. Further, both functional and structural brain changes are seen, again to a milder degree, in the first-degree relatives of people with schizophrenia (Boos, Aleman, Cahn, Pol, & Kahn, 2007; Brans et al., 2008; Fusar-Poli et al., 2007; MacDonald, Thermenos, Barch, & Seidman, 2009). This again suggests that that neural changes associated with schizophrenia are related to a genetic risk for this illness.

RISK FACTORS FOR DEVELOPING SCHIZOPHRENIA

It is clear that there are important genetic contributions to the likelihood that someone will develop schizophrenia, with consistent evidence from family, twin, and adoption studies. (Sullivan, Kendler, & Neale, 2003). However, there is no “schizophrenia gene” and it is likely that the genetic risk for schizophrenia reflects the summation of many different genes that each contribute something to the likelihood of developing psychosis (Gottesman & Shields, 1967; Owen, Craddock, & O’Donovan, 2010). Further, schizophrenia is a very heterogeneous disorder, which means that two different people with “schizophrenia” may each have very different symptoms (e.g., one has hallucinations and delusions, the other has disorganized speech and negative symptoms). This makes it even more challenging to identify specific genes

associated with risk for psychosis. Importantly, many studies also now suggest that at least some of the genes potentially associated with schizophrenia are also associated with other mental health conditions, including bipolar disorder, depression, and autism (Gejman, Sanders, & Kendler, 2011; Kim, Zerwas, Trace, & Sullivan, 2011; Owen et al., 2010; Rutter, Kim-Cohen, & Maughan, 2006).



There are a number of genetic and environmental risk factors associated with higher likelihood of developing schizophrenia including older fathers, complications during pregnancy/delivery, family history of schizophrenia, and growing up in an urban environment. [Image: CC0 Public Domain]

There are also a number of environmental factors that are associated with an increased risk of developing schizophrenia. For example, problems during pregnancy such as increased stress, infection, malnutrition, and/or diabetes have been associated with increased risk of schizophrenia. In addition, complications that occur at the time of birth and which cause hypoxia (lack of oxygen) are also associated with an increased risk for developing schizophrenia (Cannon, Jones, & Murray,

2002; Miller et al., 2011). Children born to older fathers are also at a somewhat increased risk of developing

schizophrenia. Further, using cannabis increases risk for developing psychosis, especially if you have other risk factors (Casadio, Fernandes, Murray, & Di Forti, 2011; Luzi, Morrison, Powell, di Forti, & Murray, 2008). The likelihood of developing schizophrenia is also higher for kids who grow up in urban settings (March et al., 2008) and for some minority ethnic groups (Bourque, van der Ven, & Malla, 2011). Both of these factors may reflect higher social and environmental stress in these settings. Unfortunately, none of these risk factors is specific enough to be particularly useful in a clinical setting, and most people with these “risk” factors do not develop schizophrenia. However, together they are beginning to give us clues as the **neurodevelopmental** factors that may lead someone to be at an increased risk for developing this disease.

An important research area on risk for psychosis has been work with individuals who may be at “clinical high risk.” These are individuals who are showing attenuated (milder) symptoms of psychosis that have developed recently and who are experiencing some distress or disability associated with these symptoms. When people with these types of symptoms are followed over time, about 35% of them develop a psychotic disorder (Cannon et al., 2008), most frequently schizophrenia (Fusar-Poli, McGuire, & Borgwardt, 2012). In order to identify these individuals, a new category of diagnosis, called “Attenuated Psychotic Syndrome,” was added to Section III (the section for disorders in need of further study) of the DSM-5 (see Table 1 for symptoms)

(APA, 2013). However, adding this diagnostic category to the DSM-5 created a good deal of controversy (Batstra & Frances, 2012; Fusar-Poli & Yung, 2012). Many scientists and clinicians have been worried that including “risk” states in the DSM-5 would create mental disorders where none exist, that these individuals are often already seeking treatment for other problems, and that it is not clear that we have good treatments to stop these individuals from developing to psychosis. However, the counterarguments have been that there is evidence that individuals with high-risk symptoms develop psychosis at a much higher rate than individuals with other types of psychiatric symptoms, and that the inclusion of Attenuated Psychotic Syndrome in Section III will spur important research that might have clinical benefits. Further, there is some evidence that non-invasive treatments such as omega-3 fatty acids and intensive family intervention may help reduce the development of full-blown psychosis (Preti & Cella, 2010) in people who have high-risk symptoms.

TREATMENT OF SCHIZOPHRENIA

The currently available treatments for schizophrenia leave much to be desired, and the search for more effective treatments for both the psychotic symptoms of schizophrenia (e.g., hallucinations and delusions) as well as cognitive deficits and negative symptoms is a highly active area of research. The first line of treatment for schizophrenia and other psychotic disorders is the use of antipsychotic medications. There are two primary types of antipsychotic medications,

referred to as “typical” and “atypical.” The fact that “typical” antipsychotics helped some symptoms of schizophrenia was discovered serendipitously more than 60 years ago (Carpenter & Davis, 2012; Lopez-Munoz et al., 2005). These are drugs that all share a common feature of being a strong block of the D2 type **dopamine** receptor. Although these drugs can help reduce hallucinations, delusions, and disorganized speech, they do little to improve cognitive deficits or negative symptoms and can be associated with distressing motor side effects. The newer generation of antipsychotics is referred to as “atypical” antipsychotics. These drugs have more mixed mechanisms of action in terms of the receptor types that they influence, though most of them also influence D2 receptors. These newer antipsychotics are not necessarily more helpful for schizophrenia but have fewer motor side effects. However, many of the atypical antipsychotics are associated with side effects referred to as the “metabolic syndrome,” which includes weight gain and increased risk for cardiovascular illness, Type-2 diabetes, and mortality (Lieberman et al., 2005).

The evidence that cognitive deficits also contribute to functional impairment in schizophrenia has led to an increased search for treatments that might enhance cognitive function in schizophrenia. Unfortunately, as of yet, there are no pharmacological treatments that work consistently to improve cognition in schizophrenia, though many new types of drugs are currently under exploration. However, there is a type of psychological intervention, referred to as cognitive

remediation, which has shown some evidence of helping cognition and function in schizophrenia. In particular, a version of this treatment called Cognitive Enhancement Therapy (CET) has been shown to improve cognition, functional outcome, social cognition, and to protect against gray matter loss (Eack et al., 2009; Eack, Greenwald, Hogarty, & Keshavan, 2010; Eack et al., 2010; Eack, Pogue-Geile, Greenwald, Hogarty, & Keshavan, 2010; Hogarty, Greenwald, & Eack, 2006) in young individuals with schizophrenia. The development of new treatments such as Cognitive Enhancement Therapy provides some hope that we will be able to develop new and better approaches to improving the lives of individuals with this serious mental health condition and potentially even prevent it some day.

Outside Resources

Book: *Ben Behind His Voices: One family's journal from the chaos of schizophrenia to hope* (2011). Randy Kaye. Rowman and Littlefield.

Book: *Conquering Schizophrenia: A father, his son, and a medical breakthrough* (1997). Peter Wyden. Knopf.

Book: *Henry's Demons: Living with schizophrenia, a father and son's story* (2011). Henry and Patrick Cockburn. Scribner Macmillan.

Book: *My Mother's Keeper: A daughter's memoir of growing*

up in the shadow of schizophrenia (1997). Tara Elgin Holley. William Morrow Co.

Book: *Recovered, Not Cured: A journey through schizophrenia* (2005). Richard McLean. Allen and Unwin.

Book: *The Center Cannot Hold: My journey through madness* (2008). Elyn R. Saks. Hyperion.

Book: *The Quiet Room: A journal out of the torment of madness* (1996). Lori Schiller. Grand Central Publishing.

Book: *Welcome Silence: My triumph over schizophrenia* (2003). Carol North. CSS Publishing.

Web: National Alliance for the Mentally Ill. This is an excellent site for learning more about advocacy for individuals with major mental illnesses such as schizophrenia. <http://www.nami.org/>

Web: National Institute of Mental Health. This website has information on NIMH-funded schizophrenia research. <http://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml>

Web: Schizophrenia Research Forum. This is an excellent website that contains a broad array of information about current research on schizophrenia. <http://www.schizophreniaforum.org/>

Discussion Questions

1. Describe the major differences between the major psychotic disorders.
2. How would one be able to tell when an individual is “delusional” versus having non-delusional beliefs that differ from the societal normal? How should cultural and sub-cultural variation be taken into account when assessing psychotic symptoms?
3. Why are cognitive impairments important to understanding schizophrenia?
4. Why has the inclusion of a new diagnosis (Attenuated Psychotic Syndrome) in Section III of the DSM-5 created controversy?
5. What are some of the factors associated with increased risk for developing schizophrenia? If we know whether or not someone has these risk factors, how well can we tell whether they will develop schizophrenia?
6. What brain changes are most consistent in schizophrenia?
7. Do antipsychotic medications work well for all symptoms of schizophrenia? If not, which symptoms respond better to antipsychotic medications?
8. Are there any treatments besides antipsychotic medications that help any of the symptoms of schizophrenia? If so, what are they?

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Summary and Self-Test: Schizophrenia & Related Psychotic Disorders

DEANNA M. BARCH AND JORDEN A. CUMMINGS

SUMMARY

Schizophrenia and the related psychotic disorders are some of the most impairing forms of psychopathology. Psychotic disorders involve many different types of symptoms that involved altered cognition and perception.

Symptoms include delusions, which are false beliefs that are often fixed, and hallucinations, which are perceptual experiences that occur without stimulus from the outside world generating them. Other symptoms include

disorganized speech and behaviour, flat affect, alogia, catatonia, and lack of motivation.

Problems in cognitive functioning are a critical aspect of psychotic disorders, and a major source of disability and loss of functional capacity. These include problems with episodic memory, working memory, and processing speed. Some people with schizophrenia also show deficits in social cognition.

There are important genetic contributions to the likelihood someone will develop schizophrenia, but it is important to know there is no “schizophrenia gene.” Like most forms of psychopathology, the genetic risk for schizophrenia reflects the summation of many different genes.

Environmental factors can also increase risk of developing schizophrenia such as stress, infection, malnutrition and diabetes during pregnancy. Birth complications that cause hypoxia (lack of oxygen) are also associated with an increased risk for schizophrenia.

Using cannabis increases risk for developing psychosis, especially if you have other risk factors. The likelihood is also higher for children who grow up in urban settings and for some minority ethnic groups.

Unfortunately, none of these risk factors are specific enough to be used in a clinical setting.

An important area of research is with individuals who are at “clinical high risk,” for psychosis. These are individuals who show milder symptoms that have developed recently and who

are experiencing some distress or disability. When followed over time, about 35% of these individuals develop a psychotic disorder.

Schizophrenia is treated with antipsychotic medication. Newer antipsychotics have fewer side effects. Schizophrenia is also treated with Cognitive Enhancement Therapy, which has been shown to improve cognition, functional outcome, and social cognition.



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PART VI

Chapter 6:
Post-traumatic
Stress Disorder

STEPHANIE WEIGEL

Chapter 6 Introduction

JORDEN A. CUMMINGS

Trauma- and stressor-related disorders occur in response to exposure to a traumatic or very stressful negative event, like sexual abuse, a natural disaster, a car accident, or violent assault. How we respond to trauma is variable, with some reactions and disorders clearly being based on anxiety and fear, but with other reactions being marked by anhedonia and dysphoria (APA, 2013). The DSM-5 trauma- and stressor-related disorders section includes two childhood disorders (Reactive Attachment Disorder and Disinhibited Social Engagement Disorder), as well as Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder. In this chapter, we will focus on PTSD. You will read about the symptoms of

STEPHANIE WEIGEL

PTSD, some of the vulnerabilities that people might possess for developing PTSD, as well as how we treat PTSD.

6.1 Post-Traumatic Stress Disorder

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Section Learning Objectives

- Describe the diagnostic criteria for posttraumatic stress disorder (PTSD) in adults and in children
- Identify the predictors or potential risk factors for the development of PTSD
- Outline empirically supported treatments for PTSD

- Describe the difference between strongly recommended treatments and conditionally supported treatments

In a nationally representative sample of Canadians aged 18 years and over, at least 76% of participants reported being exposed to at least one traumatic event in their lifetime (Van Ameringen, Mancini, Patterson, & Boyle, 2008). Traumatic events are defined by the DSM-5 as “exposure to actual or threatened death, serious injury, or sexual violence” (p. 271). The most commonly reported events were unexpected death of a loved one, sexual assault, and witnessing someone being seriously harmed or killed. However, only about 8% of Canadians who experience a traumatic event develop PTSD (Canadian Mental Health Association, 2013). Unfortunately, like adults, children are also exposed to high rates of trauma. At least 30% of Canadians self-report that they experienced physical and/or sexual abuse and/or exposure to intimate partner violence before the age of 15 (Afifi et al., 2014; Canadian Centre for Justice Statistics, 2017).

In Canada, the current and lifetime prevalence of PTSD was 2.4% and 9.2%, respectively (Van Ameringen et al., 2008). Rates of PTSD were higher for people living in rural areas, Western Canada, and Ontario, and the risk for developing PTSD was significantly lower among males (Van Ameringen et al., 2008). The rates of PTSD are especially

common among Canadian veterans. According to Statistics Canada, the lifetime and 12-month prevalence of PTSD among Canadian Armed Force members was 11.1% and 5.3%, respectively (Caryn, Zamorski, & Janz, 2014). Of concern, the 12-month prevalence for PTSD is twice as high among members who were deployed in Afghanistan compared to those who were not (Caryn et al., 2014).

SYMPTOMS OF PTSD

According to the DSM-5, for a person to receive a diagnosis of Post-Traumatic Stress Disorder (PTSD), they must meet the following 8 criteria (APA, 2013). First, as mentioned, the person must have been exposed to a traumatic or stressful event such as actual or threatened death, serious bodily harm, or sexual violence. The person may have experienced the event themselves, witnessed it happening to somebody else, or learned that a close family member or friend was exposed to a trauma (APA, 2013). Second, the person has intrusive symptoms such that they re-experience the trauma, for example through unwanted memories, nightmares, or flashbacks that are related to the traumatic event. These symptoms are not within the person's control, which can be particularly distressing for those with PTSD.

Third, the person avoids trauma-related stimuli (e.g., thoughts, emotions, reminders) (e.g., people, places, objects). They do so in order to avoid the overwhelming fear response that arises when they are around trauma-related stimuli. For some people with PTSD, exposure to trauma-related stimuli

can lead to an increase in intrusive thoughts, nightmares, or flashbacks. Some examples of things that people might avoid include certain locations, people, conversations or memories, rooms in their homes, etc.

Fourth, the person experiences negative changes in mood or cognition related to the traumatic event (e.g., inability to remember important parts of the event, exaggerated negative beliefs, negative emotions and the inability to experience positive emotions). Fifth, the person experiences significant changes in arousal and behaviour (e.g., irritability, hypervigilance, sleep disturbance) (APA, 2013). For example, it is not uncommon for individuals with PTSD to experience insomnia or to be hypervigilant to concerns about safety. This overarousal sometimes results in feeling tense, “keyed up” or on edge. It is also common for individuals with PTSD to have exaggerated startle responses, compared to people without PTSD.

Sixth, the disturbances in mood, cognition, and behaviour must occur for at least 1 month. Seventh, they must cause clinically significant distress or impairment in important areas of functioning (e.g., social, occupational). Eighth, the disturbances should not be better explained by the effects of a substance or another medical condition. In addition to making a diagnosis of PTSD, a psychologist can specify if the person also has symptoms of dissociation and/or if they have delayed expression of symptoms (i.e., full diagnostic criteria are not met until at least 6 months after the traumatic event) (APA, 2013).

The DSM-5 has separate diagnostic criteria for children 6 years and younger. Some important differences are that in young children, intrusive memories may not look the same as they do in adults. In children, intrusive memories can be expressed through repetitive play. Children can also experience less interest in play, an exaggerated startle response, and they may have extreme temper tantrums (APA, 2013).

PREDICTORS OF PTSD

Why do some individuals, when exposed to trauma, develop PTSD but others do not? In this section we will discuss just a few of the variables that influence the development of PTSD.

Centrality of Events

In Canada, it is estimated that 75.9% of individuals will experience a traumatic event in their lifetime, but the lifetime rate of PTSD in Canada is only 9.2% (Van Ameringen et al., 2008). Therefore, not everyone that is exposed to a traumatic event will develop PTSD. The discrepancy between the rate of trauma exposure and the rate of PTSD has led researchers to try to identify factors that increase the likelihood of developing PTSD after exposure to a trauma. One such identified factor is event centrality (Berntsen & Rubin, 2006), or how central we come to see that event to our lives, memories, and identity. The centrality of events scale (CES) was introduced by Berntsen and Rubin (2006) to measure the extent to which a memory for a trauma becomes a reference

point for one's identity, life story, and the attribution of meaning to other experiences. The CES has a full 20-item version and a short-form 7-item version. Both have high reliability and validity (Berntsen & Rubin, 2006). The CES has three factors. It measures the extent to which the individual's traumatic memory: 1) becomes a reference point for everyday inferences; 2) represents a turning point in the individual's life story; and 3) becomes a reference point for their personal identity. Each of these factors are positively related to PTSD (Robinaugh & McNally, 2011).

Berntsen and Rubin (2006) discussed why each factor of the CES may contribute to symptoms of PTSD. Berntsen and Robin (2006) proposed that the availability heuristic (Tversky & Kahnman, 1973) helps to explain the relationship between the first factor and PTSD. For example, if the trauma memories are highly accessible, then the individual will overestimate the frequency of traumatic events in everyday life, leading to unnecessary worries, precautions, and other traumatization symptoms (Berntsen & Rubin, 2006). The second factor was developed from research on how trauma can profoundly change a person's outlook (Janoff-Bulman, 1989). Berntsen and Rubin (2006) proposed that symptoms of PTSD may be exacerbated when the individual focuses on aspects of their life that can be explained by referencing this turning point in the life story, while discounting aspects that defy these references (Berntsen & Rubin, 2006). Lastly, the third factor was developed from research that suggests that an individual may perceive a trauma as causally related

to a stable characteristic of the self (Abramson, Seligman, & Teasdale, 1978; Berntsen & Rubin, 2006). Therefore, this factor is proposed to be related to PTSD when individuals attribute the trauma to stable negative identity characteristics (Berntsen & Rubin, 2006). Overall, research on event centrality supports the autobiographical memory model of PTSD, which purports that PTSD symptoms result from the over integration of the trauma into one's memory, identity, and understanding of the world (Berntsen & Rubin, 2006; Rubin, Berntsen, & Bohni, 2008; Rubin, Boals, & Berntsen, 2008).

Since the construction of the centrality of events scale (Berntsen & Rubin, 2006) research has demonstrated a robust positive relationship between event centrality and PTSD for a range of trauma types and participant populations (Gehrt, Berntsen, Hoyle, & Rubin, 2018). For example, the positive relationship between event centrality and PTSD has been found for individuals exposed to child sexual abuse (Robinaugh & McNally, 2011), military combat (Brown, Antonius, Kramer, Root, & Hirst, 2010), terrorist attacks/bombings (Blix, Solberg, & Heir, 2014), physical injury or assault/abuse, illness, exposure to death, sexual assault/abuse, accidents, and natural disasters (Teale Sapach et al., 2019; Barton, Boals, & Knowles, 2013). The positive relationship between event centrality and PTSD has also been found for a range of participant samples, including community members (Rubin, Dennis, & Beckham, 2011; Ogle et al., 2014), undergraduate students (Barton et al., 2013; Berntsen &

Rubin, 2006; Broadbridge, 2018; Fitzgerald, Berntsen, & Broadbridge, 2016), treatment-seeking individuals (Boals & Murrell, 2016; Silva et al., 2016), and military veterans (Brown et al., 2010). This relationship between event centrality and PTSD is also evident for adults ranging from 18 to 93 (Barton et al., 2013; Berntsen, Rubin, & Siegler, 2011; Wamser-Nanney, 2019; Ogle et al., 2013; Boals, Hayslip, Knowles, & Banks, 2012). However, there are nuances in the relationship between event centrality and PTSD for certain participant characteristics. For instance, younger adults (Boals et al., 2012) and women (Boals, 2010) are more likely to centralize a traumatic event and develop PTSD compared to older adults and men, respectively. Therefore, the difference in event centrality may help to explain the higher prevalence of PTSD in these populations (i.e., young adults and women; Van Ameringen et al., 2008).

Trauma Type & Social Support

There are certain types of trauma that have a greater impact on the development and maintenance of PTSD. Interpersonal traumatic events that are purposefully caused by other people contribute the most to PTSD risk and symptom severity. Events that occur by accident or by natural disaster have a far less impact on the risk for PTSD compared to interpersonal traumas (Charuvastra & Cloitre, 2008). There are several reasons explaining why interpersonal traumas are so powerful in increasing a person's risk and severity of PTSD. In interpersonal traumas, the appraisal of threat tends to be

higher, and people tend to experience a higher level of distress and decreased sense of safety in the world. In addition, interpersonal traumas can affect people's ability to effectively interact with others (Charuvastra & Cloitre, 2008).

Social support before and after an exposure to a traumatic event plays an important role in determining a person's risk and severity of PTSD (Charuvastra & Cloitre, 2008). Social support helps people to effectively regulate their emotions, which is central for recovery from PTSD. If a person is not able to effectively manage intense emotions and memories, they are more likely to re-experience traumatic events and use avoidance as a way to cope with difficult emotional experiences. Social support plays an important role throughout life. In childhood, the bond between the caregiver and child helps to establish a sense of safety and emotion regulation. Abuse during childhood is a significant risk factor for PTSD later on in life and it plays an important role in dysregulating the stress response system (Charuvastra & Cloitre, 2008).

Positive social interactions act as a protective factor against stress (Charuvastra & Cloitre, 2008). The value of social support lies in the perceived helpfulness and sense of connectedness with others. It is not the quantity of social support that is protective against PTSD, but rather it is the match between what the person needs and the type of support that is offered. Social support can decrease feelings of distress and increase safety and a sense of belonging. If a person feels isolated, ostracized, blamed, or feels unsupported by their

relationships, this can contribute to the onset and severity of PTSD symptoms (Charuvastra & Cloitre, 2008). Negative relationships can reinforce the belief that the world is a place that is unsafe and harmful.

Genetic & Biological Risk Factors

In a review on the biological risk factors for PTSD, Yahyavi, Zarghami, and Marwah (2014) found that the risk for PTSD can begin in utero. The HPA axis, which plays an important role in the stress response, is greatly affected by early development. Maternal exposure to trauma, for example, can lead to changes in the fetal brain that disrupt gene expression. An example of this is DNA methylation, which re-programs the activity of genes and impacts a person's response to stress by activating the sympathetic nervous system and causing dysfunction in the HPA axis (Yahyavi et al., 2014). Changes in these biological systems disrupts emotion regulation and the ability to effectively manage stress. However, there is growing consensus that genetic markers do not act in isolation but interact with environmental factors to impact a person's vulnerability to developing PTSD (Klengel & Binder, 2015). In addition, the genetic risk factors for PTSD are complex and the biologic pathways for this disorder are not fully understood (Sharma & Ressler, 2019).

TREATMENTS FOR PTSD

The American Psychological Association (APA) has developed a list of empirically supported treatments (ESTs)

that are indicated for the treatment of PTSD. Within this list, the APA differentiates between treatments that are *conditionally recommended* and *strongly recommended*. Treatments that are conditionally recommended all have evidence that indicates that they can lead to good treatment outcomes. However, the evidence may not be as strong, the balance of treatment benefits and possible harms may be less favorable, or the intervention may be less applicable across treatment settings or subgroups of individuals with PTSD (APA, 2017). Additional research on these conditionally recommended treatments might lead, with time, to a change in the strength of recommendations in future guidelines. Treatments that are strongly recommended all have strong evidence that they lead to good treatment outcomes, that the balance of treatment benefits and possible harms are favorable for the client, and have been found to be applicable across treatment settings and subgroups for individuals with PTSD (APA, 2017).

STRONGLY RECOMMENDED TREATMENTS

At present, the APA strongly recommends four treatments for individuals with PTSD, all which are variations of Cognitive Behavioural Therapy (CBT). These treatments include: Prolonged Exposure Therapy, Cognitive Processing Therapy, Cognitive Therapy, and traditional Cognitive Behavioural Therapy (APA, 2017). CBT is a form of therapy that focuses on how individuals' thoughts, behaviours, and emotions are interrelated. The therapist works with the client

to identify thoughts, behaviours, and emotions which might be having negative effects on the client's wellbeing and uses various skills to alter these as needed. As applied to trauma, oftentimes this takes the form of helping clients learn how to modify and challenge unhelpful beliefs related to the trauma. Modifying and challenging these unhelpful beliefs is meant to modify the client's emotional and behavioural reactions into ones that are more positive. Oftentimes a technique called exposure is incorporated into the abovementioned treatments. Exposure is a process whereby the client gradually approaches trauma-related memories, feelings, and situations. It can be conducted in a number of ways, including describing the trauma narrative aloud, listening to an audio recording of the trauma narrative, writing out the trauma narrative and/or reading it aloud, and physically going to situations which are feared and/or reminders of the trauma. These different methods of exposure are often referred to as imaginal exposure (occurring within the imagination), and in-vivo exposure (occurring in real life). By facing what has been avoided, the client presumably will learn that the trauma-related memories and cues are not dangerous and do not need to be avoided. By extension, any associated distressing thoughts, feelings, and sensations will be diminished.

There have been various studies performed with the intention of understanding how well these treatments for PTSD work and, as mentioned, they all have strong evidence to support them.

Individuals randomly assigned to exposure therapy have significantly greater pre- to posttreatment reductions in PTSD symptoms compared to supportive counseling (Bryant, et al., 2003; Bryant, et al., 2008; Schnurr et al., 2007), relaxation training (Marks et al., 1998; Taylor et al., 2003), and treatment as usual including pharmacotherapy (Asukai et al., 2010). A meta-analysis on the effectiveness of PTSD showed that clients treated with PE fared better than 86% of patients in control conditions on PTSD symptoms at the end of treatment (Powers et al., 2010). Furthermore, among PE participants, 41% to 95% lost their PTSD diagnosis at the end of treatment (Jonas et al., 2016), and 66% more participants treated with exposure therapy achieved loss of PTSD diagnosis, compared to those in waitlist control groups (Jonas et al., 2016).

Cognitive Processing Therapy (CPT) has been found to influence a clinically significant reduction in PTSD, depression, and anxiety symptoms in sexual assault and Veteran samples, with results maintained at 5 and 10 year post treatment follow-up (Cusack et al., 2016; Resick et al., 2008; Watts et al., 2013). Furthermore, rates of participants who no longer met PTSD diagnosis criteria ranged from 30% to 97% and 51% more participants treated with CPT achieved loss of PTSD diagnosis, compared to waitlist, self-help booklet and usual care control groups (Jonas et al., 2016).

Traditional CBTs have also been shown to be more effective than a waitlist (Power et al., 2002), supportive therapy (Blanchard et al., 2003) and a self-help booklet

(Ehlers et al., 2003). Researchers have also compared various components of CBT (i.e., imaginal exposure, *in vivo* exposure, cognitive restructuring) with some mixed results. Marks et al. (1998) compared exposure therapy (that included five sessions of imaginal exposure and five sessions of *in vivo* exposure), cognitive restructuring, combined exposure therapy and cognitive restructuring, and relaxation in an RCT. Exposure and cognitive restructuring were each effective in reducing PTSD symptoms and were superior to relaxation. Exposure and cognitive restructuring were not mutually enhancing when combined. Furthermore, research suggests that 61% to 82.4% of participants treated with traditional CBT lost their PTSD diagnosis and 26% more CBT participants than waitlist or supportive counseling achieved loss of PTSD diagnosis (Jonas et al., 2016).

CONDITIONALLY RECOMMENDED TREATMENTS

There are also a number of treatments which the APA indicates are conditionally recommended for the treatment of PTSD. These include Eye Movement Desensitization and Reprocessing Therapy (EMDR), Narrative Exposure Therapy (NET) and Medication (APA, 2017). When utilizing EMDR, the client is asked to focus on the trauma memory while simultaneously experiencing bilateral stimulation (typically tracking the therapist's finger with their eye; (APA, 2017). This is thought to be associated with a reduction in the vividness and emotion associated with the trauma memories (APA, 2017). With NET, a client

establishes a chronological narrative of their life. They are told to concentrate mainly on their traumatic experience(s), but also incorporate some positive events (APA, 2017). NET therapists posit that this process contextualizes the network of cognitive, affective and sensory memories of a client's trauma (APA, 2017). When the client expresses the narrative, they are able to fill in details of the trauma memories, which are often fragmented, and this helps them to develop a coherent autobiographical story (APA, 2017). In so doing, the memory of a traumatic episode is refined and understood, and symptoms are believed to be reduced (APA, 2017).

In addition to psychological treatments, four medications have received a conditional recommendation for use in the treatment of PTSD. These include the Selective Serotonin Reuptake Inhibitors (SSRIs) sertraline, paroxetine, and fluoxetine and the selective serotonin and norepinephrine reuptake inhibitor (SNRI) venlafaxine (APA, 2017). Currently only sertraline (Zoloft) and paroxetine (Paxil) are approved by the Food and Drug Administration (FDA) for PTSD (APA, 2017). From the FDA perspective, all other medication uses are "off label," though there are differing levels of evidence supporting their use. These medications work by inhibiting the presynaptic reuptake of serotonin and norepinephrine (neurotransmitters), respectively, thereby increasing the presence of these neurotransmitters in the brain.

As noted above, the evidence for the efficacy of these three treatments is conditional. EMDR received a conditional

recommendation as there is a low strength of evidence for the critical outcome of PTSD symptom reduction (APA, 2017). However, research suggests that EMDR is effective for loss of PTSD diagnosis, and prevention/reduction of comorbid depression (APA, 2017). Thus, the APA (2017) recommends that clinicians offer EMDR compared to no intervention. With regards to NET, it has received a conditional recommendation, because despite evidence of a large/medium magnitude of benefit for the critical outcome of PTSD symptom reduction, there was low or insufficient/very low strength of evidence for all other important benefit outcomes (e.g., remission or loss of PTSD diagnosis or reduction/prevention of comorbid depression). However, research suggests that NET is effective at reducing PTSD symptoms (APA, 2017). Similarly, the APA (2017), suggests that clinicians offer NET, as opposed to no treatment.

Last, with regards to psychopharmacological treatments, the APA (2017) suggests that the medications noted above all be offered, compared to no intervention. Fluoxetine has been found to reduce PTSD symptoms and prevent/reduce comorbid depression and anxiety (APA, 2017), with the benefits slightly outweighing the harms. Paroxetine has been found to reduce PTSD symptoms, contribute to PTSD remission, and prevent/reduce comorbid depression and disability/functional impairment, with the benefits clearly outweighing the harms (APA, 2017). Sertraline has been found to assist with PTSD symptom reduction, with benefits slightly outweighing the harms (APA, 2017). Last,

Venlafaxine has been found to assist with PTSD symptoms reduction, and to assist with remission, with the benefits slightly outweighing the harms (2017).

Overall, the APA (2017) posits that their findings from the panel recommendations, would be unlikely to change if the meta-analyses reported in the systematic review were updated to include the new trials. However, the note that EMDR and NET are exceptions to this, and that it is possible that their recommendations might change, pending additional research on these two treatment modalities.

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Summary and Self-Test: Post-traumatic Stress Disorder

JORDEN A. CUMMINGS

SUMMARY

Over 76% of Canadians report being exposed to a traumatic event at least once in their lifetime. Traumatic events are those that expose someone to actual or threatened death, serious injury, or sexual violence. About 8% of Canadians exposed to a traumatic event will develop post-traumatic stress disorder (PTSD).

Example traumatic events include sexual assault, witnessing domestic or community violence, or military combat.

People with PTSD experience intrusive symptoms such

that they re-experience the traumatic event, for example via unwanted memories, nightmares, or flashbacks of the event. These symptoms are not within someone's control, which can be especially distressing.

PTSD is also marked by avoidance of trauma-related stimuli that might remind the person of the traumatic event(s). People with PTSD engage in this avoidance in order to stay away from the overwhelming fear response that arises when they are around trauma-related stimuli.

Another type of symptom is the negative changes in mood or cognition related to the traumatic event such as an inability to remember important parts of the event, exaggerated negative beliefs about it, negative emotions, and the inability to experience positive emotions.

People with PTSD also experience significant changes in arousal and behaviour such as irritability, hypervigilance, and sleep disturbances. This overarousal sometimes results in them feeling tense, "keyed up," or on edge. It is also common for people with PTSD to have exaggerated startle responses, for example to loud unexpected noises.

The DSM-5 has separate diagnostic criteria for children younger than 6. Some important differences are that in young children intrusive memories might be expressed through repetitive play.

Event centrality refers to how central we come to see a traumatic event to our lives, memories, and identities. The centrality of events scale measures the extent to which a memory for a traumatic event becomes a reference point for

one's identity, life story, and the attribution of meaning to other experiences.

According to the autobiographical memory model of PTSD, symptoms result from the over integration of the trauma into one's memory, identity, and understanding of the world. Event centrality is positively associated with PTSD.


Interpersonal traumatic events that are purposefully caused by other people are most likely to lead to PTSD. Social support helps people to effectively manage their emotions, and it is central both for preventing the onset of PTSD and for helping with recovery.

The American Psychological Association (APA) has developed a list of empirically supported treatments for PTSD. They divide them into strongly recommended treatments and conditionally recommended treatments, based on how convincing the research is to support them.

Strongly recommended treatments for PTSD include several versions of cognitive behavioural therapy (CBT) including Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT). Conditionally recommended treatments including Eye Movement Desensitization and Reprocessing Therapy (EMDR), Narrative Exposure Therapy, and medication.



An interactive H5P element has been excluded

 from this version of the text. You can view it online here:

<https://fhsu.pressbooks.pub/abnormalpsych/?p=130#h5p-6>

Link: https://openpress.usask.ca/abnormalpsychology/wp-admin/admin-ajax.php?action=h5p_embed&id=8

PART VII

Chapter 7: ADHD
and Related
Behaviour Disorders
in Childhood

STEPHANIE WEIGEL

Chapter 7 Introduction

RICHARD MILICH; WALTER ROBERTS; AND
JORDEN A. CUMMINGS

Attention-Deficit/Hyperactivity Disorder (ADHD) is a psychiatric disorder that is most often diagnosed in school-aged children. It is the most prevalent childhood psychiatric disorder in Canada (Centre for ADHD Awareness, Canada [CADDAC], n.d.). ADHD occurs in 3-5% of elementary-school aged children and is more common in males than females (Johnson, 2009). In Canada, each classroom will include at least 1 to 3 students with ADHD (CADDAC, n.d.). Furthermore, at least 50% of children with ADHD will continue to have symptoms in adolescence and adulthood (Bélanger, Andrews, Gray, & Korczak, 2018). Approximately

4% of adults experience at least some symptoms of ADHD (CADDAC, n.d.).

Many children with ADHD find it difficult to focus on tasks and follow instructions, and these characteristics can lead to problems in school and at home. How children with ADHD are diagnosed and treated is a topic of controversy, and many people, including scientists and nonscientists alike, hold strong beliefs about what ADHD is and how people with the disorder should be treated. This module will familiarize the reader with the scientific literature on ADHD. First, we will review how ADHD is diagnosed in children, with a focus on how mental health professionals distinguish between ADHD and normal behavior problems in childhood. Second, we will describe what is known about the causes of ADHD. Third, we will describe the treatments that are used to help children with ADHD and their families. The module will conclude with a brief discussion of how we expect that the diagnosis and treatment of ADHD will change over the coming decades.

7.1 ADHD and Behaviour Disorders in Children

RICHARD MILICH; WALTER ROBERTS; JORDEN
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Section Learning Objectives

- Distinguish childhood behavior disorders from phases of typical child development.
- Describe the factors contributing to Attention-Deficit/Hyperactivity Disorder (ADHD)
- Understand the controversies surrounding the

legitimacy and treatment of childhood behavior disorders

- Describe the empirically supported treatments for Attention-Deficit/Hyperactivity Disorder (ADHD)

CHILDHOOD AND ADHD

Childhood is a stage of life characterized by rapid and profound development. Starting at birth, children develop the skills necessary to function in the world around them at a rate that is faster than any other time in life. This is no small accomplishment! By the end of their first decade of life, most children have mastered the complex cognitive operations required to comply with rules, such as stopping themselves from acting impulsively, paying attention to parents and teachers in the face of



Although we commonly think of children as “little bundles of energy”, one of the defining characteristics of children diagnosed with ADHD is that they are perpetually in motion even during times when they are expected to be still. [Image: Chicago’s North Shore Conventions & Visitors Bureau, <https://goo.gl/U2ZI18>, CC BY 2.0, <https://goo.gl/9uSnqN>]

distraction, and sitting still despite boredom. Indeed, acquiring self-control is an important developmental task for children (Mischel, Shoda, & Rodriguez, 1989), because they are expected to comply with directions from adults, stay on task at school, and play appropriately with peers. For children with Attention-Deficit/Hyperactivity Disorder (ADHD), however, exercising self-control is a unique challenge. These children, oftentimes despite their best intentions, struggle to comply with adults' instructions, and they are often labeled as "problem children" and "rule breakers." Historically, people viewed these children as willfully noncompliant due to moral or motivational defect (Still, 1902). However, scientists now know that the noncompliance observed in children with ADHD can be explained by a number of factors, including neurological dysfunction.

The goal of this module is to review the classification, causes, consequences, and treatment of ADHD. ADHD is somewhat unique among the psychiatric disorders in that most people hold strong opinions about the disorder, perhaps due to its more controversial qualities. When applicable, we will discuss some of the controversial beliefs held by social critics and laypeople, as well as scientists who study the disorder. Our hope is that a discussion of these controversies will allow you to reach your own conclusions about the legitimacy of the disorder.

**WHY DIAGNOSE CHILDREN'S BEHAVIOR
PROBLEMS?**

When a family is referred to a mental health professional for help dealing with their child's problematic behaviors, the clinician's first goal is to identify the nature and cause of the child's problems. Accurately diagnosing children's behavior problems is an important step in the intervention process, because a child's diagnosis can guide clinical decision making. Childhood behavior problems often arise from different causes, require different methods for treating, and have different developmental courses. Arriving at a diagnosis will allow the clinician to make inferences about how each child will respond to different treatments and provide predictive information to the family about how the disorder will affect the child as he or she develops.



On the one hand, diagnosing a child with ADHD can help him or her get beneficial treatment; however, the diagnosis can also have potentially negative effects on peer relationships and how children perceive themselves. [Image: gibsonsgolfer, <https://goo.gl/WWZfbQ>, CC BY-NC 2.0, <https://goo.gl/Filc2e>]

Despite the utility of the current diagnostic system, the practice of diagnosing children's behavior problems is controversial. Many adults feel strongly that labeling children as "disordered" is stigmatizing and harmful to children's self-concept. There is some truth in this concern. One study found that children have more negative attitudes toward a play partner if they are led to believe that their partner has ADHD, regardless of whether or not their partner actually has the disorder

(Harris, Milich, Corbitt, Hoover, & Brady, 1992). Others have criticized the use of the diagnostic system because they believe it **pathologizes** normal behavior in children. Despite these criticisms, the diagnostic system has played a central role in research and treatment of child behavior disorders, and it is unlikely to change substantially in the near future. This section will describe ADHD as a diagnostic category and discuss controversies surrounding the legitimacy of this disorder.

ADHD is the most commonly diagnosed childhood behavior disorder. It affects 3% to 7% of children in the United States (American Psychiatric Association, 2000), and approximately 65% of children diagnosed with ADHD will continue to experience symptoms as adults (Faraone, Biederman, & Mick, 2006). The core symptoms of ADHD are organized into two clusters, including clusters of hyperactivity/impulsivity and inattention. The hyperactive symptom cluster describes children who are perpetually in motion even during times when they are expected to be still, such as during class or in the car. The impulsive symptom cluster describes difficulty in delaying response and acting without considering the repercussions of behavior. Hyperactive and impulsive symptoms are closely related, and boys are more likely than girls to experience symptoms from this cluster (Hartung & Widiger, 1998). Inattentive symptoms describe difficulty with organization and task follow-through, as well as a tendency to be distracted by external stimuli. Two children diagnosed with ADHD can have very different symptom presentations. In fact, children can be diagnosed with different subtypes of the disorder (i.e., Combined Type, Predominantly Inattentive Type, or Predominantly Hyperactive-Impulsive Type) according to the number of symptoms they have in each cluster.

ARE THESE DIAGNOSES VALID?

Many laypeople and social critics argue that ADHD is not a “real” disorder. These individuals claim that children with

ADHD are only “disordered” because parents and school officials have trouble managing their behavior. These criticisms raise an interesting question about what constitutes a psychiatric disorder in children: How do scientists distinguish between clinically significant ADHD symptoms and normal instances of childhood impulsivity, hyperactivity, and inattention? After all, many 4-year-old boys are hyperactive and cannot focus on a task for very long. To address this issue, several criteria are used to distinguish between normal and disordered behavior:

1. The symptoms must significantly impair the child’s functioning in important life domains (e.g., school, home).
2. The symptoms must be inappropriate for the child’s developmental level.

One goal of this module will be to examine whether ADHD meets the criteria of a “true” disorder. The first criterion states that children with ADHD should show impairment in major functional domains. This is certainly true for children with ADHD. These children have lower academic achievement compared with their peers. They are more likely to repeat a grade or be suspended and less likely to graduate from high school (Loe & Feldman, 2007). Children with ADHD are often unpopular among their peers, and many of these children are actively disliked and socially rejected (Landau, Milich, & Diener, 1998). Children with ADHD are likely to experience comorbid psychological problems such as learning

disorders, depression, anxiety, and oppositional defiant disorder. As they grow up, adolescents and adults with ADHD are at risk to abuse alcohol and other drugs (Molina & Pelham, 2003) and experience other adverse outcomes (see Focus Topic 1). In sum, there is sufficient evidence to conclude that children diagnosed with ADHD are significantly impaired by their symptoms.

Focus Topic 1: Adult outcomes of children with ADHD

Children with ADHD often continue to experience symptoms of the disorder as adults. Historically, this fact was not recognized by the medical community; instead, they believed that children “matured out” of their symptoms as they entered adulthood. Fortunately, opinions have changed over time, and it is now generally accepted that ADHD can be present among adults. A recent prevalence estimate suggests that 4.4% of adults in the United States meet criteria for ADHD (Kessler et al., 2006). This study also found that the majority of adults with ADHD are not receiving treatment for their disorder. Adult ADHD, if left untreated, can cause numerous negative outcomes, including:

- Depression and poor self-concept, personality disorder, and other psychiatric comorbidity (Kessler et al., 2006)
- Substance abuse (Molina & Pelham, 2003)
- Poor work performance, termination from jobs,

chronic unemployment, and poor academic achievement (Barkley, Fischer, Smallish, & Fletcher, 2006)

- Divorce and problems with interpersonal relationships (Biederman et al., 2006)
- High-risk sexual behaviors and early parenthood (Barkley et al., 2006; Flory, Molina, Pelham, Gnagy, & Smith, 2006)
- Impairments in driving ability (Weafer, Fillmore, & Milich, 2009)
- Obesity (Cortese et al., 2008)

Despite the list of negative outcomes associated with adult ADHD, adults with the disorder are not doomed to live unfulfilling lives of limited accomplishment. Many adults with ADHD have benefited from treatment and are able to overcome their symptoms. For example, pharmacological treatment of adult ADHD has been shown to reduce risk of criminal behavior (Lichtenstein et al., 2012). Others have succeeded by avoiding careers in which their symptoms would be particularly problematic (e.g., those with heavy organizational demands). In any case, it is important that people with ADHD are identified and treated early, because early treatment predicts more positive outcomes in adulthood (Kessler et al., 2006).

It is also important to determine that a child's symptoms are not caused by normal patterns of development. Many of the

behaviors that are diagnostic of ADHD in some children would be considered developmentally appropriate for a younger child. This is true for many psychological and psychiatric disorders in childhood. For example, bedwetting is quite common in 3-year-old children; at this age, most children have not gained control over nighttime urination. For this reason, a 3-year-old child who wets the bed would not be diagnosed with enuresis (i.e., the clinical term for chronic bedwetting), because his or her behavior is developmentally appropriate. Bedwetting in an 8-year-old child, however, is developmentally *inappropriate*.

At this age, children are expected to remain dry overnight, and failure to master this skill would prevent children from sleeping over at friends' houses or attending overnight camps. A similar example of developmentally appropriate versus inappropriate hyperactivity and noncompliance is provided in Focus Topic 2.

Focus Topic 2: Two children referred for problems with noncompliance and hyperactivity

Case 1 – Michael

Michael, a 4-year-old boy, was referred to a child psychologist to be evaluated for ADHD. His parents reported that Michael would not comply with their instructions. They also complained that Michael would not remain seated during “quality time” with his father. The evaluating psychologist

interviewed the family, and by all accounts Michael was noncompliant and often left his seat. Specifically, when Michael's mother asked him to prepare his preschool lunch, Michael would leave the kitchen and play with his toys soon after opening his lunch box. Further, the psychologist found that quality time involved Michael and his father sitting down for several hours to watch movies. In other settings, such as preschool, Michael was compliant with his teacher's request and no more active than his peers.

In this case, Michael's parents held unrealistic expectations for a child at Michael's developmental level. The psychologist would likely educate Michael's parents about normative child development rather than diagnosing Michael with ADHD.

Case 2 – Jake

Jake, a 10-year-old boy, was referred to the same psychologist as Michael. Jake's mother was concerned because Jake was not getting ready for school on time. Jake also had trouble remaining seated during dinner, which interrupted mealtime for the rest of the family. The psychologist found that in the morning, Jake would complete one or two steps of his routine before he became distracted and switched activities, despite his mother's constant reminders. During dinnertime, Jake would leave his seat between 10 and 15 times over the course of the meal. Jake's teachers were worried because Jake was only able to complete 50% of his homework. Further, his classmates would not pick Jake for team sports during recess because he often became distracted and wandered off during the game.

In this case, Jake's symptoms would not be considered

developmentally appropriate for a 10-year-old child. Further, his symptoms caused him to experience impairment at home and school. Unlike Michael, Jake probably would be diagnosed with ADHD.

WHY DO SOME CHILDREN DEVELOP BEHAVIOR DISORDERS?

The reasons that some children develop ADHD are complex, and it is generally recognized that a single cause is insufficient to explain why an individual child does or does not have the disorder. Researchers have attempted to identify risk factors that predispose a child to develop ADHD. These risk factors range in scope from genetic (e.g., specific gene polymorphisms) to familial (e.g., poor parenting) to cultural (e.g., low socioeconomic status). This section will identify some of the risk factors that are thought to contribute to ADHD. It will conclude by reviewing some of the more controversial ideas about the causes of ADHD, such as poor parenting and children's diets, and review some of the evidence pertaining to these causes.



Studies of twins have shown that genetics are primarily responsible for ADHD. [Image: donnierayjones, <https://goo.gl/dgPvFx>, CC BY 2.0, <https://goo.gl/9uSnqN>]

Most experts believe that genetic and neurophysiological factors cause the majority of ADHD cases. Indeed, ADHD is primarily a genetic disorder—twin studies find that whether or not a child develops ADHD is due in large part (75%) to genetic variations (Faraone et al., 2005). Further, children with a family history of ADHD are more likely to develop ADHD themselves (Faraone &

Biederman, 1994). Specific genes that have been associated with ADHD are linked to neurotransmitters such as dopamine and serotonin. In addition, neuroimaging studies have found that children with ADHD show reduced brain volume in some regions of the brain, such as the prefrontal cortex, the corpus callosum, the anterior cingulate cortex, the basal ganglia, and the cerebellum (Seidman, Valera, & Makris, 2005). Among their other functions, these regions of the brain are implicated in organization, impulse control, and motor activity, so the reduced volume of these structures in children with ADHD may cause some of their symptoms.

Although genetics appear to be a main cause of ADHD,

recent studies have shown that environmental risk factors may cause a minority of ADHD cases. Many of these environmental risk factors increase the risk for ADHD by disrupting early development and compromising the integrity of the central nervous system. Environmental influences such as low birth weight, malnutrition, and maternal alcohol and nicotine use during pregnancy can increase the likelihood that a child will develop ADHD (Mick, Biederman, Faraone, Sayer, & Kleinman, 2002). Additionally, recent studies have shown that exposure to environmental toxins, such as lead and pesticides, early in a child's life may also increase risk of developing ADHD (Nigg, 2006).

CONTROVERSIES ON CAUSES OF ADHD

Controversial explanations for the development of ADHD have risen and fallen in popularity since the 1960s. Some of these ideas arise from cultural folklore, others can be traced to “specialists” trying to market an easy fix for ADHD based on their proposed cause. Some other ideas contain a kernel of truth but have been falsely cast as causing the majority of ADHD cases.

Some critics have proposed that poor parenting is a major cause of ADHD. This explanation is popular because it is intuitively appealing—one can imagine how a child who is not being disciplined at home may be noncompliant in other settings. Although it is true that parents of children with ADHD use discipline less consistently, and a lack of

structure and discipline in the home can exacerbate symptoms in children with ADHD (Campbell, 2002), it is unlikely that poor parenting alone causes ADHD in the first place. To the contrary, research suggests that the noncompliance and impulsivity on the child's part can cause caregivers to use discipline less effectively.

In a classic series of studies, Cunningham and Barkley (1979) showed that mothers of children with ADHD were less attentive to their children and imposed more structure to their playtime relative to mothers of typically developing children. However, these researchers also showed that when the children were given stimulant medication, their compliance increased and their mothers' parenting behavior improved to the point where it was comparable to that of the mothers of children without ADHD (Barkley & Cunningham, 1979). This research suggests that instead of poor parenting causing children to develop ADHD, it is the stressful effects of managing an impulsive child that causes parenting problems in their caregivers. One can imagine how raising a child with ADHD could be stressful for parents. In fact, one study showed that a brief interaction with an impulsive and noncompliant child caused parents to increase their alcohol consumption—presumably these parents were drinking to cope with the stress of dealing with the impulsive child (Pelham et al., 1997). It is, therefore, important to consider the reciprocal effects of noncompliant children on parenting behavior, rather than assuming that parenting ability has a unidirectional effect on child behavior.



It is still a common belief that giving sugar to kids makes them hyperactive; however, a critical review of the research showed that such a belief is nothing more than a myth. [Image: courosa, <https://goo.gl/0NerUI>, CC BY-NC-SA 2.0, <https://goo.gl/HEXbAA>]

Other purported causes of ADHD are dietary. For example, it was long believed that excessive sugar intake can cause children to become hyperactive. This myth is largely disproven (Milich, Wolraich, & Lindgren, 1986). However, other diet-oriented explanations for ADHD, such as sensitivity to certain food additives, have been proposed (Feingold, 1976). These theories have received a bit more support than the sugar hypothesis (Pelsser et al., 2011). In fact,

the possibility that certain food additives may cause hyperactivity in children led to a ban on several artificial food colorings in the United Kingdom, although the Food and Drug Administration rejected similar measures in the United States. Even if artificial food dyes do cause hyperactivity in a subgroup of children, research does not support these food additives as a primary cause of ADHD. Further, research support for elimination diets as a treatment for ADHD has been inconsistent at best.

In sum, scientists are still working to determine what

causes children to develop ADHD, and despite substantial progress over the past four decades, there are still many unanswered questions. In most cases, ADHD is probably caused by a combination of genetic and environmental factors. For example, a child with a genetic predisposition to ADHD may develop the disorder after his or her mother uses tobacco during her pregnancy, whereas a child without the genetic predisposition may not develop the disorder in the same environment. Fortunately, the causes of ADHD are relatively unimportant for the families of children with ADHD who wish to receive treatment, because what caused the disorder for an individual child generally does not influence how it is treated.

METHODS OF TREATING ADHD IN CHILDREN

There are several types of evidence-based treatment available to families of children with ADHD. The type of treatment that might be used depends on many factors, including the child's diagnosis and treatment history, as well as parent preference. To treat children with less severe noncompliance problems, parents can be trained to systematically use **contingency management** (i.e., rewards and punishments) to manage their children's behavior more effectively (Kazdin, 2005). For the children with ADHD, however, more intensive treatments often are necessary.

MEDICATION

The most common method of treating ADHD is to prescribe stimulant medications such as Adderall™. These medications treat many of the core symptoms of ADHD—treated children will show improved impulse control, time-on-task, and compliance with adults, and decreased hyperactivity and disruptive behavior. However, there are also negative side effects to stimulant medication, such as growth and appetite suppression, increased blood pressure, insomnia, and changes in mood (Barkley, 2006). Although these side effects can be unpleasant for children, they can often be avoided with careful monitoring and dosage adjustments.



Some critics of medicating as a possible attempt to mitigate the effects of ADHD, are concerned that the medications to treat ADHD might be over-prescribed. [Image: Tony Webster, <https://goo.gl/qo2xNB>, CC BY 2.0, <https://goo.gl/9uSnqN>]

Opinions differ on whether stimulants should be used to treat children with ADHD. Proponents argue that stimulants are relatively safe and effective, and that untreated ADHD poses a much greater risk to children (Barkley, 2006). Critics argue that because many stimulant medications are similar to

illicit drugs, such as cocaine and methamphetamine, long-term use may cause cardiovascular problems or predispose children to abuse illicit drugs. However, longitudinal studies have shown that people taking these medications are not more likely to experience cardiovascular problems or to abuse drugs (Biederman, Wilens, Mick, Spencer, & Faraone, 1999; Cooper et al., 2011). On the other hand, it is not entirely clear how long-term stimulant treatment can affect the brain, particularly in adults who have been medicated for ADHD since childhood.

Finally, critics of psychostimulant medication have proposed that stimulants are increasingly being used to manage energetic but otherwise healthy children. It is true that the percentage of children prescribed stimulant medication has increased since the 1980s. This increase in use is not unique to stimulant medication, however. Prescription rates have similarly increased for most types of psychiatric medication (Olfson, Marcus, Weissman, & Jensen, 2002). As parents and teachers become more aware of ADHD, one would expect that more children with ADHD will be identified and treated with stimulant medication. Further, the percentage of children in the United States being treated with stimulant medication is lower than the estimated prevalence of children with ADHD in the general population (Nigg, 2006).

PARENT MANAGEMENT TRAINING

Parenting children with ADHD can be challenging. Parents

of these children are understandably frustrated by their children's misbehavior. Standard discipline tactics, such as warnings and privilege removal, can feel ineffective for children with ADHD. This often leads to ineffective parenting, such as yelling at or ridiculing the child with ADHD. This cycle can leave parents feeling hopeless and children with ADHD feeling alienated from their family. Fortunately, **parent management training** can provide parents with a number of tools to cope with and effectively manage their child's impulsive and oppositional behavior. Parent management training teaches parents to use immediate, consistent, and powerful consequences (i.e., rewards and punishment), because children with ADHD respond well to these types of behavioral contingencies (Luman, Oosterlaan, & Sergeant, 2005). Other, more intensive, psychosocial treatments use similar behavioral principles in summer camp-based settings (Pelham, Fabiano, Gnagy, Greiner, & Hoza, 2004), and school-based intervention programs are becoming more popular. A description of a school-based intervention program for ADHD is described in Focus Topic 3.

Focus Topic 3: Treating ADHD in Schools

Succeeding at school is one of the most difficult challenges faced by children with ADHD and their parents. Teachers expect students to attend to lessons, complete lengthy

assignments, and comply with rules for approximately seven hours every day. One can imagine how a child with hyperactive and inattentive behaviors would struggle under these demands, and this mismatch can lead to frustration for the student and his or her teacher. Disruptions caused by the child with ADHD can also distract and frustrate peers. Succeeding at school is an important goal for children, so researchers have developed and validated intervention strategies based on behavioral principles of contingency management that can help children with ADHD adhere to rules in the classroom (described in DuPaul & Stoner, 2003). Illustrative characteristics of an effective school-based contingency management system are described below:

Token reinforcement program

This program allows a student to earn tokens (points, stars, etc.) by meeting behavioral goals and not breaking rules. These tokens act as secondary reinforcers because they can be redeemed for privileges or goods. Parents and teachers work with the students to identify problem behaviors and create concrete behavioral goals. For example, if a student is disruptive during silent reading time, then a goal might be for him or her to remain seated for at least 80% of reading time. Token reinforcement programs are most effective when tokens are provided for appropriate behavior and removed for inappropriate behavior.

Time out

Time out can be an effective punishment when used correctly. Teachers should place a student in time out only

when they fail to respond to token removal or if they engage in a severely disruptive behavior (e.g., physical aggression). When placed in time out, the student should not have access to any type of reinforcement (e.g., toys, social interaction), and the teacher should monitor their behavior throughout time out.

Daily report card

The teacher keeps track of whether or not the student meets his or her goals and records this information on a report card. This information is sent home with the student each day so parents can integrate the student's performance at school into a home-based contingency management program.

Educational services and accommodations

Students with ADHD often show deficits in specific academic skills (e.g., reading skills, math skills), and these deficits can be improved through direct intervention. Students with ADHD may spend several hours each week working one-on-one with an educator to improve their academic skills. Environmental accommodations can also help a student with ADHD be successful. For example, a student who has difficulty focusing during a test can be allowed extra time in a low-distraction setting.

WHAT WORKS BEST? THE MULTIMODAL TREATMENT STUDY

Recently, a large-scale study, the Multimodal Treatment Study (MTA) of Children with ADHD, compared pharmacological and behavioral treatment of ADHD (MTA Cooperative Group, 1999). This study compared the

outcomes of children with ADHD in four different treatment conditions, including standard community care, intensive behavioral treatment, stimulant medication management, and the combination of intensive behavioral treatment and stimulant medication. In terms of core symptom relief, stimulant medication was the most effective treatment, and combined treatment was no more effective than stimulant medication alone (MTA Cooperative Group, 1999). Behavioral treatment was advantageous in other ways, however. For example, children who received combined treatment were less disruptive at school than children receiving stimulant medication alone (Hinshaw et al., 2000). Other studies have found that children who receive behavioral treatment require lower doses of stimulant medication to achieve the desired outcomes (Pelham et al., 2005). This is important because children are better able to tolerate lower doses of stimulant medication. Further, parents report being more satisfied with treatment when behavioral management is included as a component in the program (Jensen et al., 2001). In sum, stimulant medication and behavioral treatment each have advantages and disadvantages that complement the other, and the best outcomes likely occur when both forms of treatment are used to improve children's behavior.

THE FUTURE OF ADHD

It is difficult to predict the future; however, based on trends in research and public discourse, we can predict how the field

may change as time progresses. This section will discuss two areas of research and public policy that will shape how we understand and treat ADHD in the coming decades.

CONTROLLING ACCESS TO STIMULANT MEDICATION

It is no secret that many of the drugs used to treat ADHD are popular drugs of abuse among high school and college students, and this problem seems to be getting worse. The rate of illicit stimulant use has steadily risen over the past several decades (Teter, McCabe, Cranford, Boyd, & Guthrie, 2005), and it is probably not a coincidence that prescription rates for stimulant medication have increased during the same time period (Setlik, Bond, & Ho, 2009). Students who abuse stimulants often report doing so because they act as an academic performance enhancer by boosting alertness and concentration. Although they may enhance performance in the short term, nonmedical use of these drugs can lead to dependence and other adverse health consequences, especially when taken in ways other than prescribed (e.g., crushed and snorted) (Volkow & Swanson, 2003). Stimulants can be particularly dangerous when they are taken without supervision from a physician, because this may lead to adverse drug interactions or side effects. Because this increase in prescription stimulant abuse represents a threat to public health, an important goal for policy makers will be to reduce the availability of prescription stimulants to those who would use them for nonmedical reasons.

One of the first steps for addressing prescription stimulant abuse will be understanding how illicit users gain access to medication. Probably the most common method of obtaining stimulants is through **drug diversion**. The majority of college students who abuse stimulants report obtaining them from peers with valid prescriptions (McCabe & Boyd, 2005). Another way that would-be abusers may gain access to medication is



Prescription stimulant abuse among young people is a growing concern.

[Image: Jesse! S?, <https://goo.gl/GlFyCg>, CC BY 2.0, <https://goo.gl/v4Y0Zv>]

by **malinger** (i.e., faking) symptoms of ADHD (Quinn, 2003). These individuals will knowingly exaggerate their symptoms to a physician in order to obtain a prescription. Other sources of illicit prescription drugs have been identified (e.g., pharmacy websites) (Califano, 2004), but more research is needed to understand how much these sources contribute to the problem. As we gain an understanding of how people gain access to illicit medication, policy makers and researchers can make efforts to curtail the rate of stimulant misuse. For example, because drug diversion is a major source of illicit stimulants, policymakers have enacted prescription

monitoring programs to keep track of patient's prescription-seeking behavior (Office of Drug Control Policy, 2011), and, in some cases, patients are required to pass drug screens before receiving their prescriptions. To address malingering, researchers are working to develop psychological tests that can identify individuals who are faking symptoms (Jasinski et al., 2011). Finally, pharmacologists are working to develop stimulant medications that do not carry the same risk of abuse as the currently available drugs (e.g., lisdexamfetamine) (Biederman et al., 2007).

Although all of these measures will reduce illicit users' access to stimulant medication, it is important to consider how the policies will affect access among people who need these medications to treat their ADHD symptoms. Prescription tracking programs may reduce physicians' willingness to prescribe stimulants out of fear of being investigated by law enforcement. Patients with ADHD with comorbid substance abuse problems may be denied access to stimulant medication because they are considered high risk for drug diversion. Similarly, lengthy psychological evaluations to assess for malingering and mandated drug screenings may be prohibitively expensive for less affluent individuals with ADHD. These measures to reduce illicit drug use are necessary from a public health perspective, but as we move forward and enact policies to reduce stimulant abuse, it will be equally important to consider impact of such legislation on patients' access to treatment.

BEHAVIORAL GENETICS IN UNDERSTANDING
ADHD

Much of the research on ADHD has been conducted to answer several deceptively complex questions: What causes ADHD? How are people with ADHD different from their typically developing peers? How can ADHD be prevented or treated? Historically, our tools for answering these questions was limited to observing outward human behavior, and our ability to ask questions about the physiology of ADHD was severely limited by the technology of the time. In the past two decades, however, rapid advances in technology (e.g., functional magnetic resonance imaging, genetic analysis) have allowed us to probe the physiological bases of human behavior. An exciting application of this technology is that we are able to extend our understanding of ADHD beyond basic behavior; we are learning about the underlying neurophysiology and genetics of the disorder. As we gain a fuller understanding of ADHD, we may be able to apply this knowledge to improve prevention and treatment of the disorder. Knowledge of the underlying physiology of ADHD may guide efforts to develop new nonstimulant medications, which may not carry the side effects or abuse potential of traditional stimulants. Similarly, these advances may improve our ability to diagnose ADHD. Although it is extremely unlikely that a perfectly accurate genetic or neuroimaging test for ADHD will ever be developed (Thome et al., 2012), such procedures could be used in conjunction with behavioral evaluation and questionnaires to improve

diagnostic accuracy. Finally, identifying genetic traits that predispose children to develop ADHD may allow physicians to use targeted prevention programs that could reduce the chances that children at risk for developing the disorder will experience symptoms.

Discussion Questions

1. Does ADHD meet the definition of a psychiatric disorder?
2. Explain the difference between developmentally appropriate and developmentally inappropriate behavior problems.
3. Do you believe that it is ethical to prescribe stimulant medication to children? Why or why not? What are the risks associated with withholding stimulant medication from children with ADHD?
4. How should society balance the need to treat individuals with ADHD using stimulants with public health concerns about the abuse of these same medications?

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Summary and Self-Test: ADHD and Behaviour Disorders in Children

RICHARD MILICH; WALTER ROBERTS; AND
JORDEN A. CUMMINGS

SUMMARY

Attention-Deficit/Hyperactivity Disorder (ADHD) is the most prevalent childhood psychiatric disorder in Canada, occurring in 3-5% of elementary school children. At least half of these children will continue to experience symptoms in adolescence and adulthood.

Children with ADHD have difficulty exercising self-control, complying with adults' instructions, and are often labeled as "problem children."

The practice of diagnosing children's behaviour problems, including ADHD, is controversial. Many feel that labeling children as disordered is stigmatizing and harmful to children's self-concept. Some believe that the diagnostic system pathologizes normal childhood behaviour.

The core symptoms of ADHD are organized into two clusters: hyperactivity/impulsivity and inattention. The hyperactive symptoms describe being perpetually in motion even during times when children are expected to sit still. Impulsivity describes a difficulty in delaying response and acting without considering the repercussions of behaviour. Inattentive symptoms describe difficulty with organization and task follow-through, as well as a tendency to be distracted by external stimuli.

Many laypeople and critics argue that ADHD is not a "real" disorder, claiming that children with ADHD are only considered disordered because parents and school officials have trouble managing their behaviour. Several criteria are used to distinguish between normal and disordered behaviour, including the level of impairment the symptoms cause for the child's functioning in important life domains, and that the symptoms are inappropriate for the child's developmental level.

Most experts believe that genetic and neurophysiological factors cause the majority of ADHD cases. ADHD is, indeed, primarily a genetic disorder.

Environmental risk factors may cause a minority of ADHD cases. Many of these environmental risk factors increase the

risk by disputing early development and compromising the integrity of the central nervous system. Examples include low birth weight, malnutrition, and maternal smoking during pregnancy.

Controversy has surrounded the causes of ADHD, with several causes being proposed that have no grounded in research. These include poor parenting, as well as sugar and food additives. Neither of these have been shown to contribute to ADHD.

Parents can be trained to use contingency management more effectively. Stimulant medications and parenting management are used to treat ADHD. The Multimodal Treatment Study of ADHD found that stimulant medication was the most effective treatment.

Ideas for future consideration within the study of ADHD include controlling access to stimulant medication, as well as the role of neuroscience and behavioral genetics in understanding ADHD.

SELF-TEST



An interactive H5P element has been excluded from this version of the text. You can view it online

here:

<https://fhsu.pressbooks.pub/abnormalpsych/?p=144#h5p-7>

STEPHANIE WEIGEL

Link: https://openpress.usask.ca/abnormalpsychology/wp-admin/admin-ajax.php?action=h5p_embed&id=11

PART VIII

Chapter 8: Autism
Spectrum Disorder

STEPHANIE WEIGEL

Chapter 8 Introduction

KEVIN A. PELPHREY

People with autism spectrum disorder (ASD) suffer from a profound social disability. Social neuroscience is the study of the parts of the brain that support social interactions or the “social brain.” This module provides an overview of ASD and focuses on understanding how social brain dysfunction leads to ASD. Our increasing understanding of the social brain and its dysfunction in ASD will allow us to better identify the genes that cause ASD and will help us to create and pick out treatments to better match individuals. Because social brain systems emerge in infancy, social neuroscience can help us to figure out how to diagnose ASD even before the symptoms of ASD are clearly present. This is a hopeful time because

social brain systems remain malleable well into adulthood and thus open to creative new interventions that are informed by state-of-the-art science.

8.1 Autism: Insights from the study of the social brain

KEVIN A. PELPHREY; JESSICA CAMPOLI; AND
STEPHANIE WEIGEL

Section Learning Objectives

- Know the basic symptoms of ASD.
- Distinguish components of the social brain and understand their dysfunction in ASD.
- Appreciate how social neuroscience may facilitate the diagnosis and treatment of ASD.

DEFINING AUTISM SPECTRUM DISORDER

Autism Spectrum Disorder (ASD) is a developmental disorder that usually emerges in the first three years and persists throughout the individual's life. Though the key symptoms of ASD fall into three general categories (see below), each person with ASD exhibits symptoms in these domains in different ways and to varying degrees. This *phenotypic heterogeneity* reflects the high degree of variability in the genes underlying ASD (Geschwind & Levitt, 2007). Though we have identified genetic differences associated with individual cases of ASD, each accounts for only a small number of the actual cases, suggesting that no single genetic cause will apply in the majority of people with ASD. There is currently no biological test for ASD.

Autism is in the category of *pervasive developmental disorders*, which includes Asperger's disorder, childhood disintegrative disorder, autistic disorder, and pervasive developmental disorder – not otherwise specified. These disorders, together, are labeled *autism spectrum disorder* (ASD). ASD is defined by the presence of profound difficulties in social interactions and communication combined with the presence of repetitive or restricted interests, cognitions and behaviors. The diagnostic process involves a combination of parental report and clinical observation. Children with significant impairments across the social/communication domain who also exhibit repetitive behaviors can qualify for the ASD diagnosis. There is wide variability in the precise symptom profile an individual may exhibit.

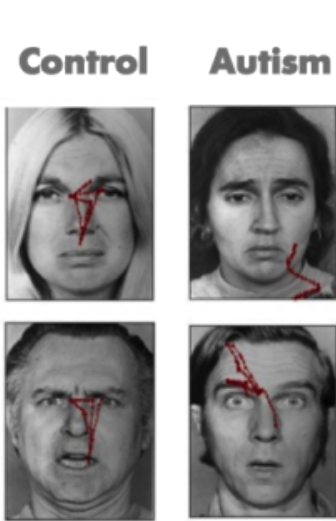


Figure 8.1. The red lines indicate the scan paths (collection of eye movements) used by people with (right column) and without (left column) autism to explore faces. Modified from Pelphrey et al., (2002).

Since Kanner first described ASD in 1943, important commonalities in symptom presentation have been used to compile criteria for the diagnosis of ASD. These diagnostic criteria have evolved during the past 70 years and continue to evolve (e.g., see the recent changes to the diagnostic criteria on the American Psychiatric Association's

website, <http://www.dsm5.org>), yet impaired social functioning remains a required symptom for an ASD diagnosis.

Previously, DSM-IV-TR included autism under a broader umbrella diagnostic category: Pervasive Developmental Disorders. Under this diagnostic category were four sub-diagnoses: autistic disorder, Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. Based on research and clinical experience that have been gained since DSM-IV was

published in 1994 (Hyman, 2013), DSM-5 made substantial changes to the conceptualization and diagnostic criteria of these disorders.

DSM-5 collapses these four disorders into one diagnosis: Autism Spectrum Disorder (ASD). This diagnosis reflects scientific consensus that the four previously distinct diagnoses are actually a single diagnosis with different levels of symptom severity and level of impairment. This change to the conceptualization of this ASD acknowledges the heterogeneity in the presentation and severity of ASD symptoms, and in the skills and level of functioning of people with ASD (American Psychological Association, n.d.). In addition, a diagnosis is made based on the severity of symptoms in two areas only: social communication impairments and repetitive/restricted behaviours.

Deficits in social functioning are present in varying degrees for simple behaviors such as eye contact, and complex behaviors like navigating the give and take of a group conversation for individuals of all functioning levels (i.e. high or low IQ). Moreover, difficulties with social information processing occur in both visual (e.g., Pelphrey et al., 2002) and auditory (e.g., Dawson, Meltzoff, Osterling, Rinaldi, & Brown, 1998) sensory modalities.

Consider the results of an eye tracking study in which Pelphrey and colleagues (2002) observed that individuals with autism did not make use of the eyes when judging facial expressions of emotion (see right panels of Figure 8.1). While repetitive behaviors or language deficits are seen in other

disorders (e.g., obsessive-compulsive disorder and specific language impairment, respectively), basic social deficits of this nature are unique to ASD. Onset of the social deficits appears to precede difficulties in other domains (Osterling, Dawson, & Munson, 2002) and may emerge as early as 6 months of age (Maestro et al., 2002).

ASD IN CANADA

In Canada, 1 in 66 children and youth (ages 5 to 17) are diagnosed with ASD, making it one of the most common developmental disabilities (Ofner et al., 2018). Approximately 1 to 2% of the population in Canada is affected by ASD (Anagnostou et al., 2014). Compared with females, males are four times more likely to receive a diagnosis of ASD (Ofner et al., 2018). More than half of children and youth with ASD are diagnosed by age six, and more than 90% receive a diagnosis by age 12 (Ofner et al., 2018). Unfortunately, the rates of ASD in Canada are increasing and this puts significant strain on the education, healthcare, and social service systems (Autism Ontario, n.d.).

In February 2019, the government of Ontario announced changes to autism funding. About 23,000 children with ASD were currently on a therapy wait list, and to ensure that these children could access services within 18 months, the government implemented drastic “childhood budgets” (Powers, 2019, March 11). This controversial autism funding model provided families a fixed amount of money that was determined by their child’s age and family income (CBC

News, 2019, July 29). The province's budget plan set significant limitations that would not meet the treatment needs of children with ASD, especially children with more severe ASD. In response, some families left Ontario to receive autism services for their children elsewhere in Canada, and protests and outrage occurred across the province (Monsebraaten & Rushowy, 2019, October 29).

To advocate for the needs of these children, a panel, called the Ontario Autism Panel, was created. This panel included parents, advocates, clinicians, academics, and adults with autism (Monsebraaten & Rushowy, 2019, October 29). Rather than a one-size-fits-all approach that is based on fixed factors like age and family income, the panel made recommendations for a new needs-based model of funding ensures that children receive the appropriate services based on their needs (Monsebraaten & Rushowy, 2019, October 29). Unfortunately, the new Ontario Autism Program (OAP) will not be fully implemented until 2021. In the interim, the government has taken steps to provide support to children and their families, including extra funding, programs, and workshops for parents (Payne, 2019, December 18). Although this program is believed to place children at the centre of care, waiting for it is crucial as it is a critical time in child development, and the costs of treatment are a significant burden for many families across Ontario (Payne, 2019, December 18).

DEFINING THE SOCIAL BRAIN

Within the past few decades, research has elucidated specific brain circuits that support perception of humans and other species. This *social perception* refers to “the initial stages in the processing of information that culminates in the accurate analysis of the dispositions and intentions of other individuals” (Allison, Puce, & McCarthy, 2000). Basic social perception is a critical building block for more sophisticated social behaviors, such as thinking about the motives and emotions of others. Brothers (1990) first suggested the notion of a **social brain**, a set of interconnected neuroanatomical structures that process social information, enabling the recognition of other individuals and the evaluation their mental states (e.g., intentions, dispositions, desires, and beliefs).

The social brain is hypothesized to consist of the amygdala, the orbital frontal cortex (OFC), fusiform gyrus (FG), and the posterior superior temporal sulcus (STS) region, among other structures. Though all areas work in coordination to support social processing, each appears to serve a distinct role. The amygdala helps us recognize the emotional states of others (e.g., Morris et al., 1996) and also to experience and regulate our own emotions (e.g., LeDoux, 1992). The OFC supports the “reward” feelings we have when we are around other people (e.g., Rolls, 2000). The FG, located at the bottom of the surface of the temporal lobes detects faces and supports face recognition (e.g., Puce, Allison, Asgari, Gore, & McCarthy, 1996). The posterior STS region recognizes

the biological motion, including eye, hand and other body movements, and helps to interpret and predict the actions and intentions of others (e.g., Pelphrey, Morris, Michelich, Allison, & McCarthy, 2005).

CURRENT UNDERSTANDING OF SOCIAL PERCEPTION IN ASD

The social brain is of great research interest because the social difficulties characteristic of ASD are thought to relate closely to the functioning of this brain network. **Functional magnetic resonance imaging (fMRI)** and **event-related potentials (ERP)** are complementary brain imaging methods used to study activity in the brain across the lifespan. Each method measures a distinct facet of brain activity and contributes unique information to our understanding of brain function.



The human brain has specialized functions to help guide our social interactions. [Image: Allan Ajifo, <https://goo.gl/jv4iXf>, CC BY 2.0, <https://goo.gl/BRvSA7>]

fMRI uses powerful magnets to measure the levels of oxygen within the brain, which vary according to changes in neural activity. As the neurons in specific brain regions “work

harder”, they require more oxygen. fMRI detects the brain regions that exhibit a relative increase in blood flow (and oxygen levels) while people listen to or view social stimuli in the MRI scanner. The areas of the brain most crucial for different social processes are thus identified, with spatial information being accurate to the millimeter.

In contrast, ERP provides direct measurements of the firing of groups of neurons in the cortex. Non-invasive sensors on the scalp record the small electrical currents created by this neuronal activity while the subject views stimuli or listens to specific kinds of information. While fMRI provides information about *where* brain activity occurs, ERP specifies *when* by detailing the timing of processing at the millisecond pace at which it unfolds.

ERP and fMRI are complementary, with fMRI providing excellent *spatial resolution* and ERP offering outstanding *temporal resolution*. Together, this information is critical to understanding the nature of social perception in ASD. To date, the most thoroughly investigated areas of the social brain in ASD are the superior temporal sulcus (STS), which underlies the perception and interpretation of biological motion, and the fusiform gyrus (FG), which supports face perception. Heightened sensitivity to biological motion (for humans, motion such as walking) serves an essential role in the development of humans and other highly social species. Emerging in the first days of life, the ability to detect biological motion helps to orient vulnerable young to critical sources of sustenance, support, and learning, and

develops independent of visual experience with biological motion (e.g., Simion, Regolin, & Bulf, 2008). This inborn “life detector” serves as a foundation for the subsequent development of more complex social behaviors (Johnson, 2006).



From an evolutionary standpoint, it was incredibly important for our survival to maintain social relationships. Therefore, it makes sense that we would be able to recognize faces within the first few days of our infancy. [Image: donnierayjones, <https://goo.gl/obrI2x>, CC BY 2.0, <https://goo.gl/v4Y0Zv>]

From very early in life, children with ASD display reduced sensitivity to biological motion (Klin, Lin, Gorrindo, Ramsay, & Jones, 2009). Individuals with ASD have reduced activity in the STS during biological motion perception.

Similarly, people at increased genetic risk for ASD but who do not develop symptoms of the disorder (i.e. unaffected siblings of individuals with ASD) show increased activity in this region, which is hypothesized to be a compensatory mechanism

to offset genetic vulnerability (Kaiser et al., 2010).

In typical development, preferential attention to faces and the ability to recognize individual faces emerge in the first days of life (e.g., Goren, Sarty, & Wu, 1975). The special

way in which the brain responds to faces usually emerges by three months of age (e.g., de Haan, Johnson, & Halit, 2003) and continues throughout the lifespan (e.g., Bentin et al., 1996). Children with ASD, however, tend to show decreased attention to human faces by six to 12 months (Osterling & Dawson, 1994). Children with ASD also show reduced activity in the FG when viewing faces (e.g., Schultz et al., 2000). Slowed processing of faces (McPartland, Dawson, Webb, Panagiotides, & Carver, 2004) is a characteristic of people with ASD that is shared by parents of children with ASD (Dawson, Webb, & McPartland, 2005) and infants at increased risk for developing ASD because of having a sibling with ASD (McCleery, Akshoomoff, Dobkins, & Carver, 2009). Behavioral and attentional differences in face perception and recognition are evident in children and adults with ASD as well (e.g., Hobson, 1986).

EXPLORING DIVERSITY IN ASD

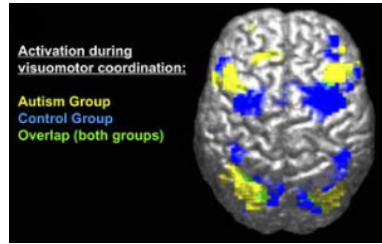
Because of the limited quality of the behavioral methods used to diagnose ASD and current clinical diagnostic practice, which permits similar diagnoses despite distinct symptom profiles (McPartland, Webb, Keehn, & Dawson, 2011), it is possible that the group of children currently referred to as having ASD may actually represent different syndromes with distinct causes. Examination of the social brain may well reveal diagnostically meaningful subgroups of children with ASD. Measurements of the “where” and “when” of brain activity during social processing tasks provide reliable sources

of the detailed information needed to profile children with ASD with greater accuracy. These profiles, in turn, may help to inform treatment of ASD by helping us to match specific treatments to specific profiles.

The integration of imaging methods is critical for this endeavor. Using face perception as an example, the combination of fMRI and ERP could identify who, of those individuals with ASD, shows anomalies in the FG and then determine the stage of information processing at which these impairments occur. Because different processing stages often reflect discrete cognitive processes, this level of understanding could encourage treatments that address specific processing deficits at the neural level.

For example, differences observed in the early processing stages might reflect problems with low-level visual perception, while later differences would indicate problems with higher-order processes, such as emotion recognition. These same principles can be applied to the broader network of social brain regions and, combined with measures of behavioral functioning, could offer a comprehensive profile of brain-behavior performance for a given individual. A fundamental goal for this kind of subgroup approach is to improve the ability to tailor treatments to the individual.

Another objective is to improve the power of other scientific tools. Most studies of individuals with ASD compare groups of individuals, for example, individuals on with ASD compared to typically developing peers. However, studies have also attempted to compare children across the autism spectrum by group according to differential diagnosis (e.g., Asperger's disorder versus autistic disorder), or by other behavioral or cognitive characteristics (e.g., cognitively able versus intellectually disabled or anxious versus non-anxious). Yet, the power of a scientific study to detect these kinds of significant, meaningful, individual differences is only as strong as the accuracy of the factor used to define the compared groups.



Trying to diagnose the precise autism disorder can be difficult; many cases share similar symptoms. However, burgeoning technology, like the fMRI, allows clinicians a glimpse into the patient's brain and thus a better understanding of his or her disorder.

[Image: Ralph-Axel Müller, <https://goo.gl/WwxCV1>, CC BY 2.5, <https://goo.gl/0QtWcf>]

The identification of distinct subgroups within the autism spectrum according to information about the brain would allow for a more accurate and detailed exposition of the individual differences seen in those with ASD. This is especially critical for the success of investigations into the

genetic basis of ASD. As mentioned before, the genes discovered thus far account for only a small portion of ASD cases. If meaningful, quantitative distinctions in individuals with ASD are identified; a more focused examination into the genetic causes specific to each subgroup could then be pursued. Moreover, distinct findings from neuroimaging, or biomarkers, can help guide genetic research. **Endophenotypes**, or characteristics that are not immediately available to observation but that reflect an underlying genetic liability for disease, expose the most basic components of a complex psychiatric disorder and are more stable across the lifespan than observable behavior (Gottesman & Shields, 1973). By describing the key characteristics of ASD in these objective ways, neuroimaging research will facilitate identification of genetic contributions to ASD.

ATYPICAL BRAIN DEVELOPMENT BEFORE THE EMERGENCE OF ATYPICAL BEHAVIOR

Because autism is a developmental disorder, it is particularly important to diagnose and treat ASD early in life. Early deficits in attention to biological motion, for instance, derail subsequent experiences in attending to higher level social information, thereby driving development toward more severe dysfunction and stimulating deficits in additional domains of functioning, such as language development. The lack of reliable predictors of the condition during the first year of life has been a major impediment to the effective

treatment of ASD. Without early predictors, and in the absence of a firm diagnosis until behavioral symptoms emerge, treatment is often delayed for two or more years, eclipsing a crucial period in which intervention may be particularly successful in ameliorating some of the social and communicative impairments seen in ASD.

In response to the great need for sensitive (able to identify subtle cases) and specific (able to distinguish autism from other disorders) early indicators of ASD, such as biomarkers, many research groups from around the world have been studying patterns of infant development using prospective longitudinal studies of infant siblings of children with ASD and a comparison group of infant siblings without familial risks. Such designs gather longitudinal information about developmental trajectories across the first three years of life for both groups followed by clinical diagnosis at approximately 36 months.



If autism is diagnosed early enough, treatments have developed to the point that children with ASD can learn and grow to have more intensive social interactions. [Image: hepington, <https://goo.gl/TIoAcY>, CC BY-SA 2.0, <https://goo.gl/rxiUsF>]

These studies are problematic in that many of the social features of autism do not emerge in typical development until after 12 months of age, and it is not certain that these symptoms will manifest during the limited periods of observation involved in clinical evaluations or in pediatricians' offices. Moreover, across development, but especially during infancy, behavior is widely variable and often unreliable, and at present,

behavioral observation is the only means to detect symptoms of ASD and to confirm a diagnosis. This is quite problematic because, even highly sophisticated behavioral methods, such as eye tracking (see Figure 1), do not necessarily reveal reliable differences in infants with ASD (Ozonoff et al., 2010). However, measuring the brain activity associated with social perception can detect differences that do not appear in behavior until much later. The identification of biomarkers utilizing the imaging methods we have described offers promise for earlier detection of atypical social development.

ERP measures of brain response predict subsequent

development of autism in infants as young as six months old who showed normal patterns of visual fixation (as measured by eye tracking) (Elsabbagh et al., 2012). This suggests the great promise of brain imaging for earlier recognition of ASD. With earlier detection, treatments could move from addressing existing symptoms to preventing their emergence by altering the course of abnormal brain development and steering it toward normality.

HOPE FOR IMPROVED OUTCOMES

The brain imaging research described above offers hope for the future of ASD treatment. Many of the functions of the social brain demonstrate significant plasticity, meaning that their functioning can be affected by experience over time. In contrast to theories that suggest difficulty processing complex information or communicating across large expanses of cortex (Minshew & Williams, 2007), this malleability of the social brain is a positive prognosticator for the development of treatment. The brains of people with ASD are not wired to process optimally social information. But this does not mean that these systems are irretrievably broken. Given the observed plasticity of the social brain, remediation of these difficulties may be possible with appropriate and timely intervention.

Outside Resources

Web: American Psychiatric Association's website for the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* <http://www.dsm5.org>

Web: Autism Science Foundation – organization supporting autism research by providing funding and other assistance to scientists and organizations conducting, facilitating, publicizing and disseminating autism research. The organization also provides information about autism to the general public and serves to increase awareness of autism spectrum disorders and the needs of individuals and families affected by autism. <http://www.autismsciencefoundation.org/>

Web: Autism Speaks – Autism science and advocacy organization <http://www.autismspeaks.org/>

Discussion Questions

1. How can neuroimaging inform our understanding of the causes of autism?
2. What are the ways in which neuroimaging, including fMRI and ERP, may benefit efforts to diagnosis and treat autism?
3. How can an understanding of the social brain help us to understand ASD?
4. What are the core symptoms of ASD, and why is the social brain of particular interest?

5. What are some of the components of the social brain, and what functions do they serve?

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Summary and Self-Test: Autism

KEVIN A. PELPHREY AND JORDEN A.
CUMMINGS

SUMMARY

Autism spectrum disorder (ASD) is a developmental disorder that usually emerges within the first three years and persists throughout the individual's life. There are three general categories of symptoms of ASD: presence of profound difficulties in social interactions and communication, combined with the presence of repetitive or restricted interests, cognitions, and behaviours. There is a wide variety of symptom combinations that may be present for people with ASD.

Previously, DSM-IV-TR included autism under a broader

diagnostic category called Pervasive Developmental Disorders. Based on research and clinical experience, however, the separate disorders were collapsed into one diagnosis for DSM-5 (ASD).

In Canada, 1 in 66 children and youth (aged 5-17) are diagnosed with ASD, making it one of the most common developmental disorders. Males are four times more likely to receive a diagnosis of ASD.

Basic social perception is an important building block for more sophisticated social behaviours, like thinking about the emotions and motivations of others. Because of the social difficulties characterizing ASD, the functioning of the social brain is of great interest to autism researchers.

To date, the most investigated areas of the social brain in ASD are the superior temporal sulcus (STS), which underlies the perception and integration of biological motion, and the fusiform gyrus (FG), which supports face perception. Very early in life, children with ASD display reduced sensitive to biological motion and lack the attention to human faces that non-ASD infants possess.

Because of the many potential symptom combinations of ASD, identification of distinct (neurological) subgroups within the autism spectrum would allow for a more accurate and detailed exploration of individual differences between types of ASD.

It is particularly important to diagnose and treat ASD early in life. The lack of reliable predictors during the first year of

life is an impediment to this early intervention. Treatment is often delayed for 2 or more years.

PART IX

Chapter 9:
Personality
Disorders

STEPHANIE WEIGEL

Chapter 9 Introduction

JORDEN A. CUMMINGS

Every one of us has our own personality that describes who we generally are. This is often how we organize our sense of self and our impressions of the people around us. Personality disorders, however, describe a form of psychopathology marked by extreme, rigid personality difficulties that can cause impairment (in multiple domains) for the individual. Moreover, they can cause a multitude of interpersonal difficulties for those around them. In this chapter we review one of the more popular theories of personality – the Five Factor Model – and discuss the differences between personality and personality disorders.

The DSM-5 organizes personality disorders into three

clusters, based on their common characteristics. Cluster A personality disorders involve odd and eccentric thinking or behaviour, and include paranoid, schizoid, and schizotypal personality disorder. Cluster B personality disorders involve dramatic, overly emotional or unpredictable thinking or behaviour, and include antisocial, borderline, histrionic, and narcissistic personality disorder. Cluster C personality disorders are marked by anxious, fearful thinking or behaviour and include avoidant, dependent, and obsessive-compulsive personality disorder.

Personality disorders are, unfortunately, some of the most challenging disorders to treat. This is because they are so entrenched, chronic, and pervasive for the people who experience them. Very few people with personality disorders present for treatment, and if they do it is often because they are experiencing social/occupational impairment or because someone else has pushed them to go. The exception is borderline personality disorder, which is quite distressing for those who experience it. Our treatment development for personality disorders lags behind that of other disorders, although there is one empirically supported treatment for borderline personality disorder: Dialectical Behaviour Therapy.

9.1 Personality Disorders

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Section Learning Objectives

- Define what is meant by a personality disorder.
- Identify the five domains of general personality.
- Identify the six personality disorders proposed for retention in DSM-5.
- Summarize the etiology for antisocial and borderline personality disorder.

- Identify the treatment for borderline personality disorder.

Personality & the Five-Factor Model

Everybody has their own unique **personality**; that is, their characteristic manner of thinking, feeling, behaving, and relating to others (John, Robins, & Pervin, 2008). Some people are typically introverted, quiet, and withdrawn; whereas others are more extraverted, active, and outgoing. Some individuals are invariably conscientiousness, dutiful, and efficient; whereas others might be characteristically undependable and negligent. Some individuals are consistently anxious, self-conscious, and apprehensive; whereas others are routinely relaxed, self-assured, and unconcerned. Personality traits refer to these characteristic, routine ways of thinking, feeling, and relating to others. There are signs or indicators of these traits in childhood, but they become particularly evident when the person is an adult. Personality traits are integral to each person's sense of self, as they involve what people value, how they think and feel about things, what they like to do, and, basically, what they are like most every day throughout much of their lives.

There are literally hundreds of different personality traits. All of these traits can be organized into the broad dimensions referred to as the **Five-Factor Model** (John, Naumann, &

Soto, 2008). These five broad domains are inclusive; there does not appear to be any traits of personality that lie outside of the Five-Factor Model. This even applies to traits that you may use to describe yourself. Table 9.1 provides illustrative traits for both poles of the five domains of this model of personality. A number of the traits that you see in this table may describe you. If you can think of some other traits that describe yourself, you should be able to place them somewhere in this table.

<p>Neuroticism (Emotional Instability) fearful, apprehensive, angry, bitter, pessimistic, glum, timid, embarrassed, tempted, urgency, helpless, fragile</p>	<p>VS</p>	<p>Emotional Stability relaxed, unconcerned, cool, even-tempered, optimistic, self-assured, glib, shameless, controlled, restrained, clear-thinking, fearless, unflappable</p>
<p>Extraversion cordial, affectionate, attached, sociable, outgoing, dominant, forceful, vigorous, energetic, active, reckless, daring, high-spirited, excitement-seeking</p>		<p>Introversion cold, aloof, indifferent, withdrawn, isolated, unassuming, quiet, resigned, passive, lethargic, cautious, monotonous, dull, placid, anhedonic</p>
<p>Openness (unconventionality) dreamer, unrealistic, imaginative, aberrant, aesthetic, self-aware, eccentric, strange, odd, peculiar, creative, permissive, broad-minded</p>		<p>Closedness (conventionality) practical, concrete, uninvolved, no aesthetic interest, constricted, unaware, alexythymic, routine, predictable, habitual, stubborn, pragmatic, rigid, traditional, inflexible, dogmatic</p>
<p>Agreeableness gullible, naive, trusting, confiding, honest, sacrificial, giving, docile, cooperative, meek, self-effacing, humble, soft, empathetic</p>		<p>Antagonism skeptical, cynical, suspicious, paranoid, cunning, manipulative, deceptive, stingy, selfish, greedy, exploitative, oppositional, combative, aggressive, confident, boastful, arrogant, tough, callous, ruthless</p>
<p>Conscientiousness perfectionistic, efficient, ordered, methodical, organized, rigid, reliable, dependable, workaholic, ambitious, dogged, devoted, cautious, ruminative, reflective</p>		<p>Disinhibition lax, negligent, haphazard, disorganized, sloppy, casual, undependable, unethical, aimless, desultory, hedonistic, negligent, hasty, careless, rash</p>

Table 9.1: Illustrative traits for both poles across Five-Factor Model personality dimensions.

DSM-5 PERSONALITY DISORDERS

When personality traits result in significant distress, social impairment, and/or occupational impairment, they are considered to be a personality disorder (American Psychiatric Association, 2013). The authoritative manual for what constitutes a personality disorder is provided by the American Psychiatric Association’s (APA) *Diagnostic and Statistical*

Manual of Mental Disorders (DSM), the current version of which is DSM-5 (APA, 2013). The DSM provides a common language and standard criteria for the classification and diagnosis of mental disorders. This manual is used by clinicians, researchers, health insurance companies, and policymakers.

According to the DSM-V, a personality disorder is characterized by a pervasive, consistent, and enduring pattern of behaviour and internal experience that differs significantly from that which is usually expected in the individual's culture. They typically have an onset in adolescence or early adulthood, persist over time, and cause distress or impairment. The pattern must be present in two or more of the four areas of cognition, emotion, interpersonal functioning, and impulse control. It must also not be better explained by another mental disorder or medical condition, or as the effects of a substance. There was much discussion in writing the DSM-V about changing the way in which personality disorders are diagnosed, but for now the system remains unchanged from the previous version of the DSM (the DSM-IV-TR). DSM-5 includes 10 **personality disorders**, grouped into three clusters: Cluster A (paranoid, schizoid, and schizotypal personality disorders), Cluster B (antisocial, borderline, histrionic, and narcissistic personality disorders), and Cluster C (avoidant, dependent, and obsessive-compulsive personality disorders).

This list of 10 though does not fully cover all of the different ways in which a personality can be maladaptive.

DSM-5 also includes a “wastebasket” diagnosis of other specified personality disorder (OSPD) and unspecified personality disorder (UPD). This diagnosis is used when a clinician believes that a patient has a personality disorder but the traits that constitute this disorder are not well covered by one of the 10 existing diagnoses. OSPD and UPD or as they used to be referred to in previous editions – PDNOS (personality disorder not otherwise specified) are often one of the most frequently used diagnoses in clinical practice, suggesting that the current list of 10 is not adequately comprehensive (Widiger & Trull, 2007).

Each of the 10 DSM-5 (and DSM-IV-TR) personality disorders is a constellation of maladaptive personality traits, rather than just one particular personality trait (Lynam & Widiger, 2001). In this regard, personality disorders are “syndromes.” For example, **avoidant** personality disorder is a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation (APA, 2013), which is a combination of traits from introversion (e.g., socially withdrawn, passive, and cautious) and neuroticism (e.g., self-consciousness, apprehensiveness, anxiousness, and worrisome). **Dependent** personality disorder includes submissiveness, clinging behavior, and fears of separation (APA, 2013), for the most part a combination of traits of neuroticism (anxious, uncertain, pessimistic, and helpless) and maladaptive agreeableness (e.g., gullible, guileless, meek, subservient, and self-effacing). **Antisocial** personality disorder is, for the most

part, a combination of traits from antagonism (e.g., dishonest, manipulative, exploitative, callous, and merciless) and low conscientiousness (e.g., irresponsible, immoral, lax, hedonistic, and rash). See the 1967 movie, *Bonnie and Clyde*, starring Warren Beatty, for a nice portrayal of someone with antisocial personality disorder.

Some of the DSM-5 personality disorders are confined largely to traits within one of the basic domains of personality.

For example, **obsessive-compulsive** personality disorder is largely a disorder of maladaptive conscientiousness, including such traits as workaholism, perfectionism, punctilious, ruminative, and

dogged; **schizoid** is confined largely to traits of introversion (e.g., withdrawn, cold, isolated, placid, and anhedonic); **borderline** personality disorder is largely a disorder of neuroticism, including such traits as emotionally unstable, vulnerable, overwhelmed, rageful, depressive, and self-destructive (watch the 1987 movie, *Fatal Attraction*,



A person with an obsessive compulsive personality disorder may have a hard time relaxing, always feel under pressure, and believe that there isn't enough time to accomplish important tasks. [Image: CC0 Public Domain, <https://goo.gl/m25gce>]

starring Glenn Close, for a nice portrayal of this personality disorder); and **histrionic** personality disorder is largely a disorder of maladaptive extraversion, including such traits as attention-seeking, seductiveness, melodramatic emotionality, and strong attachment needs (see the 1951 film adaptation of Tennessee William's play, *Streetcar Named Desire*, starring Vivian Leigh, for a nice portrayal of this personality disorder).

Due to the severity of symptoms (e.g., suicide), Canadian researchers have examined the rates of Cluster B personality disorders specifically (Cailhol et al., 2017). In Quebec, the 2011-2012 prevalence rates were 2.6% (lifetime) and 3.6% (12-month). Compared with the general provincial population, the mean years of lost life expectancy for men and women were 13 and 9 years, respectively (Cailhol et al., 2017).

It should be noted though that a complete description of each DSM-5 personality disorder would typically include at least some traits from other domains. For example, antisocial personality disorder (or psychopathy) also includes some traits from low neuroticism (e.g., fearlessness and glib charm) and extraversion (e.g., excitement-seeking and assertiveness); borderline includes some traits from antagonism (e.g., manipulative and oppositional) and low conscientiousness (e.g., rash); and histrionic includes some traits from antagonism (e.g., vanity) and low conscientiousness (e.g., impressionistic). **Narcissistic** personality disorder includes traits from neuroticism (e.g., reactive anger, reactive shame, and need for admiration), extraversion (e.g., exhibitionism

and authoritativeness), antagonism (e.g., arrogance, entitlement, and lack of empathy), and conscientiousness (e.g., acclaim-seeking). **Schizotypal** personality disorder includes traits from neuroticism (e.g., social anxiousness and social discomfort), introversion (e.g., social withdrawal), unconventionality (e.g., odd, eccentric, peculiar, and aberrant ideas), and antagonism (e.g., suspiciousness).

The APA currently conceptualizes personality disorders as qualitatively distinct conditions; distinct from each other and from normal personality functioning. However, included within an appendix to DSM-5 is an alternative view that personality disorders are simply extreme and/or maladaptive variants of normal personality traits, as suggested herein. Nevertheless, many leading personality disorder researchers do not hold this view (e.g., Gunderson, 2010; Hopwood, 2011; Shedler et al., 2010). They suggest that there is something qualitatively unique about persons suffering from a personality disorder, usually understood as a form of pathology in sense of self and interpersonal relatedness that is considered to be distinct from personality traits (APA, 2012; Skodol, 2012). For example, it has been suggested that antisocial personality disorder includes impairments in identity (e.g., egocentrism), self-direction, empathy, and capacity for intimacy, which are said to be different from such traits as arrogance, impulsivity, and callousness (APA, 2012).

DSM-5 DESCRIPTION OF EACH DISORDER

As mentioned, the DSM organizes personality disorders into 3 clusters.

Cluster A personality disorders involve odd and eccentric thinking or behaviour and include paranoid, schizoid, and schizotypal personality disorder. The **Cluster B personality disorders** involve dramatic, overly emotional, or unpredictable thinking or behaviour and include antisocial, borderline, histrionic, and narcissistic personality disorder. **Cluster C personality disorders** involve anxious, fearful thinking or behaviour and include avoidant, dependent, and obsessive-compulsive personality disorder.

PARANOID PERSONALITY DISORDER

Paranoid personality disorder is characterized by a pattern of mistrust or suspiciousness of others. Their motives are generally interpreted as malicious. Even when no evidence supports this conclusion, individuals with this personality disorder tend to assume that others mean them harm. They may be suspicious of their close friends or family, and as a result tend to avoid confiding in others. There may also be a tendency to misinterpret harmless events or comments as threats. Individuals with paranoid personality disorder can carry persistent grudges or generally present as unforgiving of even minor slights. When feeling attacked or plotted against they are quick to react with anger and often lash out or plan to seek revenge. This personality disorder often

involves an inability to trust one's romantic partner, and even in the absence of any evidence to the contrary an individual may become convinced that their partner has been unfaithful. Interpersonally they often appear hostile, stubborn, sarcastic, rigid, controlling, and critical of others. However, it is important to note that members of minority groups may appear guarded or defensive in response to discrimination or neglect by the majority society. As with any personality disorder, cultural factors must not contribute to a diagnosis of paranoid personality disorder.

SCHIZOID PERSONALITY DISORDER

If an individual generally remains detached from interpersonal relationships and has only a narrow range of emotional expression, they may be diagnosed with schizoid personality disorder. Someone with this disorder may derive no enjoyment from nor show any interest in close relationships including family, close friendships, or sexual relationships. They may choose solitary activities over interpersonal ones, find very few activities pleasurable or enjoyable, and may also seem indifferent when either praised or criticized by others. They may present as emotionally cold or distant and detached, with flattened affect. They may seem superficial or self-absorbed due to their disinterest in interpersonal relationships, and are generally not aware of (or do not respond to) social norms or cues. Individuals with schizoid personality disorder often find mechanical or abstract

tasks (such as computer or mathematics) more attractive than social activities.

SCHIZOTYPAL PERSONALITY DISORDER

Schizotypal personality disorder is diagnosed when an individual is unable or unwilling to form close relationships and has cognitive or perceptual distortions or eccentric behaviour. These individuals may experience ideas of references and strange beliefs or “magical thinking” that influences how they behave and is inconsistent with cultural/societal norms. It is important to note that many cultural contexts or religious settings include beliefs in things that would otherwise be symptoms of schizotypal personality disorder, and this must be ruled out before a diagnosis can be made. People with this disorder may have unusual perceptions that include somatic illusions, and their speech and thinking may be “odd” (i.e., vague, metaphorical, overly detailed). Suspiciousness and paranoia are often present, as is inappropriate/constricted affect (i.e., appearing emotionally “stiff”), eccentric behaviour and appearance, and lack of close connections other than immediate family. Social anxiety is also common, but differs from Axis I anxiety disorders in that it does not decrease as one becomes more familiar with someone, and it is based in paranoia rather than fears of negative judgment.

ANTISOCIAL PERSONALITY DISORDER

The diagnostic criteria for antisocial personality disorder specify that there must be a consistent pattern of disregarding or violating the rights of others since the age of 15. Specifically, this can involve unlawful behaviour or lying to or conning others for personal gain or pleasure. These individuals may be impulsive, irritable, aggressive, or reckless. As a result of these characteristics they may get into frequent physical fights or display a disregard for their own safety or that of others. They are frequently irresponsible and may fail to hold down a job or take care of financial obligations. Individuals with antisocial personality disorder often lack remorse, and as such they frequently present as indifferent to the suffering of others even when they have caused it. This personality disorder can only be diagnosed in someone 18 years or older, but conduct disorder must have been present prior to 15 years of age. There has been discussion about whether this diagnosis is disproportionately given to those from lower socioeconomic circumstances and care should be taken to tease apart survival strategies and traits from diagnosable symptoms of the disorder.

BORDERLINE PERSONALITY DISORDER

The hallmark of borderline personality disorder is a pervasive pattern of unstable interpersonal relationships, self-image, and emotions, with significant impulsivity. These individuals may respond to real or imagined abandonment by frantically

trying to avoid it, and their relationships may be intense and unstable, and characterized by alternating between viewing someone as “all good” or “all bad.” They may have an extremely unstable sense of self which translates into frequently changing interests and goals, and their impulsivity may occur in areas such as finances, sexual behaviour, substance abuse, dangerous driving, or binge eating. Suicidal behaviour is common and can include gestures, threats, attempts, and self-mutilation. Their emotions are frequently labile (unstable and reactive), and their moods may last only a few hours or a few days. Many individuals with this disorder report feeling chronically “empty,” and they may struggle with intense and inappropriate anger that may be difficult for them to control. Borderline personality disorder may also cause paranoia or dissociation that comes and goes depending on stress levels. One must note that adolescents and younger adults who are undergoing identity issues may appear to have some of the symptoms of BPD. Also, BPD is disproportionately diagnosed in females (whereas antisocial PD is disproportionately diagnosed in men) and an argument has been made in the literature that perhaps the diagnosis unfairly pathologizes stereotypically female experiences or responses to trauma. Another discussion topic has been that the exact same symptoms in case studies are diagnosed by mental health professionals as symptoms of borderline personality disorder in females, but antisocial personality disorder in males.

HISTRIONIC PERSONALITY DISORDER

A diagnosis of histrionic personality disorder describes someone who may need to be the centre of attention in order to find a situation comfortable. They may interact with others in overly and inappropriately sexually seductive or provocative ways, and their emotions change quickly and tend to be quite shallow in expression. Their physical appearance is often used as a way of drawing attention to themselves, and their speech tends towards being overly vague and dramatic (for instance, making bold statements but having no details to back up their opinions). When these individuals express emotion it is often exaggerated and theatrical. They may also be easily influenced by others or circumstances and often consider their relationships to be more intimate and close than they actually are. Above all, individuals with histrionic personality disorder are known to show excessive emotion and seek attention to an extreme degree. Given that many of these traits are largely influenced by cultural context, the extent to which they cause significant impairment or distress must be evaluated before diagnosis can be made.

NARCISSISTIC PERSONALITY DISORDER

An individual with narcissistic personality disorder may have a grandiose sense of their own importance, which means that they may exaggerate their positive traits or successes and expect recognition). They may fantasize about success,

power, beauty, brilliance, or love, and may see themselves as special and unique. This view of themselves may lead to a belief that they should only associate with other exceptional people. Someone with this disorder requires an excessive amount of admiration from others and feels entitled to special treatment. They may view others as needing to fulfill their needs and desires in a way that caters to their every whim. As such, these individuals sometimes take advantage of others in order to achieve their own goals and they may lack empathy or be unwilling or unable to recognize that others have valid thoughts, feelings, and needs. Although this disorder sometimes includes arrogant or haughty behaviour and attitudes, the individual may actually be envious of others. As a whole, this disorder involves extreme self-centred or self-absorbed behaviours and beliefs. Although ambition and confidence associated with this disorder may lead to significant vocational achievement, it may also cause impairment in functioning if an individual is unwilling to engage in tasks unless sure of success. They may also have difficulty working within a power structure that requires answering to someone with more power than themselves.

AVOIDANT PERSONALITY DISORDER

Avoidant personality disorder generally involves an unwillingness to interact with people unless sure of being liked. This includes avoiding work that involves significant interaction or being restrained within relationships because

of fearing criticism, rejection, disapproval, or shame. In fact, the individual is usually preoccupied with the idea of being criticized or rejected by others, and thus presents as inhibited when faced with new interpersonal relationships because of feeling inadequate. They may hold a view of themselves as socially inept, inferior, or unappealing. These individuals also tend to be quite reluctant to take any risks or try new activities because of an extreme fear of being embarrassed. What defines this personality disorder is the pattern of social inhibition, feelings of inadequacy or inferiority, and being hypersensitive to criticism. Unfortunately this disorder tends to create a vicious cycle, in which their fearful or tense presentation elicits negative responses from others, which in turn leads to more fear and avoidance. However, one must note that acculturation issues following immigration should not be confused with a diagnosis of avoidant personality disorder.

DEPENDENT PERSONALITY DISORDER

If someone shows a pattern of excessive neediness, clingy behaviour, submission, and fear of separation, they may be diagnosed with dependent personality disorder. This disorder may also include having difficulty making everyday decisions without seeking the input of others to an extreme degree. They may need others to take responsibility for large parts of their life, and may not be able to express dissenting opinions because of fearing disapproval or loss of support. Individuals

with dependent personality disorder may have trouble starting projects or completing tasks on their own because they lack confidence in their abilities, and they may excessively try to secure nurturing support from others, even if it means they have to do things that they find unpleasant. This disorder also tends to involve feeling uncomfortable or helpless when left alone, due to feeling intense fear over having to take care of oneself. They may go from one relationship to another in order to avoid being left alone, as a result of being preoccupied with this fear. As with most other disorders, traits of dependent personality disorder can be heavily influenced by cultural factors. Being polite, deferent, and passive is highly regarded in some cultures and in order to be diagnosed with this disorder the individual's behaviour must differ significantly from cultural norms.

OBSESSIVE-COMPULSIVE PERSONALITY DISORDER

An individual with obsessive-compulsive personality disorder presents as preoccupied with details, rules, lists, order, organization, and schedules. This preoccupation is so intense that the main point of the activity being planned gets lost. Their perfectionism interferes with accomplishing goals, but they may also be so devoted to work and productivity that leisure time and friendships are sacrificed. These individuals may be extremely inflexible and scrupulous when it comes to issues of morals, ethics, or values (although this criterion

must not be accounted for by religion or culture). They may find throwing out old or worthless items too difficult, even in the absence of sentimental value. This disorder also may make one hesitant to delegate or work cooperatively unless the workmate is willing to completely submit to how the individual feels the work should be done. In terms of finances, they may be extremely reluctant to spend money, choosing instead to hoard resources to prepare for an anticipated disaster in the future. These individuals also tend to present as extremely rigid and stubborn. Even normally “fun” activities may turn into structured tasks for someone with obsessive-compulsive personality disorder.

VALIDITY

It is quite possible that in future revisions of the DSM some of the personality disorders included in DSM-5 will no longer be included. In fact, for DSM-5 it was originally proposed that four be deleted. The personality disorders that were slated for deletion were histrionic, schizoid, paranoid, and dependent (APA, 2012). The rationale for the proposed deletions was in large part because they are said to have less empirical support than the diagnoses that were at the time being retained (Skodol, 2012). There is agreement within the field with regard to the empirical support for the borderline, antisocial, and schizotypal personality disorders (Mullins-Sweat, Bernstein, & Widiger, 2012; Skodol, 2012). However, there is a difference of opinion with respect to the empirical support for the dependent personality disorder (Bornstein,

2012; Livesley, 2011; Miller, Widiger, & Campbell, 2010; Mullins-Sweat et al., 2012).

Little is known about the specific etiology for most of the DSM-5 personality disorders. Because each personality disorder represents a constellation of personality traits, the etiology for the syndrome will involve a complex interaction of an array of different neurobiological vulnerabilities and dispositions with a variety of environmental, psychosocial events. Antisocial personality disorder, for instance, is generally considered to be the result of an interaction of genetic dispositions for low anxiousness, aggressiveness, impulsivity, and/or callousness, with a tough, urban environment, inconsistent parenting, poor parental role modeling, and/or peer support (Hare, Neumann, & Widiger, 2012). Borderline personality disorder is generally considered to be the result of an interaction of a genetic disposition to negative affectivity interacting with a malevolent, abusive, and/or invalidating family environment (Hooley, Cole, & Gironde, 2012).

To the extent that one considers the DSM-5 personality disorders to be maladaptive variants of general personality structure, as described, for instance, within the Five-Factor Model, there would be a considerable body of research to support the validity for all of the personality disorders, including even the histrionic, schizoid, and paranoid. There is compelling multivariate behavior genetic support with respect to the precise structure of the Five-Factor Model (e.g., Yamagata et al., 2006), childhood antecedents (Caspi,

Roberts, & Shiner, 2005), universality (Allik, 2005), temporal stability across the lifespan (Roberts & DelVecchio, 2000), ties with brain structure (DeYoung, Hirsh, Shane, Papademetris, Rajeevan, & Gray, 2010), and even molecular genetic support for neuroticism (Widiger, 2009).

TREATMENT

Personality disorders are relatively unique because they are often “ego-syntonic;” that is, most people are largely comfortable with their selves, with their characteristic manner of behaving, feeling, and relating to others. As a result, people rarely seek treatment for their antisocial, narcissistic, histrionic, paranoid, and/or schizoid personality disorder. People typically lack insight into the maladaptivity of their personality.



Many people with personality disorders do not seek treatment. Those with borderline personality disorder and avoidant personality disorder are exceptions. High levels of neuroticism and emotional pain may motivate them to seek help. [Image: CC0 Public Domain, <https://goo.gl/m25gce>]

One clear exception though is borderline personality disorder (and perhaps as well avoidant personality disorder). Neuroticism is the domain of general personality structure that concerns inherent feelings of emotional pain and suffering, including feelings of distress, anxiety, depression, self-consciousness, helplessness, and vulnerability. Persons who have very high elevations on neuroticism (i.e., persons with borderline personality

disorder) experience life as one of pain and suffering, and they will seek treatment to alleviate this severe emotional distress. People with avoidant personality may also seek treatment for their high levels of neuroticism (anxiousness and self-consciousness) and introversion (social isolation). In contrast, narcissistic individuals will rarely seek treatment to reduce their arrogance; paranoid persons rarely seek treatment to reduce their feelings of suspiciousness; and antisocial people

rarely (or at least willfully) seek treatment to reduce their disposition for criminality, aggression, and irresponsibility.

Nevertheless, maladaptive personality traits will be evident in many individuals seeking treatment for other mental disorders, such as anxiety, mood, or substance use. Many of the people with a substance use disorder will have antisocial personality traits; many of the people with mood disorder will have borderline personality traits. The prevalence of personality disorders within clinical settings is estimated to be well above 50% (Torgersen, 2012). As many as 60% of inpatients within some clinical settings are diagnosed with borderline personality disorder (APA, 2000). Antisocial personality disorder may be diagnosed in as many as 50% of inmates within a correctional setting (Hare et al., 2012). It is estimated that 10% to 15% of the general population meets criteria for at least one of the 10 DSM-IV-TR personality disorders (Torgersen, 2012), and quite a few more individuals are likely to have maladaptive personality traits not covered by one of the 10 DSM-5 diagnoses.

The presence of a personality disorder will often have an impact on the treatment of other mental disorders, typically inhibiting or impairing responsivity. Antisocial persons will tend to be irresponsible and negligent; borderline persons can form intensely manipulative attachments to their therapists; paranoid patients will be unduly suspicious and accusatory; narcissistic patients can be dismissive and denigrating; and dependent patients can become overly attached to and feel helpless without their therapists.

It is a misnomer, though, to suggest that personality disorders cannot themselves be treated. Personality disorders are among the most difficult of disorders to treat because they involve well-established behaviors that can be integral to a client's self-image (Millon, 2011). Nevertheless, much has been written on the treatment of personality disorder (e.g., Beck, Freeman, Davis, & Associates, 1990; Gunderson & Gabbard, 2000), and there is empirical support for clinically and socially meaningful changes in response to psychosocial and pharmacologic treatments (Perry & Bond, 2000). The development of an ideal or fully healthy personality structure is unlikely to occur through the course of treatment, but given the considerable social, public health, and personal costs associated with some of the personality disorders, such as the antisocial and borderline, even just moderate adjustments in personality functioning can represent quite significant and meaningful change.

Nevertheless, manualized and/or empirically validated treatment protocols have been developed for only one specific personality disorder, borderline (APA, 2001).

Focus Topic: Treatment of Borderline Personality Disorder

Dialectical behavior therapy (Lynch & Cuyper, 2012) and mentalization therapy (Bateman & Fonagy, 2012): Dialectical behavior therapy is a form of cognitive-behavior therapy that draws on principles from Zen Buddhism, dialectical

philosophy, and behavioral science. The treatment has four components: individual therapy, group skills training, telephone coaching, and a therapist consultation team, and will typically last a full year. As such, it is a relatively expensive form of treatment, but research has indicated that its benefits far outweighs its costs, both financially and socially.

It is unclear why specific and explicit treatment manuals have not been developed for the other personality disorders. This may reflect a regrettable assumption that personality disorders are unresponsive to treatment. It may also reflect the complexity of their treatment. As noted earlier, each DSM-5 disorder is a heterogeneous constellation of maladaptive personality traits. In fact, a person can meet diagnostic criteria for the antisocial, borderline, schizoid, schizotypal, narcissistic, and avoidant personality disorders and yet have only one diagnostic criterion in common. For example, only five of nine features are necessary for the diagnosis of borderline personality disorder; therefore, two persons can meet criteria for this disorder and yet have only one feature in common. In addition, patients meeting diagnostic criteria for one personality disorder will often meet diagnostic criteria for another. This degree of diagnostic overlap and heterogeneity of membership hinders tremendously any effort to identify a specific etiology, pathology, or treatment for a respective personality disorder as there is so much variation within any particular group of patients sharing the same diagnosis (Smith & Zapolski, 2009).

Of course, this diagnostic overlap and complexity did not prevent researchers and clinicians from developing dialectical behavior therapy and mentalization therapy. A further reason for the weak progress in treatment development is that, as noted earlier, persons rarely seek treatment for their personality disorder. It would be difficult to obtain a sufficiently large group of people with, for instance, narcissistic or obsessive–compulsive disorder to participate in a treatment outcome study, one receiving the manualized treatment protocol, the other receiving treatment as usual.

CONCLUSIONS

It is evident that all individuals have a personality, as indicated by their characteristic way of thinking, feeling, behaving, and relating to others. For some people, these traits result in a considerable degree of distress and/or impairment, constituting a personality disorder. A considerable body of research has accumulated to help understand the etiology, pathology, and/or treatment for some personality disorders (i.e., antisocial, schizotypal, borderline, dependent, and narcissistic), but not so much for others (e.g., histrionic, schizoid, and paranoid). However, researchers and clinicians are now shifting toward a more dimensional understanding of personality disorders, wherein each is understood as a maladaptive variant of general personality structure, thereby bringing to bear all that is known about general personality functioning to an understanding of these maladaptive variants.

Outside Resources

Structured Clinical Interview for DSM-5 (SCID-5)
<https://www.appi.org/products/structured-clinical-interview-for-dsm-5-scid-5>

Web: DSM-5 website discussion of personality disorders
<http://www.dsm5.org/ProposedRevision/Pages/PersonalityDisorders.aspx>

Discussion Questions

1. Do you think that any of the personality disorders, or some of their specific traits, are ever good or useful to have?
2. If someone with a personality disorder commits a crime, what is the right way for society to respond? For example, does or should meeting diagnostic criteria for antisocial personality disorder mitigate (lower) a person's responsibility for committing a crime?
3. Given what you know about personality disorders and the traits that comprise each one, would you say there is any personality disorder that is likely to be diagnosed in one gender more than

the other? Why or why not?

4. Do you believe that personality disorders can be best understood as a constellation of maladaptive personality traits, or do you think that there is something more involved for individuals suffering from a personality disorder?
5. The authors suggested Clyde Barrow as an example of antisocial personality disorder and Blanche Dubois for histrionic personality disorder. Can you think of a person from the media or literature who would have at least some of the traits of narcissistic personality disorder?

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Summary and Self-Test: Personality Disorders

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SUMMARY

Our personalities reflect our characteristic manner of thinking, feeling, behaving and relating to others. Personality traits are integral to a person's sense of self.

While there are many theories of personality, one of the most well researched is the Five Factor Model, which organizes literally hundreds of traits into five broad dimensions: Neuroticism/Emotional Stability, Extraversion/

Introversion, Openness/Closedness, Agreeableness/Antagonism, and Conscientiousness/Disinhibition.

When personality traits result in significant distress, social impairment, and/or occupational impairment, they might be considered to be a personality disorder. Personality disorders are characterized by a pervasive, consistent, and enduring pattern of behaviour and internal experience that differs significantly from that which is usually expected in the individual's culture.

Personality disorders typically have an onset in adolescence or early adulthood, persist over time, and cause distress or impairment.

Each of the 10 personality disorders is a constellation of maladaptive personality traits, not one particular trait. In this regard, they are syndromes. These can be mapped onto the Five Factor Model.

The personality disorders are grouped into 3 clusters, based on their predominant symptoms. Cluster A personality disorders involve odd or eccentric thinking or behaviour (paranoid, schizoid, and schizotypal personality disorder). Cluster B personality disorders are marked by dramatic, overly emotional, or unpredictable thinking or behaviour (antisocial, borderline, histrionic, and narcissistic personality disorder). Cluster C personality disorders involve anxious, fearful thinking or behaviour (avoidant, dependent, and obsessive-compulsive personality disorder).

The validity of personality disorders is an issue of controversy.

Personality disorders are generally ego syntonic, meaning that people are largely comfortable with themselves and their personality serves them well.

One personality disorder for which we have a well developed treatment is borderline personality disorder, which is treated with Dialectical Behaviour Therapy.

Cognitive Therapy can also be used to treat personality disorders.

Personality disorders are among the most difficult to treat disorders, because they involve well-established behaviours that are integral to a client's self-image.

SELF-TEST



An interactive H5P element has been excluded from this version of the text. You can view it online

here:

<https://fhsu.pressbooks.pub/abnormalpsych/?p=168#h5p-8>

Link: https://openpress.usask.ca/abnormalpsychology/wp-admin/admin-ajax.php?action=h5p_embed&id=13

PART X

Chapter 10: Feeding
and Eating
Disorders

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Chapter 10: Feeding & Eating
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**Chapter 10: FEEDING AND
EATING DISORDERS**

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Module Overview

In Module 10, we will discuss matters related to feeding and eating disorders to include their clinical presentation, epidemiology, comorbidity, etiology, and treatment options. Our discussion will include anorexia nervosa, bulimia nervosa, and binge eating disorder.

Module Outline

- [10.1. Clinical Presentation](#)
- [10.2. Epidemiology](#)
- [10.3. Comorbidity](#)
- [10.4. Etiology](#)
- [10.5. Treatment](#)

Module Learning Outcomes

- Describe how feeding and eating disorders present.
- Describe the epidemiology of feeding and eating disorders.
- Describe comorbidity in relation to feeding and eating disorders.
- Describe the etiology of feeding and eating disorders.
- Describe treatment options for feeding and eating

disorders.

10.1. CLINICAL PRESENTATION

Section Learning Objectives

- Describe how anorexia nervosa presents.
- Describe how bulimia nervosa presents.
- Describe how binge-eating disorder (BED) presents.

Feeding and eating disorders are “...characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning” (APA, 2022, pg. 371). They are very serious, yet relatively common mental health disorders, particularly in Western society, where there is a heavy emphasis on thinness and physical appearance. In fact, 13% of adolescents will be diagnosed with at least one eating disorder by their 20th birthday (Stice, Marti, & Rohde, 2013). Furthermore, a large number of adolescents will engage in significant disordered eating behaviors just below the clinical threshold (Culbert, Burt, McGue, Iacono & Klump, 2009). While there is no exact cause for eating disorders, the combination of

biological, psychological, and sociocultural factors has been identified as major contributors in both the development and maintenance of eating disorders.

Within the DSM 5-TR (APA, 2022), six disorders are classified under the Feeding and Eating Disorders chapter: pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder. In this book, we will cover the latter three whose diagnostic criteria are **mutually exclusive**, meaning that only one of these diagnoses can be assigned at any given time due to substantial differences in their clinical course, outcome, and treatment needs, despite a number of common psychological and behavioral features.

For more on eating disorders in general, please visit the National Eating Disorders Association website below:

<https://www.nationaleatingdisorders.org/what-are-eating-disorders>

10.1.1. Anorexia Nervosa

Anorexia nervosa involves the *restriction* of energy intake, which leads to significantly low body weight relative to the individual's age, sex, and development. This restriction is often secondary to an intense fear of gaining weight or

becoming fat, despite the individual's low body weight. Altered perception of self and an over-evaluation of one's body weight and shape contribute to this disturbance of body size.

Typical warning signs and symptoms are divided into two different categories: emotional/behavioral and physical. Some emotional and behavioral symptoms include dramatic weight loss; preoccupation with food, weight, calories, etc.; frequent comments about feeling "fat;" eating a restricted range of foods; making excuses to avoid mealtimes; and not eating in public. Physical changes may include dizziness, difficulty concentrating, feeling cold, sleep problems, thinning hair/hair loss, and muscle weakness, to name a few. When the individual loses weight, they view this as an impressive achievement and a sign of extraordinary discipline, while weight gain is seen as an unacceptable failure of self-control (APA, 2022).

The onset of the disorder typically begins with mild dietary restrictions such as eliminating carbs or specific fatty foods. As weight loss is achieved, the dietary restrictions progress to more severe, e.g., under 500 calories/day. Symptoms present in adolescence or young adulthood and rarely before puberty or after age 40. The onset of the disorder typically is preceded by a stressful life event such as leaving home for college.

For more on anorexia nervosa, please visit the National Eating Disorders Association website below:

<https://www.nationaleatingdisorders.org/learn/by-eating-disorder/anorexia>

10.1.2. Bulimia Nervosa

Unlike anorexia nervosa where there is solely restriction of food, bulimia nervosa involves a pattern of recurrent binge eating behaviors. **Binge eating** can be defined as a discrete period of time where the amount of food consumed is significantly more than most people would eat during a similar time period. Individuals with bulimia nervosa often report a sense of lack of control over-eating during these binge-eating episodes. While not always the case, these binge-eating episodes are followed by a feeling of disgust with oneself, which leads to a **compensatory behavior** to rid the body of the excessive calories. These compensatory behaviors include vomiting, use of laxatives, fasting (or severe restriction), diuretics or other medications, or excessive exercise. This cycle of binge eating and compensatory behaviors occurs on average, at least once a week for three months (National Eating Disorder Association website; APA, 2022).

It is important to note that while there are periods of severe

calorie restriction like anorexia, the two disorders cannot be diagnosed simultaneously. Therefore, it is important to determine if an individual engages in a binge-eating episode—if they do, they do *not* meet the criteria for anorexia nervosa.

Signs and symptoms of bulimia nervosa are similar to anorexia nervosa. These symptoms include but are not limited to hiding food wrappers or containers after a bingeing episode, feeling uncomfortable eating in public, developing food rituals, limited diet, disappearing to the bathroom after eating a meal, and drinking excessive amounts of water or non-caloric beverages. Additional physical changes include weight fluctuations both up and down, difficulty concentrating, dizziness, sleep disturbance, and possible dental problems due to purging post binge eating episode.

Making Sense of the Disorders

Though anorexia and bulimia share some common features, they differ as follows:

- Diagnosis anorexia if severe calorie restriction occurs alone
- Diagnosis bulimia ... if severe calorie restriction occurs **AND** there is a binge-eating episode

Symptoms of bulimia nervosa typically present later in development – adolescence or early adulthood. Like anorexia nervosa, bulimia nervosa initially presents with mild restrictive dietary behaviors; however, episodes of binge eating interrupt the dietary restriction, causing bodyweight to rise around normal levels. In response to weight gain, patients engage in compensatory behaviors or purging episodes to reduce body weight. This cycle of restriction, binge eating, and calorie reduction often occurs for years before seeking help.

Additionally, those with bulimia are often ashamed of their eating problems and attempt to hide the symptoms. The binge eating occurs in secrecy or as inconspicuously as possible. Common antecedents of binge eating include negative affect; interpersonal stressors; dietary restraint; boredom; and negative feelings linked to body weight, shape, and food.

For more on bulimia nervosa, please visit the National Eating Disorders Association website below:

<https://www.nationaleatingdisorders.org/learn/by-eating-disorder/bulimia>

10.1.3. Binge-Eating Disorder (BED)

Binge-eating disorder is similar to bulimia nervosa in that

it involves recurrent binge eating episodes along with feelings of lack of control during the binge-eating episode. The binge-eating episodes are associated with at least three of the following: eating quicker than usual, eating until uncomfortably full, eating large amounts even if not hungry, eating alone, and feeling disgust with oneself or being depressed. Despite the feelings of shame and guilt post-binge, individuals with BED will not engage in vomiting, excessive exercise, or other compensatory behaviors. These binge eating episodes occur on average, at least once a week for 3 months.

Because these binge-eating episodes occur without compensatory behaviors, individuals with BED are at risk for obesity and related health disorders. Individuals with BED report feelings of embarrassment at the quantity of food consumed, and thus will often refuse to eat in public. Due to the restriction of eating around others, individuals with BED often engage in secret binge eating episodes in private, followed by discrete disposal of wrappers and containers.

Making Sense of the Disorders

Though bulimia and BED are similar, they differ as follows:

- Diagnosis BED if binge eating occurs alone

- Diagnosis bulimia ... if binge eating occurs **AND** there are compensatory behaviors to prevent weight gain

While much is still being researched about binge-eating disorder, current research indicates that the onset of BED is adolescence to early adulthood but can begin later in life. Those who seek treatment tend to be older than those with either bulimia or anorexia. Binge eating has been found to be common in adolescent and college-age samples and for all, is associated with social role adjustment issues, impaired health-related quality of life and life satisfaction, and increased medical morbidity and mortality (APA, 2022).

For more on binge eating disorder, please visit the National Eating Disorders Association website below:

<https://www.nationaleatingdisorders.org/learn/by-eating-disorder/bed>

Key Takeaways

You should have learned the following in this section:

- Anorexia nervosa involves the restriction of food, which leads to significantly low body weight relative to the individual's age, sex, and development, and an intense fear of gaining weight or becoming fat.
- Bulimia nervosa is characterized by a pattern of recurrent binge eating behaviors followed by compensatory behaviors.
- Binge-eating disorder is characterized by recurrent binge eating episodes along with a feeling of lack of control but no compensatory behavior to rid the body of the calories.

Section 10.1 Review Questions

1. What does mutually exclusive mean? What does it mean with respect to eating disorders?
2. What are the key differences in diagnostic criteria for anorexia, bulimia, and binge eating disorder?
3. Define compensatory behavior. What disorder is this found in?

10.2. EPIDEMIOLOGY

Section Learning Objectives

- Describe the epidemiology of anorexia nervosa.
- Describe the epidemiology of bulimia nervosa.
- Describe the epidemiology of binge eating disorder.

10.2.1. Anorexia Nervosa

According to the National Eating Disorder Alliance (NEDA) website, at any point in time more women (0.3-0.4%) than men (0.1%) will be diagnosed with anorexia. Anorexia nervosa is most prevalent in postindustrialized, high-income countries such as the United States, Australia, New Zealand, Japan, and many European countries. In the U.S., prevalence is lower among Latinx and non-Latinx Black Americans than non-Latinx Whites (APA, 2022).

10.2.2. Bulimia Nervosa

According to the NEDA website, at any point in time, 1.0% of women and 0.1% of men will meet the diagnostic criteria for bulimia nervosa. A study by Stice and Bohon (2012) found that between 1.1% and 4.6% of females and 0.1% to 0.5% of males will develop bulimia and that

subthreshold bulimia occurs in 2.0% to 5.4% of adolescent females. The DSM reports that the 12-month prevalence ranges from 0.14% to 0.3% with higher rates in females and high-income countries. Rates are similar across ethnoracial groups across the U.S. (APA, 2022).

10.2.3. Binge Eating Disorder

Hudson et al. (2007) reports that BED is three times more common than anorexia and bulimia and is more common than breast cancer, HIV, and schizophrenia. It has also been found that between 0.2% and 3.5% of females and 0.9% and 2.0% of males will develop binge eating disorder with subthreshold binge eating disorder occurring in 1.6% of adolescent females (Stice & Bohon, 2012). The DSM reports a 12-month prevalence of 0.44% to 1.2% with rates 2-3 times higher in women, similar rates across ethnoracial groups in the United States and between most high-income industrialized countries (APA, 2022).

For more on statistics and research related to feeding and eating disorders, please visit the National Eating Disorders Association website below:

<https://www.nationaleatingdisorders.org/statistics-research-eating-disorders>

Key Takeaways

You should have learned the following in this section:

- BED is three times more common than anorexia and bulimia.
- All feeding and eating disorders are more common in women and high-income, industrialized countries.
- Only anorexia shows differences across ethnoracial groups in the United States.

Section 10.2 Review Questions

1. Which feeding and eating disorder is most common?
2. What gender differences occur with regards to the eating disorders?
3. Are there any other noteworthy similarities or differences in the prevalence rates of the three disorders?

10.3. COMORBIDITY

Section Learning Objectives

- Describe the comorbidity of anorexia nervosa.
- Describe the comorbidity of bulimia nervosa.
- Describe the comorbidity of BED.

10.3.1. Anorexia Nervosa

Anorexia is rarely a single diagnosis. High rates of bipolar, depressive, and anxiety disorders are common among individuals with anorexia nervosa. Obsessive-compulsive disorder is more often seen in those with the restricting type of anorexia nervosa, whereas alcohol use disorder and other substance use disorders are more commonly seen in those with anorexia who engage in binge-eating/purging behaviors. Unfortunately, there is also a high rate of suicidality, with rates reported to be 18 times greater than in an age- and gender-matched comparison group. It is also estimated that between 9% and 25% of individuals with anorexia have attempted suicide (APA, 2022).

10.3.2. Bulimia Nervosa

The majority of individuals diagnosed with bulimia nervosa also present with at least one other mental disorder. Similar to anorexia nervosa, there is a high frequency of depressive symptoms (i.e., low self-esteem), as well as bipolar and depressive disorders. While some experience mood fluctuations because of their eating pattern (occurring at the same time or following the development of bulimia), some

individuals will identify mood symptoms prior to the onset of bulimia nervosa (APA, 2022).

Anxiety, particularly social anxiety, is often present in those with bulimia nervosa. However, most mood and anxiety symptoms resolve once an effective treatment of bulimia is established. Substance use disorder, and in particular alcohol use disorder, is also prevalent in those with bulimia, with about a 30% prevalence among those with bulimia. The substance abuse begins as a compensatory behavior (e.g., stimulant use is used to control appetite and weight) and over time, as the eating disorder progresses, so does the substance abuse. There is also a percentage of individuals with bulimia nervosa who display personality features that meet the criteria for at least one personality disorder, most often borderline personality disorder. Finally, about one-quarter to one-third of individuals with bulimia have had suicidal ideation and a comparable amount have attempted suicide.

10.3.3. BED

Research shows that BED shares similar comorbidities with anorexia nervosa and bulimia nervosa. Common comorbidities include major depressive disorder and alcohol use disorder. About 25% of those with BED have shown suicidal ideation (APA, 2022).

Key Takeaways

You should have learned the following in this section:

- Anorexia has a high comorbidity with bipolar, depressive, and anxiety disorders. OCD and alcohol use disorder are also comorbid but depend on the type of anorexia (restricting or binge-eating/purging).
- Bulimia has a high comorbidity with bipolar disorder, depressive symptoms and disorders, social anxiety, and substance use disorder.
- BED is highly comorbid with MDD and alcohol use disorder.
- There is a high rate of suicidal ideation with all three disorders.

Section 10.3 Review Questions

1. Discuss the comorbidity rates among the three main eating disorders.

10.4. ETIOLOGY

Section Learning Objectives

- Describe the biological causes of feeding and

eating disorders.

- Describe the cognitive causes of feeding and eating disorders.
- Describe the sociocultural causes of feeding and eating disorders.
- Describe how personality traits are the cause of feeding and eating disorders.

What causes eating disorders? While researchers have yet to identify a specific cause of eating disorders, the most compelling argument to date is that eating disorders are **multidimensional disorders**. This means many contributing factors lead to the development of an eating disorder. While there is likely a genetic predisposition, there are also environmental, or external factors, such as family dynamics and cultural influences that impact their presentation. Research supporting these influences is well documented for anorexia nervosa and bulimia nervosa; however, seeing as BED has only just recently been established as a formal diagnosis, research on the involvement of BED is ongoing.

10.4.1. Biological

There is some evidence of a genetic predisposition for eating disorders, with relatives of those diagnosed with an eating disorder being up to six times more likely than other individuals to be diagnosed also. Twin concordance studies

also support the gene theory. If an identical twin is diagnosed with anorexia, there is a 70% percent chance the other twin will develop anorexia in their lifetime. The concordance rate for fraternal twins (who share less genes) is 20%. While not as strong for bulimia, identical twins still display a 23% concordance rate, compared to the 9% rate for fraternal twins.

In addition to hereditary causes, disruption in the neuroendocrine system is common in those with eating disorders (Culbert, Racine, & Klump, 2015). Unfortunately, it's difficult for researchers to determine if these disruptions *caused* the disorder or have been caused *by* the disorder, as manipulation of eating patterns is known to trigger changes in hormone production. With that said, researchers have explored the **hypothalamus** as a potential contributing factor. The hypothalamus is responsible for regulating body functions, particularly hunger and thirst (Fetissov & Mequid, 2010). Within the hypothalamus, the lateral hypothalamus is responsible for initiating hunger cues that cause the organism to eat, whereas the ventromedial hypothalamus is responsible for sending signals of satiation, telling the organism to stop eating. Clearly, a disruption in either of these structures could explain why an individual may not take in enough calories or experience periods of overeating.

10.4.2. Cognitive

Some argue that eating disorders are, in fact, a variant of

obsessive-compulsive disorder (OCD). The obsession with body shape and weight—the hallmark of an eating disorder—is likely a driving factor in anorexia nervosa. Distorted thought patterns and an over-evaluation of body size likely contribute to this obsession and one's desire for thinness. Research has identified high levels of impulsivity, particularly in those with binge eating episodes, suggesting a temporary lack of control is responsible for these episodes. Post binge-eating episode, many individuals report feelings of disgust or even thoughts of failure. These strong cognitive factors are indicative as to why cognitive-behavioral therapy is the preferred treatment for eating disorders.

10.4.3. Sociocultural

Eating disorders are overwhelmingly found in Western countries where there is a heavy emphasis on thinness—a core feature of eating disorders. It is also found in countries where food is in abundance, as in places of deprivation, round figures are viewed as more desirable (Polivy & Herman, 2002). While eating disorders were once thought of as disorders of higher SES, recent research suggests that as our country becomes more homogenized, the more universal eating disorders become.

10.4.3.1. Media. One commonly discussed contributor to eating disorders is the media. The idealization of thin models and actresses sends the message to young women (and adolescents) that to be popular and attractive, you must be thin. These images are not isolated to magazines, but are

also seen in television shows, movies, commercials, and large advertisements on billboards and hanging in store windows. With the emergence of social media (e.g., Facebook, Snapchat, Instagram), exposure to media images and celebrities is even easier. Couple this with the ability to alter images to make individuals even thinner, it is no wonder many young people become dissatisfied with their body (Polivy & Herman, 2004).

10.4.3.2. Ethnicity. While eating disorders are not solely a “white woman” disorder, there are significant discrepancies when it comes to race, especially for anorexia nervosa. Why is this? Research indicates that black men prefer heavier women than do white men (Greenberg & Laporte, 1996). Given this preference, it should not be surprising that black women and children have larger ideal physiques than their white peers (Polivy & Herman, 2000). Since black women are less driven to thinness, black women would appear to be less likely to develop anorexia; however, findings suggest this is not the case. Caldwell and colleagues (1997) found that high-income black women were equally as dissatisfied as high-income white women with their physique, suggesting body image issues may be more closely related to SES than that of race. The race discrepancies are also less significant in BED, where the prominent feature of the eating disorder is not thinness (Polivy & Herman, 2002).

10.4.3.3. Gender. Males account for only a small percentage of eating disorders. While it is unclear as to why there is such a discrepancy, it is likely somewhat related

to cultural desires of women being “thin” and men being “muscular” or “strong.”

Of men diagnosed with an eating disorder, the overwhelming percentage of them identified a job or sport as the primary reason for their eating behaviors (Strother, Lemberg, Stanford, & Turberville, 2012). Jockeys, distance runners, wrestlers, and bodybuilders are some of the professions identified as most restrictive regarding body weight.

There is some speculation that males are not diagnosed as frequently as women due to the stigma attached to eating disorders. Eating disorders have routinely been characterized as a “white, adolescent female” problem. Due to this bias, young men may not seek help for their eating disorder in efforts to prevent labeling (Raevuoni, Keski-Rahkonen & Hoek, 2014).

10.4.3.4. Family. Family influences are one of the strongest external contributors to maintaining eating disorders. Often family members are praised for their slenderness. Think about the last time you saw a family member or close friend- how often have you said, “You look great!” or commented on their appearance in some way? The odds are likely high. While the intent of the family member is not to maintain maladaptive eating behaviors by praising the physical appearance of someone struggling with an eating disorder, they are indirectly perpetuating the disorder.

While family involvement can help maintain the disorder, it can also contribute to the development of an eating

disorder. Families that emphasize thinness or place a large emphasis on physical appearance are more likely to have a child diagnosed with an eating disorder (Zerbe, 2008). In fact, mothers with eating disorders are more likely to have children who develop a feeding/eating disorder than mothers without eating disorders (Whelan & Cooper, 2000). Additional family characteristics that are common among patients receiving treatment for eating disorders are enmeshed, intrusive, critical, hostile, or overly concerned with parenting (Polivy & Herman, 2002). While there has been some correlation between these family dynamics and eating disorders, they are not evident in all families of people with eating disorders.

10.4.4. Personality

There are many personality characteristics that are common in individuals with eating disorders. While it is unknown if these characteristics are inherent in the individual's personality or a product of personal experiences, the thought is eating disorders develop due to the combination of the two.

10.4.4.1. Perfectionism. It should come as no surprise that perfectionism, or the belief that one must be perfect, is a contributing factor to disorders related to eating, weight, and body shape (particularly anorexia nervosa). While an exact mechanism is unknown, it is believed that perfectionism magnifies normal body imperfections, leading an individual

to go to extreme (i.e., restrictive) behaviors to remedy the flaw (Hewitt, Flett & Ediger, 1995).

10.4.4.2. Self-Esteem. Self-esteem, or one's belief in their worth or ability, has routinely been identified as a moderator of many psychological disorders, and eating disorders are no exception. Low self-esteem not only contributes to the development of an eating disorder but is also likely involved in the maintenance of the disorder. One theory, the **transdiagnostic model** of eating disorders, suggests that overall low self-esteem increases the risk for over-evaluation of body, which in turn, leads to negative eating behaviors that could lead to an eating disorder (Fairburn, Cooper & Shafran, 2003).

Key Takeaways

You should have learned the following in this section:

- Biological causes of eating disorders include a genetic predisposition and disruption in the neuroendocrine system.
- Cognitive causes of eating disorders include distorted thought patterns and an over-evaluation of body size.
- Sociocultural causes of eating disorders include the idealization of thin models and actresses by the media, SES, gender, and family involvement.

- The personality trait of perfectionism and low self-esteem are contributing factors to disorders related to eating, weight, and body shape.

Section 10.4 Review Questions

1. Define multidimensional disorders?
2. What evidence is there to suggest eating disorders are biologically driven?
3. According to the cognitive theory, eating disorders may be a variant of what other disorder?
4. Discuss the four sociocultural subgroups that explains development of eating disorders.
5. What are the two personality traits most commonly used to describe behaviors associated with eating disorders?

10.5. TREATMENT

Section Learning Objectives

- Describe treatment options for anorexia nervosa.

- Describe treatment options for bulimia nervosa.
- Describe treatment options for binge eating disorder.
- Discuss the outcome of treatment for feeding and eating disorders.

10.5.1. Anorexia Nervosa

The immediate goal for the treatment of anorexia nervosa is weight gain and recovery from malnourishment. This is often established via an intensive outpatient program, or if needed, through an inpatient hospitalization program where caloric intake can be managed and controlled. Both the inpatient and outpatient programs use a combination of therapies and support to help restore proper eating habits. Of the most common (and successful) treatments are Cognitive-Behavioral Therapy (CBT) and Family-Based Therapy (FBT).

10.5.1.1. CBT. Because anorexia nervosa requires changes to both eating behaviors as well as thought patterns, CBT strategies have been very effective in producing lasting changes to those suffering from anorexia nervosa. Some of the behavioral strategies include recording eating behaviors—hunger pains, quality and quantity of food—and emotional behaviors—feelings related to the food. In addition to these behavioral strategies, it is also important to address the maladaptive thought patterns associated with their negative body image and desire to control their physical

characteristics. Changing the *fear* related to gaining weight is essential in recovery.

10.5.1.2. Family based therapy (FBT). FBT is also an effective treatment approach, often used as a component of individual CBT, especially for children and adolescents with the disorder. FBT has been shown to elicit 50-60% of weight restoration in one year, as well as weight maintenance 2-4 years post-treatment (Campbell & Peebles, 2014; LeGrange, Lock, Accurso, Agras, Darcy, Forsberg, et al, 2014). Additionally, FBT has been shown to improve rapid weight gain, produce fewer hospitalizations, and is more cost-effective than other types of therapies with family involvement (Agras, Lock, Brandt, Bryson, Dodge, Halmi, et al., 2014).

FBT typically involves 16-18 sessions which are divided into 3 phases: (1) Parents take charge of weight restoration, (2) client's gradual control of overeating, and (3) addressing developmental issues including fostering autonomy from parents (Chen, et al., 2016). While FBT has shown to be effective in treating adolescents with anorexia nervosa, the application for older eating patients (i.e., college-aged students and above) is still undetermined. As with adolescents, the goal for a family-based treatment program should center around helping the patient separate their feelings and needs from that of their family.

10.5.2. Bulimia Nervosa

Just as anorexia nervosa treatment initially focuses on

weight gain, the first goal of bulimia nervosa treatment is to eliminate binge eating episodes and compensatory behaviors. The aim is to replace both negative behaviors with positive eating habits. One of the most effective ways to establish this is through Cognitive Behavioral Therapy (CBT).

10.5.2.1. CBT. Similar to anorexia nervosa, individuals with bulimia nervosa are expected to keep a journal of their eating habits; however, with bulimia nervosa, it is also important that the journal include changes in sensations of hunger and fullness, as well as other feelings surrounding their eating patterns in efforts to identify triggers to their bingeing episodes (Agras, Fitzsimmons-Craft & Wilfley, 2017). Once these triggers are identified, psychologists will utilize specific behavioral or cognitive techniques to prevent the individual from engaging in binge episodes or compensatory behaviors.

One method for modifying behaviors is through *Exposure and Response Prevention*. As previously discussed in the OCD chapter, this treatment is very effective in helping individuals stop performing their compulsive behaviors by literally preventing them from engaging in the action, while simultaneously using relaxation strategies to reduce anxiety associated with not engaging in the negative behavior. Therefore, to prevent an individual from purging post-binge episodes, the individual would be encouraged to partake in an activity that directly competes with their ability to purge, e.g., write their thoughts and feelings in a journal at the kitchen table. Research has indicated that this treatment is

particularly helpful for individuals suffering from comorbid anxiety disorders (particularly OCD; Agras, Fitzsimmons-Craft & Wilfley, 2017).

In addition to changing behaviors, it is also important to change the maladaptive thoughts toward food, eating, weight, and shape. Negative thoughts such as “I am fat” and “I can’t stop eating when I start” can be modified into more appropriate thoughts such as “My body is healthy” or “I can control my eating habits.” By replacing these negative thoughts with more appropriate, positive thought patterns, individuals begin to control their feelings, which in return, can help them manage their behaviors.

10.5.2.2. Interpersonal Psychotherapy (IPT). IPT has also been established as an effective treatment for those with bulimia nervosa, particularly if an individual has not been successful with CBT treatment. The goal of IPT is to improve interpersonal functioning in those with eating disorders. Originally a treatment for depression, IPT-E was adapted to address the social isolation and self-esteem problems that contribute to the maintenance of negative eating behaviors.

IPT-E has 3 phases typically covered in weekly sessions over 4-5 months. *Phase One* consists of engaging the patient in treatment and providing psychoeducation about their disease and the treatment program. This phase also includes identifying interpersonal problems that are maintaining the disease.

Phase Two is the main treatment component. In this phase,

the primary focus is on problem-solving interpersonal issues. The most common types of interpersonal issues are lack of intimacy and interpersonal deficits, interpersonal role disputes, role transitions, grief, and life goals. Once the main interpersonal problem is identified, the clinician supports the patient in their pursuit to identify ways to change. A key component of IPT-E is the supportive role of the clinician, as opposed to the teaching role in other treatments. The idea is that by having the patient make changes, they can better understand their problems, and as a result, make more profound changes (Murphy, Straebler, Basden, Cooper, & Fairburn, 2012).

Phase Three is the final stage. The goals of this phase are to ensure that the changes made in Phase two are maintained. To achieve this, treatment sessions are spaced out, allowing patients more time to engage in their changed behavior. Additionally, relapse prevention (i.e., problem-solving ways *not* to relapse) is also discussed to ensure long term results. In doing this, the patient reviews the progress they have made throughout treatment, as well as identifying potential interpersonal issues that may arise, and how their treatment can be adapted to address those issues.

Support for IPT-E is limited; however, two extensive studies suggest that IPT-E is effective in treating bulimia nervosa, and possibly BED. While treatment is initially slower than CBT, it is equally effective in long-term follow-up and maintenance of disorder (Fairburn, Marcus, & Wilson, 1993).

10.5.3. Binge Eating Disorder

Given the similar presentations of BED and bulimia nervosa, it should not be surprising that the most effective treatments for BED are similar to that of bulimia nervosa. CBT, along with antidepressant medications, are among the most effective in treating BED. Interpersonal therapy, as well as dialectical behavioral therapy, have also been effective in reducing binge-eating episodes; however, they have not been effective in weight loss (Guerdjikova, Mori, Casuto, & McElroy, 2017). Goals of treatment are, of course, to eliminate binge eating episodes, as well as reduce body weight as most individuals with BED are overweight. Seeing as BED has only recently been established as a separate eating disorder, treatment research specific to this disorder is expected to grow.

10.5.3.1. Antidepressant medications. Given the high comorbidity between eating disorders and depressive symptoms, antidepressants have been a primary method of treatment for years. While they have been shown to improve depressive symptoms, which may help individuals make gains in their eating disorder treatment, research has not supported antidepressants as an effective treatment strategy for treating the eating disorder itself.

10.5.4. Outcome of Treatment

Now that we have discussed treatments for eating disorders, how effective are they? Research has indicated

favorable prognostic features for anorexia nervosa are early age of onset and a short history of the disorder. Conversely, unfavorable features are a long history of symptoms prior to treatment, severe weight loss, and binge eating and vomiting. The mortality rate over the first 10 years from presentation is about 10%. Most of these deaths are from medical complications due to the disorder or suicide.

Unfortunately, research has not identified any consistent predictors of positive outcomes for bulimia nervosa. However, there is some speculation that individuals with childhood obesity, low self-esteem, and those with a personality disorder have worse treatment outcomes. While treatment outcome for BED is still in its infancy, initial findings suggest that remission rates of BED are much higher than that for anorexia nervosa and bulimia nervosa.

Key Takeaways

You should have learned the following in this section:

- Treatment options for anorexia nervosa include CBT and FBT.
- Treatment options for bulimia nervosa include CBT, exposure and response prevention, and the three phases of interpersonal psychotherapy.
- Treatment options for BED include the taking of antidepressants to manage depressive symptoms,

CBT, and interpersonal therapy.

Section 10.5 Review Questions

1. What is the initial (main) goal of treatment for anorexia?
2. What are the three phases of family-based treatment?
3. What is the goal for interpersonal psychotherapy? Discuss the three phases of IPT.
4. What is the overall treatment effectiveness of eating disorders?

Module Recap

Module 10 covered eating disorders in terms of their clinical presentation, epidemiology, comorbidity, etiology, and treatment options. In Module 11, we will discuss substance-related and addictive disorders, which will conclude this part.

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STEPHANIE WEIGEL

PART XI

Chapter 12: Somatic
Symptom and
Related Disorders

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Chapter 12: Somatic Symptom and
Related Disorders

WASHINGTON STATE UNIVERSITY

Chapter 12: SOMATIC SYMPTOM AND RELATED
DISORDERS

STEPHANIE WEIGEL

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Module Overview

In this module we will discuss matters related to somatic symptom disorders to include the clinical presentation, epidemiology, comorbidity, etiology, and treatment options for somatic symptom disorder, illness anxiety disorder, functional neurological symptom (conversion) disorder, and factitious disorder. We also will discuss psychological factors affecting other medical conditions in relation to their clinical presentation, diagnostic criteria, common types of psychophysiological disorders, and treatment.

Module Outline

- [12.1. Clinical Presentation](#)
- [12.2. Epidemiology](#)
- [12.3. Comorbidity](#)
- [12.4. Etiology](#)
- [12.5. Treatment](#)
- [12.6. Psychological Factors Affecting Other Medical Conditions](#)

Module Learning Outcomes

- Describe how somatic symptom disorders present.

- Describe the epidemiology of somatic symptom disorders.
- Describe comorbidity in relation to somatic symptom disorders.
- Describe the etiology of somatic symptom disorders.
- Describe treatment options for somatic symptom disorders.
- Describe psychological factors affecting other medical conditions in terms of their clinical presentation, diagnostic criteria, common types of psychophysiological disorders, and treatment.

12.1. CLINICAL PRESENTATION

Section Learning Objectives

- Describe somatic symptom and related disorders.
- Describe how somatic symptom disorder presents.
- Describe how illness anxiety disorder presents.
- Describe how functional neurological symptom (conversion) disorder presents.
- Describe how factitious disorder presents.

Psychological disorders that feature somatic symptoms are often challenging to diagnose due to the internalizing nature of the disorder, meaning there is no real way for a clinician to measure the somatic symptom. Furthermore, the somatic symptoms could take on many forms. For example, the individual may be *faking* the physical symptoms, *imagining* the symptoms, *exaggerating* the symptoms, or they could be real and triggered by external factors such as stress or other psychological disorders. The symptoms also may be part of a real medical illness or disorder, and therefore, the symptoms should be treated medicinally.

All the disorders within this chapter share a common feature: there is a presence of somatic symptoms and/or illness anxiety associated with significant distress or impairment. Oftentimes, individuals with a somatic disorder will present to their primary care physician with their physical complaints. Occasionally, they will be referred to clinical psychologists after an extensive medical evaluation concludes that a medical diagnosis cannot explain their current symptoms. As you will see, despite their similarities, there are key features that distinguish the disorders in this class from one another.

12.1.1. Somatic Symptom Disorder

Individuals with **somatic symptom disorder** often present with multiple somatic symptoms at one time. These

symptoms are significant enough to impact their daily functioning, such as preventing them from attending school, work, or family obligations. The symptoms can be localized (i.e., in one spot) or diffused (i.e., entire body), and can be specific or nonspecific (e.g., fatigue). Individuals with somatic symptom disorder often report excessive thoughts, feelings, or behaviors surrounding their somatic symptoms (APA, 2022). For example, individuals with somatic symptom disorder may spend an excessive amount of time or energy evaluating their symptoms, as well as the potential seriousness of their symptoms. A lack of medical explanation is not needed for a diagnosis of somatic symptom disorder, as it is assumed that the individual's suffering is authentic. Somatic symptom disorder is often diagnosed when another medical condition is present, as these two diagnoses are not mutually exclusive.

Somatic symptom disorder patients generally present with significant worry about their illness. Their interpretation of symptoms is often viewed as threatening, harmful, or troublesome (APA, 2022). Because of their negative appraisals, they fear that their medical status is more serious than it typically is, and high levels of distress are often reported. Oftentimes these patients will “shop” at different physician offices to confirm the seriousness of their symptoms.

12.1.2. Illness Anxiety Disorder

Illness anxiety disorder, previously known as

hypochondriasis, involves an excessive preoccupation with having or acquiring a serious medical illness. The key distinction between illness anxiety disorder and somatic symptom disorder is that an individual with illness anxiety disorder does *not* typically present with any somatic symptoms. Occasionally an individual will present with a somatic symptom; however, the intensity of the symptom is mild and does not drive the anxiety. *Acquiring* a serious illness drives concerns and they will even avoid visiting a sick relative or friend for fear of jeopardizing their own health.

Individuals with illness anxiety disorder generally are cleared medically; however, some individuals are diagnosed with a medical illness. In this case, their anxiety surrounding the severity of their disorder is excessive or disproportionate to their actual medical diagnosis. While an individual's concern for an illness may be due to a physical sign or sensation, most individual's concerns are derived not from a physical complaint, but their actual anxiety related to a suspected medical disorder. This excessive worry often expands to general anxiety regarding one's health and disease. Unfortunately, this anxiety does not decrease even after reassurance from a medical provider or negative test results, even when provided by multiple physicians and diagnostic tests.

As one can imagine, the preoccupation and anxiety associated with attaining a medical illness severely impacts daily functioning. The individual will often spend copious amounts of time scanning and analyzing their body for

“clues” of potential ailments. Additionally, an excessive amount of time is often spent on internet searches related to symptoms and rare illnesses. Illness becomes a central feature of the person’s identity and self-image. Although extreme, some cases of invalidism have been reported due to illness anxiety disorder (APA, 2022).

Making Sense of the Disorders

In relation to somatic symptom and related disorders, note the following:

- For somatic symptom disorder the patient presents with multiple somatic symptoms at one time that are significant enough to impact their daily functioning
- For illness anxiety disorder ... the patient does *not* typically present with any somatic symptoms but if they do, the symptoms are just mild in intensity

12.1.3. Functional Neurological Symptom Disorder (Conversion Disorder)

Functional neurological symptom (conversion) disorder occurs when an individual presents with one or

more symptoms of altered voluntary motor or sensory function (APA, 2022). Common motor symptoms include weakness or paralysis, abnormal movements (e.g., tremors), and gait abnormalities (i.e., limping). Sensory symptoms include altered, reduced, or absent skin sensation, vision, or hearing. Less commonly seen are epileptic seizures and episodes of unresponsiveness resembling fainting or coma (Marshall et al., 2013). The disorder was called “conversion disorder” in prior versions of the DSM and in the psychiatric literature. As noted, “The term “conversion” originated in psychoanalytic theory, which proposes that unconscious psychic conflict is “converted” into physical symptoms” (APA, 2022).

The most challenging aspect of functional neurological symptom disorder is the complex relationship with a medical evaluation. While a diagnosis of conversion disorder requires that the symptoms *not* be explained by a neurological disease, just because a medical provider fails to provide evidence that it is not a specific medical disorder is not sufficient. Therefore, there must be evidence of an *incompatibility* of the medical disorder and the symptoms. For example, an individual experiencing a seizure would require a normal simultaneous electroencephalogram (EEG), indicating that there is not epileptic activity during what was previously thought of as an epileptic seizure.

12.1.4. Factitious Disorder

Factitious disorder differs from the three previously

discussed somatic disorders in that there is deliberate falsification of medical or psychological symptoms imposed on oneself or on another, with the overall intention of deception. While a medical condition may be present, the severity of impairment related to the medical condition is more excessive due to the individual's need to deceive those around them. Even more alarming is that this disorder is not only observed in the individual leading the deception—it can also be present in another individual, often a child or an individual with a compromised mental status who is not aware of the deception behind their illness.

Some examples of factitious disorder behaviors include, but are not limited to, altering a urine or blood test, falsifying medical records, ingesting a substance that would indicate abnormal laboratory results, physically injuring oneself, and inducing illness by injecting or ingesting a harmful substance. Although most individuals with factitious disorder seek treatment from health care professionals, some choose to mislead community members either in person or online about the illness or injury (APA, 2022). While it is unclear why an individual would want to fake their own (or someone else's) physical illness, there is some evidence suggesting that factors such as depression, lack of parental support during childhood, or an excessive need for social support may contribute to this disorder (McDermott, Leamon, Feldman, & Scott, 2012; Ozden & Canat, 1999; Feldman & Feldman, 1995).

Individuals with factitious disorder are at risk for

experiencing psychological distress or functional impairment causing harm to themselves and others such as family, friends, health care professionals, and faith leaders. The DSM-5-TR states, “Whereas some aspects of factitious disorders might represent criminal behavior, such criminal behavior and mental illness are not mutually exclusive” (APA, 2022, pg. 368).

Key Takeaways

You should have learned the following in this section:

- Somatic symptom disorder is characterized by the presence of multiple somatic symptoms, whether localized or diffused and specific or nonspecific, at one time which impact daily functioning.
- Illness anxiety disorder is characterized by concern over having or acquiring a serious illness, and not the actual presence of somatic symptoms. Individuals spend a great deal of time scanning and analyzing their body for “clues” of potential ailments.
- Functional neurological symptom disorder is characterized by one or more symptoms of voluntary motor or sensory function.
- Factitious disorder is characterized by deliberate falsification of medical or psychological symptoms

of oneself or another, with the overall intention of deception.

Section 12.1 Review Questions

1. What are some commonly shared features of somatic disorders?
2. Which somatic disorder usually accompanies a medical diagnosis?
3. What are the key distinctions between illness anxiety disorder and somatic symptom disorder?
4. What are the key differences between factitious disorder and the other somatic disorders?

12.2. EPIDEMIOLOGY

Section Learning Objectives

- Describe the epidemiology of somatic disorders.

The prevalence rates for somatic disorders are often difficult to determine; however, overall estimates of somatic symptom disorder are around 4-6%. There is a trend that

females report more somatic symptoms than males; thus, more females are diagnosed with somatic symptom disorder than males (APA, 2022).

Seeing as illness anxiety disorder is a newer diagnosis (replacing hypochondriasis), prevalence rates are largely based on the previous disorder. Previous findings suggest that illness anxiety disorder occurs in 1.3% to 10% of the general population and is equal among males and females.

Prevalence rates of factitious disorder are largely unknown, likely due to the use of deception in individuals diagnosed with the disorder. Additionally, health care professionals infrequently record the diagnosis, even in recognized cases (APA, 2022).

And like the other somatic symptom disorders, the prevalence of functional neurological symptom disorder is unknown, even though transient functional neurological symptoms are common. In the United States and northern Europe, research shows that the incidence of individual persistent functional neurological symptoms to be around 4-12 of every 100,000 annually (APA, 2022).

Key Takeaways

You should have learned the following in this section:

- Though prevalence rates for somatic symptom disorders are hard to determine, it is believed that

between 1 and 10% of the population suffer from one of these disorders.

- Females are more likely to be diagnosed with somatic symptom disorder and are as likely as males to be diagnosed with illness anxiety disorder.

Section 12.2 Review Questions

1. Create a table of the prevalence rates across the various somatic disorders. What are the differences between the disorders?
2. What gender differences are evident in the disorders, if any?

12.3. COMORBIDITY

Section Learning Objectives

- Describe the comorbidity of somatic disorders.

Given that half of psychiatric patients also have an additional medical disorder, 35% have an undiagnosed medical condition, and approximately 20% reported medical problems *caused* their mental condition, it should not come

as a surprise that somatic disorders, in general, have high comorbidity with other psychological disorders (Felker, Yazel, & Short, 1996). More specifically, anxiety and depressive disorders are among the most commonly co-diagnosed disorders for somatic disorders. While there is not a lot of information regarding specific comorbidities among somatic symptom and related disorders, there is some evidence to suggest that those with illness anxiety disorder are at risk of developing OCD and personality disorders. Similarly, personality disorders are more common in individuals with functional neurological symptom disorder than the general public. Somatic symptom disorder is also comorbid with PTSD and OCD. (APA, 2022). No comorbidity information is given for factitious disorder.

There is also high comorbidity between somatic disorders and other physical disorders classified as *central sensitivity syndromes (CSSs)*, due to their common central sensitization symptoms, yet medically unexplained symptoms (McGeary, Harzell, McGeary, & Gatchel, 2016). Disorders included in this group are fibromyalgia, irritable bowel syndrome, and chronic fatigue syndrome. Comorbidity rates are estimated at 60% for these functional syndromes and somatic pain disorder (Egloff et al., 2014).

Key Takeaways

You should have learned the following in this section:

- Anxiety and depression have a high comorbidity with somatic symptom and related disorders.
- Functional neurological symptom disorder and illness anxiety disorder frequently occur with personality disorders.
- PTSD and OCD are comorbid with somatic symptom disorder.
- Central sensitivity syndrome also has high comorbidity with somatic disorders.

Section 12.3 Review Questions

1. In general, what other disorders often occur with somatic disorders?
2. Which disorder do we not know anything about?

12.4. ETIOLOGY

Section Learning Objectives

- Describe the psychodynamic causes of somatic

disorders.

- Describe the cognitive causes of somatic disorders.
- Describe the behavioral causes of somatic disorders.
- Describe the sociocultural causes of somatic disorders.

12.4.1. Psychodynamic

Psychodynamic theory suggests that somatic symptoms present as a response against unconscious emotional issues. Two factors initiate and maintain somatic symptoms: *primary gain* and *secondary gain*. Primary gains produce *internal* motivators, whereas secondary gains produce *external motivators* (Jones, Carmel & Ball, 2008). When you relate this to somatic disorders, the primary gain, according to psychodynamic theorists, provides protection from the anxiety or emotional symptoms and/or conflicts. This need for protection is expressed via a physical symptom such as pain, headache, etc. The secondary gain, the external experiences from the physical symptoms that maintain these physical symptoms, can range from attention and sympathy to missed work, obtaining financial assistance, or psychiatric disability, to name a few.

12.4.2. Cognitive

Cognitive theorists often believe that somatic disorders are a result of negative beliefs or exaggerated fears of

physiological sensations. Individuals with somatic related disorders may have a heightened sensitivity to bodily sensations. This sensitivity, combined with their maladaptive thought patterns, may lead individuals to overanalyze and interpret their physiological symptoms in a negative light.

For example, an individual with a headache may *catastrophize* the symptoms and believe that their headache is the direct result of a brain tumor, as opposed to stress or other innoculate reasons. When their medical provider does not confirm this diagnosis, the individual may then catastrophize even further, believing they have an extremely rare disorder that requires an evaluation from a specialist.

12.4.3. Behavioral

Keeping true with the behavioral approach to psychological disorders, behaviorists propose that somatic disorders are developed and maintained by *reinforcers*. More specifically, individuals experiencing significant somatic symptoms are often rewarded by gaining attention from other people (Witthoft & Hiller, 2010). These rewards may also extend to more significant factors, such as receiving disability payments.

While the behavioral theory of somatic disorders appears to be like the psychodynamic theory of secondary gains, there is a clear distinction between the two – behaviorists view these gains as the *primary* reason for the development and maintenance of the disorder, whereas psychodynamic

theorists view these gains as secondary, only after the underlying conflicts create the disorder.

12.4.4. Sociocultural

There are a couple of different ways that sociocultural factors contribute to somatic related disorders. First, there is the social factor of familial influence that likely plays a significant role in the attention to somatic symptoms. Individuals with somatic symptom disorder are more likely to have a family member or close friend who is overly attentive to their somatic symptoms or report high anxiety related to their health (Watt, O'Connor, Stewart, Moon, & Terry, 2008; Schulte, Petermann, & Noeker, 2010).

Culturally, Western countries express less of a focus on somatic complaints compared to those in the Eastern part of the world. This may be explained by the different evaluations of the relationship between mind and body. For example, Westerners tend to have a view that psychological symptoms *sometimes* influence somatic symptoms, whereas Easterners focus more heavily on the mind-body relationship and how psychological and somatic symptoms interact with one another. These different cultural beliefs are routinely seen in research where Asian populations are more likely to report the physical symptoms related to stress than the cognitive or emotional problems that many in the United States report (Sue & Sue, 2016).

Key Takeaways

You should have learned the following in this section:

- Psychodynamic causes of somatic disorders include primary and secondary gains.
- Cognitive causes of somatic disorders include negative beliefs or exaggerated fears of physiological sensations.
- Behavioral causes of somatic disorders include reinforcers such as attention gained from others or receiving disability.
- Sociocultural causes of somatic disorders include familial influence and culture.

Section 12.4 Review Questions

1. How does catastrophizing contribute to the development and maintenance of somatic disorders?
2. How do somatic disorders develop according to behavioral theorists? Does this theory also explain how the symptoms are maintained? Explain.
3. What does the sociocultural model suggest regarding somatic disorders across cultures?

12.5. TREATMENT

Section Learning Objectives

- Describe treatment options for somatic disorders.

Treatment for these disorders is often difficult as individuals see their problems as completely medical, and therefore, do not think psychological intervention is necessary (Lahmann, Henningsen, & Noll-Hussong, 2010). Once an individual does not find relief from their symptoms after meeting with several different physicians, they often do willingly engage in psychotherapy, psychopharmacology, or both (Raj et al., 2014).

Among the most effective treatment approaches is the *biopsychosocial model* of treatment. This approach considers the various biological, psychological, and social factors that influence the illness and presenting symptoms (Gatchel et al., 2007). This treatment is often achieved through a *multidisciplinary* approach where the symptoms are managed by many providers, usually including a physician, psychiatrist, and psychologist. The *interdisciplinary* approach involves a higher level of care as the multiple disciplines interact with one another and identify a treatment goal (Gatchel et al., 2007). This approach, although more difficult to find, particularly in more rural settings, is presumed to be more effective due to the integration of health care providers

and their ability to work together to treat the patient uniformly.

12.5.1. Psychotherapy

8.5.1.1. Psychodynamic. Interpersonal psychotherapy, a type of psychodynamic therapy, has been found to be efficacious in treating somatic disorders. Interpersonal psychotherapy focuses on the relationship between self-experience and the unconscious, and how these factors contribute to body dysfunction. This type of treatment has been shown to reduce anxiety, depression, and improve the overall quality of life immediately following treatment; however, effects appear to diminish over time (Abass et al., 2014; Steinert et al., 2015).

12.5.1.2. CBT. Traditional cognitive-behavioral therapies (CBT) have been employed to address the cognitive attributions and maladaptive coping strategies that are responsible for the development and maintenance of the disorder. The most common misattribution for these disorders is *catastrophic thinking*, or the rumination about worst-case scenario outcomes. Additionally, goals of CBT treatment are the acceptance of the medical condition, addressing avoidance behaviors, and mediating expectations of treatment (Gatchel et al., 2014).

8.5.1.3. Behavioral. Behavioral therapies have also been shown to effectively manage complex chronic somatic symptoms, particularly pain. The behavioral approach involves bringing attention to physiological symptoms, the

individual's attribution to those symptoms, and the subsequent anxiety produced by the negative attributions (Looper & Kirmayer, 2002).

12.5.2. Psychopharmacology

Psychopharmacological interventions are rarely used due to possible side effects and unknown efficacy. Given that these individuals already have a heightened reaction to their physiological symptoms, there is a high likelihood that the side effects of medication would produce more harm than help. With that said, psychopharmacological interventions may be helpful for those individuals who have comorbid psychological disorders such as depression or anxiety, which may negatively impact their ability to engage in psychotherapy (McGeary, Harzell, McGeary, & Gatchel, 2016).

Key Takeaways

You should have learned the following in this section:

- The biopsychosocial model of treatment is one of the most effective for somatic disorders as it considers the various biological, psychological, and social factors that influence the illness and presenting symptoms and includes a multidisciplinary approach.

- Psychotherapy options include interpersonal psychotherapy, CBT, and behavioral.
- Psychopharmacological interventions are rarely used for somatic disorders due to the side effects of the medication producing more harm than good. When used, they deal with comorbid disorders such as depression or anxiety.

Section 12.5 Review Questions

1. Discuss the difference between multidisciplinary and interdisciplinary approaches to treatment of somatic disorders.
2. What is the biopsychosocial model for treatment of somatic disorders? What are the three main components of this treatment?
3. Are there any treatments that are *not* effective in treating somatic disorders? If so, why?

12.6. PSYCHOLOGICAL FACTORS AFFECTING OTHER MEDICAL CONDITIONS

Section Learning Objectives

- Describe how psychological factors affecting other

medical conditions presents.

- List and describe the most common types of psychophysiological disorders.
- Describe treatment options for psychological factors affecting other medical conditions.

Although previously known as psychosomatic disorders, the DSM-5-TR has identified physical illnesses that are caused or exacerbated by biopsychosocial factors as *psychological factors affecting other medical conditions*. This disorder is different than all the previously mentioned somatic related disorders as the primary focus of the disorder is not the mental disorder, but rather the physical disorder. Psychological or behavioral factors adversely affect the medical condition by, "...influencing its course or treatment, by constituting an additional well-established health risk factor, or by influencing the underlying pathophysiology to precipitate or exacerbate symptoms or to necessitate medical attention" (APA, 2022, pg. 365). It is believed that a lack of positive coping strategies, psychological distress, or maladaptive health behaviors exacerbate these physical symptoms (McGeary, Harzell, McGeary, & Gatchel, 2016).

12.6.1. Psychophysiological Disorders

The most common types of psychophysiological disorders are headaches (migraines and tension), gastrointestinal (ulcer and irritable bowel), insomnia, and cardiovascular-related

disorders (coronary heart disease and hypertension). We will briefly review these disorders and discuss the associated psychological features believed to exacerbate symptoms.

12.6.1.1. Headaches. Among the most common types of headaches are **migraines** and **tension headaches** (Williamson, 1981). Migraine headaches are often more severe and are explained by a throbbing pain localized to one side of the head, frequently accompanied by nausea, vomiting, sensitivity to light, and vertigo. It is believed that migraines are caused by the blood vessels in the brain narrowing, thus reducing the blood flow to various parts of the brain, followed by the same vessels later expanding, thus rapidly changing the blood flow. It is estimated that 23 million people in the U.S. alone suffer from migraines (Williamson, Barker, Veron-Guidry, 1994).

Tension headaches are often described as a dull, constant ache localized to one part of the head or neck; however, it can co-occur in multiple places at one time. Unlike migraines, nausea, vomiting, and sensitivity to light do not often occur with tension headaches. Tension headaches, as well as migraines, are believed to be primarily caused by stress as they are in response to sustained muscle contraction that is often exhibited by those under extreme stress or emotion (Williamson, Barker, Veron-Guidry, 1994). In efforts to reduce the frequency and intensity of both migraines and tension headaches, individuals have found relief in relaxation techniques, as well as the use of biofeedback training to help encourage the relaxation of muscles.

12.6.1.2. Gastrointestinal. Among the two most common types of gastrointestinal psychophysiological disorders are **ulcers** and **irritable bowel syndrome (IBS)**. Ulcers, or painful sores in the stomach lining, occur when mucus from digestive juices are reduced, allowing digestive acids to burn a hole into the stomach lining. Among the most common type of ulcers are peptic ulcers, which are caused by the bacteria *H. pylori* (Sung, Kuipers, El-Serag, 2009). While there is evidence to support the involvement of stress in the development of dyspeptic symptoms, the evidence linking stress and peptic ulcers is slowly growing. (Purdy, 2013). Researchers believe that while *H. pylori* must be present for a peptic ulcer to develop, increased stress levels may impact the amount of digestive acid present in the stomach lining, thus increasing the frequency and intensity of symptoms (Sung, Kuipers, El-Serag, 2009).

IBS is a chronic, functional disorder of the gastrointestinal tract. Common symptoms of IBS include abdominal pain and extreme bowel habits (diarrhea or constipation). It affects up to a quarter of the population and is responsible for nearly half of all referrals to gastroenterologists (Sandler, 1990).

Because IBS is a functional disorder, there are no known structural, chemical, or physiological abnormalities responsible for the symptoms. However, there is conclusive evidence that IBS symptoms are related to psychological distress, particularly in those with anxiety or depression. Although more research is needed to pinpoint the timing between the onset of IBS and psychological disorders,

preliminary evidence suggests that psychological distress is present before IBS symptoms. Therefore, IBS may be best explained as a somatic expression of associated psychological problems (Sykes, Blanchard, Lackner, Keefer, & Krasner, 2003).

12.6.1.3. Insomnia. Insomnia, the difficulty falling or staying asleep, occurs in more than one-third of the U.S. population, with approximately 10% of patients reporting chronic insomnia (Perlis & Gehrman, 2013). While exact pathways of chronic psychophysiological insomnia are unclear, there is evidence of some biopsychosocial factors that may predispose an individual to develop insomnia such as anxiety, depression, and overactive arousal systems (Trauer et al., 2015). Part of the difficulty with insomnia is the fact that these psychological symptoms can impact one's ability to fall asleep; however, we also know that lack of adequate sleep also predisposes individuals to increased psychological distress. Due to this cyclic nature of psychological distress and insomnia, intervention for both sleep issues as well as psychological issues is vital to managing symptoms.

12.6.1.4. Cardiovascular. Heart disease has been the leading cause of death in the United States for the past several decades. Costs related to disability, medical procedures, and societal burdens are estimated to be \$444 billion a year (Purdy, 2013). With this large financial burden, there have been considerable efforts to identify risk and protective factors in predicting cardiovascular mortality.

Researchers have identified that depression is a predictor

of early-onset **coronary heart disease** (Ketterer, Knysk, Khanal, & Hudson, 2006). More specifically, there is a five-fold increase of depression in those with coronary heart disease than the general population (Ketterer, Knysk, Khanal, & Hudson, 2006). Additionally, anxiety and anger have also been identified as an early predictor of cardiac events, suggesting psychological interventions aimed at reducing anxiety and establishing positive coping strategies for anger management may be effective in reducing future cardiac events (Ketterer, Knysk, Khanal, & Hudson, 2006).

12.6.1.5. Hypertension. Also called or chronically elevated blood pressure, is also found to be affected by psychological factors. More specifically, constant stress, anxiety, and depression have all been found to impact the likelihood of a cardiac event due to their impact on vasoconstriction (Purdy, 2013). Elevated inflammatory markers such as C-reactive protein, which is indicative of plaque instability, has been found in chronically depressed individuals, thus predisposing them to potential heart attacks (Ketterer, Knysk, Khanal, & Hudson, 2006).

12.6.2. Treatments for Psychological Factors Affecting Other Medical Conditions

As more information regarding contributing factors to psychophysiological disorders is discovered, more psychological treatment approaches have been developed and applied to these medical problems. The most common types of treatments include relaxation training, biofeedback,

hypnosis, traditional CBT treatments, group therapy, as well as a combination of the previous treatments.

12.6.2.1. Relaxation training. Relaxation training essentially teaches individuals how to relax their muscles on command. While relaxation is used in combination with other psychological interventions to reduce anxiety (as seen in PTSD and various anxiety disorders), it has also been shown to be effective in treating physical symptoms such as headaches, chronic pain, as well as pain related to specific causes (e.g., injection sites, side effects of medications; McKenna et al., 2015).

12.6.2.2. Biofeedback. Biofeedback is a unique psychological treatment in which an individual is connected to a machine (usually a computer) that allows for continuous monitoring of involuntary physiological reactions. Measurements that can be obtained are heart rate, galvanic skin response, respiration, muscle tension, and body temperature, to name a few.

There are a few different ways in which biofeedback can be administered. The first is clinician-led. The clinician will actively guide the patient through a relaxation monologue, encouraging the patient to relax muscles associated near the pain region (or within the entire body). While going through the monologue, the clinician is provided with real-time feedback about the patient's physiological response. Research studies have routinely supported the use of biofeedback, particularly for those with pain and headaches that have not

been responsive to pharmacological interventions (McKenna et al., 2015).

Another option of biofeedback is through computer programs developed by psychologists. The most common, a program called Wild Devine (now Unyte) is an integrative relaxation program that encourages the use of breathing techniques while simultaneously measuring the patient's physiological responses. This type of programming is especially helpful for younger patients as there are various “games” the child can play that requires the awareness and control of their thoughts, feelings, and emotions.

12.6.2.4. Group Therapy. Group therapy is another effective treatment option for individuals with psychological distress related to physical disorders. These groups not only aim to reduce the negative emotions associated with chronic illnesses, but they also provide support from other group members that are experiencing the same physical and psychological symptoms. These groups are typically CBT based and utilize cognitive and behavioral strategies in a group setting to encourage acceptance of disease while also addressing maladaptive coping strategies.

Key Takeaways

You should have learned the following in this section:

- Psychological factors affecting other medical

conditions has as its primary focus the physical disorder, and not the mental disorder.

- The most common types of psychophysiological disorders include headaches to include migraines and tension, gastrointestinal to include ulcers and IBS, insomnia, coronary heart disease, and hypertension.
- Common treatments for these other medical conditions include relaxation training, biofeedback, hypnosis, traditional CBT treatments, and group therapy.

Section 12.6 Review Questions

1. What are the most common types of psychophysiological disorders?
2. Discuss the differences between the different types of headaches.
3. What is the difference between ulcers and irritable bowel syndrome?
4. What are the identified predictors to coronary heart disease and other cardiac events?
5. What are the most effective treatment options for psychophysiological disorders?

Module Recap

In this module, we discussed somatic disorders in terms of their clinical presentation, epidemiology, comorbidity, etiology, and treatment options. Somatic disorders included somatic symptom disorder, illness anxiety disorder, functional neurological symptom (conversion) disorder, and factitious disorder. We also discussed psychological factors affecting other medication conditions in relation to their clinical presentation, common types of psychophysiological disorders, and treatment.

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PART XII

Chapter 11:
Substance Related
& Addictive
Disorders

STEPHANIE WEIGEL

Chapter 11: Substance Related &
Addictive Disorders

WASHINGTON STATE UNIVERSITY AND
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**Chapter 11: SUBSTANCE-
RELATED AND ADDICTIVE
DISORDERS**

STEPHANIE WEIGEL

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Module Overview

Module 11 will cover matters related to substance-related and addictive disorders to include their clinical presentation, epidemiology, comorbidity, etiology, and treatment options. Our discussion will include substance intoxication, substance use disorder, and substance withdrawal. We also list substances people can become addicted to. Be sure you refer to Modules 1–3 for explanations of key terms (Module 1), an overview of the various models to explain psychopathology (Module 2), and descriptions of the therapies (Module 3).

Module Outline

- [11.1. Clinical Presentation](#)
- [11.2. Epidemiology](#)
- [11.3. Comorbidity](#)
- [11.4. Etiology](#)
- [11.5. Treatment](#)

Module Learning Outcomes

- Describe how substance-related and addictive disorders present.
- Describe the epidemiology of substance-related

and addictive disorders.

- Describe comorbidity in relation to substance-related and addictive disorders.
- Describe the etiology of substance-related and addictive disorders.
- Describe treatment options for substance-related and addictive disorders.

11.1. CLINICAL PRESENTATION

Section Learning Objectives

- Define substances and substance abuse.
- Describe properties of substance abuse.
- Describe how substance use disorder presents.
- Describe how substance intoxication presents.
- Describe how substance withdrawal presents.
- Define depressants and describe types.
- Define stimulants and describe types.
- Define hallucinogens/cannabis/combinations and describe types.
- Describe the effects of using drugs in combination.

11.1.1. Defining Terms and Adding Context

Substance-related and addictive disorders are among the most prevalent psychological disorders, with roughly 100 million people in the United States reporting the use of an illegal substance sometime throughout their life (SAMHSA, 2014). It is worth noting that the DSM-5 shifted terminology from *drug addiction* to *substance use disorder*, "...to describe the wide range of the disorder, from a mild form to a severe state of chronically relapsing, compulsive pattern of drug taking." The DSM-5 acknowledges that many clinicians will use the term *drug addiction* to describe more severe presentations, but it is omitted from the DSM-5 due to "...its uncertain definition and its potentially negative connotation" (APA, 2022, pg. 543).

What are substances? **Substances** are any ingested materials that cause temporary cognitive, behavioral, or physiological symptoms within the individual. The DSM uses 10 classes of substances: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, stimulants, tobacco, and other (or unknown).

Repeated use of these substances or frequent substance intoxication can develop into a long-term problem known as **substance abuse**. Abuse occurs when an individual consumes the substance for an extended period or must ingest large amounts of the substance to get the same effect a substance provided previously. The need to continually increase the amount of ingested substance is known

as **tolerance**. As tolerance builds, additional physical and psychological symptoms present, often causing significant disturbances in an individual's personal and professional life. Individuals with substance abuse often spend a significant amount of time engaging in activities that revolve around their substance use, thus spending less time in recreational activities that once consumed their time.

Sometimes, there is a desire to reduce or abstain from substance use; however, cravings and **withdrawal** symptoms often prohibit this from occurring. Common withdrawal symptoms include, but are not limited to, cramps, anxiety attacks, sweating, nausea, tremors, and hallucinations. Depending on the substance and the tolerance level, most withdrawal symptoms last anywhere from a few days to a week. For those with extensive substance abuse or abuse of multiple substances, withdrawal should be closely monitored in a hospital setting to avoid severe consequences such as seizures, stroke, or even death.

According to the DSM-5-TR (APA, 2022), the substance-related disorders are divided into two groups: substance use disorders and substance-induced disorders which include substance intoxication and substance withdrawal. While there are some subtle differences in symptoms, particularly psychological, physical, and behavioral symptoms, the general diagnostic criteria for substance use disorder, substance intoxication, and substance withdrawal remains the same across substances. These criteria are reviewed below, with more specific details of psychological, physical, and

behavioral symptoms in the Section 11.1.5.: Types of Substances Abused.

11.1.2. Substance Use Disorder

The essential feature of **substance use disorder**, is a “...cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems” (APA, 2022, pg. 544) and can be diagnosed for all ten substance classes except for caffeine. Distress or impairment can be described as any of the following: inability to complete or lack of participation in work, school or home activities; increased time spent on activities obtaining, using, or recovering from substance use; impairment in social or interpersonal relationships; use of a substance in a potentially hazardous situation; psychological problems due to recurrent substance abuse; craving the substance; an increase in the amount of substance used over time (i.e., tolerance); difficulty reducing the amount of substance used despite a desire to reduce/stop using; and/or withdrawal symptoms (APA, 2022). While the number of these symptoms may vary among individuals, only two symptoms are required for a diagnosis of substance use disorder.

11.1.3. Substance Intoxication

For a diagnosis of **substance intoxication**, the individual must have recently ingested a substance. Immediately following the ingestion of this substance, significant

behavioral and/or psychological change is observed. In addition, physical and physiological symptoms present as a direct result of the substance ingested. As stated above, these behavioral, physical, and physiological symptoms are dependent on the type of substance that is ingested and, therefore, discussed in more detail within each substance category (i.e., depressants, stimulants, hallucinogens/cannabis/combination). This said, the most common changes involve disturbances of perception, wakefulness, attention, thinking, psychomotor behavior, interpersonal behavior, and judgment (APA, 2022).

11.1.4. Substance Withdrawal

Finally, **substance withdrawal** is diagnosed when there is cessation or reduction of a substance that has been used for a long period of time. Individuals undergoing substance withdrawal will experience physiological and psychological symptoms within a few hours after cessation/reduction. These symptoms cause significant distress or impairment in daily functioning (APA, 2022). As with substance intoxication, physiological and psychological symptoms during substance withdrawal are often specific to the substance abused and are discussed in more detail within each substance category later in the module.

11.1.5. Types of Substances Abused

For our purposes, the most abused substances will be divided into three categories based on how they impact one's

physiological state: depressants, stimulants, and hallucinogens/cannabis/combination.

11.1.5.1. Depressants. Depressants include alcohol, sedative-hypnotic drugs, and opioids are known to have an inhibiting effect on one's central nervous system; therefore, they are often used to alleviate tension and stress. Unfortunately, when used in large amounts, they can also impair an individual's judgment and motor activity.

While **alcohol** is one of the only legal (over-the-counter) substances we will discuss, it is also the most commonly consumed substance. According to the 2015 National Survey on Drug Use and Health, approximately 70% of individuals drank an alcoholic beverage in the last year, and nearly 56% of individuals drank an alcoholic beverage in the past month (SAMHSA, 2015). While the legal age of consumption in the United States is 21, approximately 78% of teens report that they drank alcohol at some point in their life (SAMHSA, 2013).

Despite the legal age of consumption, many college-aged students engage in binge or heavy drinking. In fact, 45% of college-aged students report engaging in binge drinking, with 14% binge drinking at least 5 days per month (SAMHSA, 2013). In addition to these high levels of alcohol consumption, students also engage in other behaviors such as skipping meals, which can impact the rate of alcohol intoxication and place them at risk for dehydration, blacking out, and developing alcohol-induced seizures (Piazza-Gardner & Barry, 2013).

The “active” substance of alcohol, *ethyl alcohol*, is a chemical that is absorbed quickly into the blood via the lining of the stomach and intestine. Once in the bloodstream, ethyl alcohol travels to the central nervous system (i.e., brain and spinal cord) and produces *depressive* symptoms such as impaired reaction time, disorientation, and slurred speech. These symptoms are produced due to the ethyl alcohol binding to GABA receptors, thus preventing GABA from providing inhibitory messages and allowing the individual to relax (Filip et al., 2015).

The effect of ethyl alcohol in moderation allows for an individual to relax, engage more readily in conversation, and in general, produce a confident and happy personality. However, when consumption is increased or excessive, the central nervous system is unable to metabolize the ethyl alcohol adequately, and adverse effects begin to present. Symptoms such as blurred vision, difficulty walking, slurred speech, slowed reaction time, and sometimes, aggressive behaviors are observed.

The extent to which these symptoms present are directly related to the concentration of ethyl alcohol within the body, as well as the individual’s ability to metabolize the ethyl alcohol. There are a lot of factors that contribute to how quickly one’s body can metabolize ethyl alcohol. Food, gender, body weight, and medications are among the most common factors that affect alcohol absorption (NIAAA,1997). More specifically, recent consumption of food, particularly those high in fat and carbohydrates, slow

the absorption rate of ethyl alcohol, thus reducing its effects. Regarding gender, women absorb and metabolize alcohol differently than men, likely due to the smaller amount of body water and the lower activity of an alcohol metabolizing enzyme in the stomach. Another factor related to gender is weight—with individuals with more body mass metabolizing the alcohol at a slower rate than those who weigh less. Finally, various medications, both over the counter and prescription, can impact the liver's ability to metabolize alcohol, thus affecting the severity of symptoms that present (NIAAA, 1997).

Sedative-Hypnotic drugs, more commonly known as **anxiolytic drugs**, have a calming and relaxing effect on individuals. When used at a clinically appropriate dosage, they can have a sedative effect, thus making them a suitable drug for treating anxiety-related disorders. In the early 1900s, **barbiturates** were introduced as the main sedative and hypnotic drug; however, due to their addictive nature, as well as respiratory distress when consumed in large amounts, they have been largely replaced by **benzodiazepines** which are considered a safer alternative as they have less addictive qualities (Filip et al., 2014).

Commonly prescribed benzodiazepines— Xanax, Ativan, and Valium—have a similar effect to alcohol as they too bind to the GABA receptors and increase GABA activity (Filip et al., 2014). This increase in GABA produces a sedative and calming effect. Benzodiazepines can be prescribed for both temporary relief (pre-flight or before surgery) or long-

term use (generalized anxiety disorder). While they do not produce respiratory distress in large dosages like barbiturates, they can cause intoxication and addictive behaviors due to their effects on tolerance.

Opioids are naturally occurring, derived from the sap of the opium poppy. In the early 1800s, **morphine** was isolated from opium by German chemist Friedrich Wilhelm Adam Serturmer. Due to its analgesic effect, it was named after the Greek god of dreams, Morpheus (Brownstein, 1993). Its popularity grew during the American Civil War as it was the primary medication given to soldiers with battle injuries. Unfortunately, this is also when the addictive nature of the medication was discovered, as many soldiers developed “Soldier’s Disease” as a response to tolerance of the drug (Casey, 1978).

In an effort to alleviate the addictive nature of morphine, **heroin** was synthesized by the German chemical company Bayer in 1898 and was offered in a cough suppressant (Yes, Bayer promoted heroin). For years, heroin remained in cough suppressants as well as other pain reducers until it was discovered that heroin was more addictive than morphine. In 1917, Congress stated that *all* drugs derived from opium were addictive, thus banning the use of opioids in over-the-counter medications.

Opioids are unique in that they provide both euphoria and drowsiness. Tolerance to these drugs builds quickly, thus resulting in an increased need of the medication to produce desired effects. This rapid tolerance is also likely responsible

for opioids' highly addictive nature. Opioid withdrawal symptoms can range from restlessness, muscle pain, fatigue, anxiety, and insomnia. Unfortunately, these withdrawal symptoms, as well as intense cravings for the drug, can persist for several months, with some reports up to years. Because of the intensity and longevity of these withdrawal symptoms, many individuals struggle to remain abstinent, and accidental overdoses are common (CDC, 2013).

The rise of abuse and misuse of opioid products in the early-to-mid 2000s is a direct result of the increased number of opioid prescription medications containing *oxycodone* and *hydrocodone* (Jayawant & Balkrishnana, 2005). The 2015 report estimated 12.5 million Americans had abused prescription narcotic pain relievers in the past year (SAMHSA, 2016). In an effort to reduce such abuse, the FDA developed programs to educate prescribers about the risks of misuse and abuse of opioid medications.

11.1.5.2. Stimulants. The two most common types of stimulants abused are cocaine and amphetamines. Unlike depressants that reduce the activity of the central nervous system, stimulants have the opposite effect, increasing the activity in the central nervous system. Physiological changes that occur with stimulants are increased blood pressure, heart rate, pressured thinking/speaking, and rapid, often jerky behaviors. Because of these symptoms, stimulants are commonly used for their feelings of euphoria, to reduce appetite, and prevent sleep.

Similar to opioids, **cocaine** is extracted from a South

American plant—the coca plant—and produces feelings of energy and euphoria. It is the most potent natural stimulant known to date (Acosta et al., 2011). Low doses can produce feelings of excitement, talkativeness, and euphoria; however, as the amount of ingested cocaine increases, physiological changes such as rapid breathing, increased blood pressure, and excessive arousal can be observed. The psychological and physiological effects of cocaine are due to an increase of *dopamine*, *norepinephrine*, and *serotonin* in various brain structures (Hart & Ksir, 2014; Haile, 2012).

One key feature of cocaine use is the rapid high of *cocaine intoxication*, followed by the quick depletion, or *crashing*, as the drug diminishes within the body. During the euphoric intoxication, individuals will experience poor muscle coordination, grandiosity, compulsive behavior, aggression, and possible hallucinations and delusions (Haile, 2012). Conversely, as the drug leaves the system, the individual will experience adverse effects such as headaches, dizziness, and fainting (Acosta et al., 2011). These negative feelings often produce a negative feedback loop, encouraging individuals to ingest more cocaine to alleviate the negative symptoms. This also increases the chance of accidental overdose.

Cocaine is unique in that it can be ingested in various ways. While cocaine was initially snorted via the nasal cavity, individuals found that if the drug was smoked or injected, its effects were more potent and longer-lasting (Haile, 2012). The most common way cocaine is currently ingested is via **freebasing**, which involves heating cocaine with

ammonia to extract the cocaine base. This method produces a form of cocaine that is almost 100% pure. Due to its low melting point, freebased cocaine is easy to smoke via a glass pipe. Inhaled cocaine is absorbed into the bloodstream and brain within 10-15 seconds suggesting its effects are felt almost immediately (Addiction Centers of America).

Crack is a derivative of cocaine that is formed by combining cocaine with water and another substance (commonly baking soda) to create a solid structure that is then broken into smaller pieces. Because of this process, it requires very little cocaine to make crack, thus making it a more affordable drug. Coined for the crackling sound that is produced when it is smoked, it is also highly addictive, likely due to the fast-acting nature of the drug. While the effects of cocaine peak in 20-30 minutes and last for about 1-2 hours, the effects of crack peak in 3-5 minutes and last only for up to 60 minutes (Addiction Centers of America).

Amphetamines are manufactured in a laboratory setting. Currently, the most common amphetamines are prescription medications such as Ritalin, Adderall, and Dexedrine (prescribed for sleep disorders). These medications produce an increase in energy and alertness and reduce appetite when taken at clinical levels. However, when consumed at larger dosages, they can produce intoxication similar to psychosis, including violent behaviors. Due to the increased energy levels and appetite suppressant qualities, these medications are often abused by students studying for exams, athletes needing extra energy, and individuals seeking weight loss

(Haile, 2012). Biologically, similar to cocaine, amphetamines affect the central nervous system by increasing the amount of dopamine, norepinephrine, and serotonin in the brain (Haile, 2012).

Methamphetamine, a derivative of amphetamine, is often abused due to its low cost and feelings of euphoria and confidence; however, it can have serious health consequences such as heart and lung damage (Hauer, 2010). Most commonly used intravenously or nasally, methamphetamine can also be eaten or heated to a temperature in which it can be smoked. The most notable effects of methamphetamine use are the drastic physical changes to one's appearance, including significant teeth damage and facial lesions (Rusyniak, 2011).

While we are sure you are well aware of how **caffeine** is consumed, you may be surprised to learn that in addition to coffee, energy drinks, and soft drinks, caffeine can also be found in chocolate and tea. Because of the vast use of caffeine, it is the most widely consumed substance in the world, with approximately 90% of Americans consuming some form of caffeine each day (Fulgoni, Keast, & Lieberman, 2015). While caffeine is often consumed in moderate dosages, caffeine intoxication and withdrawal can occur. In fact, an increase in caffeine intoxication and withdrawal have been observed with the simultaneous popularity of energy drinks. Common energy drinks such as Monster and RedBull have nearly double the amount of caffeine of tea and coke (Bigard, 2010). While adults commonly consume these drinks, a

startling 30% of middle and high schoolers also report regular consumption of energy drinks to assist with academic and athletic responsibilities (Terry-McElrath, O'Malley, & Johnston, 2014). The rapid increase in caffeinated beverages has led to a rise in ER visits due to the intoxication effects (SAMHSA, 2013).

11.1.5.3. Hallucinogens/Cannabis/Combination. The final category includes both hallucinogens and cannabis—both of which produce sensory changes after ingestion. While hallucinogens are known for their ability to produce more severe delusions and hallucinations, cannabis also has the capability of producing delusions or hallucinations; however, this typically occurs only when large amounts of cannabis are ingested. More commonly, cannabis has been known to have stimulant and depressive effects, thus classifying itself in a group of its own due to the many different effects of the substance.

Hallucinogens come from natural sources and have been involved in cultural and religious ceremonies for thousands of years. Synthetic forms of hallucinogens have also been created—most common of which are *PCP*, *Ketamine*, *LSD*, and *Ecstasy*. In general, hallucinogens produce powerful changes in sensory perception. Depending on the type of drug ingested, effects can range from hallucinations, changes in color perception, or distortion of objects. Additionally, some individuals report enhanced auditory, as well as changes in physical perception such as tingling or numbness of limbs and interchanging hot and cold sensations (Weaver &

Schnoll, 2008). Interestingly, the effect of hallucinogens can vary both between individuals, as well as *within* the same individual. This means that the same amount of the same drug may produce a positive experience one time, but a negative experience the next time.

Overall, hallucinogens do not have addictive qualities; however, individuals can build a tolerance, thus needing larger quantities to produce similar effects (Wu, Ringwalt, Weiss, & Blazer, 2009). Furthermore, there is some evidence that long-term use of these drugs results in psychosis, mood, or anxiety disorders due to the neurobiological changes after using hallucinogens (Weaver & Schnoll, 2008).

Similar to hallucinogens and a few other substances, **cannabis** is also derived from a natural plant—the hemp plant. While the most powerful of hemp plants is *hashish*, the most commonly known type of cannabis, marijuana, is a mixture of hemp leaves, buds, and the tops of plants (SAMHSA, 2014). Many external factors impact the potency of cannabis, such as the climate it was grown in, the method of preparation, and the duration of storage. Of the active chemicals within cannabis, **tetrahydrocannabinol (THC)** appears to be the single component that determines the potent nature of the drug. Various strains of marijuana have varying amounts of THC; hashish contains a high concentration of THC, while marijuana has a small concentration.

THC binds to cannabinoid receptors in the brain, which produces psychoactive effects. These effects vary depending

on both an individual's body chemistry, as well as various strains and concentrations of THC. Most commonly, people report feelings of calm and peace, relaxation, increased hunger, and pain relief. Occasionally, negative symptoms such as increased anxiety or paranoia, dizziness, and increased heart rate also occur. In rare cases, individuals develop psychotic symptoms or schizophrenia following cannabis use (Donoghue et al., 2014).

While nearly 20 million Americans report regular use of marijuana, only 10% of these individuals will develop a dependence on the drug (SAMHSA, 2013). Of particular concern is the number of adolescents engaging in cannabis use. One in eight 8th graders, one in four 10th graders, and one in three 12th graders reported use of marijuana in the past year (American Academy of Child and Adolescent Psychiatry, 2013). Individuals who begin cannabis abuse during adolescence are at an increased risk of developing cognitive effects from the drug due to the critical period of brain development during adolescence (Gruber, Sagar, Dahlgren, Racine, & Lukas, 2012). Increased discussion about the effects of marijuana use, as well as psychoeducation about substance abuse in general, is important in preventing marijuana use during adolescence.

11.1.5.4. Using drugs in combination. It is not uncommon for substance abusers to consume more than one type of substance at a time. This **combination** of substance use can have dangerous results depending on the interactions between substances. For example, if multiple depressant drugs

(i.e., alcohol, benzodiazepines, and/or opiates) are consumed at one time, an individual is at risk for severe respiratory distress or even death due to the compounding depressive effects on the central nervous system. Additionally, when an individual is under the influence of one substance, judgment may be impaired, and ingestion of a larger amount of another drug may lead to an accidental overdose. Finally, the use of one drug to counteract the effects of another drug—taking a depressant to combat the effects of a stimulant—is equally as dangerous as the body is unable to regulate homeostasis.

Key Takeaways

You should have learned the following in this section:

- An individual is diagnosed with substance use disorder, substance intoxication, or substance withdrawal specific to the substance or substances being ingested though the symptoms remain generally the same across substances.
- Substance use disorder occurs when a person experiences significant impairment or distress for 12 months due to the use of a substance.
- Substance intoxication occurs when a person has recently ingested a substance leading to significant behavioral and/or psychological changes.
- Substance withdrawal occurs when there is a

cessation or reduction of a substance that has been used for a long period of time.

- Depressants include alcohol, sedative-hypnotic drugs, and opioids.
- Stimulants include cocaine and amphetamines, but caffeine as well.
- Hallucinogens come from natural sources and produce powerful changes in sensory perception.
- Cannabis is also derived from a natural plant and produces psychoactive effects.
- Many drugs are taken by users in combination which can have dangerous results depending on the interactions between the substances.

Section 11.1 Review Questions

1. What is a substance?
2. What is the difference between substance intoxication and substance abuse?
3. What is the difference between tolerance and withdrawal?
4. Create a table listing the three types of substances abused, as well as the specific substances within each category.
5. What are the common factors that affect alcohol absorption?

6. What are the effects of sedative-hypnotic drugs?
7. What receptors are responsible for increasing activity in alcohol and benzodiazepines?
8. What is responsible for the addictive nature of opioids?
9. Which neurotransmitters are implicated in cocaine use?
10. What are the different ways cocaine can be ingested?
11. List the common types of amphetamines.

11.2. EPIDEMIOLOGY

Section Learning Objectives

- Describe the epidemiology of depressants.
- Describe the epidemiology of stimulants.
- Describe the epidemiology of hallucinogens.

It has been estimated that nearly 9% of teens and adults in the United States have a substance abuse disorder (SAMHSA,

2014). Asian/Pacific Islanders, Hispanics, and African Americans are less likely to develop a lifetime substance abuse disorder compared to non-Hispanic white individuals (Grant et al., 2016). Native Americans have the highest rate of substance abuse at nearly 22 percent (NSDUH, 2013). Additional demographic variables also suggest that overall substance abuse is greater in men than women, younger versus older individuals, unmarried/divorced individuals than married, and in those with an education level of a high school degree or lower (Grant et al., 2016). With regards to specific types of substances, the highest prevalence rates of substances abused are cannabis, opioids, and cocaine, respectively (Grant et al., 2016).

11.2.1. Depressants

Concerning depressant substances, men outnumber women in alcohol abuse 2 to 1 (Johnston et al., 2014). Ethnically, Native Americans have highest rate of alcoholism, followed by White, Hispanic, African, and Asian Americans. With regards to opioid use, roughly 1% of the population has this disorder, with 80% of those being addicted to pain-reliever opioids such as oxycodone or morphine; the remaining 20% are heroin (SAMHSA, 2014).

11.2.2. Stimulants

Nearly 1.1% of all high school seniors have used cocaine within the past month (Johnston et al., 2014). Due to the high cost of cocaine, it is more commonly found in suburban

neighborhoods where consumers have the financial means to purchase the drugs. Methamphetamine is used by men and women equally. It is popular among biker gangs, rural America, and urban gay communities, as well as in clubs and all-night dance parties (aka raves; Hopfer, 2011).

A growing concern is the abuse of stimulant medication among college students as 17% of college students reported abusing stimulant medications. Greek organization membership, academic performance, and other substance use were the most highly correlated variables related to stimulant medication abuse.

11.2.3. Hallucinogens

Up to 14% of the general population have used LSD or another hallucinogen. Nearly 20 million adults and adolescents report current use of marijuana. Men report more than women. Sixty-five percent of individuals report their first drug of use was marijuana—labeling it as a gateway drug to other illicit substances (APA, 2022). Due to the increased research and positive effects of medicinal marijuana, the movement to legalize *recreational* marijuana has gained momentum, particularly in the Pacific Northwest of the United States.

Key Takeaways

You should have learned the following in this section:

- More men and Native Americans are addicted to depressants.
- Cocaine is more prevalent in suburban neighborhoods due to its cost and methamphetamine is used equally by men and women.
- Hallucinogens are used by up to 14% of the general population.

Section 11.2 Review Questions

1. Identify the gender and ethnicity differences of substance abuse across the three substance categories.
2. Are these substances abused by other unique groups of people?

11.3. COMORBIDITY

Section Learning Objectives

- Describe the comorbidity of substance-related and

addictive disorders.

Substance abuse, in general, has a high comorbidity within itself (meaning abuse of multiple different substances), as well as with other mental health disorders. Researchers believe that substance abuse disorders are often secondary to another mental health disorder, as the substance abuse develops as a means to “self-medicate” the underlying psychological disorder. In fact, several large surveys identified alcohol and drug dependence to be twice as more likely in individuals with anxiety, affective, and psychotic disorders than the general public (Hartz et al., 2014). While it is difficult to identify exact estimates of the relationship between substance abuse and serious mental health disorders, the consensus among researchers is that there is a strong relationship between substance abuse and mood, anxiety, PTSD, and personality disorders (Grant et al., 2016).

Key Takeaways

You should have learned the following in this section:

- Substance abuse has a high comorbidity within itself and with mental health disorders such as mood, anxiety, PTSD, and personality disorders.

Section 11.3 Review Questions

- With what other conditions are substance-related and addictive disorders highly comorbid?

11.4. ETIOLOGY

Section Learning Objectives

- Describe the biological causes of substance-related and addictive disorders.
- Describe the cognitive causes of substance-related and addictive disorders.
- Describe the behavioral causes of substance-related and addictive disorders.
- Describe the sociocultural causes of substance-related and addictive disorders.

11.4.1. Biological

11.4.1.1. Genetics. Similar to other mental health disorders, substance abuse is genetically influenced. With that said, it is different than other mental health disorders in that if the individual is *not* exposed to the substance, they will not develop substance abuse.

Heritability of alcohol abuse is among the most well studied substances, likely because it is the only legal substance (except cannabis in some states). Twin studies have indicated a range of 50-60% heritability risk for alcohol disorder (Kendler et al., 1997). Studies exploring the heritability of other substance abuse, particularly drug use, suggests there may be a stronger heritability link than previously thought (Jang, Livesley, & Vernon, 1995). Twin studies indicate that the genetic component of drug abuse is stronger than drug use in general, meaning that genetic factors are more significant for abuse of a substance over nonproblematic use (Tsuang et al., 1996). Merikangas and colleagues (1998) found an 8-fold increased risk for developing a substance abuse disorder across a wide range of substances.

Unique to substance abuse is the fact that both genetic and familial influence are both at play. What does this mean? Well, biologically, the individual may be genetically predisposed to substance abuse; additionally, the individual may also be at risk due to their familial environment where their parents or siblings are also engaging in substance abuse. Individuals whose parents abuse substances may have a greater opportunity to ingest substances, thus promoting drug-seeking behaviors. Furthermore, families with a history of substance abuse may have a more accepting attitude of drug use than families with no history of substance abuse (Leventhal & Schmitz, 2006).

11.4.1.2. Neurobiological. A longstanding belief about how drug abuse begins and is maintained is the *brain*

reward system. A *reward* can be defined as any event that increases the likelihood of a response and has a pleasurable effect. Most of the research on the brain reward system has focused on the mesocorticolimbic dopamine system, as it appears this area is the primary reward system of most substances that are abused. As research has evolved in the field of substance abuse, five additional neurotransmitters have also been implicated in the reinforcing effect of addiction: dopamine, opioid peptides, GABA, serotonin, and endocannabinoids. More specifically, dopamine is less involved in opioid, alcohol, and cannabis. Alcohol and benzodiazepines lower the production of GABA, while cocaine and amphetamines decrease dopamine. Cannabis has been shown to reduce the production of endocannabinoids.

11.4.2. Cognitive

Cognitive theorists have focused on the beliefs regarding the anticipated effects of substance use. Defined as the *expectancy effect*, drug-seeking behavior is presumably motivated by the desire to attain a particular outcome by ingesting a substance. The expectancy effect can be defined in both positive and negative forms. Positive expectations are thought to increase drug-seeking behavior, while negative experiences would decrease substance use (Oei & Morawska, 2004). Several studies have examined the expectancy effect on the use of alcohol. Those with alcohol abuse reported expectations of tension reduction, enhanced sexual experiences, and improved social pleasure (Brown, 1985).

Additionally, observing positive experiences, both in person and through television or social media, also shapes our drug use expectancies.

While some studies have explored the impact of negative expectancy to eliminate substance abuse, research has failed to continually support this theory, suggesting that positive experiences and expectations are a more powerful motivator of substance abuse than the negative experiences (Jones, Corbin, Fromme, 2001).

11.4.3. Behavioral

Operant conditioning has been implicated in the role of developing substance use disorders. As you may remember, operant conditioning refers to the increase or decrease of a behavior, due to reinforcement or punishment. Since we are talking about increasing substance use, behavioral theorists suggest that substance abuse is *positively and negatively reinforced* due to the effects of a substance.

Positive reinforcement occurs when substance use is increased due to the positive or pleasurable experiences of the substance. More specifically, the rewarding effect or pleasurable experiences while under the influence of various substances directly impacts the likelihood that the individual will use the substance again. Studies of substance use on animals routinely support this theory as animals will work to receive injections of various drugs (Wise & Koob, 2013).

Negative reinforcement, or the increase of a given behavior due to the removal of a negative effect, also plays a role in

substance abuse in two different ways. First, many people ingest a substance as an escape from their unpleasant life—whether it be physical pain, stress, or anxiety, to name a few. Therefore, the substance temporarily provides relief from a negative environment, thus reinforcing future substance abuse (Wise & Koob, 2013). Secondly, negative reinforcement is involved in symptoms of withdrawal. As previously mentioned, withdrawal from a substance often produces significant negative symptoms such as nausea, vomiting, uncontrollable shaking, etc. To eliminate these symptoms, an individual will consume more of the substance, thus again escaping the negative symptoms and enjoying the “highs” of the substance.

11.4.4. Sociocultural

Arguably, one of the strongest influences of substance abuse is the impact of one’s friends and the immediate environment. Peer attitudes, perception of others’ drug use, pressure from peers to use substances, and beliefs about substance use are among the strongest predictors of drug use patterns (Leventhal & Schmitz, 2006). This is particularly concerning during adolescence when patterns of substance use typically begin.

Additionally, research continually supports a strong relationship between second-generation substance abusers (Wilens et al., 2014). The increased possibility of family members’ substance abuse is likely related to both a genetic predisposition, as well as the accepting attitude of the familial

environment (Chung et al., 2014). Not only does a child have early exposure to these substances if their parent has a substance abuse problem, but they are also less likely to have parental supervision, which may impact their decision related to substance use (Wagner et al., 2010). One potential protective factor against substance use is religiosity. More specifically, families that promote religiosity may reduce substance use by promoting negative experiences (Galen & Rogers, 2004).

Another sociocultural view on substance abuse is stressful life events, particularly those related to financial stability. Prevalence rates of substance abuse are higher among poorer people (SAMHSA, 2014). Furthermore, additional stressors such as childhood abuse and trauma, negative work environments, as well as discrimination are also believed to contribute to the development of a substance use disorder (Hurd, Varner, Caldwell, & Zimmerman, 2014; McCabe, Wilsnack, West, & Boyd, 2010; Unger et al., 2014).

Key Takeaways

You should have learned the following in this section:

- Biological causes of substance-related and addictive disorders include the brain reward system and a genetic predisposition, though if the individual is not exposed to the substance they will

not develop the substance abuse.

- Cognitive causes of substance-related and addictive disorders include the expectancy effect, and research provides stronger support for positive expectancy over negative expectancy.
- Behavioral causes of substance-related and addictive disorders include positive and negative reinforcement.
- Sociocultural causes of substance-related and addictive disorders include friends and the immediate environment.

Section 11.4 Review Questions

1. Discuss the *brain reward system*. What neurobiological regions are implicated within this system?
2. Define the *expectancy effect*. How does this explain the development and maintenance of substance abuse?
3. Discuss operant conditioning in the context of substance abuse. What are the reinforcers?
4. How does the sociocultural model explain substance abuse?

11.5. TREATMENT

Section Learning Objectives

- Describe biological treatment options for substance-related and addictive disorders.
- Describe behavioral treatment options for substance-related and addictive disorders.
- Describe cognitive-behavioral treatment options for substance-related and addictive disorders.
- Describe sociocultural treatment options for substance-related and addictive disorders.

Given the large number of the population affected by substance abuse, it is not surprising that there are many different approaches to treat substance use disorder. Overall, treatments for substance-related disorders are only mildly effective, likely due in large part to the addictive qualities in many of these substances (Belendiuk & Riggs, 2014).

11.5.1. Biological

11.5.1.1. Detoxification. Detoxification refers to the medical supervision of withdrawal from a specified drug. While most detoxification programs are inpatient for increased monitoring, some programs allow for outpatient detoxification, particularly if the addiction is not as severe.

There are two main theories of detoxification—gradually decreasing the amount of the substance until the individual is off the drug completely, or eliminating the substance entirely while providing additional medications to manage withdrawal symptoms (Bisaga et al., 2015). Unfortunately, relapse rates are high for those engaging in detoxification programs, particularly if they lack any follow-up psychological treatment.

11.5.1.2. Agonist drugs. As researchers continue to learn more about both the mechanisms of substances commonly abused, as well as the mechanisms in which the body processes these substances, alternative medications are created to essentially replace the drug in which the individual is dependent on. These **agonist drugs** provide the individual with a “safe” drug that has a similar chemical make-up to the addicted drug. One common example of this is *methadone*, an opiate agonist that is often used in the reduction of heroin use (Schwartz, Brooner, Montoya, Currens, & Hayes, 2010). Unfortunately, because methadone reacts to the same neurotransmitter receptors as heroin, the individual essentially replaces their addiction to heroin with an addiction to methadone. While this is not ideal, methadone treatment is highly regulated under safe medical supervision. Furthermore, it is taken by mouth, thus eliminating the potential adverse effects of unsterilized needles in heroin use. While some argue that methadone maintenance programs are not an effective treatment because it simply replaces one drug for another, others claim that the combination of methadone

with education and psychotherapy can successfully help individuals off both illicit drugs and methadone medications (Jhanjee, 2014).

11.5.1.3. Antagonist drugs. Unlike agonist drugs, **antagonist drugs** block or change the effects of the addictive drug. The most commonly prescribed antagonist drugs are Disulfiram and Naloxone. Disulfiram is often given to individuals trying to abstain from alcohol as it produces significant negative effects (i.e., nausea, vomiting, increased heart rate, and dizziness) when coupled with alcohol consumption. While this can be an effective treatment to eliminate alcohol use, the individual must be motivated to take the medication as prescribed (Diclemente et al., 2008).

Similar to Disulfiram, Naloxone is used for individuals with opioid abuse. Naloxone acts by binding to endorphin receptors, thus preventing the opioids from having the intended euphoric effect. In theory, this treatment appears promising, but it is extremely dangerous as it can send the individual into immediate, severe withdrawal symptoms (Alter, 2014). This type of treatment requires appropriate medical supervision to ensure the safety of the patient.

11.5.2. Behavioral

11.5.2.1. Aversion therapy. Based on respondent conditioning principles, **aversion therapy** is a form of treatment for substance abuse that pairs the stimulus with some type of negative or aversive stimulus. For example, an individual may be given a shock every time they think

about or attempt to drink alcohol. By pairing this aversive stimulus to the abused substance, the individual will begin to independently pair the substance with an aversive thought, thus reducing their craving/desire for the substance. Some view the use of agonist and antagonist drugs as a form of aversion therapy as these medications utilize the same treatment strategy as traditional aversion therapy.

11.5.2.2. Contingency management. Contingency management is a treatment approach that emphasizes *operant conditioning*—increasing sobriety and adherence to treatment programs through rewards. Originally developed to increase adherence to medication and reinforce opiate abstinence in methadone patients, contingency management has been adapted to increase abstinence in many different substance abuse treatment programs. In general, patients are “rewarded” with vouchers or prizes in exchange for abstinence from substance use (Hartzler, Lash, & Roll, 2012). These vouchers allow individuals to gain incentives specific to their interests, thus increasing the chances of abstinence. Common vouchers include movie tickets, sports equipment, or even cash (Mignon, 2014).

Contingency management has been proven to be effective in treating various types of substance abuse, particularly alcohol and cocaine (Lewis & Petry, 2005). Not only has it been effective in reducing substance use in addicts, but it has also been effective in increasing the amount of time patients remain in treatment as well as compliance with the treatment program (Mignon, 2014). Despite its success, dissemination

of this type of treatment has been rare. To rectify this, the federal government has provided financial resources through SAMHSA for the development, implementation, and evaluation of contingency management as a treatment to reduce alcohol and drug use (Mignon, 2014).

11.5.3. Cognitive-Behavioral

11.5.3.1. Relapse prevention training. Relapse prevention training is essentially what it sounds like—identifying potentially high-risk situations for relapse and then learning behavioral skills and cognitive interventions to prevent the occurrence of a relapse. Early in treatment, the clinician guides the patient to identify any interpersonal, intrapersonal, environmental, and physiological risks for relapse. Once these triggers are identified, the clinician works with the patient on cognitive and behavioral strategies such as learning effective coping strategies, enhancing self-efficacy, and encouraging mastery of outcomes. Additionally, psychoeducation about how substance abuse is maintained, as well as identifying maladaptive thoughts and learning cognitive restructuring techniques, helps the patient make informed choices during high-risk situations. Finally, role-playing these high-risk situations in session allows patients to become comfortable engaging in these effective coping strategies that enhance their self-efficacy and ultimately reducing the chances of a relapse. Research for relapse prevention training appears to

be somewhat effective for individuals with substance-related disorders (Marlatt & Donovan, 2005).

11.5.4. Sociocultural

11.5.4.1. Self-help. In 1935, two men suffering from alcohol abuse met and discussed their treatment options. Slowly, the group grew, and by 1946, this group was known as **Alcoholics Anonymous (AA)**. The two founders, along with other early members, developed the Twelve Step Traditions to help guide members in spiritual and character development. Due to the popularity of the treatment program, other programs such as Narcotics Anonymous and Cocaine Anonymous, adopted and adapted the Twelve Steps for their respective substance abuse. Similarly, Al-Anon and Alateen are two support groups that offer support for families and teenagers of individuals struggling with alcohol abuse.

The overarching goal of AA is abstinence from alcohol. To achieve this, the participants are encouraged to “take one day at a time.” In using the 12 steps, participants are emboldened to admit that they have a disease, that they are powerless over this disease, and that their disease is more powerful than any person. Therefore, participants turn their addiction over to God and ask for help to right their wrongs and remove their negative character defects and shortcomings. The final steps include identifying and making amends to those who they have wronged during their alcohol abuse.

While studies examining the effectiveness of AA programs are inconclusive, AA’s membership indicates that 27% of its

members have been sober less than one year, 24% have been sober 1-5 years, 13% have been sober 5-10 years, 14% have been sober 10-20 years, and more than 22% have been sober over 20 years (Alcoholics Anonymous, 2014). Some argue that this type of treatment is most effective for those who are willing and able to abstain from alcohol as opposed to those who can control their drinking to moderate levels.

11.5.4.2. Residential treatment centers. Another type of treatment similar to self-help is **residential treatment programs**. In this placement, individuals are completely removed from their environment and live, work, and socialize within a drug-free community while also attending regular individual, group, and family therapy. The types of treatment used within a residential program varies from program to program, with most focusing on cognitive-behavioral and behavioral techniques. Several also incorporate 12-step programs into treatment, as many patients transition from a residential treatment center to a 12-step program post discharge. As one would expect, the residential treatment goal is abstinence, and any evidence of substance abuse during the program is grounds for immediate termination.

Studies examining the effectiveness of residential treatment centers suggest that these programs are useful in treating a variety of substance abuse disorders; however, many of these programs are very costly, thus limiting the availability of this treatment to the general public (Bender, 2004; Galanter, 2014). Additionally, many individuals are not able to

completely remove themselves from their daily responsibilities for several weeks to months, particularly those with families. Therefore, while this treatment option is very effective, it is also not an option for most individuals struggling with substance abuse.

11.5.4.3. Community reinforcement. The goal for community reinforcement treatment is for patients to abstain from substance use by replacing the positive reinforcements of the substance with that of sobriety. This is done through several different techniques such as motivational interviewing, learning adaptive coping strategies, and encouraging family support (Mignon, 2014). Essentially, the community around the patient reinforces the positive choices of abstaining from substance use.

Community reinforcement has been found to be effective in both an inpatient and outpatient setting (Meyers & Squires, 2001). It is believed that the intrinsic motivation and the effective coping skills, in combination with the support of an individual's immediate community (friends and family) is responsible for the long-term positive treatment effects of community reinforcement.

Key Takeaways

You should have learned the following in this section:

- Biological treatment options for substance-

related and addictive disorders include detoxification programs, agonist drugs, and antagonist drugs.

- Behavioral treatment options for substance-related and addictive disorders include aversion therapy and contingency management.
- Cognitive-behavioral treatment options for substance-related and addictive disorders include relapse prevention training.
- Sociocultural treatment options for substance-related and addictive disorders include Alcoholics Anonymous, residential treatment centers, and community reinforcement.

Section 11.5 Review Questions

1. Discuss the differences between agonist and antagonist drugs. Give examples of both.
2. What are the two behavioral treatments discussed in this module? Discuss their effectiveness.
3. What are the main components of the 12-step programs? How effective are they in substance abuse treatment?

And that concludes Part IV of the book and Block 3 of mental disorders. In this module, we discussed substance-related and addictive disorders to include substance use disorder, substance intoxication, and substance withdrawal. Substances include depressants, sedative-hypnotic drugs, opioids, stimulants, and hallucinogens. As in past modules, we discussed the clinical presentation, epidemiology, comorbidity, and etiology of the disorders. We then also discussed the biological, behavioral, cognitive-behavioral, and sociocultural treatment approaches.

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PART XIII

Neurocognitive
Disorders

STEPHANIE WEIGEL

Neurocognitive Disorders

WASHINGTON STATE UNIVERSITY

NEUROCOGNITIVE DISORDERS

STEPHANIE WEIGEL

3rd edition as of August 2022

Module Overview

In Module 14, we will cover matters related to neurocognitive disorders (NCDs) to include their clinical presentation, epidemiology, etiology, and treatment options. Our discussion will include delirium, major neurocognitive disorder, and mild neurocognitive disorder. We also discuss nine subtypes to include: Alzheimer's disease, traumatic brain injury (TBI), vascular disorder, substance/medication induced, dementia with Lewy bodies, frontotemporal NCD, Parkinson's disease, Huntington's disease, and HIV infection. Be sure you refer Modules 1-3 for explanations of key terms (Module 1), an overview of the various models to explain psychopathology (Module 2), and descriptions of the therapies (Module 3).

Module Outline

- [14.1. Clinical Presentation](#)
- [14.2. Epidemiology](#)
- [14.3. Etiology](#)
- [14.4. Treatment](#)

Module Learning Outcomes

- Describe how neurocognitive disorders present.

- Describe the epidemiology of neurocognitive disorders.
- Describe the etiology of neurocognitive disorders.
- Describe treatment options for neurocognitive disorders.

14.1. CLINICAL PRESENTATION

Section Learning Objectives

- Describe how delirium presents.
- Describe how major neurocognitive disorder presents.
- Describe how mild neurocognitive disorder presents.

Unlike many of the disorders we have discussed thus far, neurocognitive disorders often result from disease processes or medical conditions. Therefore, it is important that individuals presenting with these symptoms complete a medical assessment to better determine the etiology behind the disorder.

There are three main categories of neurocognitive disorders—delirium, major neurocognitive disorder, and mild

neurocognitive disorder. Within major and minor neurocognitive disorders are several subtypes due to the etiology of the disorder. For this book, we will review diagnostic criteria for both major and minor neurocognitive disorders, followed by a brief description of the various disease subtypes in the etiology section.

It is important to note as well that the criteria for the various NCDs are based on defined cognitive domains. These include the following, with a brief explanation of what it is:

1. Complex attention – Sustained, divided, or selective attention and processing speed
2. Executive function – planning, decision-making, overriding habits, mental flexibility, and responding to feedback/error correction
3. Learning and memory – includes cued recall, immediate or long-term memory, and implicit learning
4. Language – Includes expressive language and receptive language
5. Perceptual-motor – Includes any abilities related to visual perception, gnosis, perceptual-motor praxis, or visuo-constructional
6. Social cognition – Includes recognition of emotions and theory of mind

14.1.1. Delirium

Delirium is characterized by a notable disturbance in attention along with reduced awareness of the environment. The disturbance develops over a short period of time, representing a change from baseline attention and awareness, and fluctuates in severity during the day. There is also a disturbance in cognitive performance that is significantly altered from one's usual behavior. Disturbances in attention are often manifested as difficulty sustaining, shifting, or focusing attention. Additionally, an individual experiencing an episode of delirium will have a disruption in cognition, including confusion of where they are. Disorganized thinking, incoherent speech, and hallucinations and delusions may also be observed during periods of delirium.

Delirium is associated with increased functional decline and risk of being placed in an institution. That said, most people with delirium recover fully with or without treatment, especially if not elderly, but if undetected or the underlying cause is untreated, it may progress to stupor, coma, seizures, or death (APA, 2022).

14.1.2. Major Neurocognitive Disorder

Individuals with major neurocognitive disorder show a *significant* decline in both overall cognitive functioning (see the previously listed six domains) as well as the ability to independently meet the demands of daily living such as paying bills, taking medications, or caring for oneself (APA, 2022). While it is not necessary, it is helpful to have

documentation of the cognitive decline via neuropsychological testing within a controlled, standardized testing environment. Information from close family members or caregivers is also important in documenting the decline and impairment in areas of functioning.

Within the umbrella of major neurocognitive disorder is **dementia**, a striking decline in cognition and self-help skills due to a neurocognitive disorder. The DSM-5-TR (APA, 2022) refrained from using this term in diagnostic categories as it is often used to describe the natural decline in degenerative dementias that affect older adults; whereas neurocognitive disorder is the preferred term used to describe conditions affecting younger individuals such as impairment due to traumatic brain injuries or other medical conditions. Therefore, while dementia is accurate in describing those experiencing major neurocognitive disorder due to age, it is not reflective of those experiencing neurocognitive issues secondary to an injury or illness.

14.1.3. Mild Neurocognitive Disorder

Individuals with mild neurocognitive disorder demonstrate a *modest* decline in one of the listed cognitive domains. The decline in functioning is not as extensive as that seen in major neurocognitive disorder, and the individual does *not* experience difficulty independently engaging in daily activities. However, they may require assistance or extra time to complete these tasks, particularly if the cognitive decline continues to progress.

It should be noted that the primary difference between major and mild neurocognitive disorder is the severity of the decline and independent functioning. Some argue that the two are earlier and later stages of the same disease process (Blaze, 2013). Conversely, individuals can go from major to mild neurocognitive disorder following recovery from a stroke or traumatic brain injury (Petersen, 2011). The DSM-5-TR describes major and mild NCD as existing on a spectrum of cognitive and functional impairment (APA, 2022, pg. 685).

Key Takeaways

You should have learned the following in this section:

- The criteria for the various NCDs are based on the cognitive domains of complex attention, executive function, learning and memory, language, perceptual-motor, and social cognition.
- Delirium is characterized by a notable disturbance in attention or awareness and cognitive performance that is significantly altered from one's usual behavior.
- Major neurocognitive disorder is characterized by a significant decline in both overall cognitive functioning as well as the ability to independently meet the demands of daily living.

- Mild neurocognitive disorder is characterized by a modest decline in one of the listed cognitive areas with no interference in one's ability to complete daily activities.

Section 14.1 Review Questions

1. What are the six cognitive domains the diagnostic criteria for NCDs are based on?
2. Define delirium. How does this differ from mild and major neurocognitive disorders?
3. What are the main differences between mild and major neurocognitive disorders?

14.2. EPIDEMIOLOGY

Section Learning Objectives

- Describe the epidemiology of neurocognitive disorders.

14.2.1. Delirium

The prevalence of delirium in the general community is relatively low at 1% to 2% based on data from the United States and Finland. For older individuals presenting to North American emergency departments, the rate is 8% to 17%. Prevalence rates for those admitted to the hospital range from 18% to 35%. For those in nursing homes or post-acute care settings prevalence is 20 to 22% and 88% for individuals with terminal illnesses at the end of life. Prevalence rates are lower for younger African Americans compared to White individuals of similar age.

14.2.2. Major and Mild NCD

Major and mild neurocognitive disorder prevalence rates vary widely depending on the etiological nature of the disorder and overall prevalence estimates are generally only available for older populations. Internationally, dementia occurs in 1-2% of individuals at age 65, and up to 30% of individuals by age 85. The female gender is associated with higher prevalence of dementia overall. Estimates for mild NCD among older individuals range from 2% to 10% at age 65 and 5% to 25% at age 85. In the U.S., incidence is highest in African Americans followed by American Indians/Alaska Natives, Latinx, Pacific Islanders, non-Latinx Whites, and Asian Americans.

14.2.3. Major and Mild NCD Subtypes

Alzheimer's disease, the most commonly diagnosed neurocognitive disorder, is observed in nearly 5.5 million

Americans (Alzheimer's Association, 2017a), with 11% of those aged 65 and older and 32% older than 85 having dementia due to Alzheimer's disease. It should also be noted that somewhere between 60-90% of dementias are attributable to Alzheimer's disease, depending on the setting and diagnostic criteria. In terms of ethnoracial background in the U.S. the highest prevalence rates have been found among African Americans and Latinx of Caribbean origin (APA, 2022).

Over 2.87 million traumatic brain injuries (TBIs) happen each year within the United States, with men being 40% more likely to experience a TBI compared with women. The most common causes of TBI, in order of occurrence, are falls followed by collision with a moving or stationary object, automobile accidents, and assaults. It has also become increasingly recognized that concussion in sport causes mild TBI (APA, 2022).

Key Takeaways

You should have learned the following in this section:

- As individuals age, the rate of occurrence of delirium and dementia increases dramatically.
- Estimates for mild NCD among older individuals range from 2% to 10% at age 65 and 5% to 25% at age 85.

- As for Alzheimer's disease, prevalence rates are 11% of those aged 65 and older and 32% of those older than 85.
- Men are more likely to experience a TBI than women.

Section 14.2 Review Questions

1. What is the rate of occurrence of the neurocognitive disorders?

14.3. ETIOLOGY

Section Learning Objectives

- Define degenerative.
- Describe the symptoms and causes of Alzheimer's disease.
- Describe the symptoms and causes of traumatic brain injury (TBI).
- Describe the symptoms and causes of vascular disorders.
- Describe the symptoms and causes of substance/

medication-induced major or mild NCD .

- Describe the symptoms and causes of dementia with Lewy bodies.
- Describe the symptoms and causes of frontotemporal NCD.
- Describe the symptoms and causes of Parkinson's disease.
- Describe the symptoms and causes of Huntington's disease.
- Describe the symptoms and causes of HIV infection.

Neurocognitive disorders occur due to a wide variety of medical conditions or injury to the brain. Therefore, this section will focus on a brief description of the nine different etiologies of neurocognitive disorders per the DSM-5-TR (APA, 2022). As you will see, most of these neurocognitive disorders are both **degenerative**, meaning the symptoms and cognitive deficits become worse over time, as well as related to a medical condition or disease.

Per the DSM-5-TR (APA, 2022), an individual will meet diagnostic criteria for *either* mild or major neurocognitive disorder as listed above. In order to specify the type of neurocognitive disorder, additional diagnostic criteria specific to one of the following subtypes must be met.

14.3.1. Alzheimer's Disease

Alzheimer's disease is the most prevalent neurodegenerative disorder. While the primary symptom of Alzheimer's disease is the gradual progression of impairment in cognition, it is also important to identify concrete evidence of cognitive decline. This can be done in one of two ways: via genetic testing of the individual or a documented family history of the disease, or, through clear evidence of cognitive decline over time by repeated standardized neuropsychological evaluations (APA, 2022). It is crucial to identify these markers in making the diagnosis of Alzheimer's disease as some individuals present with memory impairment but eventually show a reversal of symptoms; this is not the case for individuals with Alzheimer's disease.

14.3.1.1. Causes of Alzheimer's disease. Autopsies of individuals diagnosed with Alzheimer's disease identify two abnormal brain structures—**beta-amyloid plaques** and **neurofibrillary tangles**—both of which are responsible for neuron death, inflammation, and loss of cellular connections (Lazarov, Mattson, Peterson, Pimplika, & van Praag, 2010). It is believed that beta-amyloid plaques, large bundles of plaque that develop *between* neurons, appear before the development of dementia symptoms. As these plaque bundles increase in size and number, cognitive symptoms and impaired daily functioning become evident to close family members. Neurofibrillary tangles are believed to appear after the onset of dementia symptoms and are found *inside* of cells, affecting the protein that helps transport

nutrients in healthy cells. Both beta-amyloid plaques and neurofibrillary tangles impact the health of neurons within the hippocampus, amygdala, and the cerebral cortex, areas associated with memory and cognition (Spires-Jones & Hyman, 2014).

Researchers have identified additional genetic and environmental influences in the development of Alzheimer's disorder. Genetically, the **apolipoprotein E (ApoE)** gene that helps to eliminate beta-amyloid by-products from the brain, has been implicated in the development of Alzheimer's disorder. One of the three variants of this gene, the e4 allele, appears to reduce the production of ApoE, thus increasing the number of beta-amyloid plaques within the brain. However, not all individuals with the e4 allele develop Alzheimer's disease; therefore, this explanation may better explain a vulnerability to Alzheimer's disease as opposed to the cause of the disease.

Various brain regions have also been implicated in the development of Alzheimer's disease. More specifically, neurons shrinking or dying within the hypothalamus, thalamus, and the locus ceruleus have been linked to declining cognition (Selkoe, 2011, 1992). Acetylcholine-secreting neurons within the basal forebrain also appear to shrink or die, contributing to Alzheimer's disease symptoms (Hsu et al., 2015).

Environmental toxins such as high levels of zinc and lead may also contribute to the development of Alzheimer's disease. More precisely, zinc has been linked to the clumping

of beta-amyloid proteins throughout the brain. Although lead has largely been phased out of environmental toxins due to negative health consequences, current elderly individuals were exposed to these toxic levels of lead in gasoline and paint as young children. There is some speculation that lead and other pollutants may impact cognitive functioning in older adults (Richardson et al., 2014).

14.3.1.2. Onset of Alzheimer's disease. Alzheimer's disease is defined by the onset of symptoms. *Early-onset* Alzheimer's disease occurs before the age of 65. While only a small percentage of individuals experience early onset of the disease, those that do experience early disease progression appear to have a more genetically influenced condition and a higher rate of family members with the disease.

Late-onset Alzheimer's disease occurs after the age of 65 and has less of a familial influence. This onset appears to occur due to a combination of biological, environmental, and lifestyle factors (Chin-Chan, Navarro-Yepes, & Quintanilla-Vega, 2015). Nearly 30% of individuals within this class of diagnosis have the ApoE gene that fails to eliminate the beta-amyloid proteins from various brain structures. It is believed that the combination of the presence of this gene along with environmental toxins and lifestyle choices (i.e., more stress) impact the development of Alzheimer's disease.

14.3.2. Traumatic Brain Injury (TBI)

TBIs occur when an individual experiences significant

trauma or damage to the head. Neurocognitive disorder due to TBI is diagnosed when persistent cognitive impairment is observed immediately following the head injury, along with one or more of the following symptoms: loss of consciousness, posttraumatic amnesia, disorientation and confusion, or neurological impairment (APA, 2022).

The presentation of symptoms varies among individuals and depends largely on the location of the injury and the intensity of the trauma. Furthermore, the effects of a TBI can be temporary or permanent. Symptoms generally range from headaches, disorientation, confusion, irritability, fatigue, poor concentration, and emotional and behavioral changes. More severe injuries can result in more significant neurological symptoms such as seizures, paralysis, and visual disturbances.

Major or mild NCD due to TBI may be comorbid with specified or unspecified depressive, anxiety, or personality disorders and PTSD. Rates of suicidal ideation are as high as 10% with rates of suicide attempt hovering around 0.8% to 1.7% (APA, 2022).

The most common type of TBI is a concussion. A **concussion** occurs when there is a significant blow to the head, followed by changes in brain functioning. It often causes immediate disorientation or loss of consciousness, along with headaches, dizziness, nausea, and sensitivity to light (Alla, Sullivan, & McCrory, 2012). While symptoms of a concussion are usually temporary, there can be more permanent damage due to repeated concussions, particularly if they are close in time. The media has brought considerable

attention to this with the recent discussions of **chronic traumatic encephalopathy (CTE)** which is a progressive, degenerative condition due to repeated head trauma. CTEs are most commonly seen in athletes (i.e., football players) and military personnel (Baugh et al., 2012). In addition to the neurological symptoms, psychological symptoms such as depression and poor impulse control have been observed in individuals with CTE. These individuals also appear to be at greater risk for the development of dementia (McKee et al., 2013).

14.3.3. Vascular Disorders

Neurocognitive disorders due to vascular disorders can occur from a one-time event such as a stroke or ongoing subtle disruptions of blood flow within the brain (APA, 2022). The occurrence of these vascular disorders general begins with **atherosclerosis**, or the clogging of arteries due to a build-up of plaque. The **plaque** builds up over time, eventually causing the artery to narrow, thus reducing the amount of blood able to pass through to other parts of the body. When these arteries within the brain become entirely obstructed, a **stroke** occurs. The lack of blood flow during a stroke results in the death of neurons and loss of brain function. There are two types of strokes—a **hemorrhagic stroke** that occurs when a blood vessel bursts within the brain and an **ischemic stroke**, which is when a blood clot blocks the blood flow in an artery within the brain (American Stroke Association, 2017).

While strokes can occur at any age, the majority of strokes occur after age 65 (Hall, Levant, & DeFrances, 2012). A wide range of cognitive, behavioral, and emotional changes occur following a stroke. Symptoms are generally dependent on the location of the stroke within the brain as well as the extensiveness of damage to those brain regions (Poels et al., 2012). For example, strokes that occur on the left side of the brain tend to cause problems with speech and language, as well as physical movement on the *right* side of the body; whereas strokes that occur on the right side of the brain tend to cause problems with impulsivity and impaired judgement, short-term memory loss, and physical movement on the *left* side of the body (Hedna et al., 2013).

After Alzheimer's disease, vascular disease is the second most common cause of NCD and population prevalence estimates are 0.98% for those between the ages of 71-79 years, 4.09% for individuals aged 80-89 years, and 6.19% for those aged 90 years and up. Within three months of a stroke, 20%-30% of people are diagnosed with dementia. Finally, stroke is more common in men up to age 65 and after that, it shifts to women. Vascular disease is frequently comorbid with major or mild NCD due to Alzheimer's disease and depression.

14.3.4. Substance/Medication-Induced Major or Mild NCD

Significant cognitive changes occur due to repetitive drug and alcohol abuse. Delirium can be observed in individuals

with extreme substance intoxication, withdrawal, or even when multiple substances have been used within a close period (APA, 2022). While delirium symptoms are often transient during these states, mild neurocognitive impairment due to heavy substance abuse may remain until a significant period of abstinence is observed (Stavro, Pelletier, & Potvin, 2013).

14.3.5. Dementia with Lewy Bodies

Symptoms associated with neurocognitive disorder due to Lewy bodies include significant fluctuations in attention and alertness; recurrent visual hallucinations; impaired mobility; and sleep disturbances such as rapid eye movement sleep behavior disorder (APA, 2022). While the trajectory of the illness develops more rapidly than Alzheimer's disease, the survival period is similar in that most individuals do not survive longer than eight years post-diagnosis (Lewy Body Dementia Association, 2017).

Lewy bodies are irregular brain cells that result from the buildup of abnormal proteins in the nuclei of neurons. These brain cells deplete the cortex of **acetylcholine**, which causes the behavioral and cognitive symptoms observed in both dementia with Lewy bodies and Parkinson's disease. The motor symptoms seen in both these disorders occur from the depletion of dopamine by the Lewy body nerve cells that accumulate in the brain stem.

14.3.6. Major or Mild Frontotemporal NCD

Frontotemporal NCD causes “progressive development of behavioral and personality change and/or language impairment” (APA, 2022, pg. 696). For the behavioral variant, individuals display at least three of the following: behavioral disinhibition, apathy or inertia, loss of sympathy or empathy, preservative or compulsive behavior, or hyperorality and dietary changes. For the language variant, they show prominent decline in language ability (i.e., speech production, word finding, object naming, grammar, or word comprehension). There is relative sparing of learning and memory and perceptual-motor functioning. Individuals with frontotemporal NCD commonly present in their 50s though the age of onset has a range of age 20 to 80 years. The median survival is 6-11 years after symptom onset and 3-4 years after diagnosis (APA, 2022).

14.3.7. Parkinson’s Disease

The awareness of Parkinson’s disease has increased in recent years due in large part to Michael J. Fox’s early diagnosis in 1991. It affects approximately 630,000 individuals (Kowal, Dall, Chakrabarti, Storm, & Jain, 2013). While many are aware of the tremors of hands, arms, legs, and face, the other three main symptoms of Parkinson’s disease are rigidity of the limbs and trunk; slowness in initiating movement; and drooping posture or impaired balance and coordination (National Institute of Neurological Disorders and Stroke, 2017). These motor symptoms are generally present at least one year prior to the beginning

of cognitive decline, although severity and progression of symptoms vary significantly from person to person.

Onset of Parkinson's disease is typically from age 50 to 89 years. Mild NCD develops early in the course of Parkinson's disease while Major NCD does not occur until individuals are much older. The prevalence of Parkinson's disease in the U.S. increases with age and is more common in men than women. The disease is comorbid with Alzheimer's disease and cerebrovascular disease. Depression, psychosis, REM sleep behavior disorder, apathy, and motor symptoms can make functional impairment worse (APA, 2022).

14.3.8. Huntington's Disease

Huntington's disease is a rare genetic disorder that involves involuntary movement, progressive dementia, and emotional instability. Due to the degenerative nature of the disorder, there is a shortened life-expectancy as death typically occurs 15-20 years post-onset of symptoms (Clabough, 2013). Although symptoms can present at any time, the average age of symptom presentation is during middle adulthood (between ages 35 and 45 years; APA, 2022). Symptoms generally begin with neurocognitive decline, particularly in executive function, along with changes in mood and personality. As symptoms progress, more physical symptoms present, such as facial grimaces, difficulty speaking, and repetitive movements. Because there is no treatment for Huntington's disease, the severity of the cognitive and physical impairments ultimately leads to complete

dependency and the need for full-time care. Suicide is among the leading causes of death in Huntington's disease (APA, 2022).

14.3.9. HIV Infection

Not many people are aware that cognitive impairment is sometimes the first symptom of untreated HIV. While symptoms vary among individuals, slower mental processing, impaired executive function, problems with more demanding attentional tasks, and difficulty learning new information are among the most common early signs (APA, 2022). When HIV becomes active in the brain, significant alterations of mental processes occur, thus leading to a diagnosis of *neurocognitive disorder due to HIV infection*. Significant impairment can also occur due to HIV-infection related inflammation throughout the central nervous system.

Fortunately, antiretroviral therapies used in treating HIV have been effective in reducing and preventing the onset of severe cognitive impairments; however, HIV-related brain changes still occur in nearly half of all patients on antiretroviral medication. There is hope that once antiretroviral therapies can cross the blood-brain barrier in the central nervous system, there will be a significant improvement in the prevalence of HIV-related neurocognitive disorder (Vassallo et al., 2014).

Key Takeaways

You should have learned the following in this section:

- Most neurocognitive disorders are degenerative meaning they become worse over time.
- Alzheimer's disease is characterized by the gradual progression of impairment in cognition as well as the presence of beta-amyloid plaques and neurofibrillary tangles.
- TBIs occur when an individual experiences significant trauma or damage to the head with the most common type being a concussion.
- Vascular disorders generally begin with atherosclerosis which leads to a stroke.
- Significant cognitive changes occur due to repetitive drug and alcohol abuse such as delirium.
- Dementia with Lewy bodies is characterized by significant fluctuations in attention and alertness; recurrent visual hallucinations; impaired mobility; and sleep disturbance.
- Frontotemporal NCD causes progressive declines in language or behavior due to the degeneration in the frontal and temporal lobes of the brain.
- Parkinson's disease is characterized by tremors of hands, arms, legs, or face; rigidity of the limbs and trunk; slowness in initiating movement; and drooping posture or impaired balance and

coordination.

- Huntington's disease involves involuntary movement, progressive dementia, and emotional instability.
- HIV infection begins with slower mental processing, impaired executive function, problems with more demanding attentional tasks, and difficulty learning new information.

Section 14.3 Review Questions

1. Define degenerative. What disorders discussed in this module are considered degenerative?
2. Identify the biological causes of Alzheimer's disease.
3. What is a TBI?
4. How do vascular disorders occur?
5. What are Lewy bodies? How does dementia with Lewy bodies differ from Alzheimer's disease?
6. What are the main symptoms of Parkinson's disease? Huntington's disease?

14.4. TREATMENT

Section Learning Objectives

- Describe treatment options for neurocognitive disorders.

Treatment options for those with neurocognitive disorders are minimal at best, with most attempting to treat secondary symptoms as opposed to the neurocognitive disorder itself. Furthermore, the degenerative nature of these disorders also makes it difficult to treat, as many diseases will progress regardless of the treatment options.

14.4.1. Pharmacological

Pharmacological interventions, and more specifically medications designed to target acetylcholine and glutamate, have been the most effective treatment options in alleviating symptoms and reducing the speed of cognitive decline within individuals diagnosed with Alzheimer's disease. Specific medications such as *donepezil* (Aricept), *rivastigmine* (Exelon), *galantamine* (Razadyne), and *memantine* (Namenda) are among the most commonly prescribed (Alzheimer's Association, 2017a). Due to possible negative side effects of the medications, these drugs are prescribed to individuals in the early or middle stages of Alzheimer's as opposed to those with advanced

disease. Researchers have also explored treatment options aimed at preventing the build-up of beta-amyloid and neurofibrillary tangles; however, this research is still in its infancy (Alzheimer's Association, 2017a)

Parkinson's disease has also found success in pharmacological treatment options. The medication *levodopa* increases dopamine availability, which provides relief of both physical and cognitive symptoms. Unfortunately, there are also significant side effects such as hallucinations and psychotic symptoms; therefore, the medication is often only used when the benefits outweigh the negatives of the potential risks (Poletti & Bonuccelli, 2013).

14.4.2. Psychological

Among the most effective psychological treatment options for individuals with neurocognitive disorders are the use of cognitive and behavioral strategies. More specifically, engaging in various cognitive activities such as computer-based cognitive stimulation programs, reading books, and following the news, have been identified as effective strategies in preventing or delaying the onset of Alzheimer's disease (Szalavits, 2013; Wilson, Segawa, Boyle, & Bennett, 2012).

Engaging in social skills and self-care training are additional behavioral strategies used to help improve functioning in individuals with neurocognitive deficits. For example, by breaking down complex tasks into smaller, more attainable goals, as well as simplifying the environment (i.e.,

labeling location of items, removing clutter), individuals can successfully engage in more independent living activities.

14.4.3. Support for Caregivers

Supporting caregivers is an important treatment option to include as the emotional and physical toll on caring for an individual with a neurocognitive disorder is often underestimated. According to the Alzheimer's Association (2017b), nearly 90% of all individuals with Alzheimer's disease are cared for by a relative. The emotional and physical demands on caring for a family member who continues to decline cognitively and physically can lead to increased anger and depression in a caregiver (Kang et al. 2014). It is important that medical providers routinely assess caregivers' psychosocial functioning, and encourage caregivers to participate in caregiver support groups, or individual psychotherapy to address their own emotional needs.

Key Takeaways

You should have learned the following in this section:

- Pharmacological interventions for Alzheimer's disease target the neurotransmitters acetylcholine and glutamate and newer research is focused on the build-up of beta-amyloid and neurofibrillary tangles.

- Psychological treatments include cognitive and behavioral strategies such as playing board games, reading books, or social skills training.
- Caregivers need to join support groups to help them manage their own anger and depression, especially since 90% of such caregivers are relatives of the afflicted.

Section 14.4 Review Questions

1. Review the listed treatment options for neurocognitive disorders. What are the main goals of these treatments?

Module Recap

Our discussion in Module 14 turned to neurocognitive disorders to include the categories of delirium, major neurocognitive disorder, and Mild neurocognitive disorder. We also discussed the subtypes of Alzheimer's disease, traumatic brain injury (TBI), vascular disorder, substance/medication induced, dementia with Lewy bodies, frontotemporal NCD, Parkinson's disease, Huntington's disease, and HIV infection. The clinical description, epidemiology, etiology, and treatment options for neurocognitive disorders were discussed.

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PART XIV

Chapter 13:
Sleep-Wake
Disorders & Sexual
Disorders

STEPHANIE WEIGEL

Sleep-Wake Disorders

MICHAEL KONRAD

Sleep-wake disorders are a group of conditions that affect the timing, quality, and amount of sleep a person gets. These disorders can disrupt a person's ability to function during the day, and may also cause a range of physical and mental health problems.

There are several different types of sleep-wake disorders, including:

1. **Insomnia:** Insomnia is a sleep disorder that is characterized by difficulty falling asleep, staying asleep, or both. Insomnia can be short-term (acute), lasting from a few days to a few weeks, or long-

term (chronic), lasting for months or even years. Some common symptoms of insomnia include:

- Difficulty falling asleep
- Waking up frequently during the night
- Waking up too early in the morning
- Feeling tired or not rested upon waking
- Daytime sleepiness
- Difficulty concentrating or completing tasks
- Irritability or mood disturbances

Insomnia can have a number of different causes, including stress, anxiety, depression, medications, and medical conditions such as sleep apnea or restless legs syndrome. Certain lifestyle factors, such as caffeine or alcohol consumption, can also contribute to insomnia.

Treatment for insomnia typically involves a combination of medication, cognitive-behavioral therapy, and lifestyle changes. Medications that may be used to treat insomnia include benzodiazepines, non-benzodiazepine sedatives, and antidepressants. Cognitive-behavioral therapy for insomnia (CBT-I) is a type of therapy that focuses on changing negative thoughts and behaviors around sleep.

Lifestyle changes that may help manage insomnia include maintaining a consistent sleep schedule, avoiding stimulants such as caffeine and nicotine, and creating a comfortable sleep environment.

The prevalence of insomnia is estimated to be around 30% of the population, with higher rates in women and older adults. Insomnia can have a significant impact on a person's quality of life, and it's important to seek medical attention if you are experiencing symptoms of the condition. In most cases, with appropriate treatment, the prognosis for insomnia is good.

2. **Sleep apnea:** Sleep apnea is a sleep disorder in which a person experiences pauses in breathing or shallow breathing during sleep. These pauses can last from a few seconds to a few minutes and can occur multiple times per hour throughout the night. Sleep apnea can be caused by a variety of factors, including obesity, aging, alcohol consumption, and anatomical abnormalities such as a deviated septum. There are three types of sleep apnea:
 1. **Obstructive sleep apnea (OSA):** This is the most common type of sleep apnea and occurs when the muscles in the back of the throat fail to keep the airway open during sleep.

2. Central sleep apnea (CSA): This type of sleep apnea occurs when the brain fails to signal the muscles to breathe during sleep.
3. Complex sleep apnea syndrome (CompSA): This is a combination of both OSA and CSA.

Common symptoms of sleep apnea include:

- Loud snoring
- Pauses in breathing or gasping during sleep
- Excessive daytime sleepiness
- Morning headaches
- Difficulty concentrating or remembering
- Irritability or mood disturbances

Left untreated, sleep apnea can have serious health consequences, including an increased risk of high blood pressure, heart disease, stroke, and diabetes.

Treatment for sleep apnea typically involves a combination of lifestyle changes and medical interventions. Lifestyle changes that may help manage sleep apnea include losing weight, avoiding alcohol and sedatives, and sleeping on one's side. Medical interventions may include continuous positive airway pressure (CPAP) therapy, which uses a machine to deliver air pressure through a

mask worn over the nose and/or mouth to keep the airway open during sleep. Surgery (e.g., Inspire) may also be an option for some people with sleep apnea.

The prevalence of sleep apnea is estimated to be around 9% of the population, with higher rates in men and older adults. If you are experiencing symptoms of sleep apnea, it's important to seek medical attention, as the condition can have serious health consequences if left untreated. With appropriate treatment, however, the prognosis for sleep apnea is good, and many people are able to manage their symptoms effectively.

3. **Narcolepsy:** Narcolepsy is a chronic sleep disorder that is characterized by excessive daytime sleepiness, sleep attacks, and other symptoms such as sleep paralysis and hallucinations. Some common symptoms of narcolepsy include:

- Excessive daytime sleepiness: This is the hallmark symptom of narcolepsy and is characterized by an irresistible urge to sleep during the day, regardless of the circumstances.
- Sleep attacks: These are sudden episodes of falling asleep, which can occur at any time, including during work or other activities.

- Cataplexy: This is a sudden loss of muscle tone, usually triggered by strong emotions such as laughter, surprise, or anger.
- Sleep paralysis: This is a temporary inability to move or speak while falling asleep or waking up.
- Hypnagogic/hypnopompic hallucinations: These are vivid, often scary, hallucinations that occur while falling asleep or waking up.

The exact cause of narcolepsy is not fully understood, but it is thought to involve a combination of genetic and environmental factors. There is no cure for narcolepsy, but treatment can help manage symptoms and improve quality of life. Treatment options for narcolepsy may include medication, lifestyle changes, and behavioral therapy. Medications that may be used to treat narcolepsy include stimulants, such as modafinil or methylphenidate, and antidepressants, which can help manage cataplexy and other symptoms.

The prevalence of narcolepsy is estimated to be around 1 in 2,000 people, with onset typically occurring in adolescence or early adulthood. Narcolepsy can have a significant impact on a person's quality of life and ability to function in

daily activities, and it's important to seek medical attention if you are experiencing symptoms of the condition. With appropriate treatment, however, many people with narcolepsy are able to manage their symptoms effectively and lead productive lives.

4. **Restless legs syndrome (RLS):** This is a condition where a person experiences uncomfortable sensations in their legs, which can cause an irresistible urge to move them. RLS can make it difficult to fall asleep or stay asleep. RLS is a neurological condition that is characterized by an unpleasant sensation in the legs (and sometimes other parts of the body) that results in an irresistible urge to move them. The sensations typically occur when a person is at rest, such as when sitting or lying down, and are often worse at night. The symptoms of RLS can range from mild to severe, and can have a significant impact on a person's quality of life. Some common sensations described by individuals with RLS include:

- Aching, burning, or creeping sensations in the legs
- Itching or tingling sensations
- A feeling of "electricity" or "pins and needles" in the legs

The urge to move the legs in response to these sensations can be overwhelming and can interfere with sleep, making it difficult to fall asleep or stay asleep.

The exact cause of RLS is not known, but there are several factors that have been associated with the condition. These include:

- Genetics: RLS appears to run in families, suggesting that there may be a genetic component to the condition.
- Iron deficiency: Low levels of iron in the brain may be a contributing factor to RLS.
- Chronic diseases: Certain chronic diseases, such as kidney disease and diabetes, have been associated with an increased risk of RLS.
- Medications: Some medications, such as certain antidepressants and antipsychotics, can cause or worsen RLS symptoms.

Treatment for RLS typically involves a combination of medication and lifestyle changes. Some medications that may be used to treat RLS include dopamine agonists, benzodiazepines, and opioids. Lifestyle changes that may help manage RLS

symptoms include regular exercise, stretching, and avoiding substances like caffeine and alcohol.

The prevalence of RLS is estimated to be around 10% of the population, with higher rates in women and older adults. While RLS is not life-threatening, it can significantly impact a person's quality of life, and it's important to seek medical attention if you are experiencing symptoms of the condition.

5. **Circadian rhythm disorders:** Circadian rhythm disorders are a group of sleep disorders that are caused by disruptions in the body's internal biological clock, which regulates sleep-wake cycles, hormone production, and other physiological processes. Some common types of circadian rhythm disorders include:
 1. Delayed sleep-wake phase disorder (DSPD): This is a sleep disorder in which a person's biological clock is delayed, causing them to have difficulty falling asleep and waking up at conventional times.
 2. Advanced sleep-wake phase disorder (ASPD): This is a sleep disorder in which a person's biological clock is advanced, causing them to feel sleepy and go to bed much earlier than normal.
 3. Non-24-hour sleep-wake disorder: This

is a sleep disorder in which a person's biological clock is not synchronized with the 24-hour day, causing their sleep-wake cycles to shift later and later each day.

4. Shift work disorder: This is a sleep disorder that occurs in people who work night shifts or rotating shifts, causing disruptions in their sleep-wake cycles and other physiological processes.

Symptoms of circadian rhythm disorders can vary depending on the type of disorder, but may include insomnia, excessive daytime sleepiness, difficulty concentrating, mood disturbances, and other symptoms.

Treatment for circadian rhythm disorders may involve a combination of lifestyle changes and medical interventions. Lifestyle changes that may help manage circadian rhythm disorders include avoiding exposure to bright light at night, maintaining a regular sleep schedule, and avoiding caffeine and alcohol. Medical interventions may include light therapy, which involves exposure to bright light at specific times of day to help reset the biological clock, or medications to help manage symptoms.

The prevalence of circadian rhythm disorders varies depending on the type of disorder, but they

are thought to be relatively common, especially among shift workers and people with certain medical conditions. If you are experiencing symptoms of a circadian rhythm disorder, it's important to seek medical attention to determine the underlying cause and develop an appropriate treatment plan.

6. **Parasomnias:** Parasomnias are a group of sleep disorders that involve abnormal behaviors, movements, emotions, perceptions, or dreams that occur during sleep or while transitioning between wakefulness and sleep. There are several types of parasomnias, including:

1. Sleepwalking (somnambulism): This is a sleep disorder in which a person gets out of bed and walks around while still asleep.
2. Sleep talking (somniloquy): This is a sleep disorder in which a person talks while still asleep.
3. Nightmares: These are vivid, frightening dreams that cause a person to wake up feeling scared or anxious.
4. Night terrors (sleep terrors): These are sudden episodes of intense fear or terror that occur during sleep, often accompanied by screaming, sweating, and rapid breathing.

5. REM sleep behavior disorder (RBD): This is a sleep disorder in which a person physically acts out their dreams, often violently or aggressively.
6. Sleep-related eating disorder (SRED): This is a sleep disorder in which a person eats while still asleep, often consuming large amounts of food or unusual items.

Parasomnias can be caused by a variety of factors, including genetics, medical conditions, medications, and substance abuse. Treatment for parasomnias depends on the specific type and severity of the disorder, but may include medication, cognitive behavioral therapy, or other types of behavioral therapy. Lifestyle changes, such as maintaining a regular sleep schedule, avoiding alcohol and caffeine before bedtime, and creating a comfortable sleep environment, may also be helpful.

The prevalence of parasomnias varies depending on the type of disorder, but they are thought to be relatively common, especially among children and adolescents. If you or someone you know is experiencing symptoms of a parasomnia, it's important to seek medical attention to determine the underlying cause and develop an appropriate treatment plan.

Diagnosis of sleep-wake disorders typically involves a

thorough medical history, physical examination, and often a sleep study, which involves monitoring a person's sleep patterns and brain activity.

Treatment options for sleep-wake disorders depend on the specific condition and its underlying causes. They may include medications, behavioral therapy, lifestyle changes, and/or the use of devices such as continuous positive airway pressure (CPAP) machines for sleep apnea. It is important to seek medical attention if you are experiencing symptoms of a sleep-wake disorder, as untreated conditions can have serious consequences for both physical and mental health.

Diagnosis, Treatment, Prognosis, and Prevalence of Sleep-Wake Disorders

1. **Insomnia:** Diagnosis of insomnia typically involves a medical history, sleep diary, and physical examination. Treatment may involve cognitive-behavioral therapy, medication, and/or addressing underlying medical or psychological conditions. The prevalence of insomnia is estimated to be around 30% of the population, with higher rates in women and older adults. The prognosis for insomnia is generally good with appropriate treatment.
2. **Sleep apnea:** Diagnosis of sleep apnea typically involves a sleep study, or polysomnography, to measure breathing patterns and oxygen levels during sleep. Treatment may involve weight loss,

positional therapy, continuous positive airway pressure (CPAP) therapy, surgery, and/or lifestyle changes. The prevalence of sleep apnea is estimated to be around 10% of the population, with higher rates in men and older adults. The prognosis for sleep apnea is generally good with appropriate treatment.

3. Narcolepsy: Diagnosis of narcolepsy typically involves a medical history, physical examination, and sleep study. Treatment may involve medication and lifestyle changes. The prevalence of narcolepsy is estimated to be around 0.05% of the population. While there is no cure for narcolepsy, medication and lifestyle changes can help manage symptoms and improve quality of life.
4. Restless legs syndrome (RLS): Diagnosis of RLS typically involves a medical history, physical examination, and sleep study. Treatment may involve medication and lifestyle changes. The prevalence of RLS is estimated to be around 10% of the population, with higher rates in women and older adults. The prognosis for RLS is generally good with appropriate treatment.
5. Circadian rhythm disorders: Diagnosis of circadian rhythm disorders typically involves a medical history, sleep diary, and physical examination. Treatment may involve timed light exposure,

medication, and/or behavioral therapy. The prevalence of circadian rhythm disorders varies depending on the specific condition, but they are relatively common among shift workers and individuals with irregular sleep schedules. The prognosis for circadian rhythm disorders is generally good with appropriate treatment.

6. **Parasomnias:** Diagnosis of parasomnias typically involves a medical history, physical examination, and sleep study. Treatment may involve medication and/or lifestyle changes. The prevalence of parasomnias varies depending on the specific condition, but they are relatively common among children and adolescents. The prognosis for parasomnias is generally good with appropriate treatment.

It's important to note that treatment and prognosis can vary depending on the severity and underlying causes of the disorder, and that each individual's experience may be different. If you are experiencing symptoms of a sleep-wake disorder, it's important to seek medical attention for proper diagnosis and treatment.

Sexual Disorders

STEPHANIE WEIGEL

SEXUAL DYSFUNCTIONS

Roughly 43% of women and 31% of men suffer from a clinically significant impairment to their ability to experience sexual pleasure or responsiveness as outlined by the SRC ([Rosen, 2000](#)). The *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM) refers to these difficulties as [sexual dysfunctions](#).

According to the DSM, there are four male-specific dysfunctions:

- delayed ejaculation
- erectile disorder (ED)

- male hypoactive sexual desire disorder
- premature ejaculation (PE)

There are three female-specific dysfunctions:

- female orgasmic disorder
- female sexual interest/arousal disorder
- genito-pelvic pain/penetration disorder

There is also one non-gender-specific sexual dysfunction: substance-/medication-induced sexual dysfunction ([American Psychiatric Association, 2013](#)). The most commonly reported male sexual dysfunctions are premature ejaculation (PE) and erectile dysfunction (ED), whereas females most frequently report dysfunctions involving desire and arousal. Females are also more likely to experience multiple sexual dysfunctions ([McCabe et al., 2016](#)).

PE is a pattern of early ejaculation that impairs sexual performance and causes personal distress. In severe cases, ejaculation may occur prior to the start of sexual activity or within 15 seconds of penetration ([American Psychiatric Association, 2013](#)). PE is a fairly common sexual dysfunction, with prevalence rates ranging from 20–30%. Relationship and intimacy difficulties, as well as anxiety, low self-confidence, and depression, are often associated with PE. Most males with PE do not seek treatment ([Porst et al., 2007](#)).

ED is the frequent difficulty to either obtain or maintain an erection, or a significant decrease in erectile firmness.

Normal aging increases the prevalence and incidence rates of erectile difficulties, especially after the age of 50 ([American Psychiatric Association, 2013](#)). However, recent studies have found significant increases in the prevalence of ED in young men, less than 30 years of age (e.g., [Capogrosso et al., 2013](#)).

Female sexual interest/arousal disorder (FSIAD) is characterized by reduced or absent sexual interest or arousal. A person diagnosed with FSIAD has had an absence of at least three of the following emotions, behaviors, and thoughts for more than six months:

- interest in sexual activity
- sexual or erotic thoughts and fantasies
- initiation of sexual activity
- sexual excitement or pleasure during sexual activity
- sexual interest/arousal in response to sexual or erotic cues
- genital or non-genital sensations during sexual activity

FSIAD is not diagnosed if the presenting symptoms are a result of insufficient stimulation or lack of sexual knowledge—such as the erroneous expectation that penile-vaginal intercourse always results in orgasm ([American Psychiatric Association, 2013](#)).

TREATMENTS

When it comes to treating sexual dysfunctions, there's some good news and there's some bad news. The good news is that most sexual dysfunctions have treatments—however, most people don't seek them out ([Gott & Hinchliff, 2003](#)). So, the further good news is that—once you have the knowledge (say, from this module)—if you experience such difficulties, getting treatment is just a matter of making the choice to seek it out. Unfortunately, the bad news is that most treatments for sexual dysfunctions don't address the psychological and sociocultural underpinnings of the problems, but instead focus *exclusively* on the physiological roots. For example, Montague et al. ([2007](#), pg. 1-7) make this point perfectly clear in *The American Urological Association's* treatment options for ED: “The currently available therapies...for the treatment of erectile dysfunction include the following: oral phosphodiesterase type 5 inhibitors, intra-urethral alprostadil, intracavernous vasoactive drug injection, vacuum constriction devices, and penile prosthesis implantation.”



Relationship issues like frequent disagreement and conflict can lead to sexual dysfunction. [Image: Ed Yourdon, <https://goo.gl/9e8YU5>, CC BY-NC-SA 2.0, <https://goo.gl/3QMoxH>]

Treatments that focus solely on managing symptoms with biological fixes neglect the fundamental issue of sexual dysfunctions being grounded in psychological, relational, and social contexts. For example, a female seeking treatment for inadequate lubrication during intercourse is most likely to be prescribed a supplemental lubricant to alleviate her symptoms. The next time she is sexually intimate, the lubricant may solve her vaginal dryness, but her lack of

natural arousal and lubrication due to partner abuse, is completely overlooked ([Kleinplatz, 2012](#)).

There are numerous factors associated with sexual dysfunctions, including: relationship issues; adverse sexual attitudes and beliefs; medical issues; sexually-oppressive cultural attitudes, codes, or laws; and a general lack of knowledge. Thus, treatments for sexual dysfunctions should address the physiological, psychological, and sociocultural roots of the problem.

SEXUAL DYSPHORIA

Gender Dysphoria is one of the most controversial disorders. With each edition of the DSM, attempts have been made to clarify the diagnosis and address the controversies. According to the DSM (APA, 2022),

Gender Dysphoria is

A marked incongruence between one's experienced/expressed gender and natal gender of at least 6 months in duration, as manifested by at least two of the following:

- A. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
- B. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
- C. A strong desire for the primary and/or secondary sex characteristics of the other gender
- D. A strong desire to be of the other gender (or some alternative gender different from one's designated gender)
- E. A strong desire to be treated as the other gender (or some alternative gender different from one's designated gender)
- F. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's designated gender)

The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if:

- A. The condition exists with a disorder of sex development.
 - B. The condition is post-transitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen—namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females).
-

Despite attempts to clarify the diagnostic criteria

controversies remain. In order to better understand these criteria it is important to understand the terminology used. This link provides additional explanation of the terminology, diagnosis, and challenges: <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria>

PARAPHILIAS

Paraphilias are described as sexual arousal to atypical objects, situations, and/or targets (APA, 2024). Atypical objects or targets may include children, corpses, animals, or clothing items. Although this is atypical and therefore unusual, sexual attraction to these targets does not in itself mean a diagnosis of a paraphiliac disorder is warranted. To be diagnosed as a disorder the reaction must be:

1. Intense and persistent
2. Cause significant distress or impairment in social, occupational, or other important areas of functioning
3. Or they harm or have the potential to harm others (such as children or non-consenting adults)

The following source provides additional details about types of paraphilias and diagnosis: <https://www.ncbi.nlm.nih.gov/books/NBK554425/>

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OUTSIDE RESOURCES

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Journal: The Journal of Sex Research

http://www.sexscience.org/journal_of_sex_research/

Journal: The Journal of Sexual Medicine

<http://www.jsm.jsexmed.org/>

Organization: Advocates for Youth partners with youth leaders, adult allies, and youth-serving organizations to advocate for policies and champion programs that recognize young people's rights to honest sexual health information; accessible, confidential, and affordable sexual health services; and the resources and opportunities necessary to create sexual health equity for all youth.

<http://www.advocatesforyouth.org/>

Organization: SIECUS – the Sexuality Information and Education Council of the United States – was founded in 1964 to provide education and information about

sexuality and sexual and reproductive health.

<http://www.siecus.org/>

Organization: The Guttmacher Institute is a leading research and policy organization committed to advancing sexual and reproductive health and rights in the United States and globally.

<https://www.guttmacher.org/>

Video: 5MIweekly—YouTube channel with weekly videos that playfully and scientifically examine human sexuality.

<https://www.youtube.com/channel/UCQFQ0vPPNPS-LYh1bKOzpFw>

Video: Sexplanations—YouTube channel with shame-free educational videos on everything sex.

<https://www.youtube.com/user/sexplanations>

Video: YouTube – AsapSCIENCE

<https://www.youtube.com/user/AsapSCIENCE>

Web: Kinsey Confidential—Podcast with empirically-based answers about sexual questions.

<http://kinseyconfidential.org/>

Web: Sex & Psychology Web: Sex & Psychology—Blog about the science of sex, love, and relationships.

<http://www.lehmiller.com/>

STEPHANIE WEIGEL

PART XV

Dissociative
Disorders &
Psychopathy

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Dissociative Disorders

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

<http://nobaproject.com/modules/dissociative-disorders>

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STEPHANIE WEIGEL

PART XVI

Case Studies of
Fictional Characters

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Major Depressive Disorder

BILL PELZ AND HERKIMER COMMUNITY
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Name: Eeyore

Source: *Winnie the Pooh* (TV Show, 1966)

Background Information

Eeyore is an older gray donkey. There are no documents indicating the exact age or specified background information, and he chooses not to share this information. Eeyore does not have an occupation. His health compared to other donkeys is slightly underweight, but slender. He chooses not to share his family background. One main difficulty Eeyore has elaborated on is his detachable tail, which seems to cause

him several problems. He has indicated that his goals are to remain strong for his friends despite his lack of confidence within himself, and as a result he often feels lonely without support from others that he is close to. Some forms of coping mechanisms include trying to feel useful in the presence of others and also trying his best to find pleasure in life.

Description of the Problem

Eeyore constantly insists that his tail falls off rather frequently. Eeyore's posture typically involves a slumped head, droopy eyes, and commonly says "thanks for noticing me." Sluggish movement is also apparent, without any physical cause for movement delay. He seems to step on his tail often and fall down. Eeyore indicates that sometimes it seems that even his close friends do not need him. Around friends, he typically makes comments about his relative unimportance and travels near the back of the pack. He also stated that although he tries to force a smile, a real smile has not existed in a long time, even though others try to cheer him up. He often feels empty even when accompanied by friends. Eeyore also seems to experience a loss of energy throughout the day, although sleeping habits are not explicitly expressed.

Diagnosis

F32.2 Major Depressive Disorder, Single Episode, Severe without Psychotic Features

Eeyore exhibits five symptoms of a major depressive episode, and has also experienced these for several years,

therefore meeting full criteria. Criteria met include depressed mood most of the day, markedly diminished interest or pleasure in activities, fatigue or loss of energy nearly every day, feelings of worthlessness, and diminished ability to think or concentrate were indicated. Overall, Eeyore exhibits severe clinical major depression and may lean toward the specifier of melancholic features. Eeyore does exhibit some of Melancholic features such as a lack of reactivity to usually pleasurable stimuli, a distinct quality of depressed mood with profound despondency and empty mood, and some psychomotor retardation. Further assessment will be needed to determine melancholic features as details are limited at this point. Postpartum onset is not a factor.

Accuracy of Portrayal

Eeyore is a character that displays a relatively accurate example of major depressive disorder. One major issue with the character portrayed is his consistent involvement with a support group. A lack of interest in activities is common with this disorder, causing most persons with depression to not frequently spend time with others. This is in contrast to Eeyore, who seems to be surrounded by friends much of the time. Also, his support groups seems rather sarcastic at times, as well as exhibiting their own issues so it may be hard to diagnose if environmental factors may prolong the depression longer than it may otherwise last. Some would argue that this may be closer to a diagnosis of Dysthymia, but since Eeyore seems to exhibit more severe symptoms closer to

major depression and each season of the show lasts less than two years, it is hard to fully identify a long term timespan of his disorder.

Treatment

Although various treatments exists, I would recommend cognitive behavioral therapy, and possibly electroconvulsive therapy if CBT does not work alone. Since donkeys have not been tested with medication normally given to persons suffering from depression, I would not advise any type of tricyclics, MAO inhibitors, or SSRIs be used. Regarding cognitive behavioral therapy, it is important that Eeyore first understands the relationship between events, emotions, and cognitions. As mentioned, he must first realize that if his tail falls off that he is not less of an individual. Furthermore, he must also realize that the need to be of worth can be self-induced and that he does not need to rely on others to find this feeling. Treatment would then be followed by instructing Eeyore on identifying, evaluating, and modifying automatic negative thought patterns that exist. He acknowledges his feelings of worthlessness, but also having the tools to evaluate his negative thoughts as something he can control should enable him to eventually take control over his thoughts. Stress management, social skills, and activities training will then follow to give Eeyore a path to improve his well-being by being able to optimally connect with others and join in on activities that spark his interests.

Name: Anthony Soprano, Jr.

Source: The Sopranos (television series, 1999–2005)

Background Information

Anthony Soprano, Jr., referred to as A.J., is a male born on July 15, 1986 to Anthony and Carmela Soprano. The family is of Italian decent and they live in New Jersey. From a very young age, A. J. had disciplinary problems in school and a possible learning disability. After extensive testing and meeting with school counselors, he was deemed to be suffering from Attention-Deficit Hyperactivity Disorder.

It was very obvious throughout the various seasons that A. J. had a strong family history of multiple psychiatric disorders. His father was diagnosed with depression from the beginning of the series. He was on medication and would see a therapist regularly. In addition, his father had antisocial personality disorder and panic disorder without agoraphobia. His father was involved in organized crime, which caused strains on his parents' relationship. Due to these marital issues between his parents, A. J. would often act out during their period of separation and possible divorce. As A. J. got older, his father insisted on him becoming more responsible and not a failure in life. As a way to make A. J. more productive, his father got him a job at a construction site. A. J. started the job and was doing well. He met a Puerto Rican girl named Blanca at the construction site and they started dating.

The two became really close, and A. J. eventually proposed to Blanca. After some reconsideration, she decided that A.

J. was not right for her and broke up with him. This is when he became depressed. A. J. continued to work at the construction site for some time, but the site of Blanca talking to other men became too much for him, so he eventually quit. Just as things seemed like they would never improve, A. J. met some childhood friends whose fathers were also in the Mafia with his father.

He started hanging out with them and seemed to be improving. He also began seeing a therapist and was prescribed Prozac. He improved to the point that he even began to take some college courses. However, these new friends turned out to be a bad influence. They were running some illegal gambling on campus and would use violence to collect money. A. J. did not seem to be affected by this, but when they badly beat up an African American student, this sent A. J. spiraling down once again.

Description of the Problem

After the breakup with Blanca, A. J. started sleeping all the time and would not come out of his room. He had a decreased appetite and anhedonia. He seemed to lack energy for quite some time. There were no suicidal ideations initially. After the African-American student incident, he again confined himself to his room and developed similar symptoms to what he was displaying after his break up with Blanca. It progressed to the point that he attempted to kill himself by tying a plastic bag around his face, wrapping a cinder block around his leg, and jumping in the pool while

his parents were out of the house. Luckily, his father came home and saved him prior to there being any significant damage. A. J. was admitted to an inpatient psychiatric facility and received the therapy he needed.

Diagnosis

The diagnosis for A. J. Soprano is Major Depressive Disorder (recurrent), F33.9, Unspecified. According to the DSM-5-TR, the following are eight of nine criteria that are met for the diagnosis:

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). NOTE: In children and adolescents, can be irritable mood.
 - A. J. exhibits a depressed mood consistently for at least two weeks in both of his major depression episodes.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
 - A. J.'s mother noticed that he quit attending his job at the pizza parlor, even though he used to enjoy working there.

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. NOTE: In children, consider failure to make expected weight gains.
 - A. J.'s mother would constantly cook different things that A. J. used to enjoy before his decrease in appetite, but none of the things she cooked seemed appealing to him.
4. Insomnia or hypersomnia nearly every day
 - A. J. could be seen sleeping throughout most of the day due to his depression.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
 - This is the only criterion that does not pertain to A. J.
6. Fatigue or loss of energy nearly every day
 - A. J. appeared to be tired at all times of the day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional)

nearly every day (not merely self-reproach or guilt about being sick)

- After Blanca broke up with him, A. J. appeared to have feelings of worthlessness.
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
- A. J. stopped attending his college classes due to his inability to concentrate.
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- A. J. actually attempts suicide, but failed to drown himself.
- Specify:
 - Longitudinal Course Specifiers (With and Without Interepisode Recovery)

A. J. displays interepisode recovery between his two major depressive episodes, making his a case of major depressive disorder, recurrent.

Accuracy of Portrayal

The average person watching A. J. on the Sopranos would receive an accurate portrayal of Major Depressive Disorder (recurrent). He displays a majority of the symptoms for the disorder in both episodes he has had. These breaks of normalcy between the two episodes are crucial in understanding major depression episodes, especially when the depression is recurrent. Major Depressive Disorder is highly heritable, so watching A. J.'s father, who also displays signs of depression, helps to understand some of the genetic influence on depression.

Treatment

Proper treatment of A. J.'s Major Depressive Disorder would, given his severe symptom levels, include beginning with antidepressant medication. Psychotherapy might also be added in A. J. case in order to increase effectiveness of treatment. It does not seem that electroconvulsive therapy would be necessary in A. J.'s case since he does not exhibit psychotic symptoms or catatonia.

Alzheimer's Dementia

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Alice Howland

Source: *Still Alice* by Lisa Genova (book, 2007)

Background Information

Alice Howland is a Caucasian female who is 50 years old. She currently works as a cognitive psychology professor at Harvard University. Overall, Howland presents as a healthy 50-year-old woman. Howland is a petite woman, but not underweight. Howland remains active in her work and social life and other than leading a hectic life appears happy. Howland lives with her husband (John) and the two have

three grown children, all of which live out of the home. Howland maintains many close friendships and is in a stable, long-term relationship. Howland does not have any reported drug or alcohol related history. Howland states that she may have a glass or two of wine with dinner, but the only medication she takes is a multivitamin. Howland has not had any head injuries or serious health issues. Howland's mother and sister died in a car accident when she was 18 and her father died the previous year from Cirrhosis of the liver. Howland allowed that her father was an alcoholic and that they did not have much contact over the last several years before his death.

Description of the Problem

Howland frequently exhibits disorientation and gets lost when she is only a few blocks from her home. She recognizes the building and knows that she is supposed to know how to get home, but her mind is blank. Howland frequently misplaces items and is unable to find them. At times, she replaces items and later finds the lost item. She frequently loses her train of thought, or is unable to remember significant details of her life. As a professor, she often visited other universities as a guest speaker or would present at conferences, lately, she would lose track near the middle to end of her lecture and have to refer to her notes. This was not common for Howland as she used her speeches repeatedly only making small changes that were easy to remember. Howland reports forgetting words during a lecture, she states

that it is not even on the tip of her tongue; the word is just completely gone from her memory. Howland recently missed a conference in Chicago, simply because she forgot about it. Howland also states that she has to write down a detailed schedule of what time and where her classes are or she will simply forget to go teach them.

Diagnosis

Dementia of the Alzheimer's Type (294.1x)

Diagnostic criteria:

1. The development of multiple cognitive deficits manifested by both
 - (1) memory impairment (impaired ability to learn new information or to recall previously learned information)
 - (2) one (or more) of the following cognitive disturbances:
 1. aphasia (language disturbance)
 2. apraxia (impaired ability to carry out motor activities despite intact motor function)
 3. agnosia (failure to recognize or identify objects despite intact sensory function)
 4. disturbance in executive

functioning (i.e. planning, organizing, sequencing, abstracting)

2. The cognitive deficits in Criteria A1 and A2 each cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning.
3. The course is characterized by gradual onset and continuing cognitive decline.
4. The cognitive deficits in Criteria A1 and A2 are not due to any of the following:
 - (1) other central nervous system conditions that cause progressive deficits in memory and cognition (e.g. cerebrovascular disease, Parkinson's disease, Huntington's disease, subdural hematoma, normal-pressure hydrocephalus, brain tumor)
 - (2) systemic conditions that are known to cause dementia (e.g. hypothyroidism, vitamin B12 or folic acid deficiency, niacin deficiency, hypercalcemia, neurosyphilis, HIV infection)
 - (3) substance-induced conditions

5. The deficits do not occur exclusively during the course of a delirium.
6. The disturbance is not better accounted for by another Axis I disorder (e.g. Major Depressive Disorder, Schizophrenia).

Howland displays impairment in recalling previous learned material and has disturbances in executive functioning. Howland is not suffering from any central nervous system conditions, systemic conditions, or substance-induced conditions. She is having difficulties at work due to her memory loss unlike her previous performance in her job. Her memory loss and confusion began gradually and steadily worsened.

- Code based on presence or absence of a clinically significant behavioral disturbance:
 - 294.10 Without Behavioral Disturbance: if the cognitive disturbance is not accompanied by any clinically significant behavioral disturbance.
 - 294.11 With Behavioral Disturbance: if the cognitive disturbance is accompanied by a clinically significant behavioral disturbance (e.g., wandering, agitation).

Howland does not present with any behavioral disturbances at this time.

- Specify subtype:
 - With Early Onset: if onset is at age 65 years or below
 - With Late Onset: if onset is after age 65 years
- Coding note: Also code 331.0 Alzheimer's disease on Axis III. Indicate other prominent clinical features related to the Alzheimer's disease on Axis I (e.g., 293.83 Mood Disorder Due to Alzheimer's Disease, With Depressive Features, and 310.1 Personality Change Due to Alzheimer's Disease, Aggressive Type).

Howland's diagnosis falls under the Early Onset subtype as she is only 50 years old.

Epidemiology

The prevalence rates of Dementia of Alzheimer's Type increases dramatically with increasing age, rising from .6% in males and .8% in females at age 65 to 11% in males and 14% in females by age 85. As age increases so do the prevalence rates; at age 90 the rates rise to 21% in males and 25% in females, and by age 95 the prevalence rates are as high as 36% in males and 41% in females. Unfortunately, 40%-60% are moderate to severe cases.

Howland was unaware of her extended families medical history because her mother passed at a young age and her

father, to her knowledge, did not display any symptoms before his death.

Accuracy of Portrayal

Overall, the book accurately displays the course of Early Onset Alzheimer's. The high and lows of mood as the disease progresses are genuine and show the true emotions that not only a person suffering from the disease deals with, but what family members and friends deal with. The book also shows how the disease progresses, somewhat slowly at first and then a continual decline in functioning, not only mentally but also physically. The rate at which each person declines is different, but overall the beginning is gradual and then the decline seems to speed up. It does seem as if the book may have sped up the disease a bit much. The confusion and slight memory loss that progresses into complete memory loss and description of living with strangers does seem to ring true. A person with this disease must frequently feel as if she is with strangers, even when she is with her own family. The book did not go into the very late stages of the disease, at which time those with Alzheimer's physical decline is serious and require feeding tubes and most usually hospitalization or nursing home care, as they are no longer able to walk, feed themselves, or even speak.

Treatment

At this time, there are no medications available to cure Alzheimer's, only medications that seem to slow the

progression. For Alice Howland the best course of treatment would include cholinesterase inhibitors during the beginning stages and an N-methyl D-aspartate (NMDA) antagonist once symptoms become more severe in nature. These medications only slow the progression of the disease, although these medications have been effective in slowing the progression of Alzheimer's in many patients. When the disease presents itself as a safety issue for Howland (forgetting that she is cooking, wandering off and getting lost or unable to take care of her personal daily needs) she needs either nursing home care or 24-hour home care. When Howland reaches the stage where she is no longer able to feed herself or walk, nursing home care is the best recourse for proper care. A healthy diet recommendation through all stages of the disease by limiting unhealthy food intake and eating healthy may help slow the progression of Alzheimer's. However, this is in combination with proper medication. As long as she is able, exercise, reading, crossword puzzles, and other mentally and physically stimulating activities may help slow the progression of the disease, however, there is not adequate research into this area.

Name: Fiona Anderson

Source: *Away From Her* (movie, 2006)

Background Information

Fiona Anderson is a Caucasian female in her late 60's/early 70's. She is fit for her age, not overweight or underweight.

Fiona's family originates from Iceland, but she was raised in Canada. She is married to Grant Anderson (for 44 years) and they have no children. Fiona is currently unemployed; after Grant retired from his job as a professor, the couple moved to Brandt County, Ontario. The couple currently lives in the farmhouse that belonged to Fiona's grandparents and have lived there for 20 years. Fiona lives an active lifestyle by going on cross country skiing trips around their property with her husband. The couple will occasionally see their other married friends, but most live far away. There is no known drug or alcohol problem. Fiona has the occasional drink at home with her husband, but in no way ever appears to have had too much. There is a subject matter that has remained unresolved between Fiona and her husband; while Grant was still teaching there was speculation and rumors that he had an affair with one of his students. Fiona, instead of enraged by Grant's adultery was thankful that he did not leave her. In order to make a better life for themselves and they moved away from all the distractions. Fiona seems to have dealt with Grant's unfaithfulness and her deteriorating memory with a great deal of acceptance and dignity.

Description of the Problem

Fiona exhibits the early signs of memory loss. When she is helping put away the dishes, she forgets, pauses, puts the frying pan in the freezer, and walks away. Her memory loss then progresses to where she has to put labels on all the cabinets and drawers of what belongs where. Fiona admits

that at times she forgets what words mean, like the word yellow. Fiona forgets how to say “wine” while offering her guest another glass. During her evaluation she is asked a series of questions involving mail, she answers the majority of the questions correct but then forgets where a person would take the mail to send it. Fiona becomes even more disoriented as time goes by and loses her way home and wanders off. Her husband is constantly finding things that she has left undone or forgot about, such as when she put a pot of water on to boil, then left the house. The most recent development of Fiona’s memory degrading happened after she was admitted to Meadowlake, a care taking facility. After being separated from her husband for only 30 days she seemed to have lost all knowledge of their married life. She exhibited recognition of his face but not what they meant to each other or the life they shared. Fiona begins to form an attachment with a man who is in Meadowlake with her; when asked about him she states, “I like Aubrey because he doesn’t confuse me.”

Diagnosis

Dementia of the Alzheimer’s Type (294.1x)

Diagnostic criteria:

1. The development of multiple cognitive deficits manifested by both
 - (1) memory impairment (impaired ability to learn new information or to recall previously learned information)

- (2) one (or more) of the following cognitive disturbances:
 1. aphasia (language disturbance)
 2. apraxia (impaired ability to carry out motor activities despite intact motor function)
 3. agnosia (failure to recognize or identify objects despite intact sensory function)
 4. disturbance in executive functioning (i.e. planning, organizing, sequencing, abstracting)
- 2. The cognitive deficits in Criteria A1 and A2 each cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning.
- 3. The course is characterized by gradual onset and continuing cognitive decline.
- 4. The cognitive deficits in Criteria A1 and A2 are not due to any of the following:
 - (1) other central nervous system conditions that cause progressive deficits in memory and cognition (e.g.

cerebrovascular disease, Parkinson's disease, Huntington's disease, subdural hematoma, normal-pressure hydrocephalus, brain tumor)

- (2) systemic conditions that are known to cause dementia (e.g. hypothyroidism, vitamin B12 or folic acid deficiency, niacin deficiency, hypercalcemia, neurosyphilis, HIV infection)
 - (3) substance-induced conditions
5. The deficits do not occur exclusively during the course of a delirium.
 6. The disturbance is not better accounted for by another Axis I disorder (e.g. Major Depressive Disorder, Schizophrenia).

Fiona meets criteria for A1 and A2; the cognitive disturbances that she exhibits are aphasia, agnosia, and possible impaired ability to carry out particular motor abilities. The impairments from criteria A1 and A2 have affected her relationship with her spouse, friends, and how she interacts with others, as well as her daily activities. Fiona does not have any recorded nervous system, substance-induced, or systemic conditions that could impair her memory. Fiona's memory loss has had a continuous decline and started gradually. She is not recorded to have any other Axis I disorders.

Code based on presence or absence of a clinically significant behavioral disturbance:

- 294.10 Without Behavioral Disturbance: if the cognitive disturbance is not accompanied by any clinically significant behavioral disturbance.
- 294.11 With Behavioral Disturbance: if the cognitive disturbance is accompanied by a clinically significant behavioral disturbance (e.g., wandering, agitation).

Fiona has presented some behavioral disturbances, such as wandering the street and woods.

Accuracy of Portrayal

Overall, the movie provides an accurate portrayal of the disease and the effects it has on the person suffering from it. A person not knowing anything about Alzheimer's would learn from the movie that with time that short-term or working memory starts to diminish first. A person suffering from Alzheimer's will gradually lose more of their memory abilities, eventually impairing their long-term memory and recall. They will also learn that people with Alzheimer's can know someone one day but not know them the next. They may also repeat the same questions or statements, having no recollection of already saying them. In the movie they say Fiona is young for already having Alzheimer's, which is not entirely accurate, as she is beyond the age of 65. This puts

her in the Late Onset category, which is more common than Early Onset.

Treatment

There is no current cure for Alzheimer's, but there are medications shown to help slow the progression of the disease. The Food and Drug Administration has approved two types of drugs that could help Fiona: cholinesterase inhibitors and memantine. A good diet and exercise will also help in creating a good environment for the medication to work and help Fiona stay mentally alert. It would also be beneficial to keep the mind working by taking part in any sort of puzzles that help exercise the brain. In the movie they admitted Fiona into a caretaking facility not too long after she was diagnosed with the disease. In my opinion, they could have waited longer to admit her. Her memory seemed to deteriorate faster after she was in the care of the home.

Tourette's Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Lionel Essrog

Source: *Motherless Brooklyn* by Jonathan Lethem (book, 1999)

Background Information

Lionel Essrog is a Caucasian male and presumably in his mid to late thirties. Lionel Essrog is an orphan and the whereabouts of his biological parents is unknown. Essrog spent his childhood and adolescence in the St. Vincent's Home for Boys in Brooklyn, New York, which is a publicly funded boarding house for orphaned young males. The

residents of St. Vincent's are required to attend public school and Essrog acquired his high school diploma but has not received any further education. Essrog currently works for a man named Frank Minna with three other of his housemates from St. Vincent's. The four of them call themselves "Minna Men" and they specialize in unconventional and frequently illegal types of jobs as provided by Frank Minna. Any familial mental health history is unknown. Essrog has no history of drug or alcohol abuse. He does not seem to have any long term goals, other than to continue working for Frank Minna. Beginning in early childhood, Essrog began experiencing compulsions which involved twitching and jerking his neck. These compulsions soon turned into various forms of motor *tics*, including incessant tapping of the metal-pipe legs of schoolroom desks and chairs as if in search of certain ringing tones, reaching for doorframes, and kneeling to grab at untied shoe laces of other classmates. One of his compulsions actually involved grabbing and kissing his fellow classmates and housemates at St. Vincent's. Because of his behavior, Essrog did not have very much social interaction with peers his age and spent a lot of time alone. Around the time he was thirteen years old, the kissing compulsion ended but was replaced with others. He was prone to tapping, whistling, tongue-clicking, winking, rapid head turns, wall stroking, and other various tics. During this time, Essrog began experiencing rapid thoughts that were becoming more and more of a compulsion to speak out loud. Many of these thoughts were echoic variations to things he heard. For

example, when Essrog heard “Alfred Hitchcock” he would silently rephrase it as “Altered Houseclock”. Essrog found it more and more difficult to withhold these compulsions and began exhibiting simple vocal tics by barking like a dog and chirping like a bird. While he still has the compulsion to do simple vocal tics, he also exhibits complex vocal tics as well.

Description of the Problem

Essrog currently displays simple and complex motor tics as well as simple and complex vocal tics. Examples of simple motor tics are eye blinking, nose wrinkling, neck jerking, shoulder shrugging, facial grimacing, and abdominal tensing. Complex motor tics include hand gestures, jumping, touching, pressing, stomping, facial contortions, repeatedly smelling an object, squatting, deep knee bends, retracing steps, twirling when walking, and assuming and holding unusual postures (including dystonic tics, such as holding the neck in a particular tensed position). Simple vocal tics include meaningless sounds such as throat clearing, sniffing, grunting, snorting, and chirping. Complex vocal tics more clearly involve speech and language and include the sudden, spontaneous expression of single words or phrases; speech blocking; sudden and meaningless changes in pitch, emphasis, or volume of speech; palilalia (repeating one’s own sounds or words); and echolalia (repeating the last-heard sound, word, or phrase). Essrog also shows coprolalia, which is the sudden, inappropriate expression of a socially unacceptable word or phrase. Essrog describes his vocal tics

as follows; “My words begin plucking at threads nervously, seeking purchase, a weak point, a vulnerable ear. It’s an itch at first. Inconsequential. But that itch is soon a torrent behind a straining dam. Once I’m able to scratch that itch, it let’s off the pressure in my head and I am able to concentrate”. Essrog’s tics cause him anxiety in social situations but the men with whom he works have learned to accept his behavior. Essrog also claims that his tics are more difficult to suppress when he is anxious or nervous.

Diagnosis

The diagnosis that seems to fit appropriately for Essrog is Tourette’s Disorder (307.23)

Diagnostic Criteria for Tourette’s Disorder (DSM-IV-TR)

1. Both multiple motor tics and one or more vocal tics must be present at the same time, although not necessarily concurrently
 - Essrog exhibits multiple motor and vocal tics.
2. The tics must occur many times a day nearly every day (usually in bouts) nearly everyday or intermittently over more than one year, and during this period there must not have been a tic-free period of more than three consecutive months.
 - Essrog’s experiences tics everyday and has

not shown any evidence of a tic-free period.

3. The onset is before age 18 years.
 - Essrog's symptoms began in early childhood. Motor tics normally develop at about 6 – 7 years of age and vocal tics normally occur at after the onset of motor tics. Essrog's onset fits this criteria.
4. The disturbance must not be due to the direct physiological effects of a substance (e.g., stimulants) or general medical condition (e.g., Huntington's disease or positive encephalitis).
 - Essrog shows no signs of substance abuse or any symptoms of medical conditions.

Accuracy of Portrayal

Jonathan Lethem's characterization of Lionel Essrog was very accurate in the portrayal of a person diagnosed with Tourette's Disorder. The age of onset was the same as listed in the DSM-IV-TR and the description of the compulsions and tics the character exuded were also accurately portrayed when compared to the diagnostic criteria of Tourette's Disorder.

Treatment

Treatment for Essrog should include a specific kind of

psychotherapy. The primary supported therapy for Tourette's Disorder is habit reversal training (HRT), commonly known now as Cognitive-Behavior Intervention for Tics (CBITS). In HRT, a person first learns to know when and where he/she is going to have a tic, followed by development of competing responses that prevent you from physically being able to perform the tic. These responses are held until the urge to tic dissipates. Over time, particularly with motor tics, the client learns that they do not need to tic to feel the release and relaxation. In many cases, Tourette's Disorder can be effectively managed. If the Tourette's Disorder is severe enough, antipsychotic medications can be helpful. These include but are not limited to Chlorpromazine, Haloperidol, and Pimozide. The severity of the tics may be exacerbated by administration of central nervous system stimulants, such as those used in the treatment for Attention-Deficit/Hyperactivity Disorder. Alternative treatments for treating Tourette's Disorder have proven to be helpful for some patients. These treatments are herbal medicines, nutritional, vitamin, and mineral supplements and behavioral therapies. It should be known that these treatments should be used as complementary and never as a substitute.

Specific Phobia

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Ronald “Ron” Billius Weasley

Source: The *Harry Potter* series by J.K. Rowling (books, 1997-2007)

Background Information:

Ron Weasley is first presented to the public audience as a young, goofy 11-year-old wizard boy. Throughout the series he transitions into a mature young adult. He attends Hogwarts School of Witchcraft and Wizardry. Overall he is an average student never going above in expectations and never going under. He is the youngest boy in the Weasley

family out of Bill, Charlie, Percy, Fred, and George. He also has a younger sister Ginny, who he is very protective of. His mother, Molly, is an incredibly loving woman, taking care of her children and running a very crazy household. Her husband's name is Arthur Weasley and he works a modest job at the Ministry of Magic. The Weasley family is very rare in the wizardry world because they come from what is known as pureblood. This means that the Weasley family only have witch and wizard blood in their biological line. It is rare and often used by other Wizardry family has a way to declare dominance among their kind. The Weasleys, however, do not mistreat others and do not consider themselves to be above the rest of the wizardry population. Their good nature is one of the few things they are rich with, as there are very poor with only a modest income. They have been known to pass on handed down clothing among the children and make them handmade gifts because they cannot afford much else. They struggle finically with getting their children everything they need for school and they live in a small house that is referred to as the Burrow. Ron has a particularly difficult time dealing with the teasing that is brought on to his family because of their financial standing. He often has to defend his family to other people, especially towards Draco Malfoy, who is not afraid to bring up the handed down clothing whenever he wants to insult Ron.

Ron has two best friends at his school. They are the beautiful and very smart Hermione Granger and the ever popular boy-who-lived, Harry Potter. They have all been

close since their first year in Hogwarts, when they all started battling against the evil wizard Voldemort. The relationship among these best friends, however, has often been rocky. Hermione and Ron fight constantly and as the books progress you can start to see a romantic relationship form. It is not until the final book that the audience completely knows the true feelings between these two characters. Ron and Harry instantly became best friends, but it was often hard for Ron to stand in the background of Harry's ever growing shadow. This caused a lot of tension between the two, but in the end the relationship stayed strong. The biggest problem Ron faced in his life was the financial well-being of his family. He was very lucky to have both of his parents still alive and not have to face the torment that was given to Hermione from being muggle-born. Once he completes his seven years of training at Hogwarts, Ron wants to become an Auror, who are known for catching evil wizards. He is very good at chess and likes to use strategies to help him in difficult situations. During his years in school Ron saw himself as the Head Boy and the Gryffindor Quidditch captain. Ron has difficulty dealing with certain situations and often lets his anger get the best of him. He tends to explode and lash out against others when things become too difficult to bear. The biggest weakness he faces is jealousy of those around him. He is not completely satisfied with what he has been given and normally wants what others have. This makes his relationships sometimes difficult, but over time Ron began to get over his jealousy issues.

Description of the Problem

In the second book of the Harry Potter series, *The Chamber of Secrets*, the audience becomes aware of the fact Ron is incredibly afraid of spiders. The being around them scares him immensely and the mere idea of spiders turns him into the world's biggest baby. When he is around them he begins to shake and he starts screaming at a high pitch. If he is able to form words at all, they are difficult to understand. His fear stops him in his tracks. Physiologically, his eyes get big, he has difficulty breathing, and his face sometimes turns white. His anxiety is so high in fact that he thinks the end of the world is happening and he must escape from the situation.

Diagnosis

It is very clear to see that Ron is suffering from a Specific Phobia, in particular Arachnophobia. This falls under the DSM-IV five general types of specific phobias in the animal type category.

As mentioned earlier, Ron does not even need to be in the around spiders to be afraid of them. Only mentioning them is enough to scare him and make him want the conversation shifted to a different topic.

B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed panic attack. Children can show affects and characteristics when it comes to specific phobias.

Children can show anxiety by crying, throwing tantrums, experiencing freezing or clinging to the parent that they have the most connection to.

His level of anxiety definitely rises, as evidenced by how his voice changes, he begins sweating profusely, he starts shaking, and he does everything he can to avoid the situation.

C. The person recognizes that the fear is excessive or unreasonable.

In Ron's case his fear of spiders started long before his traumatic experience with them in *The Chamber of the Secrets*. This even may have enhanced his fear, but he knows that is fear is often the point of joke and he understands that he sometimes takes it to an extreme level of anxiety. However, the amount of teasing he gets from others does not stop his fear from being expressed.

D. The phobic situation(s) is(are) avoided, or else endured with intense anxiety or distress.

It is clear that Ron will do anything to avoid being around spiders, including using his wizardry skills on them.

E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, social activities or relationships, or there is marked distress about having the phobia.

This does not seem like the case for Ron. He is able to conquer his fear after he builds up some esteem to do so. It is rare for him to walk away from a situation just because spiders are present, but it does require him to build up a lot of

motivation in order to follow through. His normal routine is often just delayed when a spider is present or mentioned.

E. In individuals under age 18 years, the duration is at least 6 months.

Throughout the majority of the series, Ron is under the age of 18. He has had this fear of spiders in the second book when he and Harry had to go into the Forbidden Forest in order to find out if Hagrid was really opening the Chamber of Secrets. In the third book, *The Prisoner of Azkaban*, Ron and his fellow students at Hogwarts were learning how to battle of Boggarts, which turn into their biggest fear. For Ron's case it would turn into a spider since that is his biggest fear. In the seventh book, *The Deathly Hallows*, Ron is trying to destroy an evil force and it uses his fear against him by making spiders appear. In the other books, Ron's fear does not have a huge part, but it is mentioned in small sections of the book with comments explaining that his fear has been around for quite a long time. It is quite clear that every time spiders are mentioned that Ron's fear comes up as well. This definitely exceeds six months.

G. The phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as obsessive-compulsive disorder (e.g., fear of dirt on someone with an obsession about contamination), post-traumatic stress disorder (e.g., avoidance of stimuli associated with a severe stressor), separation anxiety disorder (e.g., avoidance of school), social phobia (e.g., avoidance of social situations

because of fear of embarrassment), panic disorder with agoraphobia, or panic disorder without agoraphobia.

Ron has no other signs of a mental disorder with his fear of spiders. It seems like the phobia is the only thing that is causing problems to come about in his life. He is actually quite open about his fear of spiders and it is often mentioned in the books to release tension during difficult and dramatic times.

It is very obvious that Ron is afraid of spiders. The difference between him and other individuals is that he faces his phobias despite how bad his anxiety responds. He fits the criteria and allows for a very clear and diagnosable explanation about his disorder. It is not unrealistic to place him in this category of anxiety disorders.

Accuracy of Portrayal

The portrayal of Ron does a very good job of explaining what it would feel like to live with specific phobia and for the audience presents many realistic ideas about Arachnophobia. The books give good examples about what is going on with Ron's anxiety about the spiders and why he reacts to them in the way he does. The main problem with the portrayal is that it is often used for humor in the majority of the books. There are points when the phobia is quite obvious and understood in its full meaning, but the majority of the time is spent on Ron's phobia being mentioned as a joke. For the readers, it is used as a nice little sigh of relief during the dramatic parts of this intense book series. It is important to remember that the

Harry Potter series is mostly used for entertainment purposes and that sometimes it can over dramatic about humorous moments and complex storylines that allow for a more enjoyable read. This causes some of Ron's phobia tactics to be displayed humorously and causes it to be funny and less like a mental disorder.

Treatment

The most recommended treatment for Ron would be Behavioral Therapy. In this process exposure techniques would be used to allow Ron's anxiety levels to lower during different stages of exposure. The exposure to the spiders over a long period of time would eventually causes his anxiety levels to lower greatly. This would also cause less intensity with his fear. Ron's sessions would start with a small amount of exposure to spiders by first talking about them, showing him pictures, and being in the same room as one. The steps would increase only after Ron became comfortable with the spiders and his anxiety levels would level out. The steps would increase with exposure until Ron was able to hold a spider and not attack it or be afraid. It would also be beneficial for Ron to go through some cognitive therapy as well. This would help him identify with the truth about spiders and help him to stop thinking that they are terrible creatures. This would be important because Ron is in the magical world and his interactions are different from those in the muggle world. Ron would be able to show great improvements with his mental disorder, but he is however a stubborn red head. This

might be the only thing to stop him from being successful with his treatment.



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Conduct Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Nelson Muntz

Source: *The Simpsons* (Television series, 1989 – present)

Background Information

Nelson Muntz is a 10 year old Caucasian boy who is a student at Springfield Elementary School. Nelson is unemployed and although he is a full-time student, he is on the verge of dropping out. His health appears to be in good condition, but there was a time when he was exposed to second hand smoking. Other than that, the patient does not seem to have any physical illness. However, some problems that are

observed are how he behaves towards his peers and others. Nelson is feared by many of his classmates and peers. He is known to pick fights with the “nerds” and other kids that get in his way. Nelson is known by the community as the “bad kid on the block” and “the school bully.” Parents of other students, as well as school faculty, see him as a delinquent. Nelson’s family consists of his father, Mr. Muntz, mother, Mrs. Muntz, grandfather, Judge Muntz, and a sister who is unnamed. Little is known about the relationship between his parents as well as his relationship with them. Currently he lives with his mom, who works at Hooters as a waitress. His father is mostly absent in his life and as the story goes, Mr. Muntz abandoned his son and wife when Nelson was really young. However, there were few times in Nelsons’ life where his father does appear, such as after a football game where Nelson was the star player. Mr. Muntz came to congratulate him and invited him to have dinner at Hooters, but Nelson refused because he did not want to see his mother working there. Mrs. Muntz is known in the community as a jailbird, a prostitute, and a stripper. Mrs. Marge Simpson adopts Nelson informally. Nelson has difficulties in school when it comes to keeping up with his grades. Although he is known as a bully, there are occasions where his good nature comes out and befriends Bart Simpson and even dated Lisa Simpson. Nelson can be very disruptive and noncompliant to rules at school. He hangs out with older kids from high school, who also show no interest in education. Nelson has very little in the way of a support group, and keeping a friendship is difficult

for him. Nelson can be very demanding and if he does not get what he seeks, then there will be consequences to those who get in his way. He enjoys seeing the misery of others and in many situations will laugh at their face. Nelson does not have very strong coping skills, if not any. He expresses his emotions physically by beating up someone and or by committing pranks and small crimes. There is no known history of drug or alcohol use.

Description of the Problem

Nelson Muntz displays a multitude of symptoms that are associated with Conduct Disorder. He displays anger and frustration through the act of bullying his peers. He shows no respect to authority figures and is disobedient towards them. He places no importance on school and constantly picks on the nerds and geeks that attend his school. He performs delinquent acts such as stealing, looting, vandalizing, and cheating. Nelson has made threats to other students and physically harmed them. For example, when one of his buddies stole Lisa Simpson's cupcakes, her brother went to defend her by telling Nelson's buddy to back off and soon they engage in a physical fight. Nelson, seeing Bart Simpson fighting his buddy, joins in the fight to defend his friend. Bart accidentally makes Nelson's nose bleed causing Nelson to become angrier. The fight was interrupted by the school bell indicating recess was over and it was time to go back to class. Nelson, full of anger, threatens Bart and tells him to meet after school. For the next few days, after school,

Nelson physically beats Bart, shoves him into a trash can and rolls him down a hill. At one point or another, Nelson has terrorized virtually everyone in Springfield. He takes great pride in seeing those he believes to be inferior to him suffer pain and is in misery; he delights in other people's pain and suffering. He shows guilt or shame about his misbehavior and often justifies his cruel actions. His close friends, who are just like him, only encourage his behavior and his parents show no concern or interest in their son's behavior.

Diagnosis

The diagnosis that is appropriate for Nelson Muntz is **Conduct Disorder (312.81)**.

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules that are violated, as manifested by the presences of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months.

1. **Aggressive conduct that threatens physical harm.**
2. **Nonaggressive conduct that causes property damage.**
3. **Deceitfulness or theft.**
4. **Serious violations of rules.**

Nelson Muntz meets all three of the above criteria. His

aggression has led to physical harm to others as well as to him. He has been involved in vandalism and property damage due to recklessness. He has bullied his way into getting things that are not his. He has broken many state and school laws as well as showing no obedience to authority figures.

B. To the diagnosed with Conduct Disorder an onset of at least one criterion characteristic must be displayed prior to age 10 years:

Aggression to People and Animals:

1. Often bullies, threatens, or intimidates others.
2. Often initiates physical fights.
3. Has used a weapon that can cause serious physical harm to others.
 1. A bat, brick, broken bottle, knife, gun
4. Has been physically cruel to people.
5. Has been physically cruel to animals.
6. Has stolen while confronting a victim.
 1. Mugging, purse snatching, extortion, armed robbery
7. Has forced someone into sexual activity.

Nelson Muntz has displayed more than one of these symptoms of Conduct Disorder prior to age 10 and currently still does. These symptoms are described above under the headline "Description of the Problem."

C. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

Nelson Muntz has no interest in school and often he is found to cheat on his assignments and exams.

D. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Nelson Muntz is only 10 years old.

Accuracy of Portrayal

An average person watching *The Simpsons* would be able to come to conclusion that the character Nelson Muntz shows abnormal behaviors when compared to his peers. They will notice that his lack of a stable home does have a huge role in his delinquent behaviors. A person with an Abnormal Psychology background could easily identify Nelson's behaviors are symptoms of Conduct Disorder. The character Nelson Muntz is an accurate portrayal of how a child with Conduct Disorder behaves and acts towards others. However, in the realistic world, such symptoms are worse.

Treatment

Nelson Muntz should have a full medical examination before any treatments are given. First, Nelson's parents should be educated about the disorder as well as provided with well-established treatments. Nelson's behaviors should be modified in the class rooms as well as the play grounds. Treatments

such as goal setting and developing ways to reach those goals should be taught to Nelson on a one-to-one bases. Nelson's parents need to be more involved in his life, and therefore family therapy is recommended. According to research, the optimum method seems to be an integrated approach that involves both the child and the family, within a variety of contexts throughout the child's developmental stages as well as his and his family's life. Also, when Nelson misbehaves, he should have some sort of consequences for his actions instead of encouraging his behavior, therefore, grounding or timeout should be enforced.

Delusional Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Marshal Edward “Teddy” Daniels (Andrew Laeddis)

Source: *Shutter Island* (movie, 2010)

Background Information

Marshal Teddy Daniels is a hard working investigator in his mid-thirties. He is a Caucasian male who seems to be highly intelligent and somewhat healthy. Teddy smokes several cigarettes a day and tends to abuse alcohol. He served in World War II and encountered many traumatic experiences at the Dachau Concentration Camp in Germany. Little is known about his family history or life situation when he was

young. Teddy did, however, have a wife and three children and it is stated that his wife was emotionally unstable. Teddy is very goal orientated and spends many hours concentrating on work. His work ethic keeps him detached from family and friends. When he encounters conflict he becomes angry quickly, which interferes with his ability to control his temper. Teddy's current investigation involves the disappearance of Rachel Solando from Ashecliffe Mental Institution, located on Shutter Island.

Description of the Problem

Edward (Teddy) Daniels claims to be an investigator at Ashecliffe Mental Institution located on Shutter Island. As Teddy enters the facility with his partner, Chuck, the patients doing yard work creepily smile and wave as if they know him. Teddy asks for records of every patient on the island and is denied. He does not understand why the officials will not hand over the documents because he is well respected military personnel on a mission to discover facts about the disappearance of Rachel Solando. Teddy becomes frustrated with the institution's faculty and decides to end his mission.

A storm develops preventing Teddy to leave the island. During the storm he has delusions in which he believes patient number 67 is being kept a secret. The delusions convince him that the patient is Andrew Laeddis. He then ventures out to Ward C, which he has not been granted permission to investigate, in search of Laeddis. Upon entering Ward C, Teddy discovers George Noyce, a schizophrenic

patient, who then informs Teddy about a conspiracy theory that the institution is performing lobotomies in the nearby lighthouse. Teddy begins having dreams of a little girl asking him to save her. His wife continues to appear in hallucinations, telling him that Laeddis is still in the institution and Teddy must find him and kill him.

After the storm, the institution provides Teddy with a set of dry clothes and a fresh pack of cigarettes. The clothes happen to be those that the patients wear. The lightning from the storm affects Teddy and he begins to experience migraines. The institution then provides him with headache medication. Shortly after waking up the next day he ventures out to the coast again in search for the lighthouse. Through the hallucination of meeting a former psychiatrist in a cave, he is convinced that the institution has drugged from through the pain medications and cigarettes, causing him to experience wild dreams, sleepless nights and migraines. He feels as though everyone in the institution is purposely attempting to keep him as a patient.

Teddy makes his way to the lighthouse, finding absolutely nothing unordinary. He finds his psychiatrist in a room at the top. He confronts the psychiatrist about the conspiracy theory and how he needs off of the island to report the institution to the government. The psychiatrist debriefs Teddy about his Delusional Disorder. The psychiatrist tells Teddy that he has been a patient for over two years. He explains to Teddy that he created fictional characters by using anagrams from his name, and the names of his loved ones.

The psychiatrist informs Teddy that he murdered his wife after coming home to find his children floating in a pond. Teddy refuses to believe that he murdered his wife or that he had children. The psychiatrist persists in explaining that he had been trying a new type of therapy known as role-play therapy. The role-play therapy is used in hope for Teddy to realize on his own that he is Andrew Laeddis.

Teddy begins to have flash backs of the afternoon he came home and found his children dead. He realizes the little girl from his dreams is his daughter. He remembers that he killed his wife in the spring of 1952. He finally realizes that he is the lost patient, Andrew Laeddis. He realizes his partner, Chuck, is actually his specialty psychiatrist who had to be with him at all times because he is the most violent patient on Shutter Island. Teddy, now Andrew, is eligible to be released from Ashecliffe Mental Institution. He says to his specialty psychiatrist “What now? We need to find a way to get off of this island”. Teddy fakes a relapse because he did not want to go out into society and possibly hurt anyone else. The officers at the institution escort Teddy to have a lobotomy to “cure” his disorder.

Diagnosis

The diagnosis for Edward Daniels is **Delusional Disorder, Mix Type (297.1)**

1. Non-Bizarre Delusions for at least one month.

1. Teddy experiences non-bizarre delusions

over the course of two years. The delusions are not due to Schizoaffective Disorder, nor Mood Disorder. He does not have an alcohol dependency nor is he chronically depressed.

2. **Criterion A for schizophrenia has never been met.**
 1. Teddy does not show flat inappropriate affect. He is very sociable and his delusions are not bizarre.
3. **Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and behavior is not obviously odd or bizarre.**
 1. Teddy is able to function normally. He is sociable and is able to properly communicate.
4. **D. If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods.**
 1. Teddy is generally in a good mood. He is not depressed or anxious. He is always looking forward to catching new hints about Rachel. He gets angry when people refuse to give him what he thinks he

needs, such as case files for patients in the mental hospital.

5. E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

1. Teddy does smoke and drink however; he does not have negative episodes which develop from the substance abuse, but not alcohol dependence. He takes medications which help his migraines to go away.

6. Specify Type

1. Mixed Type

i. Delusions characteristic of more than one type.

1. Grandiose Type

1. Delusions which are inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.

i. Teddy believes that he is a valued marshal with specialized privileges to the mental hospital. He feels that people should obey his requests.

1. Persecutory Type

1. Delusions that the person (or someone to whom the person is close) is being malevolently treated in some way.
 - i. Teddy feels that the employees of the mental institution are trying to commit him at a patient. He feels that they are controlling him by giving him special medications other than simple pain killers. Teddy is also convinced that the cigarettes the institution provides are laced with drugs to cause him to become powerless

Accuracy of Portrayal

The portrayal of Delusional Disorder was accurate throughout the film. It was not apparent until the end of the film that he was suffering from a disorder, and not an actual investigator. The delusions were believable to those who do not have a complete understanding of psychology and psychotic disorders.

Treatment

The treatment psychiatrist used in the film was ultimately performing the lobotomy. Lobotomies were accepted in the fifties as reasonable treatments for psychotic disorders. In current treatment procedures lobotomies are unethical. The lobotomy procedure is the use of an ice pick type probe which is inserted through the eye in order to dismantle the brain. This develops a calming effect on the patient.

Recent treatment used for Delusional Disorder would

include both medications and psychotherapy. Medicinal treatments may involve anti-psychotics and antidepressants such as SSRI and Clomipramine. Psychotherapy treatments involve supportive therapy and cognitive therapy. The treatment used for patients must be individualized. The treatment for Andrew Laeddis should consist of cognitive therapy combined with medication.



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Cyclothymic Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Dolores Price

Source: *She's Come Undone*, (book by Wally Lamb, 1992)

Background Information

The book follows Dolores through childhood, adolescence, and young adulthood. Dolores Price begins as a young girl growing up in New England. After her father leaves her and her mother, they move in with her uptight grandmother. Her mother experiences a nervous breakdown and is sent off to a mental hospital. Dolores claims it's her "nerves." Her grandmother represses everything and has difficulty speaking

of her mother's mental issues. At the age of 13, Dolores is raped by her grandmother's upstairs tenant. Following the rape, Dolores' mother constantly gives her food. Throughout adolescence, Dolores continually gains weight until she weighs 257 pounds at age 18. She attempts to go to college, but ends up leaving and goes to Cape Cod to attempt suicide. After a failed attempt at drowning, she ends up in a private mental institution where she undergoes immense amounts of psychoanalytic therapy. Once released, she goes to Maine and gets a job as a grocery clerk. Now, as an adult, she marries an abusive and manipulative man. She does nothing to anger him until her grandmother's death. Because of his aversion to children, she has an abortion for him. Throughout her entire life, Dolores has issues with relationships. She had one close friend in childhood but never made many more in adolescence. Due to her weight and the rape, she kept to herself in high school. In college, she works tirelessly to please her roommate and the other girls she is around. She does the same with her husband, Dante. Her main goal is to please others around her to achieve approval. She is short and rebellious with her mother and her grandmother. She experiments with marijuana a few times but never uses any drug heavily. She drinks occasionally, but again never heavily. She has no real goals. She strives to be loved but gives up on it easily when it fails her. She strives to gain power over others at times but also gives up on that. Towards the end of the story, she simply wants a child, after obsessing over her abortion. It is incredibly hard for her to handle sexual

relationships after the rape and only enjoys it sometimes with Dante. She cannot handle rejection or abandonment. The only coping skill she really has is eating, and it causes her just as much pain as the issue she aims to avoid.

Description of the Problem

Dolores' weight gain stemmed from her traumatic rape. This unnecessary weight causes her to feel extraordinarily inferior to others around her. She goes through periods of depression, believing she has harmed everyone around her. She then goes through periods of what she describes as "power." She spews vicious sarcasm at those around her and is, at times, cruel. After a lesbian encounter in college, she kills the woman's goldfish to prove she has control. She enjoys leaving her therapist upon her release from therapy. She waves the fact that a psychic has given her more help in front of his face in order to anger him. In Maine, she feels accomplished often. During these times, her job performance improves, her sexual life increases, and she cleans and cooks every day for her husband. Her depression and "power" continue after therapy. If Dante is unhappy, Dolores is unhappy. She feels useless, especially when she angers him. After her grandmother's death, Dolores leaves Dante and again becomes depressed. She says she wishes she could hold on to the power and go back in time to fix what she did to others. Dolores describes her life in sections. Her parents' divorce is one section, the rape is another section, her adolescence is one section, her college life is a section, her therapy is a section, and her

adult life is a section. Throughout each section, she develops an obsession with whales. She describes a parallel between herself and whales. She craves their power and feels their hopelessness when they wash up on the beach.

Diagnosis

The diagnosis that seems most appropriate for Dolores Price is **Cyclothymic Disorder (301.13)**.

Diagnostic criteria:

A. For at least 2 years, the presence of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet criteria for a Major Depressive Episode. Note; in children and adolescents, the duration must be at least 1 year.

Dolores' times of "power" contain within them hypomanic symptoms such as excessive involvement in pleasurable, yet possibly dangerous, activities. This is manifested through her increased sex drive and sexual activity with Dante the first night they met, her increased interest in sex throughout certain times in her life, and her lesbian experience with her dorm's maid. She has elevated mood and feels control over others around her. She is grandiose and believes that she will succeed in imagining her life with Dante, who is clearly abusive and unfaithful. She also exhibits grandiosity in her correspondence with her college roommate prior to moving in. She makes up stories and a completely different life in order to create a good image. She becomes highly distracted during her stay in the halfway house with an etch-a-sketch.

She spends hours recreating artistic masterpieces on multiple etch-a-sketches and tunes out the rest of the world. Dolores also exhibits depressive symptoms at many times. She exhibits weight gain, not only in adolescence but later in her adult life after she moves back into her old house. She tries once to cut herself but is taken aback by the blood. She expresses feelings of inferiority and worthlessness and tries to stifle them with food. In her marriage, she is depressed when Dante is not happy. This drives her to an abortion. Even during the course of her heavy psychoanalytic therapy, she swings between depression and power. At times, she hates her therapist and wishes she could leave. At other times, she idolizes him and imagines sexual activity with him.

B. During the above 2 year period (1 year in children and adolescents), the person has not been without the symptoms in Criteria A for more than 2 months at a time

There is never a time in Dolores' life where she does not experience any of these symptoms. Even after therapy she still experiences hypomania and depression.

C. No Major Depressive Episode, Manic Episode, or Mixed Episode has been present during the first 2 years of the disturbance.

Although at one point Dolores contemplates committing suicide, she does so because she wants to feel united with the dying whales at Cape Cod. She does not sincerely want to die, she just wants to feel one in the same with something else. Her plan is disorganized and incomplete. She also never reaches full mania.

D. The symptoms in Criteria A are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Dolores exhibits no psychotic symptoms. She possesses no firmly held delusions.

E. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug abuse, a medication) or a general medical condition (e.g. hyperthyroidism).

Her weight gain stems from her own belief in herself, not a medical condition. While she experiments with alcohol and marijuana, she has no history of substance abuse or dependence.

F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Dolores fails at almost all of her relationships. She has no friends in high school and her only friend in college was the dorm's maid. Her marriage is unsuccessful and she fails to relate to grandmother her whole life. She does not care about school so she fails in high school and drops out in college. She only manages to succeed at a job when she is in control, or in power. After she moves back to Easterly, her jobs are menial and she only works when she is experiencing hypomania.

Accuracy of Portrayal

Dolores is not a likable character by any means. She is unsympathetic, hard to relate to, and it is almost impossible to feel bad for her. She manages to ruin her relationships all on her own and she takes tragedy to an extreme. The book demonstrates the difficulty that may be faced by others who have relationships with cyclothymic individuals. It also demonstrates the impacts a mood disorder can have on every aspect of one's life. It is accurate in its depiction of the feelings that accompany cyclothymia, describing hypomania as "power" and depression as "oppressive." Dolores' mother may also have bipolar disorder, reflecting the possibility that bipolar disorder may be more common in first degree relatives. There are some inaccuracies, though. The therapy that Dolores undergoes is inaccurate. Her therapy is very psychoanalytic in nature, focusing on her mentally unstable mother and sex. Her therapist even goes as far as to pretend to be her mother. Her treatment is also only slightly effective and she still experiences cycles as she gets older. The book does not do much to describe any sort of mental disorder. Instead, it paints a picture of a woman who has lived a miserable life, caused mainly by her own hands.

Treatment

The first treatment that should be implemented for Dolores is a lifestyle change. Her extremely sedentary lifestyle would benefit from exercise and diet, which could help stabilize

mood. This would have to be highly regulated in order for her to follow it and actually make the changes. Following the implementation of exercise, cognitive therapy should be used. Cognitive behavioral therapy, interpersonal therapy, or group therapy could be utilized. Due to Dolores' inability to relate well with others, cognitive behavioral therapy should be used. If therapy is ineffective, medication could be used, but only as a last result due to the health problems Dolores already has due to her weight.



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Transvestic Fetishism

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Glen

Source: *Glen or Glenda* (movie, 1953)

Background Information

Glen is a heterosexual Caucasian male and presumably in his late twenties. He appears to be in good physical health, appropriate weight for stature and is a smoker. Glen was raised by his biological parents and has one younger sister. According to Glen his relationship with his father was strained. Glen's father wanted a son that was interested in sports and who would be a great athlete, none of which

Glen was interested in. He expressed that his mother was more affectionate towards his sister and that he longed for that type of affection. He lives in the city, has a stable job, maintains friendships and has been engaged to be married for 1 year to his fiancée Barbara. Glen and Barbara have a healthy relationship displaying respect, open communication and expressions of affection. Glen has no history of drug, alcohol or other mental health issues.

Description of the Problem

Glen has a desire to dress in women's clothing (cross-dressing). He has expressed that being able to dress in clothing of the opposite sex makes him happy and more comfortable in his environment. While living at home he fulfills this desire by wearing his sister's clothing when none of his family members are at home. In order to fulfill his desire to wear women's clothing in public he wears one of his sister's dresses to a Halloween party. After Glen moves from his family residence, he finds it easier to cross-dress. He purchases more clothing but still hides them in case his family was to visit. Living alone also provides more instances to cross-dress in public. He is happy being male and has no desire to change his sexual orientation. Since his engagement to Barbara he is experiencing stress brought on by his need to dress in women's' clothing and whether or not to disclose this information to Barbara or keep it a secret. He finds support from a close friend (who is also a transvestite) who encourages him to be forthcoming and not hide his secret.

Diagnosis

DSM-IV-TR criteria

A. Over a period of at least 6 months, in a heterosexual male, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving cross-dressing.

Glen did not meet criteria for Transvestic Fetishism. He exhibits symptoms more associated with being a Transvestite or cross-dresser. He exhibited no recurrent, intense sexually arousing fantasies, sexual urges, or behaviors in addition to his cross-dressing.

B. The fantasies, sexual urges, or behaviors cause significant distress or impairment in social, occupational, or other important areas of functioning. It involves using nonliving objects to obtain sexual arousal.

Glen's cross-dressing created distress within himself and his relationship with Barbara. She began to see signs of difficulty or stress in Glen which create trust issue for her. Glen experiences extreme stress about the idea of telling Barbara and possible losing her because she could not understand his obsession.

Accuracy of Portrayal

Glen did not meet criteria for Transvestic Fetishism. The movie portrayed an individual who did meet criteria for cross-dressing: A desired to wear clothing of the opposite gender in some instances to relieve stress brought about by daily encounters. The essential feature of Transvestic

Fetishism is defined as recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving cross-dressing. Glen did not exhibit any sexual urges or sexual fantasies while engaging in cross-dressing. He expressed his desire to cross-dress was only for comfort and happiness within his environment. This movie did not address any of the aforementioned criteria in regards to Transvestic Fetishism.

Treatment

There is no empirically supported treatment for Transvestic fetishism. Two types of therapy have been utilized in an effort to treat this disorder: aversion therapy, involving electrical shock and orgasmic reorientation, an attempt to help individuals learn to respond sexually to generally acceptable stimuli. Both of these treatments were developed when little was known about the disorder and when it was less accepted. Today there is less focus on treatment of the disorder and more encouragement for societal acceptance. In cases where individuals have come in for treatment it is mainly due to others, such as spouses and /or family members requesting they seek treatment. Prognosis for this disorder is poor due to the fact that most individuals with this disorder do not want to change. Treatment that is demanded by others such as one's spouse or family members is almost always not successful.

Gender Identity Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Brandon Teena (Teena Ray Brandon)

Source: *Boys Don't Cry* (movie, 1999)

Background Information

Brandon Teena is an adolescent, Caucasian female who grew up in Lincoln, Nebraska. Teena prefers to live her life as a male. She does not currently appear to have a stable and persistent means of income or employment. Teena steals because of her low social economic status and non effort to obtain an occupation. Her delinquent activity has led her to attain a juvenile record before she has reached the age of 21.

Although, the whereabouts of her mother is unknown, there seems to be a distant to an almost nonexistent relationship between her and her mother. Her father died before she was born so there is absent fathering in her life from the beginning of her years. She lives with her cousin from time to time in a trailer home, yet her cousin does not support the trouble she gets into with the locals and the law. Her cousin and presumably other family members do not except her transgender choice to act as a male either. Teena mainly lives out of her travel bag with no stable, consistent place to call home. There doesn't seem to be any health concerns. There is also no evidence that there is any family mental history as well. Brandon Teena, who's legal name is Teena Brandon, has always looked like a girl, yet reported that she had always felt as guy. Cutting her hair short, wrapping up her breasts, and wearing a fake penis has in fact resembled her as looking as a male. Her past does not show any previous drug or alcoholic abuse; however, recently she has been introduced to a selected few of drugs, such as marijuana, with a group of new friends in Falls City, Nebraska. Teena's weakness appears to be females. Her goal is to have a surgical procedure to change her female sex characteristics.

Description of the Problem

Teena currently displays symptoms that indicate that she does indeed reject her identity as being a female physically. She seems to have emotional symptoms, especially when someone may mention that she is a girl and not a boy. Her cousin

continued to tell her that she was a girl, that she needs to leave the girls alone, and that she needs to accept the fact that she is a lesbian. Although Teena knows that she is physically not a male, she denies being a lesbian or homosexual. Teena cross dresses and wears a fake penis and socks in her pants in order to portray body types like a male. She denies having sexual attributes such as a having a menstruation and tries to hide all of her sexual characteristics from others. She will claim to be a hermaphrodite before she claims to be a female. Teena has not ever had sexual intercourse with a male and has resisted from being touched any areas by her genitals from any of her sexual partners. Teena could pass for a male fairly easily with a short hair cut like a guy her age, male stature, and her cross dressing efforts.

Diagnosis

The diagnosis for Teena Brandon that seems to fit appropriately is **Gender Identity Disorder in Adolescents or Adults (302.85)**.

A. In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the opposite sex, frequent dressing as the opposite sex, desire to live or be treated as the opposite sex, or the conviction that he or she has the typical feelings and reactions of the opposite sex.

Teena acted like a male and desired to be treated like a male by everyone. Teena cross dressed to look like a normal guy her age would as well. She was also very attractive to girls.

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of their sex. In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

Teena desired to change her sexual characteristics through surgical procedures. She wrapped her breasts down in order to flatten them and wore a counterfeit penis in her underwear.

C. The disturbance is not concurrent with a physical intersex condition.

Even though Teena claimed that she was a hermaphrodite, she was full characterized and constructed as a female physically and biologically.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if (for sexually mature individuals): Sexually attracted to males, sexually attracted to females, Sexually attracted to both, Sexually attracted to neither

Teena was a part of the low social economic status population and also did not indicate a means of trying to obtain an occupation while she continued to steal things.

Teena seemed to have a hard time getting along with everyone except for her female partners.

Accuracy of Portrayal

The average person watching this movie would see a reasonably accurate portrayal of the *onset* of Gender Identity Disorder, especially since Teena Brandon denies her gender and sexual characteristics as well as being a homosexual in any part of the movie. The movie helps the portrayal of gender identity disorder in a significant way by giving good examples of all the symptoms of gender identity disorder. Because the movie portrayed true events of someone's life, most symptoms did seem neither inaccurate nor exaggerated. Teena fits the adult presentation of gender identity disorder because of her persistent frustration of her biological sex. She passed as the opposite sex by cross dressing and abstained from touching or letting female partners touching her genitalia. One may think that parental relationships were being mislabeled in the movie about gender identity disorder because the only whereabouts that were known about the parents were mentioned very briefly. The course of the disorder was also mislabeled because nothing about her childhood was revealed during the movie. If her childhood was identified during the movie, then gender dysphoria would have been prevalent in her life because research shows that children with gender dysphoria that persists into adulthood results in gender identity disorder. Teena showed to have constant discomfort with her sex as being a female which

fits into the general descriptive feature of gender identity disorder. The reason why majority of people, friends, and family of Teena did not accept her sexual orientation is because there is a 1 in 100,000 occurrence opposed to 1 in 30,000 in men and men are more accepted than women. Throughout all of the details and information that was made available in the movie, the movie portrayed gender identity disorder appropriately.

Treatment

There are empirical studies that help support treatments for people who portray gender identity disorder. Psychotherapy would have been more helpful for Teena if her disorder was identified earlier. However, psychotherapy can still help Teena cope with her biological sex and behavioral patterns associated with the roles of her biological determined sex. It may reduce Teena's transsexual behavior in a very subtle way, but probably not as much because her disorder was not caught in the beginning. Another treatment that could help Teena would be hormonal therapy of surgical procedure(s). Before having any surgical procedures Teena may be given hormonal therapy in order to prevent undesired sex characteristics of the unwanted opposite sex. Various behavior therapies could help Teena by helping her to modify her behavior towards the sex she wants to be. Triadic therapy may help Teena as well. This therapy includes three different elements; living as the desired gender, sex reassignment

therapy, and hormone therapy. However, she would not have to include all of these elements into her therapy.

Name: Dil

Source: *The Crying Game* (movie, 1992)

Background Information

Dil is a young mid-twenties biracial male that prefers to live his life as a female. Dil works as a hairdresser at a salon during the day and performs as a nightclub singer at night. The bar that Dil performs at is called “The Metro”. The Metro is a gay bar filled with lesbians, gays, and transsexuals. Most of the performers at The Metro are transsexual males. Dil states in the movie, that she has a blood condition that causes her to grow weak. There are several medications that she has to take for this condition. My interpretation is the blood disorder she is speaking of is HIV/AIDS. Dil does not have any family close to her. The closest, most stable relationship in her life is the bartender at the Metro. Dil is currently single because the love of her life was killed when he was a soldier in Ireland. Dil suffers from depression and loneliness and uses alcohol to cope. She also lives a very promiscuous lifestyle in search of love and acceptance. Dil’s weakness is men and she is often abused and manipulated by the men that she “loves”.

Description of the Problem

Dil displays symptoms that she wants to be perceived as

a female. Although she still has a penis, she wants others to perceive and treat her like a female. If a man that she potentially wants to date or “mess around with” does not perceive her as a female she gets angry. However, she also blames the man if he does not recognize that she was born a male. At first, Dil would refuse to have sex with Jimmy; instead she preferred to perform oral sex on Jimmy. This was in an effort to keep him from seeing her penis. One night, after they had been drinking, Dil decided to disrobe and show Jimmy her penis. Jimmy was shocked and he hit her. Then he proceeded to vomit in the bathroom. This further sent Dil believing he would never love and accept her for who she was. Dil seemed to get really emotional when Jimmy threatened to leave her and refused to stay with her or show any type of affection toward her. The man Dil refers to as her true love did know that she was born a male and he accepted her for who she was.

Diagnosis

The appropriate diagnosis for Dil is Gender Identity Disorder in Adolescents or Adults (302.85).

A. In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the opposite sex, frequent dressing as the opposite sex, desire to live or be treated as the opposite sex, or the conviction that he or she has the typical feelings and reactions of the opposite sex.

Dil was an adult male that chose to live his life as a female. Dil

often stated that she was a lady and wanted to be treated as such. Mostly everyone around Dil (except Jimmy) knew that she was born a male. However, she still called her a woman and treated her like a woman. Dil dressed, talked, walked, and acted like a woman. Dil was a very emotional person and some may perceive that as acting like a woman. Most men would view Dil as a very attractive woman.

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of their sex. In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

Dil did not speak of wanting to have surgery to change sexes; however, she never went out without a padded dress or bra to make the illusion that there were breasts there.

C. The disturbance is not concurrent with a physical intersex condition.

Dil was not a hermaphrodite, he was simply born male and wanted to live his life as a woman. He did not state that he wanted to have surgery to change his genitals but he did want others to view him as a female.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if (for sexually mature individuals): Sexually

attracted to males, sexually attracted to females, sexually attracted to both, sexually attracted to neither.

Dil lived in what seemed to be a low-income part of town; however, she worked as a hairdresser so she was able to pay her bills. She seemed to be liked by others such as her co-workers and people at the bar. Men especially found her very attractive and likeable. However, some men often took advantage of her low self-esteem and would physically abuse her. Dil was attracted to only males, especially males that told her they loved and cared about her.

Accuracy of Portrayal

The average person watching this film would not have guessed that Dil was born a male. They would have just viewed her as an attractive woman in the beginning of the movie. Most men could probably identify with the main character in being unaware that Dil was not a born female. First of all, there are many men that look for the large Adam's apple first and if they do not see it, they assume that the female was born female. Dil did not have a large Adam's apple or a deep voice; however, she did have very large hands and feet. People watching this movie could learn that not everyone that has Gender Identity Disorder, or feels that they were born in the wrong body wants to have surgery. Some choose not to undergo surgery and hormones and all of these things because of the side effects. Others choose not to have surgery because they are comfortable living as the opposite sex without making surgical changes. Dil was

a person that was comfortable living as a female without seeking out surgery. The actor in this film definitely performed an accurate portrayal of Gender Identity Disorder. The emotion that was expressed throughout the film that Dil experienced seemed genuine. Anytime she felt jealous, scared or rejected that is when she would either seek attention from men or turn to alcohol.

Treatment

If I were a mental health professional and Dil walked into my office, I would first gather all of the proper background information and medical history and then proceed accordingly. One of the treatments for Gender Identity Disorder is hormones and surgery, but I do not think that would be a good fit for Dil because she has not expressed any interest in changing her biological sexual identity. Instead, I would recommend psychotherapy for Dil. I think Dil would benefit from psychotherapy because it would help her with gather and implement coping mechanisms to deal with her sexual identity. Also, empirical evidence supports that Dil would have better benefitted from psychotherapy if it was administered early in life but I think that she could still benefit from psychotherapy as an adult. The main purpose of psychotherapy in Gender Identity Disorder patients is to help them cope with their biologically determined sex and reinforce the behavioral patterns associated with those roles. However, with Dil the approach may be different because the role she is comfortable in is the role of the female. So

STEPHANIE WEIGEL

as a professional, I would focus more on making her more comfortable with her biology and not trying to change her into becoming a male.

Generalized Anxiety Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Piglet

Source: *The World of Pooh* by A.A. Milne (books, 1954)

Background Information

Piglet is a young male pig and Winnie the Pooh's friend. Since he is portrayed as a baby, he is probably in the age range of 0-3 years old. Piglet does not have a job and his family history is unknown. He does not have any physical health problems but he displays characteristics of anxiety and nervousness. He stutters quite a bit and he is fearful of wind and darkness. Piglet also does not like bees or wozzles (which

are creatures that Piglet has not yet seen). Piglet lives in the Hundred Acre Wood with Pooh and all of the other Winnie The Pooh characters. He lives in a house in a large beech tree with a sign outside that says “Tresspassers W” which to Piglet means his Grandfather lived there and his name was “Tresspassers William”. Piglet’s goals are to become brave, not so timid, and to catch a heffalump (a creature that resembles an elephant).

Description of the Problem

Piglet is a very timid piglet. He shows characteristics of anxiety and he stutters. He thinks of how any situation can go wrong and he argues with himself about what he should do if a situation does go wrong. For example, while trying to catch a heffalump, Piglet thinks to himself how he can fake a headache so he will not have to face one of these creatures, in case it is fierce. Then he thinks to himself that if he fakes a headache he will be stuck in bed all morning, so he does not know what to do. These are the types of scenarios that make him anxious. He has thoughts that he creates that jump from one bad scenario to another. Piglet also shakes and blushes. His ears twitch when he is scared or nervous, which is often. He is usually very flustered.

Diagnosis

The diagnosis that would best fit Piglet is **Generalized Anxiety Disorder (300.02)**.

1. **In children, to be diagnosed with Generalized Anxiety Disorder, only one of these symptoms must be present:**

- (1) Restlessness or feeling keyed up or on edge
- (2) Being easily fatigued
- (3) Difficulty concentrating or mind going blank
- (4) Irritability
- (5) Muscle tension
- (6) Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

Piglet definitely shows signs of restlessness or feeling keyed up or on edge. He also has difficulty concentrating (his thoughts jump from one bad scenario to another).

1. **Excessive anxiety and worry (apprehensive expectation), occurring more days for at least six months about a number of events or activities (such as work or school performance).**

Piglet has had anxiety problems his whole life as far as we know from the books. He definitely has probably had anxiety problems for more than six months.

1. **The person finds it difficult to control their worry.**

Piglet cannot control his worry which is why he struggles with trying to be brave. He manages to live with his worry

and anxiety but the thoughts are still there and he voices his worry to his friends.

1. **An unrealistic fear or worry, especially in new or unfamiliar situations.**

Piglet is afraid of the dark and wind. He has an unrealistic fear of heffalumps and woozles.

1. **The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a panic attack (as in panic disorder), being embarrassed in public (as in social phobia), being contaminated (as in obsessive-compulsive disorder), being away from home or close relatives (as in separation anxiety disorder), gaining weight (as in anorexia nervosa), having multiple physical complaints (as in somatization disorder), or having a serious illness (as in hypochondriasis), and the anxiety and worry do not occur exclusively during post-traumatic stress disorder.**

Piglet anxiety and worry are not due to any of the above features.

1. **The anxiety, worry, and physical symptoms cause clinically significant distress or**

impairment in social, occupational, or other important areas of functioning.

Piglet's anxiety and worry does cause him clinically significant distress because he is always worrying about or is afraid of something. He shows distress from his anxiety.

1. **The disturbance is not due to the direct psychological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder.**

Piglet does not use drugs, nor does he suffer from any physical medical conditions and he does not have any of the above disorders.

Accuracy of Portrayal

The average person reading *The World of Pooh* by A.A. Milne would be exposed to an accurate portrayal of generalized anxiety disorder in Piglet. Piglet trembles, twitches, and is shaky. Piglet also has exaggerated startle responses to things that scare him. He also shows symptoms of autonomic hyperarousal, like rapid heart rate and shortness of breath. When Piglet is in stressful conditions his anxiety levels tend to elevate and worsen. This is typical of young people with generalized anxiety disorder. Children with this disorder may

also show signs of being unsure of themselves. The book accurately portrays generalized anxiety disorder in Piglet.

Treatment

In treating Piglet, one would try to avoid medicines since he is a child and some of the side effects of certain medications can be suicidal thoughts in children. Starting out treating Piglet with cognitive behavioral therapy (CBT) would be optimal. CBT could help Piglet recognize his negative thoughts and try to change his thoughts to more positive thoughts that are more realistic. It would also help Piglet with relaxation techniques such as breathing exercises that could help him learn to relax better in stressful situations that cause anxiety for him. After participating in the behavioral therapy and learning relaxation techniques Piglet could better handle and manage his own anxiety. This could lead to a much happier, comfortable, and positive life. His quality of life would be better after the treatment.

Posttraumatic Stress Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Nick (Nicolas)

Source: *The Deer Hunter* (movie, 1976)

Background Information

Nicolas (Nick) is a white male who seems to be in his late twenties. He lives in a small town where he has two long time friends, Michael and Steven. United States (U.S.) is still in war with Vietnam and Nick and his two friends plan to go to Vietnam War and protect their country but Steven is engaged and decides to get married before his departure to Vietnam. Nick and Michael go to Steven's marriage

ceremony and seem very happy and do not seem to have any physical or psychological complication; they dance, laugh, drink and enjoy the entire night. Nick's behavior and attitude is normal and there are no observable sign of physical or mental illness associated with him. Michael is scared of going to Vietnam and very hopeless about returning back alive but Nick talks to Michael in several occasions and calms him down, promising that everything will be fine. Nick seems to be a very helpful individual in community as he lends a hand to people. Nick has a girl friend and would like to propose to her before going to Vietnam, so he proposes to his girlfriend at the end of the marriage ceremony and both decide to get married after Nick comes back from the War. After Nick's plan for marriage, he also feels bad about going to Vietnam; he is emotionally connected to his fiancée and hard for him to leave. Before Nick and his friends depart to Vietnam, they decide to go for their last deer hunt, up in the mountains close to their town. "One shot" deer hunting is Michael's favorite slang, meaning that he always wanted to catch a deer with only one shot. Michael successfully hunts a deer with only one shot and everybody enjoys the hunting that day. On the next day, they depart to Vietnam and face an unexpected battle with the Vietnamese army. It is not hard to see that they are all shocked in battle. Vietnamese soldiers attack them from all directions. After a couple of days, all three of them are taken captive in Vietnam. While captive, Nick, Michael and Steven are forced to play Russian roulette while their captors gambling on who will, or will not, blow out his brain.

Russian roulette is a lethal game in which one bullet is placed in a revolver and participants (captives here) spin the cylinder, place the muzzle against their head and pull the trigger. This is a horrifying moment for Nick and his friends. Steven who is a newly married groom, shows extreme symptoms of stress and anxiety. Nick visibly disintegrates under the abuse and torture of their captors while Michael refuses to capitulate. Michael plans to free himself and his two other friends by requesting a three bullet Russian roulette game from his captors. He manages to kill the captors and runs away with Nick and Steven. An American helicopter shows up and transports Nick to army hospital, while Michael and Steven wait for the next helicopter.

Description of the Problem

While Nick is in the U.S. army hospital inside Vietnam, he displays mild symptoms of anxiety; insomnia, lack of appetite and anxiety, are among the major symptoms he displays. When a nurse comes and talks to him, he keeps staring at people who are brought to the hospital and does not talk to anyone. After about a month, he leaves the hospital and starts to have more severe symptoms of anger, especially when he is reminded of his time in Vietnam. He completely forgets that he has a fiancée or friends; he does not call his friends to see if they are still alive and seems detached from his social environment. He has a sense of a foreshortened future because he does not have a plan to go back home or do anything while he is in U.S. camp in Vietnam. Nick is very

busy with his thoughts and does not communicate with his surroundings; social impairment is vivid at this point. He accidentally visits a bar in that town where people gamble on playing Russian roulette. As soon as he enters the bar, he starts to have intrusive distressing recollections of the time when he was captive and forced to play this game. He experiences a high level of anxiety and anger. As he is watching a candidate place a revolver to his head, Nick grabs the revolver and passionately places it to his head and pulls the trigger. He disrupts the game and the gamblers kick him out, however on the next day as he is walking down a street, he reaches the same bar. He goes inside and sits in one of the empty seats designated for a Russian roulette player. Michael, who was more emotionally stable than Steven and Nick, shows only very mild symptoms of anxiety and goes back home. His friends and family welcome him but he goes back to Vietnam to bring Nick home. He meets Nick, however Nick does not show any emotion to him, so Michael tries to play Russian roulette with him in that bar to perhaps unfreeze Nick's memory. Nick starts to communicate with Michael a little. However, Nick dies when he pulls the trigger in front of Michael.

Diagnosis

Based on the observed symptoms, the diagnosis for Nick fits well with Post-Traumatic Stress Disorder (309.81).

A. The person has been exposed to a traumatic event in which both of the following have been present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
2. The person's response involved intense fear, helplessness, or horror

Nick's symptoms certainly meet above characteristics as Nick experienced and witnessed an event in Vietnam which he was threatened to death (by the Russian roulette game). He has intense fear and feelings of hopelessness while being captive in Vietnam (Background information).

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **NOTE:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2. Recurrent distressing dreams of the event. **NOTE:** In children, there may be frightening dreams without recognizable content.
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). **NOTE:** In young children, trauma-specific reenactment may occur.
4. Intense psychological distress at exposure to internal or

external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Nick re-experienced very intense psychological distress when he observed people who were gambling on players (playing Russian roulette) in a bar. In there, he acted as if he was a captive in Vietnam and therefore took the gun from one of the players and after he pointed the gun toward his head, pulled the trigger. So he was exposed to external cues which symbolized an aspect of the traumatic event in Vietnam. Therefore he qualifies for more than one of above conditions (3, 4 and 5).

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- 1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma**
- 2. Efforts to avoid activities, places, or people that arouse recollections of the trauma**
- 3. Inability to recall an important aspect of the trauma**
- 4. Markedly diminished interest or participation in significant activities**

5. **Feeling of detachment or estrangement from others**
6. **Restricted range of affect (e.g., unable to have loving feelings)**
7. **Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)**

As it was mentioned in the background information, Nick showed no interest in any activity or in friendships. He was certainly detached from his social environment and also had no feelings of love. When his friend Michael showed up to take Nick back home, Nick did not show any interest and was not passionate about his fiancé. Therefore, he met four of above conditions (4, 5, 6 and 7).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1. **Difficulty falling or staying asleep**
2. **Irritability or outbursts of anger**
3. **Difficulty concentrating**
4. **Hypervigilance**
5. **Exaggerated startle response**

Nick clearly shows outburst of anger in several scenes of the movie. He also had difficulty concentrating when his

friend Michael tried to remind him of his fiancé and home. Unfortunately it was not shown in the movie whether Nick has difficulty sleeping. But his condition meets above criteria (2 and 3).

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

Nick had above symptoms for more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Nick's symptoms reveal an intense social impairment as well impairment in his interpersonal relationship. Therefore his symptoms meet this criterion. Nick's condition is a representation of an acute PTSD.

Accuracy of Portrayal

Nick's symptoms were well demonstrated to portray Post Traumatic Stress Disorder (PTSD). Nick experienced intense and horrifying moments in Vietnam in which he was threatened with death through Russian roulette. He observed and watched other prisoners die. Therefore, the war portrayed an accurate condition which could be the cause of PTSD. However, this movie showed Nick revisit the bar (while he is suffering from PTSD) and playing Russian roulette over and over again. Although Nick showed intense anger toward this game, PTSD patients mostly avoid experiences that remind them of their stressful event. Therefore, this part of the movie does not accurately resemble

the condition of a PTSD patient, while all other symptoms are well matched with PTSD. Overall, there was an accurate portrayal of a person's descent into PTSD.

Treatment

PTSD is highly comorbid with other anxiety problems and as such it would be beneficial to control the anxiety before starting other treatments. Therefore the primary treatment action for Nick would be to start a low dosage of an anti anxiety medication such as escitalopram (Lexapro) after a full medical examination. Once pharmaceutical treatment begins, the next level of treatment for Nick would be Prolonged Exposure (PE) therapy. This therapy will help Nick to decrease distress about his trauma and approach trauma-related thoughts, feelings, and situations that he is avoiding due to the distress. In the first part of prolonged exposure therapy, Nick needs to be educated about his disorder and common trauma reactions. This would allow Nick to learn and become more familiar about his symptoms and better understand treatment goal and process. The second part of the treatment is to train Nick how to have long breath and relax. One of the symptoms of PTSD, especially in Nick's case, is abnormal breathing habits when the patient is scared or anxious. This part of treatment will help Nick to overcome his distress by breathing differently. Real world exposure practice is the third part of this treatment in which Nick is exposed to Russian roulette game (without any bullets) over and over again. Such in vivo exposure helps Nick's

trauma related distress to lessen over time. In the last part of prolonged exposure therapy, therapist should talk to Nick while he is exposed to Russian roulette game. This helps to unfreeze Nick's memory and to let him communicate about his experience and memories with therapist and not being afraid of his memories. Talking through the trauma can also help therapist to identify Nick's negative thoughts about past event and help to modify his negative thoughts, allowing him to make sense of what happened and have fewer negative thoughts about the trauma. Family therapy is also recommended for Nick since he no longer seeks any friendship and does not have any emotions for his fiancée. Family therapy can help the Nick's friends and fiancée understand what they are going through, and help them work through relationship.

Schizophrenia

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Nina Sayers

Source: *Black Swan* (movie, 2010)

Background Information

Nina Sayers is a Caucasian female who is presumed to be in her early to middle twenties, although her actual age is unknown. She currently works as a ballerina in a New York City ballet company whose name is undisclosed. Although there are not any known distinct physical illnesses, abnormalities, disorders, or disadvantages currently within Sayers, there are observable health concerns. The patient is

visibly underweight and has serious cuts, bruises and other wounds on her feet, although both of these concerns can be attributed to her career as a dancer. However, there are also various lesions and abrasions throughout the surface of Sayers' body which cannot be attributed to anything in her current daily environment. It is speculated that these lesions could be self-inflicted. Sayers currently lives by choice with her mother. Her mother, although not diagnosed, has observable generalized anxiety disorder symptoms, as well as some neurotic personality traits. It is also observed that the mother displays a very rich sense of control over Sayers' life, such as her scheduling, room design, personal decisions, etc. Sayers appears to not have very many, if any, close friends or relatives outside of her mother. It is undisclosed whether or not Sayers has had any contact with her biological father. It is assumed that he does not actively participate in her life. Until recently, there was not any reported drug or alcohol history. However, as of late she has reported experimenting with ecstasy, a derivative of MDMA, as well as engaging in small amounts of social drinking. Her current goal is to become the principle dancer of her current ballet company. Most of her daily activities are related to improving her performance as a dancer.

Description of the Problem

Sayers currently displays a whole host of symptoms that could be indication of several disorders. The lesions and abrasions as aforementioned fit the description of self-mutilation;

however, Sayers denies ever abusing herself, and frequently reports not knowing how the lesions and abrasions appeared on her body in the first place. Sayers often suffers from both visual and audio hallucinations. These hallucinations include items such as seeing feathers physically protrude from her skin, seeing and hearing paintings laughing at her, having conversations and encounters with people that never took place, and peeling off pieces of her own skin that are obviously still in tact, among many other hallucinations. She is also currently under some delusions as well. She believes that another one of her co-dancers is trying to take her starring role in the next upcoming production from her when there is not any evidence to support such a claim. She also believes that this co-dancer is sleeping with the program director, when there is no evidence to support this claim either. In general, Sayers is very convinced that various people are intentionally trying to take this acclaimed dancing role from her, or as she refers to it, her chance to be “perfect.”

Diagnosis

The diagnosis for Sayers that seems to fit appropriately is **Schizophrenia, Paranoid Type (295.30)**.

1. **To be diagnosed with schizophrenia, two or more of the following characteristics must be present:**

1. Delusions

2. Hallucinations

3. Disorganized speech

4. Grossly disorganized or catatonic behavior

5. Negative symptoms, i.e., affective flattening, alogia, or avolition

Sayers definitely has both the first and second characteristics of delusions and hallucinations, as described in the section of “Description of the Problem.”

- 1. For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset.**

The delusions and hallucinations have made both Sayers’ work and personal life dysfunctional. She has been late for rehearsals and has caused a great amount of interpersonal disturbance amongst her coworkers.

- 1. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms that meet Criterion A and may include periods of prodromal or residual symptoms.**

The hallucinations of skin peeling and the delusion of denial of having part of her own lesions and abrasions have been

present with Sayers for the majority of her life. During the last one to two month period is when her visual and auditory hallucinations have become more frequent. It is also during the last one to two month period that the persecutory delusion of having her role taken from her has become prominent. It is unknown if she has suffered from other persecutory delusions previously.

- 1. Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.**

During observation, Sayers has not met any criteria that would indicate any of the mood disorders. Her persistent amount of dance practice may signify a possible manic episode, but since she has always spent a great deal of time practicing, it appears as if it is too consistent to be considered an episode, therefore disqualifying her from any mood disorders.

- 1. The disturbance is not due to the direct physiological effects of a substance or a general medical condition.**

As previously stated, there is not any known, distinct physical illnesses, abnormalities, disorders, or disadvantages currently within Sayers that would explain her schizophrenic symptoms. She did not have any drug history until recently, but her symptoms were present long before her intake of any substance.

- 1. If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month.**

There is no history of either of the above listed disorders present in Sayers.

To fit the Diagnostic Criteria for 295.30 Paranoid Type, the following criteria are met:

- 1. Preoccupation with one or more delusions or frequent auditory hallucinations.**

Sayers is completely preoccupied by her persistent tactile, visual, and auditory hallucinations. She is also completely preoccupied with her delusion of someone trying to take her role from her.

- 1. None of the following are prominent: disorganized speech, disorganized or catatonic behavior, or flat or inappropriate affect.**

Sayers displays none of the above listed behaviors.

Accuracy of Portrayal

The average person watching this movie would see a reasonably accurate portrayal of the *onset* of Paranoid Schizophrenia, especially since Nina Sayers is in the perfect age range for onset, but not necessarily the daily experience after onset. Of course, the movie overdramatized a lot of the symptoms that the average schizophrenic would experience, but not to the point that the symptoms were so exaggerated that to make the case that she was schizophrenic was invalid if one were to make an assessment. In fact, this movie actually somewhat helps the portrayal of schizophrenia in the media, as many movies and television shows give examples of the symptoms of Dissociative Disorder as evidence of schizophrenia, which are totally inaccurate and confuse the audience as to what schizophrenia actually is. Although symptoms would not occur as rapidly as they do in Nina Sayers in most common cases of schizophrenia, it is plausible. Therefore, *Black Swan* is a decent portrayal of a person's descent into paranoid schizophrenia.

Treatment

To treat Sayers, after a full medical examination, it would be best to immediately start her on a mid-level dosage of an anti-psychotic, such as Vesprin. Most people with schizophrenia respond very well to current medication in comparison to people with other Axis I disorders. After pharmaceutical

treatment begins and an appropriate dosage has been stabilized, it would be best to start Sayers and her mother into family therapy, as to educate and help both of them find ways to cope with this disorder, and to help Sayers' mother be more tolerant and understanding of Sayers' symptoms. Social Skill training would also be beneficial to Sayers, because as previously stated, she has no close friends or any type of social support outside of her mother. Social Skill training would also help Sayers interact more efficiently with the other people who work at the dance company, lessening interpersonal disturbances caused by her disorder.

Pathological Gambling

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Geoffrey Chaucer (aka Chaucer)

Source: *A Knight's Tale* (Movie, 2001)

Background Information

Geoffrey Chaucer is a male in his late 20's to early 30's. He is in good health and with no serious illnesses. We have no information from this movie about his past. This includes no information about his parents or where he is from. He announces that he is a writer for hire. He says that he has written a few poems and is known for his book "The Book of the Duchess". During the time of the movie, he acts as a

writer and a herald for William. He seems to have no social ties to his past other than the people who have collected his debts. During the movie, he does start to gain close relationships with the four people he is traveling and working with. There is no evidence that he has any other vices such as drinking or drug problems throughout the movie. He has difficulty dealing with his gambling urges and knowing when to stop.

Description of the Problem

Chaucer starts the story in a very depressed mood. He is first introduced to us while he walks completely naked down a trail. He comes upon a group of men along the road. He then lies about how he has lost all of his possessions. He says that he had been robbed in a sense rather than that he had lost of his possessions to his gambling problem. To get passage to the next city he blackmails the group. He blackmails them by uncovering that the group had lied about their identities and saw that they would need forged documents that he could provide if they gave him money. After forging the documents, Chaucer presented them for authentication and had them accepted. The group offers Chaucer the job of being a herald, which he accepts. At the same time, though, he is very preoccupied with watching people gambling along the alleyway. He then immediately cuts off his conversation with William to go and gamble. This leads him to be in the same position where we had first seen: naked and with a large gambling debt. When Chaucer is unable to pay for his

debts, he calls on William to get him out of the bad situation. William is given the choice of paying off Chaucer's debt or let his new friend pay for it from his hide. Chaucer admits after this that he has a problem with gambling.

Diagnosis

Based on the DSM-IV-TR criteria Chaucer fits at least eight of the ten maladaptive behaviors listed.

- **A. Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:**
 - (1) is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)

When Chaucer is given a small amount of money he immediately see people gambling and is fixated his attention on them. He then says, "I must see a man about a dog" this is a cover up so that he can leave to go gamble the little cash that he had just received.

- (2) needs to gamble with increasing amounts of money in order to achieve the desired excitement

- **(3) has repeated unsuccessful efforts to control, cut back, or stop gambling**

Chaucer is found walking naked after losing all his possessions to gambling in the last town, he then gambles away what little money he was given in the next town.

- **(4) is restless or irritable when attempting to cut down or stop gambling**
- **(5) gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)**

Chaucer is in a depressed state trudging (the slow, weary, depressing yet determined walk of a man) and then prays to his god to get him out of his tribulations. Then he gambles at the first opportunity to escape his current living style.

- **(6) after losing money gambling, often returns another day to get even (“chasing” one’s losses)**

He had lost everything but in the next town, he bet again to try to win what he lost earlier.

- **(7) lies to family members, therapist, or others to conceal the extent of involvement with gambling**

Chaucer when asked if he had been robbed stated that he

had taken an involuntary vow of poverty. This is rather than saying that he had lost all of it gambling.

- **(8) has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling**

Chaucer knowingly forges patents of nobility for the group to be able to compete in tournaments.

- **(9) has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling**

Chaucer was a herald and his gambling debt he pushed off on his newly found friends almost lost him this position and their friendship.

- **(10) relies on others to provide money to relieve a desperate financial situation caused by gambling**

Chaucer loses all his positions again and tells the collectors that William can pay for his debt that he has made while gambling, later William does come and wipe out the debt.

- **B. The gambling behavior is not better accounted for by a manic episode.**
-

Accuracy of Portrayal

The portrayal of Chaucer struggling with gambling is only a small side story. With that said, it is still easy to tell that he has a problem with his ability to control his Pathological Gambling. It is demonstrated how it is affecting him and his friends in negative ways. He even goes on later in the movie to admit to his friends that he does have a gambling problem. The only flaw in the accuracy of portrayal is that once he admits to the group that he has a problem it is never a problem again in the movie. Overall this is an accurate portrayal of Pathological Gambling

Treatment

The treatment for Chaucer's Pathological Gambling is already taking place during the movie. He makes a great first step in admitting to his friends that he does have a problem and that he needed help. After his admission, he does not have any more problems with gambling. A long term goal would be to identify why he has the urge to gamble in the first place. That is because gambling is just the symptom of an underlining problem. I would look at handling his depression. His depression is seen only shortly but with the high comorbidity of pathological gambling and depression it is important to examine it. Aversion therapy can be used to treat his urges to gamble. This is done by putting him into a condition that he would usually gamble but also exposing him to something that would cause him discomfort. This is

to learn self control and to overcome the illusion that they will win the next time. He should not gamble again for any reason. He should also look for support groups like Gamblers Anonymous to help him over his urges.



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Antisocial Personality Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: The Grinch

Source: *How the Grinch Stole Christmas!* (Movie, 2000)

Background Information

The Grinch, who is bitter and cave-dwelling creature, lives on the snowy Mount Crumpits, a 10,000 foot high mountain that is north of Whoville. His age is undisclosed but he looks to be in his 40's and does not have a job. He normally spends a lot of his time being alone in his cave. The patient appears to be suffering from antisocial personality disorder with depressed mood. There was no background history on

his family, as he was abandoned as a child. The Grinch was taken in by two ladies who treated him like he was their own like every other Who children with love for Christmas. He does not have any social relationship with his friends and family. The only social companion the Grinch has is his dog Max. There was no history of drug or alcohol use. The Grinch did have some life difficulties when he was a little boy being made fun of the way he looks at his school. The Grinch had no goal in his life except to stop Christmas from happening. The coping skills and weakness was to run away from his problems and leave the town, rather than facing problems.

Description of the Problem

The Grinch displays a number of problems. The Grinch was not a very happy man with life. He hated Christmas and wanted to stop it from happening. When he was little, he got irritated and aggressive at the school because he was being made fun of by the fat boy who now is the mayor of the town. The Grinch threw a fit and picked up the Christmas tree and threw it to the other side of the classroom. After that he no longer liked Christmas. Years and years later the Grinch decided that he was going to stop Christmas from happening. He decided to dress as Santa Claus and take away all the Christmas trees and presents from the people of Whoville. He failed to plan ahead to know what the consequences would be. As he went to Cindy Lou Who's house to steal their tree and present, Cindy Lou asked him

why he was taking the Christmas tree. He told her that he going take the tree to his place and fix the light bulb. The Grinch did not show any remorse of what he did. He wanted Christmas to be over. He also did not care for the safety of other including his dog. His dog had to be the reindeer. The Grinch was irresponsible and thinking recklessly. He wanted everyone miserable and thought that would make him feel better.

Diagnosis

The diagnosis that seems appropriate for the Grinch is Antisocial Personality Disorder (301.7).

1. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:
 1. failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are groups for arrest
 - He would have gotten big trouble for stealing all the trees and presents. Also he got in trouble by getting peoples mails in the wrong box. The Grinch did not realize there are

consequences.

2. deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure

- The Grinch lied to the little girl why he was stealing her Christmas tree and that he pretend to be a Santa.

3. impulsive behavior or failure to plan ahead

- He failed to plan ahead thinking he would not run into someone while stealing Christmas tree and present. The Grinch did not think what would happen if he did this.

4. irritability and aggressiveness, as indicated by repeated physical fights or assaults

- The Grinch was irritated by being made fun of the fat boy. He got aggressive and picked up the Christmas tree and threw it across the room,

5. reckless disregard for safety of self or others
 - He did care for other people safety especially his dog max. He made his dog do something big than his dog can really do and that it could hurt him.

6. consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
 - He was being irresponsible for what he did. He wanted to make people made and not care about anyone. He was irresponsible with his dog and didn't care if his dog got hurt or not.

7. lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
 - The Grinch had no regrets in what he had done. He didn't regret what he did to those people. The Grinch was happy to make people unhappy and

more.

2. The individual is at least age 18 years.
 - The Grinch is around in his 40's.
3. There is evidence of Conduct Disorder with onset before age 15 years.
 - The Grinch shows evidence of having conduct disorder with the onset before age 15. He first started showing symptoms around when he was 8-10 years old.
4. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.
 - During observation, the Grinch did not meet any signs showing schizophrenia but he was showing some of the signs of having a manic episode such as increased in goal-direct activities. The Grinch was very into making everyone's Christmas miserable.

Accuracy of Portrayal

The average person watching this movie would learn quite a bit about antisocial personality disorder. They would also

learn about bullying and depression. The movie did make it into fairy tale where they have happy ending for a person who has antisocial personality disorder. This is not the case in the real world with people who have that type of disorder. It does not cure them that quick. It takes time, efforts, and counseling. Though it is rare for someone who has antisocial personality disorder to seek help and get counseling. It does confuse the audience that makes them think you can cure the disorder quick when you can't. This is a movie somehow helps show people what the antisocial personality is.

Treatment

Antisocial personality disorder is one of the most difficult personality disorders to treat because people who have it tend to think there is nothing wrong with them and do not want help. It is rare for people who have antisocial personality disorder to get help. First to treat the Grinch, he needs a full medical examination to see what symptoms would come up beside antisocial personality disorder. After the full evaluation, the Grinch should seek counseling to talk about his past, learn to cope what he went through, and do some social skills training. Social skilling training would help him a lot to learn how to socialize with other people. There a few medication that could help the Grinch such as with his depression he could take antidepressant medication to help improve his depressed mood, anger, impulsivity, or irritability. However, these medication do not directly treat the behavior that

characterize antisocial personality disorder, they can be useful in addressing conditions that co-occur with this condition.



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Name: The Joker

Source: *The Dark Knight* (movie, 2008)

Background Information

The Joker is a disturbed and malicious villain who is the archenemy of Batman. His age is unknown but he looks to be in his late 40's to early 50's. His gender is obviously male with brown eyes, and sandy, light green hair. He does not have a "real" job, but some consider running the streets with thugs to be one of them. He spends majority of his time plotting to corrupt and destroy Batman along with bringing the city of Gotham to the ground. His overall health status is unknown, but to the naked eye, he physically looks ill along with the deep razor cuts to both sides of the mouth representing a permanent smile. Psychologically he appears to suffer from antisocial personality disorder, which is evident

by his hasty behavior and lack of disregard to others. He does not have a relationship with his parents or relatives. The only social relationships he does have are those with thugs and delinquents. There is no evidence of drugs or alcohol use, although he reports that his father was an extremely abusive alcoholic, who attacked he and his mother with a blade, cutting him along the corner of his lips. The only goal in The Joker's life was to destroy Batman and everything in his path. His only coping skill and weaknesses were to see someone other than himself get hurt along with Batman. He would then vanish from sight seemingly as if he had run away from his problems, not wanting to face the consequences.

Description of the Problem

The problems The Joker displays are tremendous. To begin, he absolutely hates Batman and everything to do with justice and peace. He seems to hate everything about himself as well, considering he has to hurt others around him to feel better. His only purpose in life is to destroy Gotham for no apparent reason and to destroy Batman considering he is constantly in The Joker's way to destruction. The Joker wanted humans to understand that they were "bad" and destroyers when all the while he was the one committing crimes. The Joker expressed absolutely no empathy for his ruthless actions along with being extremely sadistic. He blatantly disregarded laws and social norms of society as a whole, all of which are related to antisocial personality disorder.

Diagnosis

According to DSM-IV-TR criteria, the appropriate diagnosis would be Antisocial Personality Disorder (301.7)

1. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

1. Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are groups for arrest.

- The Joker was constantly being arrested and reprimanded by law enforcements due to his ruthless behaviors. At times it was difficult to catch The Joker committing a crime, but once he was he was punished (for a short amount of time) he would later escape to commit more crimes.

2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning other for personal profit or pleasure.

- At one time, The Joker dressed

as Bozo the clown while robbing the Gotham National City Bank. He manipulated his whole crew into robbing the bank and told them they would all split the money. However, The Joker ends up killing his crew and getting away with the money.

3. Impulsive behavior or failure to plan ahead.
 - The Joker planned seemingly impossible tasks without thinking about the consequences afterward. At one time, he tried to blow up the Gotham General Hospital. Hitting his detonator, the majority of the bombs failed to blow therefore causing him to steal a nearby city bus as a quick getaway.
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
 - Without a doubt The Joker was

constantly fighting, assaulting, torturing, or murdering another individual. One in particular would be Batman. Batman would fight The Joker, throwing him from wall to wall and all while The Joker would be laughing hysterically.

5. Reckless disregard for safety of self or others.
 - He cared very little about his own safety considering he told Batman to run him over with his Batpod. This seemed to also be an attempted sign of suicide. Also, blowing up a hospital, violently blowing up a prison inmate, and using innocent people as police officer targets are all ways he disregarded the safety for others.
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
 - The Joker was never considered

to have a job. However, he would steal to receive cash payments and money to support himself.

7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.
 - The Joker never apologized for his behavior nor having any remorse for killing innocent people. He enjoyed chaos and hurting people along with himself. He still didn't feel remorse for being in jail considering that he brutally killed an inmate while there.
2. The individual is at least age 18 years.
 - The Joker is in his late 40's to early 50's.
3. There is evidence of Conduct Disorder with onset before age 15 years.
 - It may have taken place with his abusive father when he was younger which caused the scarring on his face. It is not known how old he was when this

occurred.

4. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.
 - The Joker's behavior was constantly out of the norm. His ruthless behavior was continual for long durations of time so the presence of a Manic Episode would not be unlikely.

Accuracy of Portrayal

The average person watching the film would see that The Joker is a typical psychopath. The average person would learn the basics of antisocial personality disorder and character qualities an individual must hold in order to be classified as a psychopath. However, with antisocial personality disorder, it seems to remit by age 40 and is known to be higher among young adults than older adults. The Joker seemed to peek in his violent streaks at this age. Another inaccurate portrayal of antisocial personality disorder being used in the film was that majority of individuals suffering from antisocial personality disorders have high amounts of drug use and abuse. Drug use causes individuals to perform dysfunctional and out of the norm types of behavior. They seem to not care about the risk involved. The Joker was never seen using any types of drugs in the film. He would constantly cause harm to others on his own will without the use of mind

alternating drugs. However, there were strong accuracies of portrayal. For instance, he was a male, came from an abusive childhood, had zero empathy, and performed extremely risky and ruthless behaviors. The film helped show the most extreme form of antisocial personality disorder.

Treatment

Antisocial Personality Disorder is difficult to treat, considering the fact that individuals do not believe they are in need of treatment. If a patient is taken into counseling, there is usually a lack of improvement as the patient is usually uncooperative. The treatment that would most likely work for The Joker would be treatment in long-term structured residential settings to which he would be placed in an environment in which he cannot hurt others. If he modifies his behavior appropriately he will be able to earn privileges such as performing a non-threatening hobby of his. Since The Joker has not developed any healthy relationships in his lifetime, using psychotherapy along with behavior modification would help. Developing a relationship with a therapist would probably be beneficial for him as well. Since The Joker expressed a few signs of suicide attempts, it may be that he is suffering from depression as well. An antidepressant may help his depression and irritability. Even though antidepressants do not actually treat an individual with antisocial personality disorder, they can help with these types of comorbid conditions.

<https://youtu.be/utfHPQ6TqPY>

Social Phobia (Social Anxiety Disorder)

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Barry Egan

Source: *Punch-Drunk Love* (movie, 2002)

Background Information

Barry Egan is a Caucasian male in his early to mid-forties who lives alone in an apartment in Los Angeles, California. He is the owner of a small business that sells novelty items. Barry is not suffering from any known medical conditions or other health problems, but appears to have some mental

health concerns. He is easily provoked into violent tantrums in which he punches walls, breaks windows, or destroys others personal property. He does not appear to have any alcohol or drug dependencies; in fact, he appears to drink alcohol very minimally. Barry has seven sisters, all of whom are very domineering and verbally abusive to him. Barry's sisters have tormented and ridiculed him since childhood. As an adult, his sisters are still very controlling of his life and continue to torment him with embarrassing stories from his childhood. Barry has difficulty with personal relationships and appears to be lonely. His goals include growing his business. His hobbies include finding unbelievably good deals and repairing and learning to play the harmonium. Barry can be rather naïve and trusting of others, which leads to being taken advantage of and making poor financial decisions.

Description of the Problem

Barry is currently seeking help because he feels something might be wrong and states that he “doesn't like himself,” but is unsure if this is abnormal since he is uncertain how other people are. He states that he “cries a lot.” Barry can be described as a socially awkward individual who does not seek out or actively engage in social activity with others. It appears that Barry has little to no family support system and that his relationship with his seven sisters relates to his low self-esteem. He constantly apologizes for things even when he did not do anything wrong, and stumbles with his speech by merging words together. Barry becomes very

anxious in social situations. He endures these situations with intense anxiety and distress, which sometimes can lead to a panic attack following the interaction. Barry has a tendency to become violent when provoked with embarrassing stories from his childhood. He is known to lie and deny his actions when confronted. Barry is currently in a relationship with a woman he recently met. The relationship appears to be a positive factor in Barry's life.

Diagnosis

The diagnosis for Barry Egan is Social Phobia (300.23). According to the DSM-IV-TR the following criteria are met:

1. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. NOTE: In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.
 - Barry shows fear in meeting new people or encountering people in unexpected situations. He showed this in several situations; for example, when he met Lena for the first time he was obviously

uncomfortable and showing signs of fear and while at his sister's house he also showed a marked fear of scrutiny from his sisters.

2. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed panic attack. NOTE: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.
 - Barry's reaction to his sisters demoralizing remarks about him from the other room was a panic attack that took the form of Barry kicking out the glass at his sister's house.
3. The person recognizes that the fear is excessive or unreasonable. NOTE: In children, this feature may be absent.
 - Barry did not know exactly what was wrong with himself, but his attempt to reach out to his brother-in-law showed that he knew that something was unreasonable and that he needed help.
4. The feared social or performance situations are

avoided or else endured with intense anxiety or distress.

- Barry avoided meeting Lena at his sister's house as best he could. When his sister brought Lena to his work to introduce the two, he was extremely anxious and distressed. He started fumbling all over the place, unable to perform his job and having a hard time communicating with Lena and his sister.
5. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- Barry lived his life without much interaction with others before meeting Lena. Although he was lonely, he did not have the ability to initiate healthy interaction with others. He made a call to a 900 number as a way to engage in conversation with a woman.
6. In individuals under age 18 years, the duration is at least 6 months.

- Even though Barry is in his forties, he has evidence of symptoms beyond 6 months. According to his sisters stories of Barry as a child, he might have been diagnosable before 18 years of age.
7. The fear or avoidance is not due to the direct psychological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., panic disorder with or without agoraphobia, separation anxiety disorder, body dysmorphic disorder, a pervasive developmental disorder, or schizoid personality disorder).
 8. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in anorexia nervosa or bulimia nervosa.
 - Barry appears not to be on any medications or illegal drugs, nor does he appear to have another diagnosable mental disorder.

Specify if:

- Generalized: if the fears include most social

situations (also consider the additional diagnosis of Avoidant Personality Disorder)

- It appears that Barry works well with the other men in his company although Barry's interaction with the men is limited and somewhat awkward.

Accuracy of Portrayal

There are few portrayals of a main character with social phobia in movies and television. Barry's character in the movie gave an excellent portrayal of someone suffering from social phobia and the struggles they must face on a daily basis. The portrayal of his seven sisters gave a good indication that his upbringing was a humiliating and traumatic experience and gave insight into reasons why Barry might suffer from the disorder. Barry's relationship with Lena is less accurate to the "real-life" relationship someone with social phobia might experience. His awkward demeanor, inability to maintain eye contact, and lack of conversation skills were accurately portrayed. The manner in which the two met was also likely since Lena pursued Barry and made most of the first moves in the relationship. The inaccuracy is in the fact that Barry and Lena found love and appeared to "live happily ever after," which unfortunately does not happen for many individuals diagnosed with social phobia. In addition, Barry's love for Lena seemed to give him the courage to confront the criminals that were taking advantage of him; however, it is unlikely for someone with social phobia to be assertive

or confrontational. These two factors do not exclude social phobia as a diagnosis for Barry, they are just not the norm for what one might expect for someone diagnosed with social phobia.

Treatment

Cognitive behavioral therapy is likely the most effective treatment for Barry. This treatment will help change Barry's pattern of thought about certain events by helping Barry better understand the reality of the situation and help Barry focus less on the idea that he will be embarrassed or humiliated. He will learn to identify and change his automatic negative thoughts. He will learn that everybody makes mistakes and that sometimes being embarrassed is going to happen but it will be okay. Therapy will also help give him coping strategies to change his behavior in anxiety provoking situations, as well as, giving him the skills to help manage his emotions and violent temper. Exposure therapy will help Barry learn that he can handle social situations without anxiety. Family therapy would likely not benefit Barry greatly but may help enlighten his sisters on the cause and effect their actions have on others lives. It would likely be most beneficial to meet with each sister one at a time with Barry as opposed to as a whole group.

Name: Charlie Kaufman

Source: *Adaptation* (movie, 2002)

Background Information

Charlie Kaufman is a Caucasian male in his mid-forties who lives with his twin brother Donald in an apartment they share together. He is a screenwriter who has been tasked with producing an adaptation of the book *The Orchid Thief* by Susan Orlean. Charlie appears to be suffering from some form of depression because he is constantly in doubt of his abilities to adapt the novel into a formidable screenplay, which affects his daily routines and interactions with his brother. There is no evidence of substance abuse (either drugs or alcohol), and he does not appear to be predisposed to partaking in consumption of dangerous substances. Charlie's brother Donald constantly agitates him because he is embarking on a career in screenwriting and Charlie does not approve of his methods; he is baffled when Donald sells his work for a large amount of money. Charlie appears to have trouble with starting and maintaining close personal relationships, as evidenced by his awkwardness with a former girlfriend and a waitress at a local diner he frequents. He is able to start conversations but does not know how to keep them going and is not particularly skilled at inviting other people to join him in activities.

Description of the Problem

Charlie is a socially awkward person and although he is able to start minimal conversations with strangers and acquaintances, he is very nervous and cannot seem to keep

his thoughts in one particular order that would benefit the situation. His family support system seems to only come from his twin brother, who is almost completely opposite in terms of personality, social interactivity, and general comfort with life. Since a lot of his thoughts are narrated for the audience, it is apparent that he craves relationships and people to share life experiences with but cannot bring up the courage to engage anyone past initial conversations. Charlie suffers from a severe case of writer's block and takes his anger out on his brother, who is subsequently flourishing in his screenwriting endeavors. Much to the chagrin of Charlie, Donald seems to have picked up screenwriting and ran away with it and that bothers Charlie because he deems Donald an inferior screenwriter and too cliché to produce anything worthwhile. Charlie's anxiety in social situations is profound and is outlined by a fantasy he indulges in regarding the diner waitress.

Diagnosis

The diagnosis for Charlie Kaufman is Social Phobia (300.23). According to the DSM-IV-TR the following criteria are met:

1. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. NOTE: In

children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.

- Charlie shows a marked level of anxiety and fear when introduced to new people, especially in social situations. Excellent examples of these situations are when he meets a former girlfriend's new "friend," and when he is served by the waitress at the diner.
2. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound situationally predisposed panic attack. NOTE: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.
- When Charlie meets the ex-girlfriend's "friend", it is obvious that he is speechless and cannot speak to him or the ex-girlfriend about his current situation. The waitress at the diner also causes Charlie to suffer through anxiety that freezes his conversation and makes the interaction very awkward.

3. The person recognizes that the fear is excessive or unreasonable.
 - Charlie knows that he is a socially awkward person and his continued interactions with his twin brother as well as his trip to New York to talk to Susan Orlean highlight his need to express himself in a socially acceptable way.
4. The feared social or performance situations are avoided or else endured with intense anxiety or distress.
 - On the trip to New York, Charlie ultimately avoids speaking with Susan Orlean and instead attends Robert McKee's seminars. He then has Donald imitate him and interview Susan so he does not have to face her.
5. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
 - Charlie's avoidance behaviors and awkward social interactions severely

hinder him from completing the screenplay and even render his trip to New York a waste of time and ultimate threat to his life as he is not able to talk to Susan Orlean in person.

6. In individuals under age 18 years, the duration is at least 6 months.
 - Charlie is well above the age of 18, but the film seems to suggest that his problems have persisted well beyond 6 months.
7. The fear or avoidance is not due to the direct psychological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., panic disorder with or without agoraphobia, separation anxiety disorder, body dysmorphic disorder, a pervasive developmental disorder, or schizoid personality disorder.)
 - Charlie's social awkwardness and anxiety due to the social situations is not accounted for with any other condition or disorder. He seems to be genuinely suffering from a social phobia and no drugs or alcohol influence his behaviors.

8. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in anorexia nervosa or bulimia nervosa.
 - Charlie is not under the influence of any substances (legal or illegal), and his condition seems to be independent of any other diagnoses.

Specify if:

- Generalized: if the fears include most social situations (also consider the additional diagnosis of Avoidant Personality Disorder.)
 - Charlie is able to maintain a steady job, do excellent work, and keep relationships with coworkers and everyday acquaintances, though to a minimal extent and not without awkward social interaction.

Accuracy of Portrayal

Charlie Kaufman is an adequate representation of a person suffering from a social phobia. It is not a perfect rendition, but it covers the base areas well enough to establish a passing resemblance. The character is not completely socially

awkward, as he is able to strike up a conversation a few times (which do not lead to any sort of reliable, close relationship.) Charlie's brother Donald plays a nice juxtaposition to his social anxiety and awkwardness, as evidenced by Donald's general openness and lack of social anxiety. This suggests that, as children, Charlie probably suffered greatly from witnessing his brother's easiness with social situations. A huge inaccuracy is the fact that Charlie becomes assertive and decides to fly to New York on a whim to meet with Susan Orlean. Also, his sudden insistence to check out what is going on between Susan and John Laroche is not typical of someone suffering from social phobia in any context. Although nothing good comes of these actions, the sheer fact that he pushed his social anxieties aside for those particular instances does not accurately portray someone with full blown social phobia. These are the only flaws portrayed by Charlie and the depiction is a passable example of social phobia.

Treatment

The most effective route to take with a person suffering from social phobia would be a treatment centered on cognitive behavioral therapy. This type of therapy could alter Charlie's thought processes to allow him to acclimate himself to social situations in a socially acceptable manner. Through cognitive behavioral therapy, Charlie could slowly eliminate negative thoughts attached to social situations and therefore be comfortable enough to pursue relationships outside of the scope he has become accustomed to developing his entire life.

He would be able to cope with social stressors such as the inevitable times when meeting new people will not go over very well and the situations in which established relationships start to deteriorate for numerous reasons. Slowly integrating real-life situations into the therapy (exposure) would then help Charlie come to terms with the changes that would come in his life and set him on the path to being a socially normal person. If the therapy was effective, Charlie would not become a new man overnight; rather, it would probably take years and consistent dedication to the changes to see him become adaptive to social situations.

Borderline Personality Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Mad Hatter

Source: *Alice in Wonderland* (movies, 1951 & 2010)

Background Information

In the 1951 film

Mad Hatter appears to be Caucasian male is in his late thirties, although his age is never disclosed. He is a fictional character in Alice's dream. In the movie there are not any known physical or mental illness to be associated with the Mad Hatter, although there are visible traits to be noted for. He

appears to be eccentric in his behavior and also in his appearance. He is dressed in a olive green blazer, with a green vest, aqua bow tie, beige button down shirt in which the collar is up, green pants and a large green top hat where on the side there is a 10/6 paper. He has white hair sticking out from the hat, and is rather pink in complexion throughout the movie. Prior to Alice stumbling upon them, the Mad Hatter and the Hare can be seen having a party celebrating non-birthdays (a celebration of all the other days in the year that are not one's birthday). Currently the Mad Hatter lives in the forest that is a figmentation of Alice's dream. It is unknown if the Mad Hatter has any family, although he can be seen quite often with the Hare and a little mouse. The Hare can be seen has having similar traits as the Mad Hatter; not being able to sit in one spot, interrupting others, speaking rather fast, constantly moving and appears to break teacups.

In the 2010 version

The Mad Hatter appears to be living in a forest that is part of Alice's dream, in which he lives with Mally and the Hare. He appears to be in his mid-thirties, although his age is never disclosed. He is Caucasian and dresses vibrant. He has on a rather large top hat on, which has random objects stick out of it. Under the hat can be seen his is orange hair that is rather wild. His face is painted, in which his eyes are painted an array of colors; such as blue on, orange, and brown on one eye and the other pink and orange and purple on the other eye. His whole face is painted white. He can be seen wearing

a brown tattered suit that is randomly put together, in which it matches his personality perfectly. Throughout the movie, his parents and other family members are never disclosed. Although he is rather fond of the White Queen and he remains loyal to her. The Mad Hatter lost his enjoyment and became “crazy” due to the Queen of Hearts overtaking the White Queen. This happened when the Jabberwocky came and destroyed the White Queen’s area and caused massive damage to her property. After that the Mad Hatter was never the same, he was no longer happy.

Description of the Problem

In the 1951 film

The Mad Hatter can be seen singing and dancing with the Hare. They are drinking tea and while dancing they continue to pour each other tea. Once they discover Alice has been watching them, they stop their dancing and signing. They run to Alice to tell her ” it’s *very very* rude to sit down without being invited”, but quickly overcome this once she compliments them on their singing. While the Mad Hatter is talking to Alice, he has his elbow in a cup of tea, and at one point he even pours tea from the kettle down his shirt and makes the tea go into a cup. They ask Alice where she came from but never give her a chance to answer, because they become distracted by clean cups they stumble upon. While dancing with the Hare to teach Alice about what non-birthday celebration is, the Mad Hatter makes a cake appear

in place of where his top hat was. At one point he dips his plate into his tea and takes a bite out of the plate. He never stays with one thing, while talking to Alice about birthdays, he insists that she drinks some tea, but as she starts to drink her tea he starts to sing “clean cup clean cup!!” Before Alice can even take a sip of her tea he has dragged her off to the other end of the table and proceeds to ask her if she would like more tea. He can hardly sit still, every few minutes; he is compelled to move down the table and has Alice and the Hare to move down with him. It is clear that the character has difficulty focusing their attention to one aspect and also has difficulty remaining in one spot. The Hatter asks her “Why is a raven like a writing desk?” but never gives Alice the chance to answer. He quickly becomes angry when she attempts to answer the question, but his attention is diverted when the White Rabbit comes exclaiming he is late. The Mad Hatter tells the White Rabbit that his watch is two days old and proceeds to destroy the White Rabbit’s watch by dipping it in tea and adding an assortment of food to the watch. After placing all the food into the watch the Hare smashes the watch with his sledgehammer and the Mad Hatter and he kick out the White Rabbit.

When called to Alice’s trial as a witness, he decides to throw the Queen of Hearts a unibirthday party, but this makes the Queen happy and does not last long due to Alice seeing Chester the Cat on top of the Queen’s head and the Mad Hatter running on top of the Queen to obtain Chester the Cat.

Upon seeing Alice approach him, he climbs on the table and walks across it, as he breaks plates and teacups along the way. Mally tells him that it is the wrong Alice, the Mad Hatter is positive that it is not the wrong Alice, and this is the correct one. While Alice is having tea with the Mad Hatter, the Hare and Dormouse, Chester the cat appears. While Chester is having tea, he brings up a topic that is sore for the Mad Hatter, who instantly becomes enraged in which Dormouse has to remind the Mad Hatter he needs to calm down. He is rather protective of Alice; when the guards of the Queen of Hearts come he hides her in a tea kettle. Upon making sure that Alice is safe, Mad Hatter puts her on his hat, after he had shrunk her, and takes her for a walk. While walking he starts to talk about the Jabberwocky and becomes enraged when Alice tells him that she will not slay the Jabberwocky. Talking to Alice about why she needs to slay the Jabberwocky, Mad Hatter becomes emotional, and tells Alice she has changed. He continues to go to lengths to protect Alice; he throws his hat with her on it across the field, so the Queen of Heart's guards do not capture her, instead they capture him. He lies to the Queen and tells he has not seen Alice; when she is clearly sitting next to the Queen. Instead of answering the Queen's question, he tells her that he is thinking of things that start with M: moron, mutiny, murder and malice. He decides to charm the Queen, by tell her that he wants to make her a hat for her rather large head. Once the White Queen regained her land again, the Mad Hatter is happy. To show

his happiness he does The Futterwacken Dance, which he was not able to do when the White Queen was not in power.

Diagnosis

The diagnosis the Mad Hatter seems to fit best is Borderline Personality Disorder (301.83).

1. Borderline Personality disorder is consider a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts. This is indicated by having 5 or more of the following characteristics:
2. Being frantic to avoid abandonment, either real or imagined
3. A pattern of intense, unstable interpersonal relationships characterized by alternating between extreme variances of idealization and devaluation
 - He displays this among Mally and the Hare. He is constantly changing his mood and one minute is harsh to them, and the next minute he thinks they have the greatest idea ever. Also, he instantly he is drawn to Alice once he sees her. He goes out of his way to protect Alice from the Queen of Hearts.

4. Identity disturbance: markedly and persistently unstable self-image or sense of self
 - Although he knows he is the Mad Hatter, he does not seem like he knows this all the time. In the 2010 version the Mad Hatter saw himself as being with the White Queen, but after the Queen of Hearts took over, he no longer knew who he was. He was one minute was having tea with Mally and the Hare, the next minute protecting Alice from the Queen of Hearts, and also he was someone that made hats.

5. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
 - The Mad Hatter in the 2010 version fits this better, in that he is willing to himself at risk constantly for Alice. He takes on the Queen of Hearts' guards, he repeatedly insults them and challenges them. Although it is never disclosed, he displays a several symptoms of someone that may have substance abuse, he is quick to change his behavior, his moods are hardly stable; they vary greatly from

sadness, happiness, and anger, his behavior is eccentric; he talks in riddles and is constantly moving.

6. Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior
7. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
 - He displays this GREATLY. He varies through multiple emotions, one minute he is happy then the next minute he is angry. Upon seeing Alice he drops what he is doing and decides to walk across the table to get to her. He is happy to see her because she is the right Alice and is the one that can slay the Jabberwocky. While Chester pops in for tea and brings up the topic of the Queen of Hearts taking over, Mad Hatter becomes angry instantly and cannot control his anger until Mally reminds of where he is. He displays symptoms of Attention Deficit Hyperactivity Disorder, one minute he is talking about something and his attention becomes drifted to something else. The Mad Hatter in the 1951 could qualify of

Attention Deficit Hyperactivity Disorder due to his lack of being able to focus on one thing. One minute he is telling Alice to have tea but then makes everyone move down because he saw a clean cup. He is constantly over talking the Hare and Alice. His emotions are unstable; he can easily become angry but can be pacified quickly. Both of the Mad Hatters are impulsive in the sense they do something without thinking about it. For instance in the 2010 version, the Mad Hatter is quick to insult the Queen of Hearts, but is quickly able to get himself out of being killed by telling the Queen he wants to make her a hat for her big head. In the 1951 version, the Mad Hatter throws the Queen of Hearts a unbirthday party when he is on trial for Alice.

8. Chronic feelings of emptiness
 - Personally I feel like he has these feelings, and hides them by being eccentric. Reasoning for why he would have feelings of emptiness is that when the Queen of Hearts took over, he could no longer do what he loved; being with the White Queen. He is now living in a

forest and displays multitudes of emotions rather rapidly. You can sense he is hiding his true feelings; depression of the White Queen no longer in charge.

9. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
 - He becomes angry instantly when Chester brings up the day of when the Queen of Hearts took over. Mally has to remind him of where he is and to control his anger.
10. Transient, stress-related paranoid ideation or severe dissociative symptoms

Accuracy of Portrayal

In a sense both Mad Hatters portray this disorder but the 2010 version does a better job of doing so. The 2010 version shows more emotion and you can see what caused him to become eccentric. His mood varies rapidly; he is quick to be impulsive and has a short attention span. He displays having other mental illness, such as depression and attention deficit hyperactivity disorder. His attention is constantly shifted between topics and is always moving. He has a hard time sitting still; he is never in one spot. The depression would be due to the Queen of Heart coming to power. She destroyed

the property that he lived on, it was the end of the world that he knew. Even though the White Queen lost her power, he still remained loyal to her. In losing the property that he lived on, and the White Queen no longer being in power, caused the Mad Hatter to be even more eccentric, psychotic.

Treatment

To treat the Mad Hatter a Diagnostic Interview for Borderline Patients would first be given. The interview looks at areas of functioning that are associated with borderline personality disorder. The four areas of functioning include Affect (chronic/major depression, helplessness, hopelessness, worthlessness, guilt, anger, anxiety, loneliness, boredom, emptiness), Cognition (odd thinking, unusual perceptions, nondelusional paranoia, quasipsychosis), Impulse action patterns (substance abuse/dependence, sexual deviance, manipulative suicide gestures, other impulsive behaviors), and Interpersonal relationships (intolerance of aloneness, abandonment, engulfment, annihilation fears, counterdependency, stormy relationships, manipulativeness, dependency, devaluation, masochism/sadism, demandingness, entitlement). The best treatment for Borderline Personality Disorder is dialectical behavior therapy; this treatment focuses on the patient building a life that balances changes and handle situations that occur in their life. Patients with Borderline Personality Disorder respond best to psychotherapy. Establishing trust between the patient and therapist is difficult to create and also maintain once

established. Types of psychotherapy that can be used are cognitive-behavioral therapy, transference-focused therapy, dialectical-behavioral therapy, schema-focused therapy, and metallization-based therapy. Also it would best to place the Mad Hatter in a stable environment, and around people that have stable moods.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=277#oembed-1>

Name: Ernie “Chip” Douglas “Aka” Larry Tate/Ricky Ricardo/ the Cable Guy.

Source: *Cable Guy* (Movie, 1996)

Background Information

From his reminisces, Chip grew up in a neglected home. His father was out of the picture, and his mother seemed to be some sort of cocktail waitress, or prostitute which is concluded from Chip watching a family scene on the television and saying to his mom” When am I going to get a brother to play with?,” while his mother replies,” Honey, that’s why mommy is going to happy hour,” as she leaves

the house. Now in his early thirties, Chip works an eccentric cable guy who has a distinct lisp. The scene opens as Steven Kovacs waits on Chip to arrive to install his cable. It appears that Steven has waited all day on Chip. Finally, when Steven is in the shower, Chip arrives and starts banging on the door saying, “Cable guy,” multiple times, and with each time getting louder and more annoyed. Finally, Steven comes to the door, upset that he was late, and Chip also becomes upset and states that he will just leave instead. After Steven asks Chip to come inside, Chip starts looking around the living room for a spot to put the cable wires. He starts talking to the walls in a sexual manner, and even displaying gestures to the walls that makes Steven uncomfortable.

Once Chip installs the cable, Steven asks him for free cable since his friend told him all he had to do was slip the cable guy a fifty-dollar bill. Chip then asks Steven to hang out with him later on yet Steven was “busy” so Chip asked again, “Well, what are you doing tomorrow?” Steven agreed and Chip exited saying “See you tomorrow pal.” While hanging out, Chip takes Steven to the large satellite receiver where Chip becomes overly emotional about how people’s satellite usage will expand and how you will one-day play video games with your friends in Vietnam. Afterwards, Steven asked what his name was, and Chip becomes highly emotional and explains with a dramatic monologue how it amazes him at the thought that Steven wanted to know his name, and goes on to say that his name is Ernie Douglas, but everyone calls him Chip.

After Chip incentivizes his friendship with Steven by

giving gifts such as a new home theater system while having no regard for personal space or privacy, although Steven asks Chip to return it, Chip becomes upset and says that he has given him friendship and that is greater than that stuff. Chip insists on awkward social activities, including dinner at Medieval Times where Chip becomes overwhelmingly aggression by competing in jousting, and sword fighting with Steven. The next day, Chip ignorantly stumbles upon Steven and his friends playing basketball, invited himself to join them, and ruined the game by breaking the goal. The next day, Chip leaves Steven thirteen messages on his machine, and undoes his cable, so that Steven will call him. Chip arrives furious that he only calls when he needs something.

To make Steven feel better about his girlfriend problems, Chip hosts a karaoke party with all the equipment he gave to Steven and without his knowledge, hires Steven a prostitute whom he slept with that night. Outraged, Steven throws Chip out, and Chip promises he will fix it. By fixing it, Chip goes stalks Steven's girlfriend Robin with her date, and waits for him incognito in the bathroom and severely assaults her date then shows up at Robin's house and installs her free cable. After Steven tells Chip he does not want to be friends anymore, Chip calls Robin to make her paranoid about how Steven is supposedly acting and then informs the police that Steven has stolen property. Once Steven is out on bail, Chip invites himself over to Steven's parents where he instigates a game of porno password and insinuating that he slept with

Robin. Infuriated, Steven punches Chip and Chip leaves. The next day, Chip kidnaps Robin, takes her to the huge satellite dish, and holds her hostage with a staple gun. Steven chases Chip and Robin up to the very top of the satellite. When the helicopter shines a light on Chip, he hallucinates that it is his mother telling him to jump. So, right as the world is waiting to hear the verdict on a huge case, Chip jumps and lands on the receiver, which knocks out the city's cable. However, Chip survives the fall and makes a mends with Steven and Robin, and as the helicopter pilot airlifts Chip away, he calls Chip pal, which starts the whole cycle over again.

Description of the Problem

Chip shows instability with personal relationships such as friendships. He becomes frantic if he believes if his friend(s) are abandoning him. He has no job, He had been fired from several cable companies in which he used different television names as his own such as Larry Tate, which is known from "I dream of Jeannie." Chip has feelings of abandonment, which stems from his neglectful childhood, where the television raised him instead of his parents. Chip has intense emotional problems such as erratic acts of aggression, violence, revenge, and dramatic emotions in terms of sobbing. Within moments, Chip can show signs that he absolutely loves his friends and then despise or hate the same friends. Chip shows signs of self-harming impulsivity such as reckless behavior including frequent trips to the large satellite dish, drinking, and hiring prostitutes. His risk of suicide behavior increased

when he assumed he no longer had any friends and attempted, but failed at a suicide attempt.

Diagnosis

301.83 Borderline Personality Disorder

DSM-IV-TR criteria:

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts. This is indicated by having 5 or more of the following characteristics:

1. Being frantic to avoid abandonment, either real or imagined
 - Chip shows this throughout the entire movie at his multiple attempts to keep Steven as his friend, and then included Robin into the mix, and lastly the helicopter pilot.
2. A pattern of intense, unstable interpersonal relationships characterized by alternating between extreme variances of idealization and devaluation
 - Chip exhibits extreme highs and lows on how he feels about himself as a good and bad friend to Steven. Chip does this when he cooks Steven breakfast after a party the

next morning (high) then feels incredibly bad at the fact that he hired a prostitute that Steven slept during the night (low). To fix the friendship, Chip goes out to make things right with Steven and Robin (high).

3. Identity disturbance: markedly and persistently unstable self-image or sense of self
 - Until Steven's friend did a background check, it was unaware. However, Chip was terminated from multiple cable companies where he had different alias from television shows such as Ricky Ricardo, and Larry Tate. Even though that Chip believes he is a great friend, he has broken into Steven's house and disrupted his privacy by wiring cameras in Steven's home and using them as blackmail.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
 - It is not real clear, however, there were scenes of him drinking alcohol and what seems to him being either drunk or drugged. In addition, by hiring the

prostitute for Steven, Chip knows how to get women, whether it is through giving free cable or something else.

5. Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior
 - Chip displays few suicidal behaviors. However, Chip did imply that he should end his life when the police shined the light on him, and then plunged to what he thought would be his death. Chip survived the fall.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
 - When Chip first met Steven to install his cable, he was very annoyed that Steven took a moment to answer the door, and then switched his mood to friendly when he asked Steven to hang out with him. Another instance occurred when Steven did not reply to Chip's 13 messages on the machine, until Steven's cable went out and then was upset at the fact that Steven only called when he needed something. Chip displayed signs of

depression or dysphoria when he was telling Steven that no one ever asked his name until then.

7. Chronic feelings of emptiness
 - Chip appears to feel empty from an early age as he lives in a neglectful home. There is no father present and a mother who goes out to happy hour in search of a man. In his adult age, Chip feels empty because no one takes the time to ask for his name let alone befriend him.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
 - Frequent temper outbursts and anger along with fights are seen throughout Chip's behavior towards Steven. Chip has temper tantrums when Steven does not want to be his friend. Chip becomes angry and vengeful when Steven says he does not want to be his friend anymore. Chip shows erratic when he plays basketball with the guys and begins to name call and play "street ball" after someone runs into him. Chip has two physical fights, one with Steven at the

Medieval Times where he comes at Steven with a sword, a joust, and a mace. The second occurrence is where he waits for Robin's date in the bathroom and assaults him until he has to be rushed to the hospital.

9. Transient, stress-related paranoid ideation or severe dissociative symptoms

Accuracy of Portrayal

I believe that Chip matches most of the criteria of this disorder unquestionably if not perfectly. His uncontrollable anger issues, feelings of emptiness, unstable interpersonal relationships, and his abandonment issues seem to make him fit the criterion of this disorder. Some things that need to be addressed is the few instances of self-mutilation to himself, including impulsivity, and suicide behaviors. More examples of suicidal tendencies needed to be seen in order to accurately diagnose him with Borderline Personality Disorder. In the movie, Chip only has the one instance of self-harm, which was the attempted suicide, and although Chip portrays himself to know the prostitute, he never mentions that he himself has had personal encounter with her, nor does it ever show that Chip was sexual impulsive. With some of the criteria still uncertain, Chip does fit eight out of the nine characteristics.

Treatment

To accurately diagnose Chip with BPD, He would be given the Diagnostic Interview for Borderline Patients Test, the Structured Clinical Interview (SCID-II) and the Personality Disorder Beliefs Questionnaire (PDBQ). For treatment, the best thing available is the Dialectical behavior therapy. In this therapy, it is broken down into three focuses, which would help Chip survive and build a meaningful life by helping him to balance change and accepting his life's situations. First, life-threatening or harmful situations are addressed in Chip's life. This would include self-harm from self-mutilation or attempted suicide; each instance would be dealt with accordingly. Then, Chip would be gently pushed to experience emotions that are painful for him. Pushing Chip to experience intense emotions head-on is a type of exposure with response prevention therapy. As Chip faces his toughest emotional outbreaks with different situations, Chip's anxiety levels will eventually decrease. The decreased anxiety will allow Chip to experience those situations again only without the emotional outbreaks and anxiety. Lastly, Part three addresses living problems. Although it is unclear in the movie of Chip's living conditions, this portion of the DBT will help Chip feel complete as a person. By feeling complete, Chip would be able to deal with the feelings of "emptiness" and the imagined fears of being abandoned. Once Chip is able to cope with these feelings, he will be able to identify when these feelings are beginning and be able to recognize that they are not real. By being able to identify these feelings,

Chip will be able to control his outbursts of anger and mood swings.



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Intermittent Explosive Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Matt Foley

Source: Saturday Night Live (TV series, early 1990s)

Background Information

Matt Foley is a 35 year old, male motivational speaker. Physically he is severely overweight due to his steady diet of government cheese. This may lead to high blood pressure and other health complications. He also seems to have trouble breathing normally, not just during his “rage” episodes. He doesn’t speak of any interpersonal relationships, family or other, so family history and his childhood environment are

unknown. Matt did admit openly that he is twice divorced and lives in a van down by the river, and he is very unsatisfied with these two facts. His social skills are very awkward. When he is around people he is loud and generally awkward, either not understanding social cues or (more likely) ignoring them. He becomes very physical with others, lifting them, invading “personal space” and so on. One episode he talked about began with shaking children to “drive his point home” that Santa wasn’t real (during this episode he was being paid to dress as Santa at The Mall. At time of evaluation he had been on a coffee binge, drinking it for four hours straight. With the exception of his coffee spree there is no evidence or admittance of harder drug use. He has little to no coping skills, often reverting to yelling to relieve tension. He generally frightens people with his behavior. And while his goal in life is to not live in a van by the river (and convincing young kids that they don’t want that, too) he seems unable to help himself in achieving that goal.

Description of the Problem

Matt Foley’s personality is off-setting. While he can seem overly enthusiastic, it is a façade to hide his short temper. His irritability is evidenced in all his mannerisms, from his constant fidgeting to the way his voice grows louder the more irritated he becomes. He constantly has to adjust his pants and shake out his arms to get rid of his temper “tingling” in his arms. He is very short with people who think differently than he does, choosing to be verbally demeaning

instead of allowing them their own opinions. This is costing him his audience when he gives speeches and not allowing him to form connections. Not being able to make positive relationships is harming his work performance and not allowing him to advance on to higher positions. Higher positions would mean a pay increase and allow him to move into a more permanent habitation (such as an apartment or a house).

His explosive nature has also led him to destroy other individual's property. While at a house for a job he annihilated a coffee table in the living room. He was sorry after the fact, but could not seem to say anything other than "whoopsie." He also once forcefully suggested he move in with another person to set them on the right path. During another episode he yelled at a mother to "shut your cake hole!" and he promptly destroyed a Christmas scene set at The Mall. Yet another episode he discussed involved him interviewing a highly respected comedian/talk show host (Conan O'Brien). The interview included Matt yelling insults, such as threatening to use the studio's curtains to "wipe (his) rear end with (them)." His episodes last about 6 minutes (specifically 5 minutes and 49 seconds) and occur sporadically.

Diagnosis

Diagnosis is Intermittent Explosive Disorder, DSM-IV 312.34. Matt clearly shows an inability to control his impulses. His episodes last less than a half hour at time and

usually result in a physical altercation or destruction of property. They are also grossly uncalled for as Matt loses control “at the drop of a hat.” His actions are neither planned nor used for personal gain, other than to relieve his anger. Having no history of drug abuse or suggestion of family history of mental health, it can be safely assumed that Matt is not under the influence of anything other than his own unchecked rage. That is, his actions are not accounted for by any other mental disorder or substance abuse. Since Matt is divorced he may have some unresolved anger issues, or he may have had a tense marriage where it was not unusual for him to go into episodes. Matt also says he is remorseful for the destruction of property, proving he does have a sense of what he’s doing is wrong. Similar episodes have occurred before, one time involving public property at The Mall, the other involving verbal abuse during an interview with a well-known comedian Conan O’Brien.

Accuracy of Portrayal

Intermittent Explosive disorder is an impulse disorder that is specifically a lack of restraining anger and aggression. Statistically men are more likely to have IMED than women. The episodes are grossly out of proportion to the situation, be it a yelling match or breaking something. These episodes are also not accounted for by another mental disorder, drug use, or by any physiological condition (such as brain injury, dementia, Alzheimer’s, and so on.). Matts episodes are short in duration (generally no longer than 20 minutes), which

is consistent with the diagnosis for IMED. The breaking of the table and Christmas scene could also be accidental rather than purposeful, but it's still accounted for by his episode. His "drug use" (coffee and espresso binge) is atypical, but not unheard of. His aggressive tendencies are interfering with his life and relationships, and will continue to do so until he gets a handle on his behavior. In all these ways, Matt is a perfect example of an individual who suffers with IMED.

Treatment

As mental health professionals would agree, there are a few options for Matt Foley. Empirically supported treatment for Matt could include drug therapy such as β -Blockers, $\alpha(2)$ -agonists, anti-anxiety, anti-convulsion, ant-depressants, antipsychotics, and mood stabilizers. Drug therapy can be used with or separate from cognitive behavioral therapy. In cognitive behavior therapy individuals identify stressors that lead to episodes and how to cope or avoid them. Other forms of treatment include social skills training, in which the individual works on improving their interpersonal skills. Although social skill training is a form of treatment it is less effective than drug and/or cognitive behavioral therapy.

Matt Foley would benefit most from the combination of drug therapy and cognitive behavior therapy. Matt would be a good candidate for β -Blockers, because they specifically block the β 1 and 2 receptors that stimulate the body into "fight or flight" mode. They would also help to lower his blood pressure, which may further help to reduce his stress

and anxiety by strengthening his health. In cognitive behavior therapy he and his therapist would work specifically on ways to control his anger or use it in more constructive ways. One strategy for controlling his anger would be to record specific instances that send him into episodes. Knowing these situations would allow him and his therapist to work on ways to reduce his rage should these situations ever occur again.

Name: James Howlett (Wolverine), Logan, formerly Weapon Ten, Death, Mutate #9601, Jim Logan, Patch, Canucklehead, Emilio Garra, Weapon Chi, Weapon X, Experiment X, Agent Ten, Canada, Wildboy, Peter Richards, many others, but primarily claiming Logan as his primary name.

Source: Marvel Comics (As Wolverine, cameo) Incredible Hulk #180 (1974), (as Wolverine, fully) Incredible Hulk #181 (1974), (as Patch) Marvel Comics Presents #1 (1988), (as Weapon X) Marvel Comics Presents #72 (1991), (as Death) Astonishing X-Men #1 (1999)

Background Information

Logan is more than one hundred years of age, although he has the appearance and health of a man roughly 35-40 years of age. Born James Howlett, he was a frail boy of poor health from Alberta, Canada during the late 19th Century. He was the second son of wealthy landowners John and Elizabeth Howlet. His mother, who was institutionalized for a time

following the death of her first son, John Jr., in 1897, largely neglected James. Elizabeth later committed suicide. He spent most of his early years on the estate grounds and had two playmates that lived on the Howlett estate with him: Rose, a red-headed girl who was brought in from town to be a companion to young James, and a boy nicknamed “Dog” who was the son of the groundskeeper, Thomas Logan. James assumed the name “Logan” while living incognito following a violent incident involving his companion Rose, who was consequently wrongly accused of murder. Logan is a veteran of several conflicts and wars including World War II. He has served in covert government operations working under the title **Weapon X** as an assassin. Logan worked as a miner in British Columbia for a time and was highly regarded as being a hard worker. He has also worked as an adventurer, instructor, bartender, bouncer, spy, government operative, mercenary, soldier, and sailor. Logan has an almost immunity to the intoxicating effects of alcohol, but no evidence of use or abuse of any other substances is apparent. Logan tends to make friends easily enough, but due to his violent and tragic past has difficulties with trust. Logan’s romantic relationships are often complicated and tedious, frequently becoming situations where either his love cannot be displayed, or his love is for someone committed to someone else. Logan’s difficulty with interpersonal relationships as well as his propensity toward violent outbursts often causes him to withdraw and spend a lot of time alone. This isolation often serves as a means of coping.

Description of the Problem

Logan has a strong and often forceful demeanor. He often engages in aggressive competitive behaviors, as well as being somewhat of a bully when in certain company. He seems to be tender toward women, but sees other males as either competition, or subordinates. Logan shows a generally hostile disposition, as well as a tendency to engage in aggressive forms of humor in the limited instances in which he interacts with others. When engaged in conversation, he is often abrupt and bordering on rude.

Logan's (Wolverine's) skeleton includes six retractable one-foot long bone claws, three in each arm, that are housed beneath the skin and muscle of his forearms. Logan can, at will, release these slightly curved claws through his skin beneath the knuckles on each hand. This ability coupled with Logan's short fuse and incredible physical ability often makes him dangerous.

Diagnosis

Intermittent Explosive Disorder, DSM-IV 312.34. Logan displays a number of impulsively violent outbursts, many of which last only a short time, but are extremely severe and destructive. Logan often displays violent outburst of temper, threatening others, even peers with physical harm, as well as considerable destruction of property both with his claws as well as other means. Logan is quick to anger and aggress and is often severe in his reactions to perceived threats to his

safety. During one of his altercations with another male from his past, Logan inadvertently killed his childhood companion, Rose, by impaling her with his claws. One form of aggression, known as *amok*, is characterized by acute, unrestrained violence, typically associated with amnesia. This is primarily seen in southeastern Asia but has also been seen in Canada and the United States. Unlike IED, *amok* does not occur frequently but in a single episode. One reason for suspecting that Logan may be suffering from this is due to two factors:

1. Logan has extreme memory loss due to having had his memories “wiped” from his consciousness after his service as Weapon-X
2. Logan possesses memories of being a Samurai in Japan. Perhaps during his travels in the Far East, he found himself in southeastern Asia.

The only reason for mentioning this is due to Logan’s chronological age being much longer than that of a non-mutant human.

Accuracy of Portrayal

Being male, Logan is more at risk of having developed IED. IED is one of the impulse-control disorders that involve the inability to control impulses of anger, or rage and often results in violent physical outbursts or violent verbal attacks. Logan definitely displays these tendencies. Logan doesn’t

seem to have any other mental disorders such as schizophrenia, bipolar, affecting him, however during the process of “wiping” his memory, a degree of brain injury may have occurred. Logan’s extremely reactive nature and his severity during his explosive episodes is often maladaptive and causes him to have to be transient in nature, drifting from location to location, rarely settling down into one specific location. His romantic relationships have been complicated by his angry outbursts as well. Enemies he has made in the past due to his mercenary work and covert government work have caused the death of at least one potential life mate.

Treatment

Since few controlled studies exist involving treatment of IED, Logan would probably benefit from cognitive behavioral therapy (CBT), helping him to identify triggers for his outbursts. Teaching him coping skills such as diaphragmic breathing, counting, and also the keeping of a stress and incident journals to help him identify what triggered specific incidents and what to do to avoid them or possibly handle them differently if a similar situation arises. Anger management and group therapy could also be effective as well. If these were unsuccessful, or only marginally effective, then the use of certain medications such as anti-convulsion, anti-anxiety, mood regulators, anti-depressants, antipsychotics, beta-blockers, alpha (2)-agonists, or phenytoin could be indicated.

Narcissistic Personality Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Jenna Maroney

Source: 30 Rock (Television series, mid 2000s)

Background Information

Jenna Maroney is a forty-three year old woman, who was born Ystrepa Grokovitz on February 24, 1969. She grew up in Bakersfield, CA. Her father, was a burger server in suburban Santa Barbara. He dumped Jenna's mother, a dental hygienist, for another woman. Jenna still says she will "always be his little girl." After being spurned, Jenna's mother made her sit on every mall Santa's lap in Bakersfield in an attempt to find

him. Jenna has a sister who urinated in one of Jenna's eyes when she was little, which causes it to not open all the way. Another sister is deceased. She did not get along with her half-sister, Courtney, who is now deceased. Upon hearing of her sister's demise, Jenna showed no obvious signs of sorrow or grief. Jenna also has a niece, who draws pictures of her Auntie Jenna. Jenna finds the pictures to be offensive, when in fact they are just childlike renderings of Jenna.

During Jenna's teen years, her mother moved what family she had left from California to Florida. Jenna attended high school on a boat, which has subsequently sunk. At the age of 16, Jenna was engaged to a congressman. She has also reportedly dated O.J. Simpson, a music producer, a sniper, a mob boss, and hinted at having been in a three-way relationship with Rosanne and Tom Arnold. Jenna's started singing at a young age, as a distraction for her mom, who was busy shoplifting. Jenna went on to study voice at Northwestern University and also at the Royal Tampa Academy of Dramatic Tricks, where she majored in playing prom queens and murdered runaways. She has been in various films and commercial, and is currently employed as an actress on a television series.

There is no history of substance use, however, there is a history of binge eating, but the episode was brief, and Jenna's eating habits have since returned to normal. Jenna is in good health, with no reported concerns.

Jenna seems to have coped with her life difficulties by becoming the "center of attention," and the center of her

own universe. Abandoned by her father and used by her mother as a decoy, Jenna possibly feels unloved and rejected. Jenna's inability to empathize with others and sustain lasting relationships with are major weaknesses. She is constantly battling with someone, whether it be a co-worker, a friend or a family member. Currently, Jenna is involved with a transvestite who dresses as Jenna. In fact, Jenna met her lover while participating in a Jenna Maroney Look-Alike Contest, in which Jenna herself only placed fourth. Her new lover won the contest, and they have been intimate since that time.

Description of the Problem

Jenna does not feel she has any problems, other than not receiving the attention and recognition she feels she deserves. Her achievements are not commensurate with her desire to be "worshipped," and adored. Jenna feels she is entitled to special treatment and when this fails to occur within her career or social life, she becomes explosive and stubborn. She has an excessive need for admiration, as evidenced by her choice of careers. She seems to have no empathy regarding others, and on the rare occasions empathy is displayed by Jenna, it is not genuine empathy, but a means to an end. In other words, she fakes empathy to manipulate others, or for personal gain. Jenna repeatedly poisoned a co-worker in the hopes of dating one of the "hot" EMT workers who came to the rescue. Jenna is severely jealous of her co-star in her current television series, and is constantly looking for ways to undermine him. She dreams of unparalleled success and

believes she is the most beautiful, talented woman to grace this planet. While Jenna does not see this as a problem, the rest of society fails to agree with her assessment of herself, and this causes much frustration for Jenna. Jenna reacts very unfavorably to even the slightest criticism, as she believes herself to be perfect and unique. If she is criticized, she feels that the person doing the critique, “just doesn’t understand her,” because they are not as special and wonderful as she.

Diagnosis

Jenna best fits the diagnostic category of Narcissistic Personality Disorder (301.81)

- A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
 - has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
 - is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love (perfect marriage to the perfect spouse)

- believes that he or she is “special” and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
 - requires excessive admiration
 - has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations (“You owe me because I’m that good”)
 - is inter-personally exploitative, i.e., takes advantage of others to achieve his or her own ends
 - lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
 - is often envious of others or believes that others are envious of him or her
 - shows arrogant, haughty behaviors or attitudes
- Other Symptoms:
 - history of intense but short-term relationships with others; inability to make or sustain genuinely intimate relationships

STEPHANIE WEIGEL

- a tendency to be attracted to leadership or high-profile positions or occupations
- a pattern of alternating between unrealistic idealization of others and equally unrealistic devaluation of them
- assessment of others in terms of usefulness
- a need to be the center of attention or admiration in a working group or social situation
- hypersensitivity to criticism, however mild, or rejection from others
- an unstable view of the self that fluctuates between extremes of self-praise and self-contempt
- preoccupation with outward appearance, “image,” or public opinion rather than inner reality
- painful emotions based on shame (dislike of who one is) rather than guilt (regret for what one has done)

Jenna qualifies for almost every single diagnostic criteria, as outlined in the Description of the Problem and her Background information. There is some overlap with Histrionic Personality Disorder, as Jenna does frequently use

her sexuality to gain her desires, however, she fits more of the Narcissistic criteria than the HPD criterion.

Accuracy of Portrayal

The portrayal of narcissism in this character is fairly accurate, although there is some overlap with Histrionic Personality Disorder. One of the deciding factors whether this was NPD or HPD was the fact that Jenna falls in love with a man who dresses as her. Narcissus was also in love with himself and was forever doomed to gaze upon his reflection in a pool of water, until he died. It is said as his boat crossed over into the afterlife, he leaned over to catch on last glimpse of himself in the water. This is the epitome of Jenna. While more males than females are diagnosed with NPD, (7% for males and 4 % for females), Jenna is a prime example of a female narcissist.

Treatment

Narcissists rarely seek treatment, as their perception is that they are “better” than everyone else. If a narcissist does enter treatment, psychotherapy is the recommended course of treatment, and perhaps some group therapy. If group therapy is utilized, clear boundaries should be set as to respecting other people in the group. Prognosis poor.





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Anorexia Nervosa

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Giselle Vasco

Source: *Skinny* by Ibi Kaslik (book, 2004)

Background Information

Giselle Vasco is a twenty-one year old, Caucasian female of Hungarian decent. She was the first born of two daughters after her parents, Thomas and Vesla, immigrated to the United States in the early 1970's to escape the communist repression of their country. Giselle's younger sister Holly is eight years behind her in age but, much like her sister, has a very grounded and intellectual personality. They both

stand approximately five feet, eleven inches tall and have a very close relationship. Giselle and Holly are both considered accomplished in their own rights, even at young ages with Giselle enrolled in medical school and Holly being acknowledged as a “stand-out athlete” at her high school. At the present time, Giselle is home from medical school, taking a leave of absence to clear her mind and regroup her life. She is working at a hospital in the mental health ward as a companion to many patients. It is described that, after her first love had left, Giselle became a callous lover who would frequently sleep around – trusting nobody with her heart. This stayed a constant until she met her current boyfriend, Solomon (Sol), who desperately loves Giselle.

Both sisters however, are plagued by the fact that their father had recently passed away due to a heart attack. In the midst of this tragic loss, both sisters struggle in the grieving and coping processes respectively. Giselle and her father always had a rocky relationship that stemmed from a time before she was even born. Thomas questioned the faithfulness of his wife in the frequent suggestions that Giselle may not be his biological daughter. This was an obstacle that was battled through from Giselle’s birth up until her father’s death-and even after. The relationship between the girls and their mother, however, seems to be solid.

Giselle acknowledges that when she was her sister’s age (approximately 14) one of her primary focuses was to discover ways to “be smaller.” It is presumed that Giselle, and the entire Vasco family for that matter, were a religious group.

At one point, Giselle asks for God's forgiveness after lying to her mother about her weight at the time. Giselle also acknowledges that she would masturbate in upwards of six times a day and would drink only lemon water. In lieu of her desire to "be smaller," Vesla would frequently take Giselle to see the doctor regarding her weight, often against her wishes. There is no mention of a history of drug or alcohol use by Giselle.

Description of the Problem

As mentioned earlier, while in high school, Giselle's mother would constantly bring her to the doctor to check up on her weight. Giselle would do things like put rocks or weights in her pockets to tip the scale at 120 pounds, as opposed to the 95 that she weighed. Her lack of a proper diet surrounds her potential diagnoses. Holly describes her sister's systematical approach to the dinner table as Giselle would figure out ways to clear her plate without digesting a single bite of food (i.e. dropping food on the floor, pretending to use the restroom and flushing portions of her meal). Aside from a lack of food toward her diet, Giselle would only drink lemon water.

Sexually, Giselle is not what you would call repressed. She became very sexually ambiguous after the departure of her first love. Also, as discussed earlier, Giselle would spend much of her time locked in her room, masturbating up to six times per day.

On a relational level, Giselle and her father always struggled with the speculation the she may not be his

biological daughter. We go on to discover that this is indeed true. This made it hard for them to ever truly salvage a meaningful father-daughter relationship.

Diagnosis

In my personal opinion, Giselle's diagnosis would be as follows: Axis I, Anorexia Nervosa, Binge Eating/Purging Type (307.1) and Axis IV, Problems with Primary Support Group.

Criteria needing to be met for above Axis I diagnosis as follows (from DSM IV-TR):

1. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
 - Over the course of years, Giselle would consume an insufficient diet consisting of little or no food and lemon water, putting her at a weight that was below 85 percent than expected for her height. She constantly resists the cautions of her mother and doctor in regard to her weight.

2. Intense fear of gaining weight or becoming fat, even though underweight.
 - Giselle exhibits this behavior in her everyday way of thinking. Even though she is of above average height, she intensely pursues a body weight that is unhealthy for her to maintain. Also, she takes extreme measures to ensure that her body weight stays exceedingly low and, in turn, dangerous to her general well-being.
3. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
 - Although she is what is considered underweight, Giselle is indifferent to this fact and yearns to continue to lose dangerous amounts of weight. She evaluates herself as being "too big" but seems to have a partial awareness that she is ill—she may not be in denial.
4. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following

hormone, e.g., estrogen, administration.)

- Symptoms of this nature were not discussed; however details about her sexual history and excessive masturbation are mentioned.

Accuracy of Portrayal

Although it may not be glaringly clear, should the average person read this book, they would find a fairly accurate portrayal of the onset and manifestation of the eating disorder Anorexia Nervosa. I say that it may not be clear, in large part, due to the fact that this work is narrated by two individuals (both sisters) as almost two different stories. Not only is Giselle's case of Anorexia a prevalent point in the novel, but so is the poor relationship between Giselle and her father as well as the family dynamic after their father's death. There were, however, some very accurate descriptions of what behaviors would be exhibited from an individual with this disorder. Her constant dilemma on how to trick those around her into believing she was eating a healthy diet is quite common in individuals with Anorexia. Giselle also references her constant hunger, although she denies it to those around her. Her cold and clammy hands as well as constant fatigue are also associated features of Anorexia that allude to her problem. With that being said, I feel that the book does an exceptional job of portraying an individual with Anorexia Nervosa.

Treatment

In treating Giselle for her disorder, the treatment team would focus their attention around two main goals: (1) To help Giselle gain weight and (2) To address Giselle's psychological and environmental issues. A major step in treatment, as in the treatment of any disorder, would be to make sure that Giselle is aware that she has a problem. The most widely used form of treatment for this disorder is family and group therapy, which cannot be utilized to its full potential should the patient not admit that he/she needs help. In Giselle's case, her sister and mother would play a very significant role in treatment. As a clinician, you would like to see Giselle's family encouraging her on a regular basis, reinforcing the fact that she looks fine the way she is (while eating a normal diet), and that it is not necessary for her to exhibit these unhealthy behaviors. More specifically, I believe that Giselle's sister Holly should be utilized as best as possible during treatment as they have always had a very strong bond and friendship. If anyone would be able to aid in "breaking through" to Giselle about her disorder, I think it would be her little sister.

Self-help groups are also successful in the treatment of those with Anorexia. Treatment for Giselle should include regular group meetings with individuals who have experienced the same negative outcomes in their lives due to the disorder. The thought here is that by discussing the topic of Anorexia among those who have it, Giselle will be afforded the opportunity to become more educated on the subject and, eventually put herself in a position where she is aware of the

harm she is causing her body. Over time, between family therapy and self-help group therapy, hopefully a certain sense of cognizance will begin to develop with Giselle in regard to the harm she is causing herself-this will hopefully lead to a change in attitude and eventually behavior.



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Alcohol Abuse

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Lila Blewitt

Source: *Lila: An Inquiry into Morals* by Robert M. Pirsig
(book, 1991)

Background Information

Lila Blewitt is a Caucasian female and presumed to be middle aged, although her actual age is unknown. She is currently riding on a sailboat with a man she met the previous night in a bar located along side a river on the East Coast. Lila does not have an occupation. In the past, Lila has been a prostitute as well as a waitress. Lila's mother was critical of her. As a child,

when Lila did something good, the mother said nothing; but when she did something bad, her mother mentioned the incident repeatedly. Lila was previously married to a trucker and had a daughter. Her husband and daughter are deceased. Lila's daughter died by smothering in her blanket, and her husband died in a car accident. She likes to dress very provocatively, but with no originality.

Description of the Problem

Lila has very little direction in life, and her mental processes and conversations are very surface. She dresses overtly sexual, and believes that with enough alcohol, relations with men are reduced to pure biology where they belong. Lila does not moderate her intake of alcohol, and drinks often and to the point of complete intoxication. She takes medication called Empirin whenever she begins to sense a psychotic episode is coming on. These episodes appear to be induced by social stressors, such as disagreements or arguments. Lila also suffers from severe delusions, odd ideations, and catatonia. Lila's medication was stolen from her purse; she ended up lost in New York City and thought that taking all of her clothes off would be a good idea because then somebody would "see" her and help her. Lila's social life greatly suffers due to impulsively rapid shifts between seeing individuals as either a rescuing friend, or as an enemy out to get her. Also while she was lost in New York City, Lila ordered three rum and cokes, although she didn't end up being able to pay for them, and then thought that her childhood pet and dead husband were

giving her directions on how to get back to the sailboat she had been riding on. Once back at the sailboat, Lila saw a doll floating in the river and believed it to be a human baby. Also at times, Lila's speech is highly disorganized, described by the author as "word salad."

Diagnosis

The diagnosis for Lila that seems to fit appropriately is Schizophrenia, Disorganized Type (295.10) with a comorbidity of alcohol abuse (305.00).

A. To be diagnosed with schizophrenia, two or more of the following characteristics must be present:

1. Delusions
2. Hallucinations
3. Disorganized speech
4. Grossly disorganized or catatonic behavior
5. Negative symptoms, i.e., affective flattening, alogia, or avolition

Lila displayed all of these characteristics throughout the book.

B. For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset.

- Lila was unable to hold down a job, drifting through life without goals or direction. Her

interpersonal relationships suffered drastically. Everywhere that she went, people would end up wanting to get and stay away from her. Lila was unable to maintain stability in her life, with no home or occupation. She had to rely on others to take care of her.

C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms that meet Criterion A and may include periods of prodromal or residual symptoms.

- The author indicated from conversations with a childhood friend of Lila's that she had suffered from the above stated symptoms throughout her adult life.

D. Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

- Lila did not seem to display symptoms of mood disorders. Other than during a psychotic episode, Lila's mood remained relatively stable throughout the book. She did not display depression, but she did display catatonia. Any time that she displayed

anxiety, it would be involving a break from reality.

E. The disturbance is not due to the direct physiological effects of a substance or a general medical condition.

- Lila's substance abuse involved heavy drinking, but her above symptoms were never consequences of being under the influence of alcohol at that time.

F. If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month.

- There is no history of either of the above listed disorders present in Lila.

To fit the Diagnostic Criteria for 295.10 Disorganized Type, the following criteria are met:

1. Disorganized speech.
 - The author would describe the way Lila conversed as being "word salad." It would make sense to Lila, but not to the listener.
2. Disorganized behavior.
 - Lila got lost in New York City because she was not paying attention to the direction that she was walking in, nor the direction that she would need to later

return. She also thought that it would be acceptable to take her clothes off in order to get somebody to “see” her. She often needs others to rescue her from situations that she got herself into.

3. Flat and inappropriate affect.
 - During a psychotic episode, Lila’s affect became completely flat. She would not speak or respond to any outside stimulus for an entire day.

To fit the diagnosis for Alcohol Abuse (305.00)

1. Recurrent substance use in situations in which it is physically hazardous and continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
 - Lila would drink to the point of being intoxicated in public places where she did not know anybody, when she did not have the money to pay for the drinks, and did not even know her own whereabouts. As a result of her behavior while intoxicated, Lila would behave inappropriately and aggressively towards others. These behaviors would cause Lila

to be an outcast in her social circle.

2. The symptoms have never met the criteria for Substance Dependence for this class of substance
 - Lila does not meet the criteria for Substance Dependence. Although drinking alcohol did cause Lila the above stated problems, Lila did not drink as frequently as is required to be considered dependent.

Accuracy of Portrayal

The average person reading this book would see an accurate portrayal of a person whose behavior qualifies for alcohol abuse. The author does not make Lila out to be dependent on alcohol, but he does show how Lila overconsumes alcohol to the point of causing her problems in her social life, as well as putting herself in hazardous situations. The comorbidity of her alcohol abuse with her schizophrenia is also an accurate portrayal for someone with less severe schizophrenia, occurring in episodes rather than ongoing. The book also illustrates for the reader accurately what may be going on inside the mind of a person during a schizophrenic episode as well as while abusing alcohol.

Treatment

To treat Lila's alcohol abuse, the first step would be to provide

treatment for her Schizophrenia. No long term success for treatment of her alcohol abuse could occur while Lila was suffering from a psychotic disorder without treatment. Once Lila was in treatment for Schizophrenia, you would then address her alcohol abuse. Lila would have to realize and admit that she was abusing alcohol. The fact that alcohol abuse was causing social problems for Lila as well as putting herself in dangerous situations could be presented to Lila so that she would correlate alcohol abuse with its negative consequences. While her treatment for schizophrenia could involve medication, it would be important to look at possible drug interactions before prescribing her any medication to help her stop drinking. Next, Lila could start cognitive behavioral therapy to explore her emotional reaction to events in her life and her ensuing behaviors and their further consequences, while emphasizing alcohol abuse throughout this process. Last, Lila could attend Alcoholics Anonymous to learn more about alcohol abuse and to have a social environment that is supportive of her while she is learning to change her behaviors involving alcohol abuse.

Panic Disorder without Agoraphobia

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Tony Soprano

Source: *The Sopranos* (Television series, 1999–2005)

Background Information

Tony was born of Italian descent on August 24, 1960 and is male. At time of symptoms Tony was 39 years of age. Tony Soprano declares himself to be in the “waste management” business but is actually involved in criminal activity. The Tony is the *capo* in the Dilteo crime family. The duties included with this occupation are collecting “loans” and “persuading” people to pay back money that was “loaned” to

them. These “persuasions” include physical attacks as well as other forms of violence. Tony has the added responsibility to attempt to keep peace between him and other members of the organization. Tony is in relatively good health for a man his age, but is noticeably overweight. Tony’s family mental health is very stressful. Tony has stressful relationships with his wife and work associates. An especially stressful and dysfunctional relationship with the mother is also present. Tony has a history of alcohol and tobacco use. Major life difficulties include stress from work and problems from aging mother. Tony displays poor coping skills, often resorting to anger and aggression. The use of alcohol and promiscuous relationships are used as escaping behaviors.

Description of the Problem

Tony has had several episodes of fainting. The first faint attack was described by Tony as a feeling of “ginger ale in the skull”. The symptoms Tony experiences during his panic attack episodes include “racing” heart, feeling faint and dizzy, chest pains, and breathing difficulties. Specific problems these symptoms are causing are increased difficulty dealing with demands from his occupation, increased stress with family responsibilities (especially issues involving the future of the Tony’s aging mother). Tony is hesitant to admit he is experiencing depression but ultimately does state that he is depressed. Tony became deeply saddened by the departure of ducks he had been caring for. He came to the realization the

departure of the ducks symbolized his fear of losing control of his family, job, and life in general.

Diagnosis

Diagnosis for the Tony meets criteria for Panic disorder without Agoraphobia, DSM-4 TR code 300.01. Tony has recurrent, unexpected panic attacks and shows worry about the implications of the attack (e.g. losing control). The Tony does not display characteristics of agoraphobia. The panic attacks do not appear to be due to the Tony's use of alcohol, tobacco, or any other pre-existing physical conditions.

Accuracy of Portrayal

The average person watching the portrayal of the Tony would think that panic disorder is only caused by extreme life stress and that the disorder has minimal impact on other aspects of life functioning. The main point for accuracy of portrayal included with this character is he also displays major depressive disorder. This lends to the accuracy of portrayal due to the high comorbidity between panic disorder and major depressive disorder, which is between ten to 65 percent. Also, accuracy of the portrayal comes from the recurrent and unexpected nature of the panic attacks. The inaccuracies from the portrayal include the presentation that panic attacks are only associated with highly stressful life events. Other inaccuracies are the lack of behavioral change and lack of impact on Tony's relationships and social life.

Treatment

The primary source of treatment would be cognitive behavioral therapy. CBT would focus on having Tony face behaviors and thinking patterns that sustain or trigger the panic attacks. This treatment would have Tony realistically ask themselves such questions as, “what is the worst thing that could happen?” For Tony, questions might include, “what is the worst that could happen to my business or family if something were to happen to me?” When Tony is forced to look at the worst outcome and realize that everything would go on if this outcome happened, he learns the source of his panic is less terrifying. Cognitive behavioral therapy might also be supplemented with anti-depressant medication due to his co-occurring depressive symptoms. The treatment that is displayed on the show for Tony is a psychoanalytic approach. The American Psychiatric Association does not acknowledge the role of intensive psychoanalytic therapies, including psychoanalysis, in the treatment of panic disorders. However, studies have shown significantly reduced panic symptoms from panic-focused psychodynamic psychotherapy (Barbara et al., 2007). More evidence must be gathered before the treatment presented in the show is recognized as a significant treatment for panic disorder.

Panic Disorder with Agoraphobia

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Dr. Helen Hudson

Source: *Copycat* (movie, 1995)

Background Information

Dr. Helen Hudson is a retired criminal psychologist. Her exact age is not given but she is estimated to be in her mid 40's. She is a physically healthy female without a family of her own. No family background is provided in the film. Dr. Hudson is very renowned in her field and often lectures on the subject. She testifies against and profiles serial killers. Dr. Hudson was attacked by a killer she testified against and

witnessed him kill one of her police bodyguards. After he was sentenced to jail, he threatened to kill her. This triggered a deep fear and extensive amount of anxiety in Dr. Hudson. Due to her fear and anxiety, Dr. Hudson confines herself to her home and puts in premium security systems to attempt to feel safe. Because Dr. Hudson does not leave her home, her social relationships are confined to her live-in assistant and anonymous online friends she communicates with through chat rooms and games. She is a heavy drinker and takes many pills for her condition. Upon becoming homebound, Dr. Hudson retired from clinical practice and writes books to generate an income.

Description of the Problem

Dr. Hudson was extremely traumatized by her attack and the violence and death she witnessed. After the attack, Dr. Hudson not only retired from her practice but also became totally homebound to avoid contact with anyone who might be a potential serial killer. She feels she is “the pin-up girl” for serial killers. She believes they all know her and want to either impress her with their killings or want to kill her. Dr. Hudson displays perceptions of imminent danger in even simple tasks such as retrieving the newspaper from the hallway in front of her apartment door. When she does attempt to leave the apartment, even in the face of another attack, it brings on such severe panic that she almost becomes unconscious and returns to her home, even though there is an intruder inside. She has nightmares, paranoia, hyperventilates, becomes dizzy,

breaks out in sweat, and sometimes will pass out from her panic symptoms. She occasionally hallucinates that she is seeing her attacker. Her panic attacks happen often enough that she keeps anti-anxiety medications in several places in her house for easy access. She has a live-in assistant to aid her in case she passes out during her attacks. Because of her alcohol and pill use, she does not trust her own thoughts or actions from time to time. She is often agitated. In severe stress situations, Dr. Hudson will sometimes laugh inappropriately. Dr. Hudson does not verbally discuss the symptoms she is feeling but she does obviously sweat during her attacks and blurred vision is implied with camera use in the film. She has a deep distrust of others and views herself as superior to others much of the time, especially police officers.

Diagnosis

The diagnosis for Dr. Helen Hudson would be Panic Disorder with Agoraphobia (300.21) and is comorbid with Post-Traumatic Stress Disorder (309.81).

DSM –IV–TR Criteria

A. Both:

1. Recurrent, unexpected panic attacks
2. At least one of the attacks has been followed by one month or more or one or more of the following:
 1. Persistent concern about having additional attacks.
 2. Worry about the implications of the attack or its consequences (e.g. losing

control, having a heart attack, “going crazy”)

3. A significant change in behavior related to the attacks

- Dr. Hudson does have recurrent, unexpected attacks and has shown a drastic change in behavior.

B. The presence of agoraphobia

- Dr. Hudson does not leave her home.

C. The panic attacks are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hyperthyroidism)

- Although Dr. Hudson drinks heavily, her panic is not brought on by alcohol. Instead, it is a coping mechanism that she uses to numb her thoughts or “kick in” her medications.

D. The panic attacks are not better accounted for by another mental disorder such as social phobia (e.g. occurring on exposure to a feared social situation), specific phobia (e.g. on exposure to specific phobic situation), obsessive-compulsive disorder (e.g. on exposure to dirt in someone with an obsession about contamination), post-traumatic stress disorder (e.g. in response to stimuli associated with a severe stressor), or separation anxiety disorder (e.g. in response to being away from home or close relatives).

- Dr. Hudson does display the symptoms of PTSD. It is comorbid to her panic and anxiety. She experienced a life-threatening situation and has recurrent thoughts and dreams about the experience.

Accuracy of Portrayal

The people viewing this film would get a very accurate portrayal of panic disorder with agoraphobia along with post-traumatic stress disorder. Dr. Hudson displays many of the symptoms of all three conditions. Her condition is discussed in the film so it would give the general public the appropriate labels for both panic attacks and agoraphobia. However, PTSD is not discussed and seems to be the root of her problems. It is hard to feel completely confident in this diagnosis without a discussion with the character/author. Many of the symptoms one would feel in a panic disorder need to be verbally expressed. Is she feeling the symptoms of a heart attack? Is she nauseous? Does she feel like she is choking? Do all of her thoughts stem back to her attack? Only the physical symptoms are apparent to the viewer. The agoraphobia is well displayed in the film. She very obviously suffers with the feeling she will be in a situation that will not allow her to escape and will suffer as she did when she was attacked by a killer. Post-traumatic stress disorder is comorbid in this diagnosis. Dr. Hudson's symptoms were brought on by a horrific, life-threatening event. She does have continued

thoughts about this situation along with sleep disturbances from the attack.

Treatment

Dr. Helen Hudson would probably be very difficult to treat since she is a psychologist and would have been trained in and practiced treatments for her disorder. By taking an anti-depressant medication, she could hopefully reduce her agoraphobic symptoms and with a benzodiazepine she could control her panic attacks. However, beginning other therapies would a healthier way for her to overcome her issues. Hopefully the medications would not need to be a long-term solution.

Teaching Dr. Hudson some relaxation techniques would help her avoid the thought processes that lead to her panic and agoraphobic symptoms. Practicing and using diaphragmatic breathing and positive meditation when panic symptoms present themselves would be a good coping skill for her. Keeping a thought record to help her recognize what situations or thought processes bring about her attacks would also be helpful. Recognition of detrimental thought processes and the relaxation techniques might help to reduce her panic symptoms and possibly help her avoid them altogether.

Discussing the statistical data of people killed by serial killers would be a starting point in cognitive therapy for Dr. Hudson. She probably has a higher than chance probability of being targeted because she is a famous criminal psychologist and killers might try to impress her by outwitting her, but

generally speaking the chance of being killed by a serial killer is low. Next, having Dr. Hudson go through some low-level fear exposures would be necessary. This would include viewing photos of serial killers and viewing documentaries about them.

Next, developing and rehearsing coping responses could be done. Here, intense imagery would be used to help Dr. Hudson imagine her darkest fears and increase her anxiety so that realistic solutions to her fears could be developed. In this case, possibly watching films of people being attacked (fictionally) and what they could have done to prevent or escape the attack.

To begin dealing with her agoraphobia, baby steps could be taken to get here to a place where she feels comfortable leaving the home. First might be opening the door to her apartment and just standing in the doorway. Second, walking out of the door and standing in the hallway. Third standing in the hall with the door to the apartment closed. These steps would continue hopefully to the point where she might even return to the convention hall in which she was attacked.

Ending Dr. Hudson's reliance on alcohol would also have to be dealt with in her therapy. She uses this as a numbing agent or as a kicker to her anti-anxiety drugs. In confronting her issues, it would be assumed she could become less reliant on these substances and live a much more normal life.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=289#oembed-1>

Obsessive-Compulsive Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Character Name: Adrian Monk

Source: *Monk* (Television series, 2002-2009)

Background Information

Adrian is a 51 year old widowed male with no children. Adrian shows no signs of physical ailments or other health problems. He does not have a history of drug or alcohol abuse. He presently works for the San Francisco Police Department as a consultant in homicide cases. Adrian obsesses over high levels of order and neatness and, therefore, has trouble functioning in the outside world. He also self-reports

an extensive list of phobias. These symptoms were evident in childhood, but seem to have been exacerbated by the death of his wife. His goals are to extinguish the many phobias he suffers from and to experience some level of happiness. Adrian's social circle consists of a few co-workers who are familiar with his condition.

According to Adrian, his parents were highly strict and very over-protective when he was a child. Adrian's mother has been deceased since 1994. His father abandoned the family when Adrian was 8 years old, and they have only recently begun communicating again. Mental history of the father and mother are unknown. Adrian's brother, Ambrose, suffers from agoraphobia. Ambrose has little social contact and fears leaving his home. Relationships with both his father and brother are strained, but otherwise healthy. No other family mental illness is known.

Though not a family member, an important person in Adrian's life is his assistant. This person assists Adrian in his professional life as well as his personal life. Adrian has had two consecutive assistants that have filled this role for him. This assistant is aware of Adrian's many phobias and does her best to help him avoid stressful situations. For example, she is responsible for always having anti-bacterial hand wipes available to "protect" Adrian from the germs he fears.

Description of the Problem

The greatest catalyst of Monk's behaviors seems to be the tragic death of his wife, Trudy, who was murdered in a car bombing. Adrian was previously employed by the SFPD as a

homicide detective but received a psychiatric discharge after the murder of his wife. Following his wife's death, Adrian retreated to his home and refused to leave for three years. With the help of his nurse/assistant, he has reluctantly entered out into the world again, but still suffers from extreme obsessions, compulsions, and fears. Adrian has been unable to solve his wife's homicide, and this causes great emotional distress to him. He often re-visits and obsesses over the case. Adrian self-reports that he has 312 phobias and continues to accumulate more as time goes on. These phobias range from common fears such as heights or germs to unordinary fears such as, milk or mushrooms. Adrian also suffers from phobias of dentists, sharp objects, vomiting, ladybugs, glaciers, death, snakes, crowds, fear and small spaces. These fears prohibit him from completing everyday tasks such as driving, shopping, and social interaction.

Adrian's work as a consultant for the SFPD requires him to visit crime scenes and evaluate evidence. His photographic memory is especially helpful in his line of work. However, his anxiety often prevents him from being able to use his talents. For example, he arrived at a crime scene that had a burnt out bulb in a chandelier and was unable to work until the bulb had been changed. In another instance, he was unable to work because a police officer's zipper was undone. Adrian is very intent on every aspect of his life being orderly, neat, and clean. He has a habit of cleaning household cleaning appliances, such as vacuums. Balance and symmetry are also important. While working undercover at a bank, he added

his own money to every deposit so that the amounts would be whole dollars. He also declined to see a therapist with an amputated arm because he could not get over the asymmetry.

Adrian keeps a meticulous home, with everything in order at all times. He is obsessed with cleaning and cleaning products. He has established certain menus and ways of eating that he also finds organized and acceptable. For example, he will only drink a certain kind of water and cuts his pancakes into squares because he prefers the symmetry. If travel is absolutely necessary, he goes to extreme lengths to pack. Everything must be kept in sealed plastic bags and he will often pack brand new, individually wrapped bedding so he does not have to use something that someone else has used.

Diagnosis

The main diagnosis for Mr. Monk appears to be Obsessive Compulsive Disorder (300.3). This disorder is classified in the anxiety disorders. DMS criteria require that either obsessions or compulsions must be present in order to qualify for the disorder. Both do not have to be present. Adrian appears to have both obsessions and compulsions. To qualify for this disorder, the client must exhibit uncontrolled concern about specific ideas and feel compelled to repeat particular acts of series of acts. Adrian's concern over harmless objects, such as milk, and his compulsion to touch things, such as poles, makes him a candidate for Obsessive Compulsive Disorder.

Other DSM criteria include:

1. The person has recognized that the obsessions or compulsions are excessive or unreasonable

2. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it.
3. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.
4. The disturbance is not due to the direct physiological effects of a substance or general medical condition.

Adrian fits this criterion as well. He is intelligent and sees that his behaviors are unreasonable, but is comforted by them anyway. His grooming and cleaning habits often take excessive amounts of time and go beyond what would reasonably be considered clean. He has no other known physical or mental problems that would cause his behavior. There is no history of substance abuse.

Associated features of OCD that are present in Adrian's behavior are avoidance of situations where the objects of obsessions are present, frequent doctor visits, and feelings of guilt/responsibility. Adrian also exhibits the associated features of compulsive acts in order to alleviate anxiety, excessive cleansing or grooming practices, and extreme need for symmetrical aligning of objects.

Accuracy of Portrayal

I think the portrayal of Adrian Monk is an accurate description of Obsessive Compulsive Disorder. Someone watching this series would be able to learn about the irrational fears and the difficulties that Adrian has in overcoming them despite how irrational they are. They would be able to see how his behaviors prohibit him from functioning at an optimal level. Another positive aspect of the show is that it shows Adrian as someone with a mental illness, but he is not vilified or seen as inferior. I think this helps promote the idea that having mental illness is not shameful. One possible problem with the show is how his behaviors are usually seen as quirky but still functional. [For someone suffering from OCD in real life, the consequences can be much more detrimental and debilitating. Also, although he is presented as a gloomy character, real OCD can lead to severe depression in the affected individual. Also, he seems to have more phobias than compulsions. Aside from touching poles, he does not exhibit the repetitive behaviors associated with OCD.](#)

Treatment

Treatment for Adrian could include a prescription for an SSRI medication in order to increase his serotonin production. This could aid in the reduction of depression symptoms, anxiety symptoms, and obsessive-compulsive symptoms. In addition to medication, intense behavioral

therapy, specifically exposure therapy with response prevention, is also recommended. This would involve exposing Adrian to the things he fears most (whenever practical and ethical) and compelling him to experience his anxiety until it comes down to a bearable or normal level. In Adrian's case, however, this would be very time-consuming due to the number of phobias he possesses. Due to Adrian's difficulty in establishing interpersonal relationships following his wife's death, grief counseling may also be indicated. Also, his assistant could be included in much of the therapy so that she could be reinforcing appropriate behaviors in his daily life.

<https://youtu.be/0s6fTrSnoIw>

Bipolar II Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Casey Roberts

Source: *Mad Love* (Movie, 1995)

Background Information

Casey Roberts is a female high school student in her late teens. Upon arriving at a new high school, she appears to be fairly normal in behavior. However, it is apparent from early on that she has almost no social relationships, or even more, a desire to have any. Aside from a relationship with her parents, who appear supportive and loving, she only has one other relationship which consumes her throughout

the movie: her relationship with her boyfriend Matt. This relationship is what drives many of her actions throughout the movie. Her parents say there is no past mental health history in their families. However, they are in denial of her having an actual mental illness and attribute it to her trying to get back at them for controlling her, so the real history may not be reported. No major drug or alcohol use is apparent although casual drinking is seen throughout the movie and nicotine use, especially while in her depressed episode, is also shown. There are no outward health problems visible in Casey. She is a very intelligent girl with a very strong willed personality. However, she does not seem to care too much about asserting that intelligence towards any goals. School is in no way important to her.

Description of the Problem

Although Casey is at some points able of living and functioning normally, she has a past of suicidal behavior. As stated in the Background Information, she has little to no social relationships. However, she does appear to be a fairly friendly person. Probably the largest hindrance on her functioning is her impulsivity. She seems to think that she should do and be able to do whatever she wants when she pleases. Towards the end she also has a tendency towards thoughts that are very sporadic in nature. Casey displays much risk taking behavior without seeing any important consequences that could occur from them. She is also temperamental and very easy to irritate. Delinquent behavior

is also presented in her behaviors in the form of truancy and the case of her pulling a fire alarm in the school. She also has very strong thoughts of guilt and states that as punishment for the things she has done to Matt, he should leave her. When the onset of her illness begins to be very apparent, she shows much distractibility and tends to not behave correctly in social situations. Insomnia also is presented along with strange ideas. These ideas could possibly also be symptoms of Schizophrenia such as thinking people are always watching her and out to get her. She believes that she must put cut outs of eyes up around their apartment to protect them.

Diagnosis

The diagnosis for Casey is Bipolar II Disorder (296.89). To reach that diagnosis the following must be true:

1. Presence (or history) of one or more Major Depressive Episodes.
 - Within the movie there is a Major Depressive Episode. Her parents also referred back to the fact that Casey had experienced episodes before as well.
2. Presence (or history) of at least one Hypomanic Episode.
 - A Hypomanic Episode was also included in the movie. Evidence on whether or

not she had been through more than one episode of this before was not provided.

3. There has never been a Manic Episode or a Mixed Episode.
 - Casey's symptoms were not severe enough to classify as a Manic or Mixed Episode.
4. The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
 - Although Casey had some odd behaviors that seemed almost similar to ones that would be presented in Schizophrenia or a very similar disorder, they would not be classified as actual delusions. The inconsistencies in her behaviors seem to classify more into Bipolar Disorder.
5. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
 - Casey's ability to form relationships was greatly affected by her symptoms. Also,

distress was definitely seen within social situations. Casey was found in a bathroom with her dress off and hitting the walls and crying.

A diagnosis of a Major Depressive Episode was found by the following:

1. Must include five or more of the following over a 2-week period:
 1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). NOTE: In children and adolescents, can be irritable mood.
 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
 3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. NOTE: In children, consider failure to make expected weight gains.
 4. Insomnia or hypersomnia nearly every

day

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

- Casey presented symptoms a, d, g, and i.

2. The symptoms do not meet criteria for a Mixed Episode.
 - Her symptoms were not presented as both Manic and Depressive on a nearly

daily basis.

3. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
 - Distress and impairment were definitely apparent in social situations. The example of the bathroom scene previously mentioned demonstrated this.
4. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
 - No drugs were being used besides nicotine and no other stated medical condition was present.
5. The symptoms are not better accounted for by Bereavement, i.d., after the loss of a loved one; the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness suicidal ideation, psychotic symptoms, or psychomotor retardation.
 - No loved ones were lost; the symptoms had been reported for over 2 months and

she had attempted suicide numerous times.

A diagnosis of a Hypomanic Episode was found according to the following:

1. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual non-depressed mood. It is characterized as a period of increased energy that is not sufficient or severe enough to qualify as a Manic Episode.
 - Casey's mood was elevated while they were traveling and she was in her Hypomanic Episode. The severity of it would not classify as a Manic Episode however.
2. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
 1. inflated self-esteem or grandiosity
 2. decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
 3. more talkative than usual or pressure to keep talking

4. flight of ideas or subjective experience that thoughts are racing
 5. distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
 6. increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
 7. excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
 - Casey presents symptoms b, c, e, and g within her Hypomanic Episode.
3. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.
- She seemed to function almost normally when the episode was not happening. When she started presenting symptoms, her level of functioning obviously decreased.

4. The disturbance in mood and the change in functioning are observable by others.
 - Like previously stated, her changes were observable.
5. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.
 - Her Hypomanic Episode did not strike Matt as “scary” or needing help immediately like her Depressive Episode. No hospitalization was seen as necessary.
6. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).
 - No drugs were being used besides nicotine and no other stated medical condition was present.

Accuracy of Portrayal

Watching the portrayal of Casey would give a person a fairly good look into Bipolar Disorder. Most people label someone as “bipolar” when really they are just having mood swings or maybe suffering from Cyclothymic Disorder. This idea

of such rapid switching is not accurate. Although Casey did have her moments of sudden anger or happiness, that can be accounted for by simply an experience she had or something that was said. Simple reactions like this are very common. However, her episodes as portrayed were seen as changing over periods of time, not just in an instant, giving the watchers a pretty good insight on the disorder. In the film, Casey's mother stated that Casey suffered from depression. This may have influenced watchers to disregard her Hypomanic symptoms. Overall, the audience would get a fairly good look into the actual life of a person with Bipolar Disorder.

Treatment

When Casey arrived for treatment, a medical work up would occur to make sure the disorder was accurately diagnosed. This would also allow knowledge of the current episode, suicidal thoughts, and hopefully more family history. Casey would probably then be prescribed lithium carbonate. Because of the potency of this drug, her dosage would need to be very closely monitored. Therapy would also be a very useful tool for Casey's treatment. Cognitive behavioral therapy would be a good start to help her deal with her emotions and stress. Therapy would also help Casey to fully understand Bipolar Disorder and to know in the future when an episode may happen. Likewise, education would be essential for her parents. Helping them understand what

exactly is happening with Casey and to recognize her episodes would be very beneficial.

Oppositional Defiant Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Stewie Griffin

Source: *Family Guy* (Television series, 1999 – Present)

Background Information

Stewie Griffin is a Caucasian male who is presumed to be one years old, although he may be four to five years old because in later episodes he attends preschool. Stewie is unemployed but shows a mastery level of physics and mechanical engineering. He has designed such things as mind control devices, weather control, fighter jets, and teleportation devices. Although there are not any known distinct physical illnesses, abnormalities, or disorders currently within Stewie Griffin, there are

observable health concerns. The patient displays unprovoked hostility towards others, constant disobeying of parental rules, is extremely vengeful and vindictive, and easily loses his temper quite frequently. Stewie currently lives with his parents, Peter and Lois Griffin. Stewie's father, Peter Griffin shows observable symptoms of mild mental retardation. This is evident when he took an IQ test in one of the episodes and scored a 70. It is also observed that Stewie's parents exhibit a strong sense of control over his life, such as scheduling play dates for him to go on, toys he can/can not play with, and what/when, he can eat. Stewie exhibits strong introversion in social relationships. He does not have close relationships with anyone outside of his immediate family. This is due to the fact that Stewie sees his peers as obstacles in his path toward world domination. Because of this, he frequently kills off the lesser characters with tanks, guns, and other assorted weaponry. There have not been patterns of consistent alcohol usage by Stewie, but he has excessively used alcohol on occasion. This is particularly problematic, as any type of alcohol usage by a one year old can severely inhibit brain development. Stewie's goal is to attain world domination by first killing his mother, who he fears will stand in his way. All of Stewie's daily activities are designed to accomplish these two goals by creating weapons such as rocket launchers, engaging in violent criminal activities, carjacking, loan sharking, and forgery. Other weaknesses that Stewie displays are his stresses of infant life, such as teething and eating his vegetables.

Description of the Problem

Stewie Griffin currently displays a multitude of symptoms indicative of oppositional defiant disorder. He displays disobedient actions towards authority figures; however, Stewie believes that he is conducting himself in an appropriate manner for his own self-preservation. He also suffers from delusional behaviors such as having conversations with his stuffed teddy bear Rupert. He protects Rupert and will avenge any harm that comes Rupert's way. Stewie deliberately annoys his peers by picking on them and continuously making rude remarks about their appearance or inabilities as a person. He also shows anger and resentment towards his mother because he feels that he is wrongly punished for activities he is supposed to carry out for the betterment of himself and world domination. As a result of this, he is also very spiteful and vindictive. For example, in one episode Stewie loans Brian some money and they contractually agree that payment would be made on a certain date, but Brian does not repay on that date, so Stewie beats Brian with a bat daily until he receives payment. Stewie often uses a scapegoat for his own mistakes. When his attempts to kill his mother fail, he blames her for being unfair and bitchy.

Diagnosis

The diagnosis for Stewie Griffin that fits appropriately is **Oppositional Defiant Disorder (313.81)**.

A. To be diagnosed with Oppositional Defiant Disorder a pattern of negativism, hostile, and defiant behavior lasting at least 6 months during which four (or more) of the following are present:

1. Often loses temper
2. Often argues with adults
3. Often actively defies complying with adults' requests/rules
4. Often deliberately annoys people
5. Often blames others for his or her mistakes
6. Is often easily annoyed by others
7. Is often angry and resentful
8. Is often spiteful or vindictive

Stewie Griffin undoubtedly shows more than four symptoms of Oppositional Defiant Disorder, as described in the section "Description of the Problem."

B. Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

Stewie possesses the ability to talk fluently at age one and interact with people at an intimate social level that is not yet observable in the one year old population. Typical one year olds rely heavily on parental care, where Stewie is significantly more independent than his peers (e.g. taking trips to San Francisco and Rhode Island).

C. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

Stewie is significantly impaired in social functioning because he does not develop and nurture his relationships, instead he sees his peers as obstacles towards his goal that he must defeat at all costs. Because of this, he does not have any significant social relationship with anyone outside his immediate family.

D. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.

Characteristics of oppositional defiant disorder can be observed in the patient in all settings and instances throughout his daily activities.

E. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

The patient is between the ages of 1-4 years old.

F. There is a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior towards authority figures.

Stewie is in constant conflict with how he is going to succeed in killing his mother and attaining world domination.

G. Occurs outside of normal developmental levels and leads to impairment in functioning.

Stewie's behavior is clearly outside of normal development for a one year old, and this leads to impairment in functioning such as developing strategies to kill his mother and take over the world (e.g. making weapons with the purpose of carrying out these goals).

Accuracy of Portrayal

The typical person watching Family Guy would be able to reach the conclusion that the character Stewie Griffin is abnormally developing compared to his average peer. A person with an Abnormal Psychology background would be able to further determine that Stewie showed all the symptoms for Oppositional Defiant Disorder. This is a

cartoon character created to break the boundaries of normal development for babies, even to represent the general helplessness of an infant through the eyes of an adult. This show helps illustrate Oppositional Defiant Disorder by successfully creating a character that exemplifies every characteristic of the disorder, and not wavering from season to season. Although Stewie is not an accurate portrayal of the average one year old, he still can be related to children suffering from this disorder. Therefore, Stewie Griffin is an accurate illustration of someone with Oppositional Defiant Disorder.

Treatment

To treat Stewie Griffin, after a full medical examination, it would be best to teach him problem-solving skills as well as parent management training. Problem solving skills would help Stewie learn to solve problems in a logical and predictable manner. The downfall with this strategy is that is time consuming and on average requires 20 sessions. Another effective way to treat Oppositional Defiant Disorder is parent management training. This allows the parents to develop and implement structured management programs at home. This is designed to improve interactions between child and parent. Parents implementing this strategy should positively reinforce good behaviors. A secondary methodology of treating Oppositional Defiant Disorder is to medicate the child using Ritalin. Research has shown children treated with Ritalin who have Oppositional Defiant Disorder, 75% of the children no longer showed symptoms of ODD.

Name: Walker Bobby and Texas Ranger “TR” Bobby

Source: *Talladega Nights: The Ballad of Ricky Bobby* (Movie, 2006)

Background Information

Walker and Texas Ranger Bobby are pre-pubescent males, with an estimated age of 11 and 7, respectively. Neither boy holds a job because of their young age. The Bobby brothers do not display any specific health issues. Walker and Texas Ranger live with both of their parents and their maternal grandfather, Chip. Their father, Ricky, is a famous racecar driver who displays some symptoms of Narcissistic personality disorder, claiming that he is “the best there is,” and that he “piss[es] excellence.” Their mother, Carley, does not show any observable symptoms of a mental disorder. However, she is very materialistic, markedly aggressive when provoked, and shows extreme devotion to her husband, at least until the promise of better prospect comes along (e.g., she leaves Ricky for Cal when Ricky can no longer race). In other words, their mother is a gold-digger. The family unit is still very much intact – they eat dinner together every night and attend all of Ricky’s races together. While the bonds between the family are obviously very strong, Walker and Texas Ranger display many types of defiant and hostile behaviors toward authority figures. Most likely due to their lack of shock and surprise, these behaviors are not typically directed towards their parents. Rather, the Bobby brothers act out to other close adults like both of their grandfathers, Chip and Reese, and their grandmother, Lucy. In fact, the boys’

mother and father seem to condone this behavior, claiming that they did not raise “sissies”. Walker and Texas Ranger were never portrayed as having done illicit drugs, although they did inquire about a comment that their grandfather Reese had made about possessing marijuana. Besides the problems that they have run into at school due to behavioral issues, the boys do not possess any real life difficulties. They do not have any deeply defined goals either as they are just kids looking to enjoy themselves while they can. Due to their inconsistent and overindulgent lifestyle, Walker and Texas Ranger’s coping skills are not very good. They handle less-than-perfect situations with immaturity and anger, often lashing out at whoever they believe will take it. Their weaknesses are handling new, unwanted situations (such as Sunday school) and being polite to adults.

Description of the Problem

Walker and Texas Ranger currently display a multitude of symptoms indicative of oppositional defiant disorder. They are consistently defiant and hostile, spouting out at whomever they believe deserves the criticism or hatred. These two display a constant need to argue and swear, especially to adults. They argue most often with their grandfathers, Chip and Reese, their grandmother, Lucy, and their teachers in school. There is nothing off limits for these boys. Their actions and criticisms are often unnecessary and cruel – usually just for the purpose of upsetting or annoying the adults around them.

Diagnosis

The diagnosis for the Bobby brothers that fits most appropriately is **Oppositional Defiant Disorder (313.81)**. **To be diagnosed with Oppositional Defiant Disorder the following criteria must be met:**

1. A pattern of negativism, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:
 1. Often loses temper
 2. Often argues with adults
 3. Often actively defies or refuses to comply with adults' requests or rules
 4. Often deliberately annoys people
 5. Often blames others for his or her mistakes or misbehavior
 6. Is often touchy or easily annoyed by others
 7. Is often angry or resentful
 8. Is often spiteful or vindictive

*Note – Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

Walker and Texas Ranger meet all criteria for oppositional defiant disorder except for number 5, blaming others for mistakes or misbehavior. They constantly insulted and swore at adults, threw

Chip's war medals off of a bridge to make him mad, argued with their teachers, and purposefully peed their pants and refused to take them off just to prove a point. These behaviors are more extreme than those of children at similar developmental levels. Where most children their age might only do these sorts of things once, Walker and Texas Ranger do them all of the time.

1. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

The boys do not know how to function in a social setting, repulsing most adults who come into contact with them. The boys do not seem to care what other people think of them. They say mean things, causing adults to react negatively, creating a vicious cycle of disobedience. Academic functioning, although mentioned briefly, is most likely effected. Texas Ranger, specifically, flaunted his bad behavior in the classroom.

1. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.

The characteristics previously described are displayed in many contexts over a lasting period of time. They are not a result of a psychotic or mood disorder.

1. Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Walker and Texas Ranger are approximately 11 and 7 years old, respectively. They did not physically aggress towards others and did not commit any serious crimes.

1. Recurrent pattern of negativistic, defiant, disobedient, and hostile behavior towards authority figures.

The symptoms are constant – they do not vary from day to day. Their disobedience is only in response to authority figures.

1. Occurs outside of normal developmental levels and leads to impairment in functioning.

Most children their ages do not insult, swear, and act out this much. The quality of their interactions are severely inhibited and functioning is impaired.

Accuracy of Portrayal

The average person watching these boys would immediately recognize that there is a significant problem. Walker and Texas Ranger are on the extreme side of disobedience. Most parents would probably be able to relate the problems of these characters to those of their own children, only to a much lesser degree. They would learn that Oppositional Defiant Disorder is characterized by defiance, hostility, frequent outbursts of rage, swearing, and disobedience. The portrayal of this disorder is very accurate – the boys' behavior was consistent throughout the movie and did not waiver. Their depiction, in particular, was very extreme as their behavior

was observed both at home and in school. The inaccurate aspects of the boys' portrayal would be their display of oppositional behaviors in unfamiliar territory, their lack of temper tantrums or clear frustration with difficult situations, and the ease and rapid pace of change in behavior once their grandmother decided it was time to start acting appropriately.

Treatment

In the movie, Walker and Texas Ranger's grandmother, Lucy, took things into her own hands. She established what she called, "Granny Law," and broke the boys like "wild horses" with community service, yoga, disposal of their weapons, and church attendance.

As a mental health professional, it would be best to first conduct a structured or semi-structured clinical interview to explore fully the family's history, the symptoms that pertain to ODD, and the possible co-morbid problems that can occur as a result of the disorder. The first measure of treatment that should be implemented are Problem-Solving – Skills-Training programs, which involve teaching children how to solve problems in a logical and predictable manner. The only setback of this training is that it is extremely time-consuming, requiring an average of twenty sessions. Another possible treatment is called Parent Management Training. This training teaches parents how to effectively implement contingency management programs at home, allowing both parent and child to better enjoy their interactions by learning how to praise positive behaviors, establishing schedules and sticking to them, and maintaining effective timeouts. This

STEPHANIE WEIGEL

greatly increases awareness in the child as to what is expected of them as well as what will happen if they misbehave.

Autistic Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Arnie Grape

Source: *What's Eating Gilbert Grape?* (movie, 1993)

Background Information

Arnie Grape is a Caucasian male who is 17 years old and is close to turning 18. He does not go to school and spends most of his time with his older brother, Gilbert. Arnie appears to be mentally disabled or developmentally disabled. When Arnie was born, the doctor said he would be lucky if he lived to the age of 10 and when he turned 10, the doctor said he could die at anytime. He has repetitive speech, which it seems as if he is listening but then turns around, and does the same

things over again. He engages in very dangerous behaviors but is not aware of how dangerous his behaviors are. For example, he climbed up the water tower in the town and was dangling off the side of the ladder laughing the entire time not knowing how serious the situation was. Arnie lives with his mother, brother, and two sisters. He is very close to his older brother because Gilbert takes care of him. His mother, Bonnie, who has not left the house in seven years, became morbidly obese and depressed when her husband committed suicide. His two sisters, Amy and Ellen, take care of the chores and do all the cooking. Arnie is very friendly to other children in his town but it does not appear that he has very many friends because they do not understand his ways of communication, although there were many children at his eighteenth birthday party. There is an instance when Arnie will not go into the basement because he said “dad is down there” and then he does a hanging motion. Arnie does not appear to take any medication or see a regular physician or psychologist. His feelings are easily hurt because he does not fully understand what people are saying to him. Arnie does not appear to have any goals other than trying to survive.

Description of the Problem

Arnie kills a grasshopper by cutting its head off in the mailbox and a little while after he kills it he gets very upset at himself and is sad that the grasshopper died. He has certain hand movements that he constantly does. He puts his hand to his mouth a certain way when he is in an uncomfortable situation. He has eye twitches and he blinks quite often. Arnie

is always running off and hiding from Gilbert or climbing the water tower. Gilbert knows where Arnie is hiding but plays a game and pretends that he does not know Arnie is up in the tree and he thinks Gilbert has no idea where he is. When other people get hurt or when Arnie says mean things to others he thinks that it is very funny and usually laughs hysterically. He is arrested for climbing the water tower and when they put him in the cop car, all he is worried about is the cops turning on the lights and sirens. He is not able to take care of himself. For example, Gilbert puts Arnie in the bath and tells him that he is a big boy and can wash himself. Gilbert leaves and comes back the next morning to find Arnie still in the bathtub. Arnie repeats everything that people tell him to do and what they say in general. After the bathtub incident, Arnie is afraid of any kind of body of water. He gets very upset and starts to hurt himself when he tries to wake his mother and she never wakes up.

Diagnosis

The diagnosis for Arnie Grape that fits most appropriately is **Autistic Disorder (299.00)**. To be diagnosed with Autism Disorder criteria A, B, and C must be met:

1. **A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):**

(1) qualitative impairment in social interaction, as manifested by at least two of the following:

(a) marked impairment in the use of multiple nonverbal

behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction

(b) failure to develop peer relationships appropriate to developmental level

(c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)

(d) lack of social or emotional reciprocity

(2) qualitative impairments in communication as manifested by at least one of the following:

(a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)

(b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others

(c) stereotyped and repetitive use of language or idiosyncratic language

(d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

(3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus

(b) apparently inflexible adherence to specific, nonfunctional routines or rituals

(c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements)

Arnie meets the criteria for deficits for three out of the four in section one, as described in the section of “Description of the Problem”. Arnie does not meet the criteria in (c) because he was always trying to talk to people and make friends with them. Arnie meets all the criteria for section two because he repeats every word a person says to him, he is not able to carry on a conversation with anyone, and he does not seem to have any imaginative friends. He does not meet the criteria in section three listed under (b) because he does not have any specific rituals. Arnie meets the criteria for (a) and (c) because he was obsessed with taking care of a cricket and kept it in a jar and he constantly made the same hand movements when he felt uncomfortable in a situation.

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years:

1. Social interaction
2. Language as used in social communication
3. Symbolic or imaginative play

Arnie’s history was not given prior to age three but one could conclude that he had delays in all three areas prior to age three.

C. The disturbance is not better accounted for by Rett’s Disorder or Childhood Disintegrative Disorder.

Arnie was born with his disorder and has had it his whole life. The doctors did not expect him to live long but he did and

everyone called him a miracle child.

Accuracy of Portrayal

The average person watching this movie would probably think this individual is mentally disabled. They would see that he needs a caretaker constantly, that he is not able to communicate well with others and that he is unaware of the outside world around him. These symptoms could be confused with mental retardation or a mental disability. To be specifically diagnosed with autism all the criteria above have to be met. Arnie met all the criteria so if an individual was familiar with or educated on autism they would be able to see an accurate portrayal of autism. This movie lets people see the different types of autism. The types of autism that are usually shown in the media are children who are quiet, reserved and do not talk to anyone, but Arnie was the complete opposite. He was loud, tried to speak to everyone, and was not afraid of most things. Throughout the entire movie, no one talked about Arnie's disorder nor did they label what he had been diagnosed with at birth. *What's Eating Gilbert Grape?* was an accurate portrayal of an individual with autism.

Treatment

First, a full medical and psychological evaluation would be given to Arnie. Arnie would need to be put in a stable setting. Currently he lives with his mother and siblings but his mother is unable to take care of him. He needs an individual to take care of him full time and that individual needs to be specialized in how to take care of his needs. He also needs an individual to work with him on his communication

skills, yes, he is past the developmental stage of language, but having that daily practice could help him greatly with his language skills. Arnie also needs behavioral treatment therapy so that he is able to understand how to act in certain situations. He needs more support from his family, everyone needs to be interactive in his treatment and give a helping hand

Name: Mandy (Amanda)

Source: *Fly Away* (movie, 2011)

Background Information

Mandy is a 16-year-old Caucasian female who lives at home with her mother Jeanne. Jeanne makes sure Mandy has a consistent daily routine and tries to teach her day-to-day responsibilities. Mandy seems to be making slow progress and then other days she regresses, especially when her mother is not as attentive to her needs. Mandy's mother is a single mother who works from home to be able to provide constant care for her daughter. Her father Peter comes to visit occasionally but is not consistently there. He loves his daughter and tries to interact with her, but cannot seem to without becoming overwhelmed and angry. Mandy goes to a school for the mentally disabled; however, she does not like the staff and is always acting out to be able to go home. She takes medication twice a day, and has doctor visits regularly. She has a difficult time coping with certain situations and does not know how to control her emotional impulses. Her mother has to hold her and tell her to breathe before she

will calm down. Sometimes the outbursts are so bad there is nothing and no one that can control or sooth her. Jeanne also uses singing to calm and refocus her daughter. Mandy is very responsive to this technique and it gets her back down to a controllable level. This is the only form of positive coping shown. Mandy's weaknesses are her short temper, and violent outbursts. This makes it almost impossible for her to be out in public or in a social setting.

Description of the Problem

When a situation arises that a normal 16 year old could handle, she seems to react like a young child. Mandy repeats anything said to her, displaying echolalia. Mandy also has outbursts of aggression. Her aggressive behaviors include biting, pushing, punching, yelling, and running away from her mother. She has overly dramatic emotional swings during these outbursts, where she is very enthusiastic or very upset. While Mandy is experiencing these fits, she becomes physically abusive with objects, throwing them at walls and other objects around her. After the outbursts Mandy encounters, she feels sympathetic only to her mother. She is the only person that she will apologize to for her behavior.

In addition to the above outbursts, almost every night while she is sleeping she yells out, "Mandy's a bad girl, I hate myself!" Her mother will then have to comfort Mandy. When Mandy is in public, her emotions are erratic; she is very enthusiastic or extremely angry. She is not concerned with the reactions of people around her or how her behavior impacts others. She has no impulse control and immediately

acts on how she feels. She begins to feel the need for some social interaction, but due to lack of knowledge on how to do so, she is angered by this emotion as well. Her interest in the opposite sex becomes more apparent and at one point in the film she asks her mother if she will ever get married. This shows her longing for human interaction and her capability to understand social interactions. Physically, Mandy's hands are disfigured and are constantly curled. She walks on her toes primarily, and she rocks whenever she feels anxiety.

Diagnosis

Autistic Disorder (299.00) is the criteria that Mandy fits in the DSM-IV diagnostic system. The patient must meet criteria for category A, B, and C to be diagnosed with Autistic disorder.

- **A) A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):**
 - Qualitative impairment in social interaction, as manifested by at least two of the following:
 - Impairments in social interaction may include the following:
 - Pronounced deficits in non-verbal social behavior

- Lack of eye contact
- Facial expressions
- Body posturing
- Gesturing
- Lack of age-appropriate peer relationships
 - Possibly interacting with parts of people
- Absence of spontaneous attempts to share interests or pleasure with others
 - Not pointing to or showing things to others
- Lack of social/emotional reciprocity

- Lack joint attention
 - Fail to share actively with other's activities or interests
 - Act as if unaware of the presence of others
 - Select solitary activities
- Qualitative impairments in communication including both verbal and nonverbal communication, as manifested by at least one of the following:
 - Delay or absence in spoken language
 - not compensated for by attempts to communicate nonverbally
 - Inability to converse

appropriately with others
regardless of the presence of
speech

- Odd, stereotyped, repetitive uses of language
- Absence of imaginative or pretend play
- There is also a great deal of variability in communication.
 - Ranging from the absence of expressive or receptive language to fluent speech with semantic/inappropriate social uses.
 - Echolalia is the repetition of a phrase heard in the present or the past.
 - Occurs in up to 75% of individuals with PDD who are verbal
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- Receptive language continues to impair social communication in that individuals have difficulties in understanding abstractions.
 - Echolalia and receptive language are not utilized in a functional communicati

ve fashion by
those with
autism.

- Restricted and stereotyped behavioral patterns require at least one of the following criterion:
 - Restricted interests that are abnormally intense
 - Can range from cars and trains to numbers and letters
 - Inappropriately intense or odd in their content
 - Rigid adherence to routines or rituals
 - Repetitive motor mannerisms
 - Opening and closing doors
 - Preoccupation with parts of objects
 - May become overly interested in moving parts of objects
 - Compulsive behaviors
 - Lining up objects in a specific way

- Slight alterations in routines can cause behavioral outbursts
 - Motor stereotypes
 - Hand or finger-flapping
 - Rocking
 - Spinning
 - Non-specific motor abnormalities
 - Toe walking
 - Unusual hand movements or body postures
 - Continuous course for those with autism however, school-aged children may show improvements in social, play, and communicative functioning, which ultimately can improve further intervention
- **B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: 1. Social interaction 2. Language as**

used in social communication 3. Symbolic or imaginative play

- **C. The disturbance is not better accounted for by Rhetts's Disorder or Childhood Disintegrative Disorder.**

There would be no difficulties in diagnosis for Mandy as being autistic. She meets criteria in A, B, and C. Pertaining to the previously stated problems, Mandy is clearly autistic.

Accuracy of Portrayal

Most people who watch the film would label Mandy as having a mental disability. The average person would not know the criterion that depicts autism. Mandy clearly can be labeled as autistic because she meets all of the above criteria. Most films that portray individuals with autism show them as quiet and socially distant. This movie shows an individual with an extreme case of autism and does a very good job showing how hard it is to live with this disorder. The movie did a good job showing the daily hassles for the family members and how it affects the individuals self esteem. People watching this film got a truthful insight on the life of an individual with autism and would learn about the disorder through the film and Mandy's character. *Fly Away* was an accurate portrayal of an individual with autism.

Treatment

First, Mandy would undergo a full medical and psychological evaluation. She would need to be put in a stable environment and be able to express some sort of responsibility and self

support. Mandy lives with her mom and has a good support system but at her age Mandy needs to be able to do things on her own without some supervision and her mother is not trained properly to be able to provide that. Currently she lives with her mother. She needs to have a specialized worker that can help her but not treat her like a child. Developing her self sufficient skills will help her be able to control more of her emotional responses and better understand social interactions. She also needs an individual to work with her on her communication skills. Even though Mandy is past the developmental stage of language, but having that daily practice could help her greatly with her language skills. Mandy will also need behavioral treatment therapy so that she is able to understand how to act in certain situations and control her violent outbursts. With behavioral therapy, more developed communication skills, family support and more accountability Mandy will be able to better cope and function with her disorder.

Dysthymic Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Bill Dauterive, born Gillaume Fontaine de la Tour D'Haute Rive

Source: *King of the Hill* (Television series, 1997-2010)

Background Information

Bill Dauterive is a Caucasian male around the age of 42. This age estimate is based on his friends, including Hank Hill, who has been stated to be 42 years old, and that he was in the same school grade as his friends. Bill is from an upper-class family in Louisiana, around New Orleans. His family is not present very often and the only remaining relative he has is a male

cousin. His self-reports of childhood hardships caused by his father could be fictitious because there is no way to verify this. He has almost no family so genetic factors are hard to account for. His cousin is in good shape and healthy. Bill is the opposite. He was told by a doctor that he would become diabetic if he did not change his lifestyle.

He was a high school athlete, nicknamed the “Billdozer”. He was very popular, had many friends and even held the school touchdown record. He was drafted into the military his senior year of high school and never graduated. He has remained in the Army and is now a Sergeant barber. He is not particularly poor or wealthy. He is a simple person and does not have any extravagant tastes or interests that he has reported.

He met his wife, Lenore, at a concert. She cheated on him and subsequently they divorced. This is reportedly when the depressive symptoms began appearing. He could not heal from the divorce and claims he still loves her. He became overweight and started losing his hair. His friends Dale Gribble, Jeff Boomhauer, and Hank Hill constantly comment on his depression and try to help him. He has had this core group of friends from a young age. They all live on the same street and get together in the alley to have a beer often. Bill is obsessed with Hank’s wife and believes she is the perfect picture of a woman. She is the complete opposite of Bill’s ex-wife. Even though he has a core group of these 3 friends, they often make fun of him and sometimes exclude him. He has a very poor sense of hygiene and his house is often very dirty. His friends and their wives often make remarks about this.

He is in a depressive state most of the time. The only time he is out of a depressive state is when he is with a woman (who always later rejects him) or gets very involved in a project, such as an instance where he turned his home into a halfway house. He enjoyed the company and enjoyed being needed, but the occupants took advantage of him and he missed so many days at work the Army almost reported him Absent Without Leave, or AWOL. He clings to women he gets into relationships with very quickly. He will be overly dedicated to the women but they always end up taking advantage of him and ending the relationship. He perceives relationships to be more serious than they are in reality. This behavior inevitably drives them away.

Description of the Problem

Bill often states that he is depressed. This depression has lasted since his divorce, which is estimated to be 7-9 years ago. He is in a depressed state most of the time. Others describe him as very depressed and down. He has some periods of normality, but usually he is just depressed. He believes no one loves him or will love him and gets into relationships in which he is very likely to be rejected. He overeats and does not take care of himself very well. He has a very poor image of himself but does not seem to care enough to attempt to better himself.

He often speaks of his ex-wife and the divorce and of still loving her. If he is not working, he is at home eating and watching TV or in the alley having a beer with his friends. He does not do much else. His friends often remark on his

bringing up of his divorce and try to set him up with women, but the women usually reject him. There have been a few relationships he has ended himself, but the majority are not his choice. His friends attempt to tell him he is too good for his ex-wife and that she is not coming back.

Bill gets particularly depressed around the holidays. He usually spends Thanksgiving with Hank Hill's family, which is very intrusive to them. He went through a period of suicidal actions and thoughts but never completed or repeated these behaviors. His friends were constantly watching him.

Diagnosis

The disorder Bill Dauterive most accurately can be diagnosed as having is Dysthymic Disorder (300.4).

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years.

Bill is self-described as being depressed a lot of the time. His friends also state that he is depressed all of the time and it has been going on for longer than 2 years. In fact, it is closer to 7 years.

B. Presence, while depressed, of two (or more) of the following:

1. poor appetite or overeating
2. insomnia or hypersomnia
3. low energy or fatigue

4. low self-esteem
5. poor concentration or difficulty making decisions
6. feelings of hopelessness

Bill experiences overeating, low energy and fatigue, low self-esteem, and feelings of hopelessness. Occasionally he experiences insomnia and poor concentration. Quite often his despair will lead him to overeat which leads to further low self-esteem. The symptoms seem to compound themselves. Bill's friend Hank is usually the one who makes a lot of Bill's decisions because he has difficulty doing so himself, whether everyday decisions or more meaningful decisions.

C. During the 2-year period of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.

Bill fits this and does not seem to reach the 2 month mark for absence of symptoms. Bill's symptoms of depression seem to be chronic. He is never out of his depressed state for longer than a few days and this is usually because he has found someone to be in a relationship with for a short time.

D. No Major Depressive Episode has been present during the first 2 years of the disturbance i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, In Partial Remission.

This is hard to account for because Bill is being seen 7 years after the onset. Since it has lasted so long, however, Dysthymic Disorder accounts for it very well.

E. There has never been a Manic Episode, a Mixed Episode,

or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder.

There has been no evidence of a hypomanic episode. The closest period would be when Bill experiences some type of normalcy does not last very long. He does not have manic episodes or even hypomanic episodes. Sometimes he is obsessive but that does not last very long and he slips back into depression, no period of normalcy is seen. He does not qualify for Cyclothymic Disorder because he does not have periods of hypomanic or manic symptoms.

F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.

Bill does not have symptoms of a Psychotic Disorder.

G. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

Bill does not present with any substance abuse or other medical conditions. Before the onset of Dysthymic Disorder, he was happy, popular, and content with his life. He does drink a beer in the alley with his friends nearly everyday, but it is usually just one beer. If he is feeling extremely depressed, he will drink to excess, but this is a result of his depression, not a cause.

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

This disorder impacts every portion of Bill's life. He needs to

be needed, and when he is, for short periods of time, it makes him miss work; he was almost listed as AWOL on more than one occasion. In his social life, his depression causes major impairment. All his friends state that he is depressed all the time. He does not take care of himself which leads to low self-esteem. This majorly impacts his attempts at finding a date. He does not make new friends, and he only has the core group of friends he grew up with. When he attempts to meet new people, he is usually rejected and thus, he does not try very often.

Regarding etiology, Bill's Dysthymia seems to have been caused by his divorce, so the psychosocial causal factor fits. There is no way to determine if genetic factors are possible as his only living relative is a male cousin.

Accuracy of Portrayal

An average person watching Bill in *King of the Hill* would get a very good idea for what Dysthymic Disorder is. Bill expresses almost all of the symptoms, almost all of the time. The portrayal is accurate in that Bill exhibits almost all of the symptoms of Dysthymic Disorder, nearly all the time. Saying that Bill is depressed all of the time is not an exaggeration. In people with Major Depressive Disorder there are longer periods of normalcy, but in Dysthymic Disorder there are not long periods of normalcy. More often than not, Bill is depressed. Major Depressive Disorder is more about episodes of depression, but Dysthymic Disorder is depression nearly all of the time, and Bill exhibits this. The only inaccuracy was

his period of suicidality, but this was a cry for help, not an actual wish of death. It was not repeated.

Treatment

Dysthymia has not been widely studied and this impacts research on treatment. Many findings from Major Depressive Disorder have been applied to Dysthymic Disorder, since it is often referred to as a milder form of Major Depressive Disorder.

One could begin by treating Bill with an antidepressant. After the appropriate dosage was found, he would begin psychotherapy. Bill needs to be taught about the disorder and recognize that he is not in a normal state of mind and begin to come out of it. Since he does not really have any family to speak of to attend therapy with him, his friends should accompany him because they are the individuals he sees most often. They could be shown that their comments to Bill are hurtful and need to end. If Bill's core group of friends were taught about Dysthymic Disorder they could learn ways to help Bill when he was feeling down and make him feel better about himself and the situations he finds himself in.

A therapist could use cognitive therapy to help Bill change how he sees the world and to think more optimistically. This would show Bill that not every bad thing that happens is a crisis and which events to just let go of. He needs help getting over his divorce and gaining his self-esteem back. Other recommendations that he find a hobby he likes and

recommend him to someone to help him with nutritional skills, such as what to eat and what to cook.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=299#oembed-1>

Name: Andrew Largeman

Source: *Garden State* (movie, 2004)

Background Information

Andrew is a 26 year old actor and waiter from New Jersey. He was living in Los Angeles when he got the news that his mother has passed away. Returning to New Jersey for his mother's funeral, he has to face his psychiatrist father with whom he has no relationship. When Andrew was nine years old a terrible accident occurred where he pushed his mother over a dishwasher door that left her paralyzed. This left him in a depressed and distant state. His mother was a very depressed individual too. Andrew resented the fact that he could never make her happy and that he had pushed her out of anger, leaving her paralyzed.

He appears to be very lost and detached. Drugs such as marijuana and ecstasy have been used by Andrew. He has complaints of reoccurring headaches. Andrew seems to be isolating himself from his father and others. In Los Angeles in particular, he has no friends and no desire to attain any. His general lack of attention is established when he forgets to remove the gas pump from the car when finished getting gas.

Andrew feels like he does not have a problem and for the first time has stopped taking the medication that has been prescribed to him. After meeting a female friend, Andrew feels that he can relate to her and seems less depressed when he is with her. However, this is largely just taking his mind off his problems and his symptoms are still apparent.

Gideon Largeman is Andrew's father who is a psychiatrist. After his wife's accident involving Andrew, Gideon tries to suppress a deep loathing towards his son. He blames Andrew for the accident that left his wife paralyzed. To "curb the anger" that he holds towards his son, he heavily medicates him starting at a young age to "protect him from his own feelings". He puts Andrew on Lithium that has left him in an emotionless haze for many years. He feels that when Andrew was younger he had an anger problem so he decided to place him in boarding school following his mother's accident. His mother was very depressed and abusing alcohol before her accident. She died while drowning in a bath tub. This was known to be an accident and not a suicide attempt, although it was very suspect.

Description of the Problem

Andrew looks depressed and acts depressed. He zones out and lacks attention to certain important daily functions. There is not any color present in his bedroom, everything is white and sterile. He also experiences terrible dreams of being in a situation where the people around him and himself are about to die, yet he still does not or cannot show any emotion. He is just in a daze, without care of what is going on in the world around him. He has explained that he has not cried in many years. It is apparent that he isolates himself from his family and friends.

Diagnosis

The appropriate disorder after evaluating Andrew is Dysthymia Disorder (300.4)

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years.

Andrew has indicated that he has been depressed for as far as he can remember. Before the accident that left his mother paralyzed, Andrew felt depressed by the fact that he couldn't make his mother happy. After causing his mother to be paralyzed he also become depressed and was sent to boarding school where he was isolated from his family. He shows a great amount of guilt for his mother's accident and her recent death.

B. Presence, while depressed, of two (or more) of the following:

1. Poor appetite or overeating

2. **Insomnia or hypersomnia**
3. **Low energy or fatigue**
4. **Low self-esteem**
5. **Poor concentration or difficulty making decisions**
6. **Feelings of hopelessness**

Andrew experiences low energy, low self-esteem, poor concentration, and feelings of hopelessness. He seems to have low energy by the way he carries himself. He is late to work, has no interest and lacks energy when talking to people. Not being to work on time seems to be a reoccurring event for Andrew, as his boss mentions his last warning before he is replaced. Andrew expresses low self-esteem by explaining that he has a “fucked up family”. He blames himself for his mother’s accident and remains in isolation most of the time. His concentration on important things is also lacking. He has driven away with the gas pump still attached to his car, and has occasionally not responded to his name being called. Andrew has a sense of hopelessness; he does not have hope in the fact that he can fix the relationship between his father and him.

C. During the 2-year period of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.

Andrew meets this by explaining that he has felt this way from at least the age of nine. Before his mother’s accident he felt like he could not make her happy when she was depressed. He is also to blame for his mother’s accident and has been in therapy for depression since the age of 9.

D. No Major Depressive Episode has been present during the first 2 years of the disturbance i.e., the disturbance is not better accounted for by Chronic Major Depressive Disorder, Major Depressive Disorder or in Partial Remission.

The criteria of Dysthymia are met due to the amount of time that Andrew has experienced these depressed symptoms. It is estimated that he has had these symptoms for approximately 17 years. No major depressive episode has occurred. He has successfully carried a job, and has played a major role in a film.

E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder.

It is not apparent that Andrew has had Manic, Mixed or Hypomanic Episodes. The depression seems to remain at a consistent level over the time period estimated to be depressed. He does not meet the criteria for Cyclothymic disorder because Andrew has not experienced or expressed levels of Hypomanic episodes. He also has not experienced as time period of 2 or more months were he has shown no symptoms of depression.

F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.

Andrew shows no symptoms of a chronic Psychotic Disorder such as Schizophrenia or Delusional Disorder.

G. The symptoms are not due to the direct

physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

Andrew shows no symptoms that occur from drug, or medication abuse. The lithium that Andrew has been taking is to help his depression and aggression and he shows no signs of abusing it. He has experienced some drug and alcohol use. However it appears that it is only in social situations and he expressed signs of hesitation and has refused drugs from peers.

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Andrew's symptoms have significantly impaired his social relationship with peers, friends, co-workers and his father. He shows little interest in having friends around and has been isolating himself for a long period of time. He has no relationship with his father and other family members and has isolated himself from them as well. Andrew's job as a waiter seems to be coming to an end. He is consistently late and is on his last warning before he job position is replaced.

Early Onset – Occurred before the age of 9 and has continued through his adulthood.

Accuracy of Portrayal

When the average person watches Andrew it is obvious that he is depressed. It is also obvious that this depression has lasted a significant amount of time and has been consistent. He shows that he is suffering with depression more often

than not. However, there are times where it seems as if Andrew is not depressed, such as when he is with his newest female friend. Yet, Andrew still shows apparent symptoms of depression and guilt that would categorize him with Dysthymia Disorder. One may inaccurately portray Andrew as someone who has major depressive disorder but, this is not the case. Andrew's depression has lasted more than two years and he is depressed for most of the time. They may also label him with drug abuse; however, drugs are not a consistent player in his life. He knows to refuse it and to my knowledge has done ecstasy once after pressure from peers.

Treatment

Pharmacotherapy would be the most effective treatment for Andrew's dysthymia. Andrew has been on anti-depressants and involved in therapy since the age of nine. He has been heavily medicated with Lithium prescribed by his father. From a mental health professional perspective Andrew should not be on Lithium. It is obviously not helping him or eliminating the depression he is feeling. The Lithium dosage is too high and maybe triggering some of the depression he is experiencing. Trying another form of anti-depressants and finding the correct amount needed, with the addition to psychotherapy appears to be the most effective treatment for Andrew.

Psychotherapy should be incorporated with Andrew's treatment plan once his pharmacotherapy has been correct and is showing significant results in decreasing his depression.

Therapy involving his father in attempt to repair their relationship should also be in Andrew's treatment plan. This could relieve a lot of the stress and guilt built up in the both of them. Talk therapy is shown to benefit those with dysthymia. It will give him an opportunity to talk about his problems and learn ways to deal with him in a healthy manner.

Cognitive behavior therapy could also be helpful in treating Andrew's dysthymia disorder. Here he can go over and review that his behavior as a child needs to be put in the past. He needs help realizing that what has happened cannot be taken back but, instead needs to be moved on from.

Bulimia Nervosa

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Shelly Hunter

Source: *Hunger Point* (movie, 2003)

Background Information

Shelly Hunter is a Caucasian female currently in high school. Although her age is unknown, she is presumed to be a teenager. A first look at Hunter gives evidential proof that she is seriously underweight. This raises serious concerns about her health. Hunter lives at home with her domineering mother, Marsha, and David, her passive father. She is the younger sister of Frannie, who is away at college and also

struggles with eating. Shelly has a very strenuous relationship with her mother. As a child Hunter was always very slender, but she grew up listening to her mother lecture Frannie, who was not as slender, on the importance's of being slim. Mrs. Hunter's obsessive belief that being slender is the most important thing has severely distorted Hunter's views on eating. Hunter clearly seeks approval from her mother and puts great strains on her body to reach that approval. Hunter's life is devoted to her weight. Her time is spent obsessing about being slender. She does not know how to cope with her eating disorder and her irrational views on being skinny. The eating disorder is also causing severe mental problems with Hunter. She is exhibiting signs of depression and distrust from her family.

Description of the Problem

Hunter displays the symptoms of an eating disorder. She is abnormally underweight for her age and is very unhealthy. She exhibits the characteristics of Bulimia Nervosa. She eats very little when she is in the presence of other people. Most undoubtedly when she is eating in front of her mother, she becomes very self conscious about what and how much she eats. After restraining from food intake for a period of time she then will over eat. She stuffs herself with large portions of food. After doing so she begins to feel shame and guilt for over eating. The way she deals with her guilt is to self- induce vomiting. This purging is a defense mechanism Hunter uses to cope with "disappointing" herself as well as her mother.

Although it only lasts for a short while, she feels satisfied with her body after vomiting.

Diagnosis

The diagnosis for Hunter appropriately fits **Bulimia Nervosa (307.51)**.

To be diagnosed with **Bulimia Nervosa** one or more or a combination of the following characteristics must be present:

1. Eating in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances; it is common for more than 10,000 calories to be consumed per binge.
2. An abnormal constant craving for food; a sense of a lack of control of eating during an episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
3. Eating is usually done in secret.

Hunter displays the characteristics of 1 and 3. As described in the “Description of the Problem” she eats large portions of food alone.

B. Recurrent inappropriate, compensatory behavior in order to prevent weight gain. Such as self-induced vomiting, misuse of laxatives, diuretics, enemas, or other medications, fasting, or excessive exercise.

Hunter exhibits these compensatory behaviors in order to

prevent weight gain. She fasts for a long period of time. She then will binge eat and self-induce vomiting.

C. The binge eating and inappropriate compensatory behaviors both occur on average at least twice a week for three months.

Hunter began binge eating at a very young age and continues to binge eat into her high school years.

D. Self-evaluation is unduly influenced by body shape and weight.

Hunter has a very unhealthy view about her body. She is constantly concerned with gaining weight. Even though she looks too slender and unhealthy to others, she views herself as overweight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Hunter will eat very little for a short period of time, and then she will binge eat to self-induce vomiting.

Accuracy of Portrayal

The average person watching this movie would see an accurate portrayal of the behavioral characteristics of Bulimia Nervosa. Hunter displays the onset characteristics of someone suffering from this disorder. Someone watching this movie would learn that having an eating disorder can cause many other problems. Hunter became very untrusting and displayed signs of depression. Bulimia Nervosa took control over Hunter's life and began to affect her mentally.

Therefore, the movie *Hunger Point* portrays an accurate depiction of Bulimia Nervosa.

Treatment

After fully examining Hunter it might be best to start her on some medications. To help with depression Tricyclic antidepressants or Selective Serotonin Re-Uptake Inhibitors (SSRI's) could be prescribed to elevate her mood. Vitamin and mineral supplements would be prescribed until signs of deficiency disappeared and normal eating patterns were reestablished. The vitamins would also help to treat acid reflux caused by bulimia. After Hunter's weight becomes stabilized it would be a good idea to start a behavioral therapy program. This will help to change the mindset of Hunter and her negative views about her body. This will also help to control her binge eating habits. Not only does Hunter need individual therapy, but she and her mother need family therapy. Mrs. Hunter needs therapy in order to understand that her obsessive beliefs, about being slender, caused her daughter to become diagnosed with bulimia nervosa. Communication exercises will be exhibited to help resolve conflict and re-establishing boundaries. The treatments will better help Hunter to have control over Bulimia Nervosa and to gradually overcome the disorder.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=301#oembed-1>

Name: Blair Waldorf

Source: Gossip Girl (television series, 2007–present)

Background Information

Blair Waldorf is a 16 year old female who lives in Manhattan, New York. She is a full time student, and attends a private high school. She is in good health, and her family is in good mental health. Her parents are divorced, mother in Manhattan and father in Paris. She has a great relationship with her father, but he left his family for a male model, so Blair suffers slightly with separation anxiety and depression. Her mother has very high status in Manhattan, and would do anything to keep it that way. Blair and her mother get into arguments every now and then, but no more than a normal teen and her mother. Blair is an only child. Serena is Blair's best friend and has been since they were little. Blair is snobbier of the two, and Serena keeps her grounded without

going overboard. They often get into tiffs, but always end up making up. Blair's ex-boyfriend is Nate. They dated from age 5 until 16. Dealing with the breakup of her longtime lover, Blair goes a little crazy and her separation anxiety and depression shows up again. Blair drinks often, and for some reason in the world that she lives in, adults do not seem to care. She could walk into a bar and drink martinis all night, and it would be completely normal. She does not do drugs, however. Her biggest life difficulty is staying queen bee at her high school. She goes through a lot throughout the show, but staying the most popular girl in school is always her top priority. Her number one goal is to attend Yale after she graduates, and later become a trophy wife just like her mother was. Blair copes with her problems by putting other people down. She loves the fact that she is at the top of the totem pole, and she is not afraid to let anyone and everyone know it. She also often uses alcohol to cope with her problems.

Description of the Problem

During the first season of *Gossip Girl*, the fact that Blair had been to treatment in her past comes up a few times. Blair's eating habits are normal for the first few episodes, but after she experiences different stressors, her eating habits become abnormal again. She starts to pick at food most of the time, but binges at other times. Also, her best friend Serena and her mother started to bring up the fact that her symptoms were returning. She completely closed them off and ignored the fact that they were. Every time that she would get into a

fight with Serena, her ex boyfriend, or her mother, her lack of control for eating would return. One incident that was shown on the show was that Blair had gotten into a huge fight with Serena on Thanksgiving, which caused Blair to be extremely snappy with her mother. She found out that her mother lied to her about her father coming into town for the holiday, which caused a fight with her mother as well. She was picking at her Thanksgiving meal during dinner, and when her mother told her to go pick out a dessert, she stormed off to the kitchen. She found an apple pie that she wanted to eat, but instead of just taking one piece, she stared at it for a few minutes, and binged and ate the entire pie. Immediately, she went into her bathroom and started to purposely vomit. She has always had an issue with her self-image, and the binging and purging was her solution to make herself feel better. After vomiting in her bathroom, she called Serena, and she quickly came over and let Blair cry on her shoulder. This is not the only incident that Blair had with binging and purging, but it was a very critical event to Blair's illness.

Diagnosis

The diagnosis for Blair Waldorf fits most appropriately with **Bulimia Nervosa (307.51)**.

To be diagnosed with Bulimia Nervosa, you must have the following characteristics:

1. Recurrent episodes of binge eating. An episode of

binge eating is characterized by the following:

1. Eating in a discrete period of time (e.g., within any 2-hour period), an amount of food that is larger than most people would eat during a similar period of time and under similar circumstances.
2. A sense of lack of control of eating during an episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

Blair Waldorf displays both of these characteristics. When she has an episode, it is as if she cannot control what food she is putting into her body, or how much food she is putting into her body.

1. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise.

Blair Waldorf will do whatever she thinks is necessary to prevent weight gain, and her methods of choice are self-induced vomiting and fasting.

1. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for three months.

The television show does not state what age Blair Waldorf started binge eating, but while she was only 16 years old, her mother discussed Blair already having gone to treatment for her Bulimia. So this must have been a problem in her life for quite a few years.

1. Self-evaluation is unduly influenced by body shape and weight.

Blair Waldorf is very self-conscious of her body image and her weight. Her mother mentions a few times that she needs to watch her weight, so this may have helped lead to Blair's body image issues.

1. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Blair Waldorf will eat a very small amount and continue to pick at food at every meal, until another episode of bingeing and purging occurs.

Accuracy of Portrayal

The average person watching *Gossip Girl* and watching Blair with her eating disorder would learn the behavioral characteristics of Bulimia Nervosa. Someone watching this television show would understand that it is a disorder that a person cannot necessarily always control. There can be triggers that can lead to an episode, just like any other illness. This portrayal is accurate of Bulimia Nervosa. However, the

show does not show the seriousness as much as it should of this disorder. It was mislabeled in this way because it has affected Blair's mental health, so any issue in her life that leads to her showing any signs of depression will most likely lead to an episode. This is her way of dealing with problems in her life, and Gossip Girl does not show the severity of this.

Treatment

After evaluating Blair Waldorf's condition, it would be best to start her with a behavioral therapy program. She was not taught the proper way to handle her emotions and deal with problems that arise in her life, and therapy would help approach these issues. Therapy could also approach her body image issues, and help her to devise an exercise program that would make her feel more in shape and healthy. Her mother and her friends would have to help monitor her eating habits, but after understanding her condition fully and seeing that there are other ways of dealing with issues, Blair would take on a better eating schedule. Also, putting Blair on a very low dosage antidepressant or Selective Serotonin Re-Uptake Inhibitors (SSRI's) and monitoring her progress very closely while on this medication would help a great deal. Communication exercises will also be necessary between Blair and her mother to teach them how to discuss this illness in a healthier manner. These different treatments will, in time, help Blair overcome this disorder. She will be able to talk about her feelings and problems, rather than regressing to bingeing and purging.

Histrionic Personality Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Michael Scott

Source: *The Office* (American television show, 2005–2011)

Background Information

Michael Scott is a forty-six year old Caucasian male from Scranton, Pennsylvania. Scott is the regional manager at Dunder Mifflin Inc., a local paper and printer distribution company, where he has worked for the last fifteen years. There are no known medical conditions held by Scott, though his family history is unknown. He claims to be of English, Irish, German, Scottish, and Native American

descent, though this is unconfirmed, and perhaps an exaggeration. The patient's outward appearance is well put together, as he presents as a business professional, and there are no obvious health concerns. Despite his seemingly composed demeanor, Scott displays exaggerated emotions and reactions. In addition to this, romantic relationships have proven turbulent for Scott throughout his life, as he goes from one relationship to the next with the other person usually being the one to end it. He has few close friends or relatives, and tends to perceive new friendships as closer than they actually are. Scott believes his subordinates to be his family, and often times gets involved in their personal lives without their consent. His parents divorced when he was young (age unknown), and he displays clear resentment towards his stepfather and sister, whom he once didn't talk to for fifteen years. Scott has a very close relationship with his mother now, though this was not case when he was a child. Though Scott seems to be lacking in managerial style, responsibility, and delegation, he demonstrates above average sales abilities due to his personable qualities. Scott does not have a history of drug or alcohol abuse, though he will drink in social situations and when pressured to do so by coworkers.

Description of the Problem

The patient demonstrates many personality traits that could be indicative of a variety of disorders. Scott seeks attention every opportunity he gets, and this often interferes with his ability to function in his job as manager. In addition to

attention-seeking, Scott often interrupts his subordinates from working to discuss his personal life. This behavior not only affects his ability to work, but it interferes with the overall productivity of the office. It is Scott's belief that he should not be seen as just a boss, but more of a close friend and even family member, to the dismay of his subordinates. This expectation of a close bond leads Scott to display rapidly shifting emotions, from exuberant and hopeful, to depressed and hopeless. There seems to be a lack of consistency in his behavior, rather a dramatic shift from extremely happy to irreversibly sad. In Scott's depressed state, he feels as if the entire office should be focused on his problem and that others' problems pale in comparison, such as his birthday being of more importance than a coworkers cancer scare. When he is happy, however, work at the office ceases to a halt, as his well-being is put before the needs of the company. In addition to his attention-seeking and rapidly shifting emotions, the patient is easily suggestible and is often the victim of pyramid schemes and persuasive coworkers. Scott also shows a pattern of theatric behavior, including different characters, voices, and personalities, in which he uses as distractions on a constant basis.

Diagnosis

The diagnosis that seems to fit most appropriately for Scott is **Histrionic Personality Disorder (301.50)**.

To qualify for a diagnosis of Histrionic Personality

Disorder, a person must display the following general criteria of a Personality Disorder:

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

1. Cognition (I.e., ways of perceiving and interpreting self, other people, and events)
2. Affectivity (I.e., the range, intensity, and appropriateness of emotional response)
3. Interpersonal functioning
4. Impulse Control

Mr. Scott displays dysfunctions in many, if not all, of the above categories. His thoughts are consumed by his thinking that he is a comedian, consistently referring to his improv classes and impersonations. The affectivity displayed by the patient is continuously out of proportion to the situation, such as halting the workday for an office meeting over a minor problem, oftentimes a non-work related problem. His interpersonal and relationship functioning is severely limited, demonstrated by his lack insight into the true feelings (I.e. disdain) of the people in his life. His impulse control is lacking, if not nonexistent.

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

The displayed symptoms cause, and have caused, significant distress in the areas of work relationships, friendships, and romantic relationships. The observed behavior also has

negative consequences in many aspects of his life, including resentment and distain from coworkers, as well as from his superiors and romantic partners.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The inflexible nature of his symptoms clearly affects his ability to function in his day-to-day tasks. His ability to function is severely impacted by his need for attention, as he demonstrates a lack of motivation and productiveness in his occupation and social life. This enduring pattern has also led to resentment from his subordinates, who believe he is incompetent due to his emotional outbursts.

D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

Scott's symptoms have been present for at least six years, though they seem to have been present during his entire employment at Dunder Mifflin, and are pervasive in both his work and personal life. The symptoms can be traced back to his early adulthood, as demonstrated by his lack of friendships and romantic relationships in the past. The symptoms may also be a result of early childhood experiences, as he lacked a father-figure and his mother seemingly neglected him.

E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

Although the patient demonstrates some characteristics

consistent with Narcissistic Personality Disorder, he is too suggestible to fit this criteria. As those with Narcissistic PD are interpersonally exploitative, Scott demonstrates a need for immediate attention as opposed to a need for future success. Neither mood, psychotic, nor anxiety disorders better account for his symptoms.

E. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

The presenting symptoms are not the result of drugs, alcohol or head trauma.

To fit the Diagnostic Criteria for 301.50 Histrionic Type, at least five (or more) of the following criteria must be met:

1. Uncomfortable in situations in which they are not the center of attention

In many instances, such as making a coworkers wedding all about him, caring more about his superficial wound than an employee with a concussion, holding impromptu meetings to discuss his personal life, or dozens of other examples, Scott demands the attention be on him and only him. Typically in a situation in which he is not the center of attention, Scott is visibly uncomfortable and can barely sit still.

2. Interaction with others are often characterized by inappropriate sexually seductive or provocative behavior

Although Scott does not demonstrate sexually seductive behavior, he exhibits provocative behavior on a regular basis

by use of inappropriate jokes or sexual advances on coworkers.

3. Displays rapid shifting and shallow expressions of emotions

Scott goes from angry, to upset, to jealous, to happy, to ecstatic very rapidly, and displays a pattern of shallow emotions. For instance, after hitting a coworker with his car, the patient displayed little remorse or genuine emotion.

4. Consistently uses physical appearance to draw attention to self

5. Has a style of speech that is excessively impressionistic and lacking in detail

6. Shows self-dramatization, theatricality, and exaggerated expression of emotion

After a superficial wound, the patient exaggerated the symptoms for the entire day, demanding the focus of that workday be on his recovery. Scott also demonstrates theatricality through use of characters, voices, and impromptu presentations.

7. Is suggestible, i.e., easily influenced by others or circumstances

Scott is highly suggestible, and has been observed to lose substantial amounts of money in pyramid schemes due to his trusting nature and easily influenced personality. The patient is so suggestible that he has participated in highly risky behaviors, such as placing his face in drying cement, from pressure from those around him.

8. Considers relationships more intimate than they

actually are

In many aspects of his life, the patient demonstrates a destructive attachment style, oftentimes believing those around him are closer to him than they actually are. Scott believes the office staff to be his family, and considers a temporary employee to be his best friend after only one day of knowing him. As with his friendships, Scott's personal relationships suffer from the same overzealous attitude. While once dating a woman, Scott placed his own photo over the photo of her ex-husband, while also proposing to her after three dates.

Accuracy of portrayal

To those watching *The Office*, the portrayal of Michael Scott as a person with Histrionic Personality Disorder is quite good, though those with the disorder are more often females than males. Those with Histrionic Personality Disorder are known to use their body as a seductive tool, and Scott's portrayal lacks this important quality of the disorder. However, due to the differing presentation of Histrionic Personality Disorder between men and women, this trait may be unnecessary for the diagnosis. The sudden change of emotion is quite accurately portrayed, as well as the attention-seeking behavior patterns. As symptom expression is accurately portrayed, so too is the onset of symptoms. Histrionic PD is expressed most often in a person's early adult years, and those with the disorder typically come from a family history of neglect or lack of attention from the

primary caregiver during pivotal developmental years. For this reason, the attention-seeking and self-centered behavior tends to manifest later in life as a result of the early experience. This symptom is accurately portrayed in the show as well. Overall, the portrayal of Michael Scott as a person with Histrionic Personality Disorder is accurate in many ways.

Treatment

The best course of treatment for Scott would be therapy. Cognitive-behavioral therapy would be beneficial in a similar way by helping him to cope with his emotional outbursts. CBT would provide Scott tools for controlling his behavior in a more systematic and structured way to be able to function more productively in the workplace. In addition to systematic planning, it is recommended that Scott be given assertiveness training to help with his propensity for taking advice from others. Behavioral rehearsals may aid in his workplace manner and help him to establish appropriate workplace behaviors. Although family counseling is not an option, it is recommended that Scott participate in relationship counseling to help establish a long-lasting, stable relationship.



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view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=303#oembed-1>

Name: Regina George

Source: *Mean Girls* (movie, 2004)

Background Information

Regina George is a sixteen year old Caucasian female. She is a junior in high school at North Shore High School. Regina comes from a very wealthy family and does not have a job besides attending school. She is presumed to be in good health since the film did not mention any health conditions. Regina George is considered the ring leader of the meanest girl clique at North Shore High. She is the queen bee of the popular girls group that pride themselves on making each other look as hot as possible while they put others down in the process.

As previously mentioned Regina comes from a very affluent family. They live in a beautiful mansion considered to be the biggest and most lavish house out of any of the 'mean girl clique'. Regina's relationship with her parents is very twisted and abnormal. One example of this backward

relationship is displayed when Regina brings her friends over and her mom insists on inserting herself into Regina and her friend's conversations. Not only does her mom think of her as her best friend but her parents allowed her take the master bedroom simply because she desired it. Regina does not have a strong relationship with either parent but drifts more toward her mother.

Regina George has a preoccupation with her looks. She is constantly talking about how she is either too fat or that she is not pretty enough and also seeks confirmation about her body and looks through others. She does not have a regular drinking problem or drug abuse issue since she is so preoccupied with her appearance and that would definitely tarnish her ideal reputation. Her obsession with her appearance would have to be one of her biggest weaknesses. With regard to her weight, she is constantly seeking new and unsearched ways of losing weight.

Description of the Problem

This patient displays many of the traits associated with a number of personality disorders, but most strongly shows symptoms of Histrionic Personality Disorder. Regina George is an attention junkie. She seeks out attention from people in every aspect of her daily life. This hunger for attention has created tension between Regina and her group of friends. Her need for attention impairs her abilities to function inside the classroom, hindering her performance in school. Regina often wears seductive clothing that most girls and women

would not walk out the front door in, let alone wear to school. Another way Regina actively seeks attention is by talking about people behind their backs. In a three way phone call, she deliberately tries to sabotage one of her close friend's relationships with another close friend of hers. This attack displays her need to be needed. She felt threatened by their relationship so the only means of coping with the problem to her was by pinning two of her friends against each other. When Regina has a problem, the only way she knows to resolve it is by making someone else feel inferior. Along with these distorted coping skills, Regina displays extreme variances in her emotions. When she is happy she is through the moon happy and when she is mad she is definitely going to let someone know about it. When Regina has a problem going on in her life, she thinks that every single one of her friends must stop what they are doing and solve the problem with or for her. One example of this is shown when Regina is eating lunch, wants something else to eat, and then she says that she is really trying to lose five pounds. She is flabbergasted when the rest of the clique does not immediately pipe in to say that she is already flawless.

Diagnosis

The diagnosis that seems to fit most appropriately for Regina George is Histrionic Personality Disorder (301.50). To qualify for a diagnosis of Histrionic Personality Disorder, a person must display the following general criteria of a Personality Disorder:

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

1. Cognition (I.e., ways of perceiving and interpreting self, other people, and events)
2. Affectivity (I.e., the range, intensity, and appropriateness of emotional response)
3. Interpersonal functioning
4. Impulse Control

Regina George has shown impairments through all of these conditions. She has shown that all that consumes her thoughts is the obsession she has with her appearance and the appearance of others. Her displayed affectivity is most often over exaggerated to the situation. Most notable was her reaction to her "friend" not inviting her to her house party: she single handedly brought the entire student body to a crippling halt by sharing a "burn book" with them. This book contained pictures and captions (written by Regina herself) about different people in their school. The pictures were not the most flattering and the captions were mean spirited and hurtful to say the least.

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

Her symptoms have caused her significant turmoil in her relationships at home, school, and in her daily life. Her

behavior has caused many issues in all aspects of her life, such as with friends turning against her, her family not being very supportive and the entire student body rallying against her.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Regina's apparent inflexible nature has caused tremendous impairment among her social life as well as her occupational or school life. Regina's preoccupation with her outward appearance has left her little if any time to focus on things that really matter to people such as her character and demeanor towards others.

D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

The behaviors that Regina displays in the movie *Mean Girls* has been going on her entire life, per her mother's report. She has been the same appearance obsessed girl since she was born. This pattern of attention seeking, mean behavior escalated in middle school when she made up a rumor about a girl being a lesbian in the eighth grade.

E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

This patient does display some of the characteristics of a person with narcissistic personality disorder and perhaps even some dependent PD characteristics, but the disorder that Regina displays through the entire movie is HPD.

F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse,

a medication) or a general medical condition (e.g., head trauma).

The symptoms are not as a result of drugs, alcohol, or any general medical condition.

To fit the Diagnostic Criteria for 301.50 Histrionic Type, at least five (or more) of the following criteria must be met:

1. Uncomfortable in situations in which they are not the center of attention

Regina George is not only uncomfortable in situations in which she is not the center of attention but she most notably does not allow herself to be in a situation where she is not the center of attention. When a new girl starts going to North Shore, and the girl is as pretty as or prettier than her, Regina makes a concerted effort to make that girl her new best friend forever.

1. Interaction with others are often characterized by inappropriate sexually seductive or provocative behavior

Regina definitely displays this behavior in every aspect of her life. She cannot even sing in the Christmas talent show without being in a midriff tube top shirt with a matching much too short skirt.

1. Displays rapid shifting and shallow expressions of emotions

Regina has an extremely wide range of shallow emotions. For example when she is confronted with an old friend (the one she spread the lesbian rumor about) she shrugs it off as if it never happened. Her ability to show no remorse and be so nonchalant about something that destroyed a young impressionable human being show her shallow expression of emotion.

1. Consistently uses physical appearance to draw attention to self

She uses her body, her beauty, and her weight to keep people focused on herself. When someone tries to shift the conversation she always finds a way to get the attention back on herself.

1. Has a style of speech that is excessively impressionistic and lacking in detail

Regina has an immature speaking style. When talking in the cafeteria she uses many words that are not even words such as 'skeeze' to describe other students.

1. Shows self-dramatization, theatricality, and exaggerated expression of emotion

In regard to her constant obsession with her weight, Regina has all of her friends focus on the things that she should be doing on her own to lose the weight. When Regina goes to

a dress shop to be fitted for her prom dress and finds that she cannot fit the one she wants she has a tyrannical outburst.

1. Is suggestible, I.e., easily influenced by others or circumstances

Regina is highly suggestible especially since she does not focus on the facts. She is a person who will take a person for their word. When one of her friends tries to help her with a “weight-loss” bar she takes it without question. She is shocked to later find out that the bars she has been eating for the past few months has been the sole contributor to her slow but steady weight gain.

1. Considers relationships more intimate than they actually are

Accuracy of Portrayal

To the average person watching the movie *Mean Girls*, Regina George would seem like the typical high school bitch. She is popular, pretty, and, most of all, rich. To most laypeople they would not think to make the connection that she has histrionic personality disorder even though she does a phenomenal job portraying an individual with this disorder. Regina displays the symptom most commonly associated with having histrionic personality disorder, those being sexually seductive behaviors. Regina is sexually seductive in appropriate times such as high school girls and Halloween but most notably she is seductive at times when it is completely

inappropriate. Her extreme variances and range of shallow emotions are another key symptom of histrionic personality disorder. The fact that Regina is unhappy and uncomfortable with not being the center of attention is another symptom of histrionic personality disorder. The portrayal of Regina George in the movie *Mean Girls* is an accurate portrayal a person living with histrionic personality disorder.

Treatment

The best treatment for histrionic personality disorder is through therapy. The most effective therapy treatment would be Cognitive Behavioral Therapy. Cognitive Behavioral Therapy would help Regina to be able to control her emotionality better as well as give her some tools to cope with life in a more adaptive way. Regina would benefit from CBT in that it would help her in her interpersonal relationships to be better able to make and maintain friendships.



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Attention-Deficit/Hyperactivity Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Bart Simpson

Source: *The Simpsons* (Television series, 1989–present)

Background Information

Bart Simpson is an eight-year-old male with no history of a mental health diagnosis. Bart has been labeled an “underachiever” by authority figures and has poor grades in school ranging from D-minus to F. Bart can be ingenious regarding things that interest him such as learning portions

of the Talmud to help reunite his idol, Krusty the Clown with Krusty's father, Rabbi Krustofsky. However, this drive is absent for school-related performance. His academic achievements are behind those of his fourth-grade peers.

He has a history of consistent and sometimes significant trouble making. He also reports feelings of frustration with the narrow-minded people in his town for judging him by his problematic thoughts and actions. His relationship with his father is volatile and dysfunctional. One minute he is being strongly scolded by his father and the next him and his father bond over a collaborative prank. He once told Bart it was not okay to lose a children's miniature golf tournament and made Bart stare angrily at this opponent for 15 minutes a day. There is evidence that his father forgets his youngest daughter even exists (Bart's infant sister). Bart's mother tends to "over-mother" her children and once left the family for a brief period due to a mental breakdown. Despite this, Bart has no significant problems in the relationship with his mother. Bart enjoys skateboarding, bubble gum, Squishees from the Kwik-E-Mart, and a single-handedly bringing a homicidal TV sidekick to justice – twice.

Family Mental Health History:

Marge Simpson is Bart's mother. She is described as a happy homemaker and mother of three. Marge puts up with the antics of her husband (Homer, Bart's father) and children in good spirits, for the most part. Though, in 1992 the combined stress of her workload and family's problems caused her to have a mental breakdown. She went away to

spend time at “Rancho Relaxo” before returning home to her overly-dependant family. Marge over-mothers her children and reports staying with Homer because he makes her feel needed. Marge speaks out about issues such as violence and moral hygiene. The townspeople respond with frustration for her disregard of social norms. However, she also has a history of gambling addiction. She worked to overcome this addiction but it always lingers as a possible problem.

Homer Simpson is Bart’s father. Homer’s father Abe raised Homer in the absence of his “radical hippie mother.” Homer has a reported low IQ of 55 accompanied by periods of forgetfulness and ignorance. A crayon was discovered to be lodged in his brain and when removed his IQ rose to 105. However, he did not like his new ability to understand reason so he had the crayon re-inserted. This returned his IQ to 55. Other contributors to his low functioning include his exposure to radioactive waste, his alcohol use, and repetitive cranial trauma. It is uncertain whether his low level of functioning can attributed to genetics or to his life events. Homer works in a nuclear power plant and has remained an entry-level employee longer than any other employee. Prior to that, he attempted other jobs on impulse. At work, he falls asleep constantly and does not perform his duties. Homer displays regular instances of explosive anger. He does not attempt to hide this in public. He is ruled by his impulses. These impulses combined with his intense rage leads him to strangle Bart on occasion. His impulses change frequently affecting his attention span. He pursues many hobbies and

enterprises and then quickly changes his mind about them. Abraham Jay “Abe” Simpson is Bart’s paternal grandpa. He is a grizzled old man who is incredibly long-winded and often ignored. The stories he tells seem wildly inaccurate and often consist of events that are physically, or historically impossible. For example, he reports serving in World War I, although he was a small child at that time. He reports many confrontations with famous figures and writes letters to organizations making unreasonable requests such as asking the president to get rid of three states because there are too many and requesting that *Modern Bride Magazine* feature more people with wrinkles and toothless grins. He reports homicide attempts of Adolf Hitler via javelin throw in the 1936 Olympics. It appears that Grandpa Simpson suffers from some mental health impairment(s). Without knowing his history, it is hard to tell whether this is a lifelong disease or one that attributed to old age. If he has suffered these delusions for a long period, suffice it to say some of Bart’s mental health problems could be genetically linked to his grandpa.

Bart’s eight-year-old sister Lisa is a high-achieving student who is already a member of MENSA with an IQ of 159. She is smart, witty, and goal oriented. Lisa does not appear to have any limiting mental health symptoms. Bart’s younger sister Maggie and two maternal aunts are also featured on the show but do not seem to have any notable mental health limitations.

Description of the Problem

Bart displays multiple symptoms that are indicators for several mental health disorders. He shows very consistent symptoms for ADHD. Several problems arise as a result of Bart being distracted by video games. Specifically, he misses important family announcements because he is so distracted by his video games. Similarly, upon getting a satellite dish, Bart and his father became so distracted by the television that he could not study for an important achievement test. During the test, Bart continued to be distracted by daydreaming about things he saw on television the night before. This resulted in him failing the test and being held back a grade. In another instance, Bart got an F on a test so the school psychiatrist recommended he repeat the fourth grade. Out of desperation to avoid being held back, he promises to study but is repeatedly distracted so did worse on the next test. For the third test, Bart tries to focus while he is studying, but is still easily distracted and is forced to slap himself continually to continue his studying. The next day, still slapping himself, he finishes the test to receive a D- allowing him to pass by one point. During another instance, Bart also spontaneously interrupts an important lecture. There are many more instances where Bart becomes distracted, leading him to fail at tasks.

Diagnosis

The most appropriate diagnosis for Bart seems to be

Attention-Deficit/Hyperactivity Disorder (under code 314.0). He fits the Inattentive Type meeting the following symptoms: 1, 2, 3, 4, 6, 8. Bart displays many problems with attention and distractibility. His symptoms seem sufficient for satisfying this ADHD, Inattentive Type criteria. However, he also displays some dominant symptoms for ODD and CD. These symptoms undergo dramatic changes from episode to episode creating some difficulties in rendering a diagnosis.

Two types of ADHD: 1) Inattentive Type, and 2) Hyperactive-Impulsive Type.

- **DSM-IV-TR criteria:**
- **Inattentive Type and Hyperactive-Impulsive Type:**
 - **1. Inattentive Type:**
 - **Six or more of the following symptoms of inattention have been present for at least 6 months to a point that is disruptive and inappropriate for developmental level:**
 - 1) **Often does not give close attention to details or makes careless mistakes in schoolwork, work, or other activities.**
 - 2) **Often has trouble keeping attention on tasks or play activities.**
 - 3) **Often does not seem to listen when spoken to directly.**

- 4) Often does not follow instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).
- 5) Often has trouble organizing activities.
- 6) Often avoids, dislikes, or doesn't want to do things that take a lot of mental effort for a long period of time (such as schoolwork or homework).
- 7) Often loses things needed for tasks and activities (e.g. toys, school assignments, pencils, books, or tools).
- 8) Is often easily distracted.
- 9) Often forgetful in daily activities.

- 2. Hyperactive-Impulsive Type:
 - Six or more of the following symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for developmental level:
Hyperactivity:

1) Often fidgets with hands or feet or squirms in seat.

2) Often gets up from seat when remaining in seat is expected.

3) Often runs about or climbs when and where it is not appropriate (adolescents or adults may feel very restless).

4) Often has trouble playing or enjoying leisure activities quietly.

Is often “on the go” or often acts as if “driven by a motor”.

5) Often talks excessively.

Impulsiveness:

6) Often blurts out answers before questions have been finished.

7) Often has trouble waiting one’s turn.

8) Often interrupts or intrudes on others (e.g., butts into conversations or games).

Accuracy of Portrayal

A viewer of the Bart Simpson character can see many accurate symptoms of ADHD, but his character has many overlapping symptoms of Oppositional Defiant Disorder and even Conduct Disorder. His problems with attention are

displayed in numerous experiences. However, he also displays multiple symptoms of deceitfulness, serious violations of rules, deliberately annoys people, and often argues with adults. These symptoms are found in individuals with ODD or CD. However, Bart does not demonstrate the temper, anger, or aggressiveness problems that can also be found in ODD or CD. The Bart Simpson character does display ADHD symptoms with fair accuracy, over many different episodes but also displays the ability to effectively organize delinquent behaviors in others, which would be less likely for someone with ADHD. So, there are some inconsistencies in his character but that is to be expected for a character with such different dramatic storylines, in weekly episodes for over 20 years.

Treatment

Treatment of Bart should begin with a structured or semi-structured clinical interview discussing developmental and family history, ADHD symptoms, and symptoms of comorbid problems. Intelligence testing, achievement testing, and reports from parents and teachers will also provide valuable insight. In light of the 2011 study by Dr. Lidy Pelsser of the ADHD Research Centre in the Netherlands, it seems appropriate to begin Bart on restricted, non-allergenic diet to eliminate allergens related to ADHD symptoms. A strictly supervised restricted elimination diet is a valuable instrument to assess whether ADHD is induced by food. This diet should be followed and monitor his symptoms closely for five weeks.

If ADHD symptoms have not drastically improved or disappeared after five weeks, the diet should be ceased and medication will be the next course of action. Medication should be used to treat Bart's core ADHD symptoms. Central nervous system (CNS) stimulants have a high success rate for ADHD. Bart would begin taking a low dose of Ritalin. It should be taken two times a day; morning before breakfast and at night before dinner. He should begin taking 6mg tablets and then can move up to 60mg a day. A combination of medication and behavior therapy will be used to treat co-occurring problems for the long term. This therapy will promote improvements in the parent-child interactions, aggressive responses, and social skills. Parent training can also provide parents with skills to effectively interact with a child with ADHD.



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Name: Clark Griswold

Source: *National Lampoon's Christmas Vacation* (movie, 1989)

Background Information

Clark Griswold is a forty-four year old male patriarch of a traditional middle-income family with a wife and two teenage children (one son and one daughter). Clark works as a food additive designer for a large firm. His achievement is inconsistent and fluctuates from high level (creating a new “varnish” to keep cereal crispy in milk) to minimal effort and being “invisible” to his boss. Although Clark proclaims himself as “a regular family man, trying to do what’s best for his wife and kids,” his actions contradict his behavior. On more than one occasion, Clark has introduced his children as “Rusty and what’s-her-name”. This verbal outburst demonstrates a subconscious disconnect between beliefs and actions. Clark’s wife, Ellen, does not display outwardly noticeable symptoms of mental health disorder. She demonstrates a loving relationship to her husband (a.k.a “Sparky”) and children, although she tends to enable the household behaviors and live in a state of denial about Clark’s eccentricities until his behavior is extreme. The children both display typical teenage angst and disinterest in family situations. Both minor children have past experience with illegal substances, but do not present addictive behaviors (see *National Lampoon's Vacation*, 1983). Clark’s cousin Eddy displays a possible genetic link to maladaptive behaviors. For example, when Clark does not receive his anticipated

Christmas bonus from work, Eddy kidnaps Clark's boss. Clark displays poor coping skills and reacts abruptly and inappropriately in both public and private settings. Although he lives in constant pursuit of the ultimate family vacation, his overall achievement goals are shallow and limited to materialistic gain.

The close proximity of relatives that may or may not always get along under normal circumstances, increases tensions and exacerbates Clark's ADHD symptoms. Family support and understanding for display of symptoms is minimal and inconsistent, although time spent together is abundant. Most of Clark's outbursts or behaviors are dismissed as normal for him. As of 1989, Clark has received no official mental health diagnosis but has displayed multiple symptoms that his family normally dismisses as "part of his character." Individuals from the outside view Clark as impulsive and prone to quick outbursts. It is possible that Clark displayed symptoms before age seven but went undiagnosed due to the lack of information regarding ADHD prior to 1970. Subsequent controversy and downplay of ADHD from critics may have interfered with proper diagnosis and treatment.

Description of the Problem

Clark presents with several significant symptoms pointing to Attention-Deficit/Hyperactivity Disorder. Clark is easily distracted and demonstrates an inability to stay on task with everyday items. However, he does overindulge on items he

deems important. Clark becomes so involved in his quest for the perfect family vacation and Christmas lights for the house that he misses quality family time and activities with the group. Clark has a tendency to behave in an overly energetic manner and is unable to rest or at times maintain an even temperament. He is quick to anger at even mundane situations and consistently holds extreme grudges. Furthermore, he shows inappropriate affect and significant impairment in both personal and professional settings. For example, while Christmas shopping for his wife; Clark is unable to maintain composure with the female working the counter. He also displays inappropriate affect and coping behaviors with anger towards his boss by demonstrative and abrupt outbursts.

Diagnosis

Clark's symptoms fit best with a diagnosis of Attention-Deficit/Hyperactivity Disorder (314.0) from the DSM-IV-TR, with the specific subtype of Inattentive Type best describing his symptoms. Clark meets the following symptoms for Inattentive Type: 1, 2, 3, 4, 5, 8, 9. Although he presents with symptoms for Hyperactive-Impulsive Type, he does not display the required six or more for a complete diagnosis. Clark's hyperactive and impulsive behaviors may be caused by environmental factors. The following symptoms must be met to be diagnosed with Attention-Deficit/Hyperactivity Disorder:

1. Inattentive Type:

Six or more of the following symptoms of inattention have been present for at least 6 months to a point that is disruptive and inappropriate for developmental level:

1) Often does not give close attention to details or makes careless mistakes in schoolwork, work, or other activities.

Clark overlooks specific details in personal activities with an elevated risk such as driving or home improvement. During a family trip to choose a Christmas tree, Clark became distracted by his frustration with another driver and drove the car directly parallel under the bed of a semi-truck. He was unaware of his wife's warnings to stop or that he was pulling under the truck until after the action was complete. His home improvement skills lack detail such as the time he stapled his shirt sleeve to the top floor guttering while precariously balanced on a ladder.

2) Often has trouble keeping attention on tasks or play activities.

While Christmas gift shopping for his wife, Clark was distracted by the counter attendant and unable to focus on the task at hand. He continuously rambled, stumbled on words, or changed sentence syntax by saying "hooter" instead of "hotter". Clark displayed difficulty staying on task or keeping his attention on the purpose of his trip.

3) Often does not seem to listen when spoken to directly.

Clark's daughter, Audrey continuously updated him of her "freezing" body parts during a trek to find the family

Christmas tree. He remained unaware of the situation, even after his wife expressed concern that Audrey's eyes were frozen. He dismissed the problem once he realized he was being addressed.

4) Often does not follow instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).

Failed to latch the ladder placed against his house and slid down to the ground from the second floor. Clark also overlooked the directions for the "twinkling" holiday lights and was unable to change them from the constant on position.

5) Often has trouble organizing activities.

Clark forgets to bring the saw necessary to cut down the tree on the family Christmas tree trip and also manages to freeze most of his daughter's body by leading them through massive snow and freezing temperatures without adequate preparation. His son, Rusty, spends most of the time during the Christmas light installation retrieving items from various locations or untangling the jumbled mess of string lights.

6) Often avoids, dislikes, or does not want to do things that take a lot of mental effort for a long period of time (such as schoolwork or homework).

7) Often loses things needed for tasks and activities (e.g. toys, school assignments, pencils, books, or tools).

8) Is often easily distracted.

Clark asks his wife about his mother-in-law waxing her

lip during a serious conversation about holiday tension. He becomes trapped in the attic and becomes distracted by the case of home movies he found while searching for warm clothing. He proceeds to watch the movies instead of trying to find a way out of the attic.

9) Often forgetful in daily activities.

Clark is easily distracted and forgets basic activities or the involvement of others.

Some symptoms that cause impairment were present before age 7 years. There has to be an onset of symptoms prior to 7 years old, but a diagnosis can occur much later.

Unable to find medical history confirming childhood diagnosis but this could be due to the lack of information regarding ADHD prior to 1970.

Some impairment from the symptoms is present in two or more settings (e.g. at school/work and at home).

Clark's behavioral problems are consistent at both home and work, with home being his largest source of symptomatic display.

There must be clear evidence of significant impairment in social, school, or work functioning.

Clark displays inappropriate affect and displays attentional deficits at work and home.

The symptoms do not happen only during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder. The symptoms are not better accounted for by another mental disorder (e.g. Mood

Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Clark's does not demonstrate the symptoms associated with other disorders to warrant a full diagnosis of Mood Disorder, Anxiety Disorder, Dissociative Disorder, or Personality Disorder. He does present with OCD like symptoms and should be observed to assure an accurate diagnosis.

Accuracy of Portrayal

Clark's ADHD oriented behavior traits are consistent over the course of each movie. His excessive talking, trouble organizing activities, trouble staying focused when spoken to directly, and forgetfulness of daily activities are just a few of the direct ADHD symptoms that Clark displays. However, He does not consistently display the passiveness normally associated with Inattentive ADHD. Clark is compliant and passive during some events, yet he is also prone to outbursts and demonstrates a quick temper. ADHD shows a high comorbidity with Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD), but Clark's temper and outbursts are more likely caused by environmental and psychological factors, thereby presenting an inaccuracy in the portrayal. The average viewer watching Clark Griswold may consider his behaviors are more consistent with Obsessive-Compulsive Disorder (OCD). Clark displays an inability to curb impulses and recurrent thoughts and is prone to act according to his own volition, regardless of the outcome on others. Although

these attributes illustrate OCD, they are just a few of the many symptoms of ADHD that Clark exhibits.

Treatment

The best course of treatment should begin with a structured or semi-structured clinical interview to obtain Clark's family and medical history, and pervasive symptoms pertaining to ADHD and co-morbid disorders. Empirically supported treatment includes stimulant medication to relieve core symptoms. FDA-approved medications are useful for reducing physical symptoms. Specifically, ADHD responds best to stimulant medications such as Ritalin, Cylert, and Dexedrine. Due to the severity and inability to predict side effect occurrence from Cylert, the better pharmaceutical choice is either Methylphenidate (Ritalin) or Dextroamphetamine Sulfate (Dexedrine) for Clark's symptoms. Potential stimulant medication side effects include insomnia, decreased appetite, and potential dependence. Dosage is prescribed based on patient age, weight, and medical history. Clark should begin with the lowest possible dosage and gradually increase prescription strength only at the advice of a therapist or doctor. Behavior therapy is preferred as the primary treatment choice in conjunction with pharmacotherapy and can be useful for improving social skills, modifying behavioral deficits, and reducing aggression. Additionally, family support methods are vital to effective treatment plans.



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Anorexia Nervosa

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Name: Trevor Reznik

Source: *The Machinist* (movie, 2004)

Background Information

Trevor Renik is a middle aged male of Euro-Asian decent. Trevor is a blue-collar worker. Trevor works for a company, National Machine, as a welder. Trevor's work environment is not a positive or friendly one. Trevor's age and family history are not known through the film. Trevor Reznik is not a healthy individual: he smokes cigarettes, he does not sleep, he does not eat at all, and consumes large amount of

caffeine. Trevor states he does not drink frequently, but is seen drinking throughout the film. Trevor is not seen eating once throughout the film, nor does he engage in any physical exercise.

Trevor is socially withdrawn and does not have any close friends or family members. The interactions with women in the beginning of the film indicate that Trevor is lonely. Trevor's interactions with women show he does not have healthy relationships with women. One is with a prostitute, Stevie, whom he is a patron of throughout the film. Another woman is a waitress, Maria, whom Trevor believes he interacts with, but is actually one of Trevor's hallucinations. Realistically, Trevor never interacted with his waitress, whom was unrecognizable to Trevor when he is not hallucinating. Trevor's work environment is a constant stressor. Trevor's boss informs Trevor he "is on his shit list". Trevor is confronted by his bosses and asked for a Urinary Analysis because they believe he "looks like shit" thus he must be on drugs. Co-workers invite him to play poker and Trevor declines, upon doing so a co-worker responds "What's wrong with you, you used to be alright" while another co-worker says "You were never alright, but you used to hang". Trevor creates a hazardous situation at work while in an induced fatigue hallucination resulting in a co-worker losing his hand due to Trevor's actions. Trevor's co-workers are hostile and aggressive towards him after the work-related accident, thus Trevor experiences persecutory delusions and referential delusions. Trevor experiences many

life-stressors throughout the film such as injuring others, himself, losing his job, losing relationships, and legal issues.

Trevor is consumed by his own delusions and hallucinations, which are induced from a hit-and-run. Trevor allows his memory to torment himself and has poor coping skills. Trevor's coping technique of thought repression to handle the hit-and-run make him feel enormous amounts of guilt. The implicit guilt Trevor experiences is explicitly seen throughout the film by his sticky notes in his home. Trevor's hit-and-run provoked the negative image of self to control all aspects of his life. Trevor has no desired goals or outcomes from his life, except to answer sticky notes he leaves himself. "Who are you?" is a sticky note Trevor leaves himself to remind him to seek for whom he really is. Trevor's weaknesses are his inability to interact socially and distinguish what is actually reality. Trevor is paranoid from his hallucinations and delusions and he frequently feels as if people are following him. Trevor thoughtfully analyzes situations to "expose" plots against him, while doing so he throws himself in front of a moving car in order to get information from the police. Upon doing so, the police inform him he is committing a felony and so he runs through underground tunnels to evade pursuit. Trevor finally realizes who he is by the end of the film: he is an individual that killed a little boy by committing a hit-and-run. After realizing who he is, a "killer", Trevor turns himself into the police for the hit-and-run. The individual who he hallucinated throughout

the film was himself as Ivan and Maria, the victim's mother. Trevor is able to sleep once he turns himself into the police.

Description of the Problem

The opening scene is Trevor standing in front of a mirror looking at his self then replies, "shit", in disgust while looking at his reflection. Trevor holds a negative image of himself. In this scene, Trevor's shirt is off and his underweight body is revealed. Trevor displays physical symptoms of Anorexia Nervosa such as his body weight, sunken eyes, and puffy cheeks.

Individuals who interact with an individual suffering from Anorexia Nervosa display concern for their health. This is displayed as Trevor is asked "Are you alright?" throughout the film, indicating others do not perceive him as being in an okay state. Others ask Trevor if he uses drugs throughout the film. The prostitute and waitress try to feed Trevor food in many scenes. The women say, "If you were any thinner, you wouldn't exist".

Trevor's actions of not eating and properly nourishing his body are common for individuals suffering from Anorexia Nervosa, specifically the restrictive type. Trevor orders pie at a diner he goes to but he is never seen eating the pie. Fatigue is a common sign of Anorexia Nervosa due to malnourishment. Trevor reports to always be tired, cannot sleep, nor has slept in the past year. Trevor's sexual relations are not atypical of one with Anorexia Nervosa since he is the prostitute's "best costumer".

Trevor socially withdraws, which is a symptom associated with Anorexia Nervosa. Trevor loses touch with reality and those whom interact with him call him crazy and psycho. The persecutory delusions and referential delusions may be a side effect from long-term malnutrition and dehydration. Trevor believes his coworkers are plotting against him and ends up losing his job when he behaves erratically by physically attacking his co-workers. The physical attack results in Trevor becoming short in breath, another common symptom displayed with the disorder.

Diagnosis

One possible diagnosis for Trevor Reznik from the DSM IV-TR would be **Anorexia Nervosa, Restrictive Type, (307.1)**. Trevor experiences many social and economical stressors as well, including a hostile work environment, negative co-worker interactions, social interaction non-existent, job loss, committing a hit-and-run, and a loss of relationships.

Criterion that are met for Anorexia Nervosa include:

A. Refusal to maintain body weight at or above a minimally normal weight for age and height.

Trevor was substantially under 85% of the body weight he should have maintained.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body shape on self-evaluation, or denial of the seriousness of the current low body weight.

Trevor was disturbed by his body image as indicated with

his response to his reflection. Trevor denied the seriousness of his underweight body. He does not seem aware of his diet, weight, or health thus, in denial of his personal health.

Difficulties diagnosing Trevor Reznik include: lack of knowledge about family history, lack of personal history, lack of medical history, and lack of self-report from him.

Accuracy of Portrayal

Trevor Reznik's suffering from Anorexia Nervosa is not very apparent due to his inattentiveness about his body weight. Therefore, Anorexia Nervosa may be mislabeled in this film. Trevor never explicitly states or indicates he has a fear of gaining weight, which is typical for those whom suffer from Anorexia Nervosa. Trevor's lack of concern with his body weight is not an accurate portrayal of an individual who suffers from Anorexia Nervosa.

If an individual watching the film knows what signs and symptoms to be aware of when assessing an individual who suffers from Anorexia Nervosa, then they may be able to diagnose Trevor Reznik as having the disorder. An individual who is aware of common symptoms and signs of Anorexia Nervosa may be able to decipher Trevor's disorder as an accurate portrayal. A stressor, murdering a little boy, may have been the on-set for Anorexia Nervosa and, as such, the film does accurately depict the course typical of individuals with Anorexia Nervosa. This includes Trevor not eating, acknowledging his poor health, and holding a negative image

of self. Trevor never ate food during the film. Trevor's physical symptoms were very apparent but others in the film attributed this to drug use. Trevor's fatigue, delusions, and hallucinations may be symptoms due to severe malnourishment and dehydration. Individuals who watch the film would be able to understand how one who suffers from Anorexia Nervosa lives with constant paranoia of his self-image and induced on-set of Anorexia Nervosa that may have caused the delusions and hallucinations from inadequate diet. The film is accurate because people suffering from Anorexia Nervosa do not acknowledge the pervasiveness of their disorder. Trevor never acknowledges that his poor health is due to his lifestyle.

Treatment

Treating Trevor Reznik would require him to acknowledge having the disorder, Anorexia Nervosa. The patient's willingness and acceptance of the disorder are essential for treatment to a progressive lifestyle to changing behavior. Treatment would focus on two main goals: 1) Trevor must gain weight and nourish his body with an adequate diet and 2) address Trevor's psychological and environmental stressors. An empirically supported treatment widely used is family and group therapy. Trevor lacks a support system such as family and friends who are usually the people who initiated treatment for individuals suffering from the disorder. Typically, family and friends monitor diet and exercise for individuals suffering from Anorexia Nervosa. The lack of

a social support Trevor receives makes treatment difficult. Trevor would have more success in self-help groups since he lacks a family for family therapy. The self-help group meetings would allow Trevor the opportunity to interact with others suffering from Anorexia Nervosa. The self-help group meetings would enlighten Trevor about Anorexia Nervosa tremendously. In order for self-help treatments to be successful Trevor must attend the meetings regularly and change his behavior through the acquisition of new knowledge. The self-help groups may be the social support Trevor needs to overcome Anorexia Nervosa. Trevor must change his attitude, behaviors, diet, and physically exercise to live a healthy lifestyle. If Trevor avoids situations and environments that are mental triggers for his disorder he will overcome the disorder with successful treatment. Trevor's successful treatment seems unlikely and he seems vulnerable to enduring a chronic episode that will ultimately end in his body's expiration.



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Mood Disorders

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Athletes, unlike nonathletes, do not show major changes in their mood. Instead they show signs in their performance, such as decreased energy, poor performance, and dissatisfaction with their performance. It is very important for the sports medical team to watch for these signs so they can better help and understand the athlete and, if necessary, call a sports psychologist to do further testing. According to the National Institute Of Mental Health, approximately 20.9 million American adults, or about 9.5 percent of the U.S. population age 18 and older in a given year, have a mood disorder ([NIMH](#)). The median age of onset for mood

disorders is 30 years There are three common mood disorders that are affect an athletes, which include, depression, dysthymia and bipolar disorders.

- *Depression* is characterized by feelings of sadness and loss of interest in the activities that a person normally enjoys. Additional symptoms include feelings of worthlessness, difficulty concentrating, and weight loss.
 - An example of this is shown in the New York Mets pitcher, Pete Harnisch. According to Kamm 2008, Harnisch was coming off of a shoulder injury and was expected to be the ace pitcher for the Mets. He stopped chewing tobacco and found himself losing weight, fatigued, and unable to sleep. Harnisch approached his manager saying he did not feel he could pitch opening day. The manager then ridiculed him in front of the team which caused a riff in the relationship between them. Harnisch approached another staff, to which he was given Benadryl, for his insomnia and misdiagnosed with Lyme disease, an inflammatory disease spread through a tick bite, before the proper diagnosis of depression was finally made. Once

diagnosed, Harnisch was prescribed Paxil, underwent psychotherapy and made an excellent recovery. His pitching was just as good on Paxil as off. If a sports medical team had interviewed Harnisch they would have found that Harnisch had feelings of sadness and guilt as well as a lack of joy. Harnisch also had a history of depression in his family. A sports medical team can find and diagnose depression by observing the athlete for being down or sad, loss of appetite, concentration disturbances, irritability, lack of energy, lack of pleasure from things, and guilt. Also asking questions seeing if there is a history of depression in the family can be beneficial.

- Although, depression is common in athletes, there aren't many studies that show who, females or males, are more prone to the disorder. However, in a general population, women are more likely than men to experience depression. (Mule, 2004).
- Another issue that has drawn a lot of negative attention in the sport's world recently is that of concussions in pro football and the issues being had by the

NFL. Over the past decade, the prevalence of concussions in football players has increased drastically, and it seems that older players with histories of concussions are seeing more and more complications. Due to the increase in concussions and the permanent and long term problems they bring about, the NFL and NCAA is most-likely going to adopt new rules to better protect those who have had concussions and all those who are at risk for a concussion.

- Athletes may also suffer from **Dysthymia** which is a less intense form of depression where there is no prolonged well state or less episodic. In order of an athlete to be diagnosed with this disorder they must show two of the following signs: poor appetite, sleep disorder, low energy, low self-esteem, poor concentration and a feeling of hopelessness.
- ***Bipolar Disorders:*** are characterized by manic and depressive episodes.
 - Although the number of athletes who suffer with bipolar disorder is unknown, the National Institute of Mental Health has stated that about 5.7 million adults or

2.6 percent of the U.S population is affect with this disorder ([NIMH](#)).

- Bipolar disorder has affected several professional athletes such as Ilie Nastase (tennis) and Dimitrius Underwood (football). In a hypomanic episode, athletes may seem only outrageous and overly aggressive, but something more may be laying underneath. For instances, Miami Dolphins Defensive Tackle, Dimitrius Underwood. In 1999, Underwood took a knife to his neck. Judgment becomes impaired and athletes frequently turn to drugs or alcohol, especially if there is a prior history of abuse. Barrett Robbins, (football) with the Oakland Raiders missed the super bowl in 2003 because he went on a drinking binge the night before. Robbins had already been diagnosed with bipolar disorder and the team was aware of his condition. However, he stopped taking his medicine during preseason camp and developed erratic behavior before the super bowl. Although the team noticed he had started drinking, a sign of bipolar, no one intervened.
- It is important for the sport medical team

to pay attention to the nuances of medical conditions such as bipolar disorder. Knowing about the disorder, Robbins should have been placed in a buddy system environment where someone made sure he was ok. This person would have reported any problems or signs to the team physician. This would have been extremely important at the time of extreme stress such as the Super Bowl.

Related Articles, links and photo to the disorders described above:

- [Signs of Depression and Dysthymia](#)
- [Neural Substrates of Symptoms of Depression Following Concussion in Male Athletes With Persisting Postconcussion Symptoms](#)
- [Link Between Concussions and Depression](#)
- [What is a Concussion?](#)
- [Neurological Basis Of Depression Following Sports Concussion Found](#)
- [Dead athletes' brains show damage from concussions](#)
- [Concussion Linked To Depression In Retired American Football Players – New Research Coincides With Expert Presentation At ACSM](#)

[Annual Meeting](#)

image

Pete Harnisch



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view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=309#oembed-3>

image

Ilie Nastase



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Anxiety Disorders

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For most athletes, performance comes easy on and off the field. However there are some athletes do well in practice and once a game day approaches they tend “freeze up”. This is called performance anxiety, which is the most common form of Anxiety disorder that is found in sports world. However, they tend to find ways to avoid this anxiety, but what happens when they are diagnosed with other forms of anxiety such as Generalized Anxiety disorder(GAD), panic disorder, social anxiety disorder, post traumatic stress disorder (PTSD) or obsession compulsion disorder (OCD). Approximately 40 million American adults ages 18 and older, or about 18.1

percent of people in this age group in a given year, have an anxiety disorder, and half of them have recurrent anxiety disorders. ([NIHM](#))

- *Generalized Anxiety Disorder (GAD)*: is characterized by extreme worry of apprehension. Uncomfortable muscle tension and sleep disturbances are also associated with GAD. Many athletes have a normal state of anxiety, but some have trait anxiety.
 - Trait anxiety starts early in life. These athletes get stressed out before games and evaluations. They project catastrophic results such as not making the team or striking out. The best way to distinguish between GAD and normal anxiety is whether or not the person feels the anxiety is difficult to control. The athlete may present themselves to the trainer with headaches, upset stomach or diarrhea rather than anxiety. The athlete may also have difficulty concentrating or insomnia, but the most important symptom of GAD is the asking of what if questions, such as presenting with a headache saying what if I have a brain tumor.
 - There is no percentage was to who,

females or males athletes, are more prone to GAD. However, as a general population, women tend to show a more problems with this than men, with a 6.6 % to 3.6% ([Medindia Health, 2010](#))

- ***Panic Disorder:*** also known as panic attacks, are spontaneous and unexpected feelings of being out of control. They are characterized by trembling, shortness of breath, sweating, and choking.
 - An example of this is a boxer who quits fighting in the middle of an important match. This boxer would panic and do illegal fouls on his opponent even while already ahead in the match. He had been disqualified for more than one match. Those in his corner wondered if he suffered from panic disorder and indeed he did.
 - During a panic disorder an athlete's abilities are greatly diminished and judgment is impaired. During such attacks, an athlete reverts back to basic flight or fight instinct. If the sport medical team thinks that an athlete is having a panic attack during competition, it is best to pull the athlete to the sidelines and narrow the athlete's field of vision

and or auditory input. . This can be done by cupping one's hand on the side of the face. Then make eye contact with the athlete and tell them everything will be alright. Using a paper bag to revive correct breathing and a quick break to the locker room can also be beneficial.

- *Social Anxiety Disorder*: also known as Social Phobia, is a fear of social or performance situations where an individual perceives being judged by others. Symptoms of social anxiety disorder are similar to that of panic attacks. Typically the individual will try to avoid these situations at all costs.
 - Ricky Williams, a running back for the Miami Dolphins, is an example of an athlete with social anxiety disorder. Early in his career, Williams would give postgame interviews with the media while still wearing his helmet. His visor on his helmet would still be down. Williams always knew he was “Wired differently.” He would avoid social situations however, since he was a star athlete, his behavior would be shrugged off as the typical behavior of a coddled athlete. Williams said, “If I didn’t want to

honor an obligation, I knew someone would cover for me. It was easy for me to hide.”

- During his second professional season, Williams was playing with the New Orleans Saints and broke his ankle. The stress from this injury heightened the anxiety, and no one from the sport medical staff was paying attention to his emotional needs. Williams went to the internet and self-diagnosed social anxiety disorder and sought out a therapist. When he told his coach about his condition, he was yelled at to stop being a baby. An emotional disorder is still seen as just a weakness by many sports organizations. After psychotherapy, Williams was able to move on to the Miami Dolphins and become one of the most productive running backs in the league.
- Another type of social anxiety disorder is performance anxiety.
 - *Performance anxiety* is a specific type of social anxiety disorder. An athlete who has performance anxiety “freezes up” during

certain situations. It was present as the sudden inability to perform for no known reason what used to be a routine athletic task. An example of this is a pitcher who can throw well in practice, but freezes up during a game.

- One example of someone who has this is Chuck Knoblauch, of the New York Yankees. His case was so bad that it actually ended his career. Rick Ankiel, a pitcher for the St. Louis Cardinals, went through a similar situation. Rick was the top prospect in the organization and had one great season on the mound. The next season, Rick couldn't even throw a strike and eventually was removed from his

position and sent down to the minors. He was no longer able to deal with the pressure of being a major league pitcher and hasn't pitched since. He was able to recover and become a very good position player for the organization and currently plays outfield for the Kansas City Royals.

- Another recent case is that of Vince Young, quarterback for the Tennessee Titans of the National Football League. This disorder caused him to vanish for a short period of time and brought up talks of suicide. Luckily, for Vince Young, he was able to bounce back from his

disorder and became successful once again in the NFL.

- *Posttraumatic Stress Disorder (PTSD)*: An athlete with PTSD is someone who has seen or experienced a traumatic or life threatening event that caused them to have nightmares and intrusive memories. Athletes in high risk sports such as; football, auto racing, horse racing and boxing, possess a higher potential to develop PTSD.
 - An example of an athlete with PTSD is Julie Krone, a jockey. However, being a woman in a man's sport, Julie's symptoms went unnoticed because of her reputation of toughness which almost led her to committed suicide. Julie won the Belmont Stakes in 1993 and became the first and only woman to win a leg of the Triple Crown of horse racing. That summer she had a terrible fall, off her horse, in Sarasota, falling under several horses and being trampled. She ended up with 14 screws and 2 plates. She recovered from this well, almost as if it was a challenge for her to do so. The PTSD actually started 2 years later after a horse pitched her off in a race. To protect herself during the fall, she covered her

head with her hands causing her hands to break. Krone stated that “It fried me and I couldn’t talk.” It was not the severity of the fall that caused the PTSD. It was the fact that she had been sensitized and the life events during the second fall made it have great psychological meaning. Julie said, “The heart and he hands are the biggest organs a jockey has. The first spill got my heart; the second one got my hands, my trademark, the way I uniquely communicated with my mounts.”

- Krone started showing the symptoms of PTSD. She had flashbacks of the spill when approaching the starting gate, reoccurring nightmares of the spill, and experienced the event when someone swung a golf club near her, the feeling of the wind created by the club reminded her of the sensation of the horses passing over her. Krone sought help but no one diagnosed PTSD. She had blurred vision, which was caused by anxiety, but was told there was nothing wrong. One day she had another bad day at the track and was considering suicide. She spoke to a psychiatrist friend at the track and the psychiatrist suggested that they talk.

Eventually this psychotherapy led to the prescribing of an SSRI which helped Krone return to normal

- When an athlete has a minor injury and takes longer to return than normal, PTSD also needs to be considered. It should also be considered for vague medical conditions such as headaches, stomachaches, and backaches. An example of this is a runner showing above symptoms months after an injury has healed.
- Women, as a general population, also tend to suffer with PTSD more often than men with a 10-14% to 5-6%. ([Medindia, 2010](#))
- *Obsessive-Compulsive Disorder (OCD)*: Athletes with OCD, experience intrusive or disturbing thoughts, impulses or images that cause anxiety or distress. Those with OCD try to suppress these thoughts, but no matter how hard they try, they cannot get these thoughts out of their mind. They may have compulsions as well such as hand washing or counting. These compulsions are done to alleviate the stress of the thoughts.
 - An example of an athlete with OCD is Julian Swartz who was diagnosed with

OCD in the ninth grade. His senior year, Julian was the Associated Press High School Basketball Player of the Year. Julian attended the University of Wisconsin, and during his freshman year helped them make the Final Four. However doubt plagued him as to whether he was good enough or working hard enough. He developed depression and attempted suicide. Finally Julian transferred to a NCAA division III school where there was less pressure to perform. His OCD became controllable again. Given his disorder, choosing the smaller school would have been the best knowing his condition and the possible outcomes or triggers of events. Another famous sport star affected by OCD is Los Angeles Galaxy and English soccer Star David Beckham. He has been quoted saying the things must be in straight lines or in pairs.

- There is a common question that is asked among athletes and that is whether or not they, an athlete, is more prone to OCD. This question came about because of the daily rituals a

player goes through everyday while in practice.

- OCD can be separated from superstitious rituals in sports but the OCD interferes with the athlete's life. An example of this is obligatory running or exercise. The affected athlete will get into a "Have to do" attitude. The athlete will feel anxiety if he or she does not run or exercise to a certain level. These individuals will organize their lives around the activity and this can impact interpersonal relationships in a negative way. This athlete used the excuse that the running or exercise will help to maintain a certain

weight or muscularity.
They will even
exercise when told not
to by the sports
medical team.

- Both, male and female athletes, are likely to suffer with OCD because of the daily rituals they go through. Those with a “practice makes perfect” attitude are twice as likely to suffer than regular athletes.
- *Attention Deficit Hyperactivity Disorder (ADHD)*: is characterized by hyperactivity or inattention or the combination of these two. This disorder is usually diagnosed in childhood. The athlete has difficulty finishing projects, often loses things, and is forgetful. ADHD is also more common in athletes than non-athletes because several things are happening at once and people with ADHD are more energetic and spontaneous, which in some sports can be helpful. However, there are some negative side effects that may come along with an athlete.
 - An example of ADHD negatively affecting an athlete is that of a goalie who is unable to have the patience to wait for the play to develop and tackles the striker

or forward. However, ADHD can also work to a goalie's advantage since they have to be aware and pay attention to everything that is happening on the field of play.

- Another negative example is that of a hockey player who had his performance affected by the people in the stands who might be yelling his name and distracting him while the other team slides the puck into the goal. ADHD athletes tend to do well in sports where there is constant chaos such as hockey or soccer where the play is unpredictable and the athlete has to be aware and react throughout the entire duration of the contest. They tend to excel less in those sports that are slow paced such as baseball and football where there is significantly more down time.
- ADHD can also interfere with the ability to focus on what the coach is wanting from the athlete, which in return, makes a coach frustrated.
- An athlete can see a sports psychiatrist and get a prescription for a stimulant medication, but must be careful in regards to banned substances of the sport.

STEPHANIE WEIGEL

- Treatment includes stimulants such as methylphenidate (Ritalin).

Related articles, links and photos

- [Don't Choke. How to Reduce Performance Anxiety](#)
- [Practice makes perfect: Are athletes prone to OCD?](#)

image

Chuck Knoblauch

image

Vince Young



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This is a video of the struggles experienced by Rick Ankiel that can easily be attributed to his Social Anxiety Disorder. He cannot throw strikes (The successful pitch in baseball and the goal of all pitchers) and is getting booed and harassed by

the crowd. It was a very sad thing to witness because he has so much potential that was limited because of anxiety and pressure to perform. Rick's story as stated above did end well as he recovered from this disorder to go on and experience success once again.

PTSD.jpg

Army Col. Michael J. Roy, left, who oversees the exposure therapy at Walter Reed Army Medical Center, conducts a demonstration of a life-like simulator that represents a new form of Post Traumatic Stress Disorder treatment with Army Sgt. Lenearo Ashford, Technical Services Branch, Uniformed Services University, on Sept. 16, 2008, in Washington, D.C. Defense Dept. photo by John J. Kruzel

image

David Beckham

external image 1271980562_9824443932.jpg

These sports above, are consider good for an athlete with ADHD because it requies about of energy.

Personality Disorders

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Everyone, who has played sports before, has heard the saying “there is no I in Team.” That means that noone is able to take all the blame for a win or lose, it is a team afford. However if a athlete suffers from a personality disorder, such as narcissism, more than likely its all about them, and what they do to make the team better. They tend to believe that without them, the team is nothing.

- *Narcissism*: is essentially self love that is characterized by grandiosity, self-focus, self importance and self-absorption with a lack of

compassion and empathy for others.

- In regards to sport performance, a study in 2002 by Wallace and Baumeister, found that narcissists performed better in all conditions that provided greater self-enhancement opportunities. There is a reasonable expectation of those with higher narcissistic levels to have a different cognitive approach and behavior to the sport than those with low levels of narcissism.
- Wallace and Baumeister did four studies and across them, narcissists were found to have a higher value of performance under conditions of high pressure, challenge, and evaluation compared to those with low levels of narcissism.
- Narcissism is a very important variable in relationship to performance under pressure.
 - Pressure is defined as all situations in which there is a perceived importance in performing well.
- Sport provides a stage upon which an opportunity for glory, public evaluation, admiration from others exhibitionism,

demonstration of ability and focus on other's attention can be fostered to extreme levels and exploited in a potentially acceptable manner.

- Therefore, due to the amount of pressure placed upon the athlete to perform in sport, narcissists will strive to succeed in order to better foster their self image in their own eyes as well as the eyes of others.
- Common symptoms include:
 - a lack of feeling, empathy, or concern for others
 - a willingness to take advantage of others
 - excessive feelings of self-importance
 - exaggerated personal achievements and abilities
 - an expectation to be seen as superior without cause
 - a fantasy or preoccupation with power, wealth, beauty, personal abilities, or success
 - a demand for favorable

treatment without appropriate reasons

- an insistance on being the object of admiration and attention



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Eating and Body Dysmorphic Disorders

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Like stated in the introduction, everyone, who looks at an athlete as a role model, tend to want the same body as that athlete; however, they do not understand the extremes an athletes goes though to get there bodies that way In some cases, those extremes arent safe. For intance, many athletes suffers from eating disorders such as anorexia or bulima nervosa, and binge-eating disorder, which are common in both males and females. Males tend to also suffer from muscle or body dysmorphic, but current study have shown that they suffer from eating disorders as well. Studies have shown that

16 -72% of female athletes suffer from an eating disorder (Montgomery,2010). While only 5- 15% of males suffer, however more men tend to suffer more with binge-eating,. Studies have shown the 35% of men have this disorder.(Chang)

- *Anorexia Nervosa*: is an eating disorder characterized by unrealistic fear of weight gain, self-starvation, and conspicuous distortion of body image.
 - Athletes with Anorexia Nervosa refuse to maintain a healthy body weight. Their body weight is 85% lower than that of expected weight or fail to make expected weight gains. They experience an intense fear of gaining weight.
 - When an athlete becomes anorexic, their performance is affected by the weakness caused by the disorder. The athlete will say they are fat when they are clearly thin to everyone else. These athletes have difficulty admitting they have a problem.
 - An example of this is a gymnast who will strive to make herself thin by not eating or eating a diet of celery to maintain the thin stature expected in the sport. When a sport medical team observes an athlete that appears to be too thin, anorexia

should be suspected. When dealing with anorexia, the sports medical team should focus on the distress the athlete currently has rather than focusing on the weight issue. Suggesting going to see if there is a problem is better perceived by the athlete than telling them to go to therapy.

- A widely used diagnostic tool, the [body mass index](#) measures the body fat based on the weight and the height of an individual. Developed by a Belgian scientist Adolphe Quetelet, it helps to calculate how healthy a person is, based on his weight and identify whether the person is underweight, overweight or [obese](#). The relation of BMI to fatness differs for people of different age and gender. For example, the BMI of women is likely to be higher than that of men.
 - To calculate your BMI, just take your weight in kilograms and divide it with your height in meters. The result has to be again divided by the height in meters. For example if your weight is 60 kg and height is 1.50 m, then the BMI would be 26.67 ($60/1.50 = 40$ and $40/1.50$)

= 26.67). Thereafter you can compare your BMI to the weight ranges set out by the World Health Organization (WHO). This applies to both adult men and women but varies for children and older people.

- Calculating BMI, is the same for both men and women. Below is a chart for you to better understand the use of the BMI

- **Interpreting Your BMI**

- If your BMI is 19 to 24.9 you have a healthy weight.
 - If your BMI is 25 to 29.9 you are considered to be overweight and may incur

moderate
health risks.

- If your BMI is 30+ you are considered to be obese. Obesity is linked to increased risk of cancer, heart disease and other health problems.
- It is vital that while working out the BMI, the body frame and build also be taken into consideration . Therefore the BMI by itself may not be

accurate for a weight trainer, a pregnant woman or an athlete.

People who are over 60 years of age cannot calculate their BMI by this tool, as their bones start to weigh less due to old age. An athlete can use this test to figure out whether they fall into the healthy or anorexic zone.

- *Bulimia Nervosa*: is an eating disorder characterized by recurrent binge eating, followed by

compensatory behaviors. Bulimia Nervosa is often seen in athletes who are of normal weight or can be slightly overweight.

- Then these individuals will engage in compensatory behaviors such as laxative, self-induced vomiting, or excessive exercise to get rid of or makeup for what they ate. The food they eat is typically high in sweet and calories.
 - They frequently make wide fluctuations in weight.
 - One example of an athlete with bulimia is a jockey. Jockeys have to make a certain weight in order to be able to mount a horse and to work. It is a common practice of Jockeys to self-induce vomit to make weight.
 - Bulimia does not typically affect an athlete's performance. The athlete may be affected from the stress of guilt, depression, and family conflicts caused by the disorder.
- *Binge-Eating*: also known as compulsive overeating, is characterized by periods of uncontrolled, impulsive or continuous eating beyond the point of feeling comfortably full.

Although there is no purging, there many be periods where the individual fasts, have repetitive diets. They often tend to have a feeling of shame or self hatred after a binge.

- According to some studies, not all athletes are engaging in disorders. The video that is located at the in “related video” section will explain what sports are more susceptible to eating disorders (Kakaiya).
- ***Muscle Dysmorphia***: also called as bigorexia and is also known as reverse anorexia, because instead of trying to lose weight an athlete is trying to gain more weight.
 - Athletes, such as body builders are mostly affected with this disorder along with men who are involved in boxing and wrestling (Page,2010)
 - Signs and symptoms may include:
 - The feeling that he or she is small and underdeveloped.
 - Constantly check themselves in the mirror.
 - Getting anxious if they do not work out every day.
 - Doing resistance training, and exercise.

- Side effects include:
 - Damaged muscles, joints, cartilage, tendons and/or ligaments.
- This preoccupation can interfere with normal social and occupational lives. The sport medical team should ask the athlete if they are taking over the counter medications or creatine. Some of these supplements, especially those containing stimulants, can cause manic episodes in those prone to bipolar disorder.
- Some athletes will not take the substance or stop if the sports medical team strongly points out that the governing body of the sport could disqualify them from competition for taking the substance.
- Muscle Dysmorphia is common mainly among men, however, it is soon in both sexes.
- *Body Dysmorphic Disorder(BDD)*: this is a condition in which the athlete will have obsessions and distressing thoughts that repeatedly intrude into the persons awareness. Individuals with BDD experience problems with perceived appearance flaws that cause stress.

- Just as people with eating disorders obsess about their weight, people with BDD become obsessed over an aspect of their appearance.
- People with BDD may worry their hair is thin, their face is scarred, their eyes aren't exactly the same size, their nose is too big, or their lips are too thin.
- Although the imperfections are small that people with BDD obsess over, they firmly believe that everyone notices that aspect and think everyone is looking at it. But for a person with BDD, the concerns feel very real, because the obsessive thoughts distort and magnify any tiny imperfection.
- These extreme thoughts can cause the individual to not go out in public and think they are just too ugly to be seen in public.
- Individuals with BDD will likely use compulsions to counteract the obsession over their physical appearance. An example would be, if a person with BDD thought their nose was ugly they would constantly check it in the mirror, apply make up, or frequently ask people if their

nose looks ugly. Compulsions are a way to temporarily release some amount of stress.

- Treatment includes one of two things
 - Medications such as Serotonin reuptake inhibitors or antidepressants that decrease the obsessive and compulsive behaviors.
 - Cognitive behavioral therapy, which is a three step process.

Substance Abuse Disorders

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Current research has found that people who suffer with eating disorder, such as the ones previously listed, also suffer from substance abuse disorders such as alcohol abuse, and the most common, steroid abuse.

- *Alcohol Abuse*: is characterized as the excessive use of alcohol and alcoholic drinks.
 - High school athletes have a higher tendency to abuse alcohol than their nonathletic classmates, and male athletes have a higher tendency for abuse than

female athletes.

- On the collegiate level, athletes have a higher tendency to consume large quantities per setting and were found to have three times more DUIs than their non-athletic counterparts.
 - Alcohol dependence can impact negatively the athlete's performance as well as allegiance to the team. It can also have a negative effect on team moral as the player's abuse is affecting the total performance of the team. It is the critical job of the sports medical team to educate the athletes on the affects of alcohol.
 - Younger athletes are usually unaware of the potential for abuse of alcohol. Education can help deter abuse. This counseling should not only include how it affects the athlete's performance on the field, but how it can affect an athlete's life and family.
- *Anabolic Steroid Abuse* is charcaterized as are compounds, derived from testosterone, which promote tissue growth and repair. Because they have been used improperly by body builders and other athletes, they are controlled substances under United States federal law.

- It is estimated that one billion people in the United States have at least once used illegal steroids. Half of these users started before the age of 16. Estimates for body builders range from 50-80%.
- The athletes who have a higher potential for steroid use are those emphasizing strength and endurance such as weightlifting (80-90%) and track and field(40-50%).
- Ever wondered how those bulky weight lifters got so big? While some may have gotten their muscles through a strict regimen of weightlifting and diet, others may have gotten that way through the illegal use of anabolic-androgenic steroids.
- “Anabolic” refers to a steroid’s ability to help build muscle and “androgenic” refers to their role in promoting the development of male sexual characteristics. Other types of steroids, like cortisol, estrogen, and progesterone, do not build muscle, are not anabolic, and therefore do not have the same harmful effects.
- While using the steroids, the athlete will experience a feeling of euphoria, irritability, and grandiosity. These feelings may reach the point of feeling invincible. This can lead to roid rage, the violent behavior sometimes a side effect of steroids. Steroids can cause this change in behavior; those with no history of antisocial behavior have been

known to commit murder. Physical side effects of steroid use for men include shrinking of the testicles, reduced sperm count, infertility, baldness, development of breasts, increased risk for prostate cancer include prostate enlargement, shrinkage of testicles, reduced sperm count, impotence, difficulty or pain in urinating. Side effects for steroid use for women include growth of facial hair, male-pattern baldness, changes in or cessation of the menstrual cycle, enlargement of the clitoris, and a permanently deepened voice

- . Steroids are also physically and psychologically addictive. When a steroid user stops use, he or she may become anxious, depressed, and overly concerned with his or her physical shape.
- Another type of steroid is **Steroid precursors**. such as androstenedione (“andro”) and dehydroepiandrosterone (DHEA), are substances that the body converts into anabolic steroids. They are used to increase muscle mass.
- Symptoms for both male and females include:
 - Acne, really bad acne, especially on face and back
 - Baldness
 - A slow down of growth in athletes who aren’t done growing yet

Abnormal Psychology

- High blood pressure, unhealthy cholesterol changes, and heart disease
- Blood clots and stroke
- Liver damage, jaundice, or liver cancer
- Headaches, aching joints, and muscle cramps
- Nausea, vomiting, and diarrhea
- Sleep problems
- Increased risk of ligament and tendon injuries, which can end your athletic career for good

Symptoms in guys include:

- A low sperm count
- Impotence (inability to get an erection)
- Breast and nipple growth
- Enlarged prostate (a gland in the penis)

Symptoms in girls include:

- Breast shrinkage
- More face and body hair
- Voice deepening
- Problems with menstrual periods
- Clitoris enlargement

In addition to the above symptoms, there are also putting themselves at a higher risks for serious infections like hepatitis or HIV, which cause the AIDS virus.

Athletes may struggle to see that steroid use is very bad. They may say, “how can anything be wrong with something that will make me stronger and faster?” In 2005 Jose Canseco used this very justification for his steroid use in baseball. Steroid users are often reluctant to give up a drug that is perceived as good for enhancing performance and the way he or she looks. The sports medical teams need to take the approach of helping the athlete with his or her decision making skills. The Sports medical teams should be prepared to display how great athletes have made the positive decision to stay away from steroids so they could lengthen their careers, be more durable and decrease their likelihood to get hurt, be a better teammate for the team, and increase their decision making abilities. The athlete should be asked if the use of steroids is a viable choice in concurrence with the moral lessons of fair play learned by participation in the sport. Providing the athlete with this information and leading them down this road early in sports participation can help to curb steroid abuse later in life.

Links

- [NIDA InfoFacts: Steroids \(Anabolic-Androgenic\)](#)
- [Anabolic Steroids](#)
- [Research Report Series – Anabolic Steroid Abuse](#)

- [The Safety and Efficacy of Anabolic Steroid Precursors: What is the Scientific Evidence?](#)



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=317#oembed-1>

https://youtu.be/fmu_h8HCiGo

Expressive language disorder (315.31)

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Definition

ELD occurs when a person has problems expressing him or herself using spoken language. A child with an expressive language disorder is not able to communicate thoughts, needs, or wants at the same level or with the same complexity as his or her peers. The child often has a smaller vocabulary than his or her peers.

DSM-IV-TR diagnostic criteria

- A. The scores obtained from standardized

individually administered measures of expressive language development are substantially below those obtained from standardized measures of both nonverbal intellectual capacity and receptive language development. The disturbance may be manifest clinically by symptoms that include having a markedly limited vocabulary, making errors in tense, or having difficulty recalling words or producing sentences with developmentally appropriate length or complexity.

- B. The difficulties with expressive language interfere with academic or occupational achievement or with social communication.
- C. Criteria are not met for Mixed Receptive-Expressive Language Disorder or a Pervasive Developmental Disorders.
- D. If Mental Retardation, a speech-motor or sensory deficit, or environmental deprivation is present, the language difficulties are in excess of those usually associated with these problems.

Coding note: If a speech-motor, sensory deficit, or neurological condition is present the condition should be coded on Axis II.

Associated features

- Children with expressive language disorder have

great difficulty in the use of expressive language – the ability to express his or herself verbally. Proper pronunciation of words, however, is not a difficulty. Instead, the child with ELD may instead show difficulty in constructing sentences, using correct grammar, or word finding which prevents him or her from communicating their needs and wants in an age-appropriate fashion. There may be disturbances in fluency and formulation with an abnormally rapid rate and erratic rhythm in speaking. There may also be disturbances in structure (“cluttering”). When it is acquired, there may be difficulties in motor articulation, speed, syllabic repetition, monotony, and proper syllabic stress.

- While children with ELD have the same level of language, comprehension ability, and intelligence they generally show a smaller vocabulary than their peers. For example; many different ways in which expressive language disorder can manifest it. Some children do not properly use pronouns, or leave out functional words like “is” or “the.” Other children cannot recall words that they want to use in the sentence and substitute general words like “thing” or “stuff.” Some children cannot organize their sentences; these children would comprehend the material they are trying to express but they just cannot create the appropriate sentences to express

their thoughts. Generally, ELD is dissevered into two types; the developmental and acquired type. The developmental type most commonly shows no specific cause and is generally apparent when the child first begins the learning process; whereas the acquired type is most commonly caused by damage to the brain (stroke, concussion).

Child vs. adult presentation

Children most often present with developmental ELD (see “Etiology”), whereas ELD in adults it is usually only seen after direct damage has been inflicted to the brain. Note, however, that acquired ELD can happen at any age.

Gender and cultural differences in presentation

- Boys are more commonly diagnosed with developmental ELD than girls, with studies finding anywhere from a 2:1 to 5:1 ratio. In almost every culture you will find people that struggle with their own language and how to correctly express oneself. Therefore, it is hard to distinguish any difference in presentation among cultures.
- Assessment should take into account individuals’ cultural and language context, particularly individuals growing up in a bilingual environment. Standardized measures for language development and nonverbal intellectual capacity must be

relevant for cultural and linguistic groups.

Epidemiology

- A commonly seen disorder of which estimates of the number of of school age children qualifying for a ELD diagnosis range from 3-7%
- Language delays occur in 10-15% of children under the age of three.

Etiology

There are two types of ELD; in the acquired type, one experiences some type of direct trauma to the brain, such as a stroke or traumatic brain injury, which results in difficulties in the use of expressive language. The developmental type of ELD is seen in children, has no known cause, and usually appears during early development when a child is learning to speak.

Empirically supported treatments

Expressive language disorder is normally treated in two ways. The first option for treatment is a child with this disorder to work one-on-one with a speech therapist, where the child practices communication and speech skills. Another type of treatment involves the parents and teachers of the child to work as a team to incorporate the needed language skills in the child's everyday activities. These treatments are often used together for a more effective treatment.

Selective Mutism (313.23)

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DSM-IV-TR criteria

- A. Consistent failure to speak in specific social situations (in which there is an expectation for speaking, e.g. at school) despite speaking in other situations.
- B. The disturbance interferes with educational or occupational achievement or with social communication.
- C. The duration of the disturbance is at least one month (not limited to the first month of school).

- D. The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
- E. The disturbance is not better accounted for by a communication disorder (e.g. stuttering) and does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic disorders.

Associated features

- In unfamiliar settings or situations a child with Selective Mutism is often described as “excessively shy”. This can be misleading due to the fact that shy children can withhold from conversations for hours or days, but will eventually begin speaking. Shy children can function in social settings.
- Children with Selective Mutism suffer from fear of social embarrassment, social isolation and withdrawal, clinging, compulsive traits, negativism, temper tantrums, or controlling behavior, along with the excessive shyness that is seen in children that are shy.
- When confronted with a conversation, a child with this disorder will attempt to avoid it, using stiff body language, avoiding eye contact, maintaining a blank facial expression.
- These children are often very normal in the home

and around the family members. They are also sometimes teased by their peers. There may also be an associated Communication Disorder or a general medical condition causing abnormalities of articulation.

- Children suffering from this can be over dependent on their parents.
- Mute children are not mute because they do not want to speak but because they are afraid to speak.

Child vs. adult presentation

Children are affected by Selective Mutism, which usually appears between the ages of 4–6. When children leave the home setting, usually for school or daycare, the symptoms begin to appear. Children do not outgrow this disorder, but it has usually been treated and overcome by adolescence.

Gender and cultural differences in presentation

- Children of immigrants are often more uncomfortable or unfamiliar with the new country's language and this lack of communication should not be confused with or misdiagnosed as Selective Mutism.
- Females tend to present with Selective Mutism more frequently than males. According to the Developmental and Behavioral Pediatrics "A Handbook for Primary Care," females with this

disorder outnumber males 2:1.

Epidemiology

- 90% of children with Selective Mutism also have a social phobia. In many cases Selective Mutism lasts for only a few months, however, the symptoms may last up to several years.
- Selective Mutism is very rare, with rates of 0.1% to 0.7% in the general population and 1% in mental health institutes being reported. These extremely low rates are due, in part, to limited research.

Etiology

- There is a genetic predisposition to Selective Mutism, with most cases having a first degree family history; 70% being a Social Phobia or 30% being Selective Mutism. Since this condition is so rare, the etiology is poorly understood. There are many theories on etiological factors for this disorder, but three main ones have emerged, due to consistency in cases.
- The three main etiological factors for Selective Mutism are anxiety, developmental delays, and not being exposed to the local language. Many clinicians consider trauma as a factor for Selective Mutism, (before the age of 3) however, trauma tends to cause global mutism (refusal to speak to

everyone) instead of a selective development.

- In one study, Kristensen linked Selected Mutism with many nonlinguistic developmental problems. Some of these problems included motor delays, elimination disorders, and pre- and perinatal problems. Selective Mutism is also highly found among immigrant children, although sometimes it may be misdiagnosed due to unfamiliarity or uncomfortableness with the host country's language. When these children cannot speak the language, it may affect their confidence.
- Other children may also tease them about their inability to speak well, their accent, or minor grammatical errors. The child cannot participate in school due to the language barrier, which predisposes them to Selective Mutism, a disease only reinforced by the teasing.
- One study by BarHaim also suggested that a deficit may exist in the child's auditory efferent system. This deficit prevents the child from desensitizing their own vocalizations if the child is anxious they will cope with this deficit by developing Selective Mutism.

Empirically supported treatments

- When treating Selective Mutism, the main goal is to treat the anxiety, not to force the child to speak.

Treating Selective Mutism usually begins with therapy. Family members, teachers, and the therapist should work together to attempt to reduce the child's anxiety, reduce the pressure they feel to speak, and increase their self esteem.

- Therapy also attempts to create a desensitized atmosphere so that the child is able to practice speaking. Cognitive Behavioral Therapy is used to help the child to work toward specific goals. Therapy can be difficult because the child refuses to speak and feels uncomfortable.
- In the most chronic cases, usually after all other options have been exhausted, medications have been used in combination with therapy. Selective serotonin reuptake inhibitors (SSRIs) have proven to be effective in some cases. SSRIs do not treat the Selective Mutism but the anxiety symptoms which is a main etiological factor. These medications are usually given for 9 to 12 months.

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Rumination Disorder (307.53)

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DSM-IV-TR criteria

- A. Repeated regurgitation and rechewing of food for a period of at least one month following a period of normal functioning.
- B. The behavior is not due to an associated gastrointestinal or other medical condition (e.g., esophageal reflux).
- C. The behavior does not occur exclusively during

the course of Anorexia Nervosa or Bulimia Nervosa. If the symptoms occur exclusively during the course of Mental Retardation or a Pervasive Developmental Disorder, they are sufficiently severe to warrant clinical attention.

Associated features

- A child or infant with rumination disorder will often experience repeated regurgitation and/or re-chewing of food as well as weight loss, bad breath and tooth decay, repeated stomachaches and indigestion, and raw and chapped lips. Vomitus may be seen on the individual's chin, neck, and clothing, but the regurgitation is often not visible to others. When associated weight loss and growth failure occurs, it can often seem unexplained.
- In children and adults, regurgitation typically occurs within minutes of a meal and may last several hours. It generally occurs regularly after most meals. The individual with rumination disorder may appear to gain satisfaction from mouthing the regurgitated food rather than being disgusted by the vomitus, as well.
- The adult also experiences tooth decay and erosion as well as aspiration, but generally does not experience weight loss as with children and infants. The aspiration associated with this disorder can

cause recurrent bronchitis or pneumonia, bronchospasms, reflex laryngospasms, and asthma.

Child vs. adult presentation

- Little is known about the prevalence of rumination disorder. We do know that rumination has been reported in not only infants and adults with mental retardation but also in infants, children, and adults of normal intelligence.
- Lack of information on the prevalence of the disorder may be due to secrecy of those actually diagnosed.

Gender and cultural differences in presentation

Rumination occurs in both males and females, but seems to be more common among male infants. Rumination disorder has often been reported in other countries, but the frequency is unclear. Most of the studies conducted relating to the disorder have been shown to be unreliable.

Epidemiology

- Although there are no recent systematic prevalence reports of rumination disorder, the cases that have been studied and reported suggest that rumination is a very rare disorder. The typical age of onset is between the age of 3 and 12 months.
- In individuals with mental retardation, the onset of

this disorder can occur at any age, but typically occurs around the age of 6.

Etiology

- The exact cause of rumination is unclear. However, several theories, ranging from psychosocial to organic origins have been proposed. One of the most common psychosocial theories of the etiology of rumination disorder is the development due to an abnormal mother-infant/child relationship. In terms of this relationship, lack of stimulation, neglect, and stressful life situations are some of the factors associated with this disorder.
- One of the most common learning based-theories proposes that the development of this disorder is for the purpose of self-stimulation. The self-stimulation tends to increase after the pleasurable sensations produced by the process of rumination or the increased attention from others after the ruminating. Negative Reinforcement relating to stress may play a part in the cause of rumination.

Empirically supported treatments

- Treatment of this disorder often depends on the etiology and associated behavior. Treatment is usually a behavioral modification plan designed to

promote normal eating behavior. In this type of treatment, efforts are typically directed toward the parent-child relationship and are often focused on improving the caregiver's ability to recognize and respond to the child's needs in the appropriate fashion. Parents may be taught parenting techniques that aim to increase attention, interaction, and stimulation.

- Generally, rumination in infants of average intelligence stops on its own, but the disorder should still be treated because infants without treatment could experience malnutrition and dehydration, which could eventually lead to death.

Tourette's Disorder (307.23)

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DSM-IV-TR criteria

- A. Both multiple motor tics and one or more vocal tics must be present at the same time, although not necessarily concurrently (A tic is a sudden, rapid, recurrent, non-rhythmic, stereotyped motor movement or vocalization).
- B. The tics must occur many times a day nearly every day (usually in bouts) nearly everyday or intermittently over more than one year, and during this period there must not have been a tic-free

period of more than three consecutive months.

- C. The onset is before age 18 years.
- D. The disturbance must not be due to the direct physiological effects of a substance (e.g., stimulants) or general medical condition (e.g., [Huntington's disease](#) or positive encephalitis).

Associated features

- According to the American Psychiatric Association (2000), “associated features of Tourette’s disorder commonly include obsessions and compulsions. These can include clicking of the tongue, squatting, sniffing, hopping, skipping, throat clearing, and stuttering. Other common associated features are hyperactivity, distractibility, and impulsivity.” Rejection by others due to the tics and other disruptions can impair both functioning and acceptance in social, school, and work settings.
- Individuals with Tourette’s may also have an increased anxiety about having tics in social situations, causing them to stray away from going out or being accepted by others. “In severe cases of Tourette’s Disorder, the tics may directly interfere with daily activities, such as reading and writing” (American Psychiatric Association, 2000). Other disorders that are frequently associated with Tourette’s include Obsessive–Compulsive

Disorder, Attention-Deficit/Hyperactivity Disorder, and Learning Disorders (American Psychiatric Association, 2000).

- Epidemiology shows the high relevance of Tourette's Disorder to Obsessive-Compulsive Disorder; around 30% of children diagnosed with OCD also have Tourette's. On the reverse side, 60% of children with Tourette's will also generally have some form of OCD (Wagner, 2006, p.65). Furthermore, there are also signs of self-injurious behaviors, sleep disturbances, aggression, anxiety, and depression.

Child vs. adult presentation

- Tourette's Disorder appears to be more profound among boys than girls during early childhood, but to be more severe in women than men in adulthood.
- In most cases the disorder peaks in severity at 10-12 years of age. In about 25% of patients the disorder does not improve until adolescence. In 10% of patients the disorder is severe and persists through adulthood.

Gender and cultural differences in presentation

- Tourette's Syndrome occurs in people from all ethnic groups; males are affected about three to

four times more often than females. Through different cultures, it appears that associated features vary.

- In clinical settings the disorder is diagnosed approximately 3 to 5 times more often in males than in females, the gender ratio is perhaps low as 2:1 in community samples.

Epidemiology

- Since TS develops in the adolescence years and must be present before age 18, children are more likely to develop TS than adults. In fact, TS is known, for most cases, to decrease in severity and frequency and can even disappear entirely by early adulthood. TS has been reported in a wide variety of both racial and ethnic groups. TS occurs more frequently in males than females with a ratio of 1.5:3 times more likely (APA, 2000).
- A person with Tourette's has about a 50% chance of passing the genes to one of his or her children. Based on cases in North America and Europe, it tends to be most common in males. There is a male to female ratio of 3:1 or 4:1 and a mean onset age of about 7 years old. Vocal tics usually occur later than motor tics, around a mean of age 11.

Etiology

The etiology of TS is purely biological, but the disorder does have some psychological disorders associated with it. Some associated co-morbid disorders include obsessive compulsive disorder (OCD), anxiety disorders, learning disorders, and attention deficit/hyperactivity disorder (ADHD). TS is a neurological disorder that comes in two forms: genetic, or vulnerability, and non-genetic. The term “vulnerability”, means that the child has developed TS genetically. Individuals are at a greater risk for TS if they have a first degree relative who has the disorder. Not everyone who inherits the disorder with express the symptoms associated with the disorder, such as tics. There are a variety of ways that vulnerability can be expressed and include full-blown Tourette’s Disorder, Chronic Motor or Vocal Disorder, OCD, and some Attention/Hyperactivity Disorders (APA, 2000). When TS is said to be non-genetic, the individual usually will not have TS since it is a biological disorder associated with genes. The non-genetic individual could be experiencing tics from having another mental disorder, certain medications, or a general medical condition.

Empirically supported treatments

- The primary supported therapy for TS is habit reversal training (HRT). In HRT, a person first learns to know when and where he/she is going to have a tic, followed by development of competing

responses that prevent you from physically being able to perform the tic. These responses are held until the urge to tic dissipates. Over time, particularly with motor tics, the client learns that they do not need to tic to feel the release and relaxation. In many cases, TS can be effectively managed, and approximately one third of child patients can outgrow TS by adulthood. If TS is severe enough, antipsychotic medications can be helpful. These include but are not limited to Chlorpromazine, Haloperidol, and Pimozide.

- Alternative treatments for treating TS have proven to be helpful for patients. These complementative treatments are herbal medicines, nutritional, vitamin, and mineral supplements and behavioral therapies. It should be known that these treatments should be used as complementary and never as a substitute.

LINKS:

- Author David Sedaris describes his childhood with Tourette's. This story begins at minute 30:40 and ends at 45:30.
 - [David Sedaris and Tourette's](#)
 - "Edge of Sanity." This American Life. Chicago Public Radio. Feb. 4, 2000
- The following video discusses Tourette's

Syndrome. See Video: http://www.youtube.com/watch?v=hNSHLOI_-aU&feature=fvst. (uploaded by drmdk)

- A real life story of a young man with TS who has encouraging results with surgery. See video <https://youtu.be/nDkrD1uCGsM> <http://www.youtube.com/watch?v=nDkrD1uCGsM>. (uploaded by Westymedia)
- The following [link](#) from NPR's Day to Day program follows writer Marcus McPeck Villatoro as he discusses his and his daughter's Tourette's Syndrome.

Encopresis (307.7)

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DSM-IV-TR criteria

- A. Repeated passage of feces into inappropriate places, whether involuntary or intentional.
- B. At least one such event a month for at least 3 months
- C. Chronological age is at least 4 years (or equal developmental level)
- D. The behavior is not due exclusively to the direct physiological effects of a substance (e.g. laxatives)

or a general medical condition except through a mechanism involving constipation.

- *Code as follows:*
 - 787.6 – With Constipation and Overflow Incontinence
 - 307.7 – Without Constipation and Overflow Incontinence

Associated features

A child with Encopresis may be embarrassed or ashamed because of the soiling of clothing. They may often avoid social situations (e.g. summer camp or school). A sudden change in routine can also cause an increase in the risk. The soiling can often affect self-esteem in an individual with Encopresis. Smearing of the feces can often be caused by a child's attempt to clean up the feces. When the incontinence is deliberate it may have an association to Oppositional Defiant Disorder or Conduct Disorder. Many children with Encopresis and chronic constipation are enuretic and may be associated with vesico-ureteric reflux and chronic Urinary tract infections.

Child vs. adult presentation

- Primarily a childhood disorder.
- The disorder usually doesn't present itself until around the age of 4.

Gender and cultural differences in presentation

The disorder is thought to be more common in males than females, by a ratio of 6 to 1

Epidemiology

The prevalence of this disorder is approximately 1% of 5 year olds. Males are more likely than females to present with this disorder. May effect 1-2% of children under the age of 10. About 90% of cases are due to functional constipation.

Etiology

- There are two types of Encopresis, with constipation and overflow incontinence (787.6) and without constipation and overflow Incontinence (307.7).
- Encopresis without constipation and overflow incontinence: There is no evidence of constipation on physical examination or by history. Feces are likely to be of normal form and consistency, and soiling is intermittent. Feces may be deposited in a prominent location. This is usually associated with the presence of Oppositional Defiant Disorder or Conduct Disorder or may be the consequence of anal masturbation. Soiling without constipation appears to be less common than soiling with constipation.

- Encopresis with constipation and overflow incontinence: There is evidence of constipation on physical examination or a history of a stool frequency of less than three per week. Feces in overflow incontinence are characteristically (but not invariably) poorly formed, and leakage can be infrequent and continuous, occurring mostly during the day and rarely during sleep. Only part of the feces is passed during toileting, and the incontinence resolves after treatment of the constipation.

Empirically supported treatments

- There is typically three phase associated with the treatment process. The three phases of treatment are “cleaning out”, stool softening agents, and scheduled sitting times on the commode. The first phase “cleaning out” consists of an enema or suppository to help promote the removal of fecal matter from the colon. Phase two is often called the top down approach. The use of stool softening agents to help prevent constipation and thus reducing the probability of constipation. Phase three is a non medicated approach. This approach attempts to control excreting fecal matter by assigning specific times to use the restroom, decreasing the risk of constipation.
- Dietary changes are important

- Reduction in the intake of constipating foods such as dairy, peanuts, cooked carrots, and bananas.
- Increase in high-fiber foods such as bran, whole wheat products, and fruits and vegetables.
- Higher intake of liquids, such as juices, although an increased risk of diabetes and/or tooth decay has been attributed to excess intake of sweetened juices.
- ***Note*** - It is important not to punish or humiliate the child because this does not improve the situation.

Additional information can be found at the [Mayo Clinic](#) website on this disorder.

Reactive Attachment Disorder of Infancy or Early Childhood (313.89)

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DSM-IV-TR criteria

- A. Markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years, as evidenced by either (1) or (2):
 - (1) Persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or

highly ambivalent and contradictory responses (e.g., the child may respond to caregivers with a mixture of approach, avoidance, and resistance to comforting, or may exhibit frozen watchfulness).

- (2) Diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments (e.g., excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures).
- B. The disturbance in Criterion A is not accounted for solely by developmental delay (as in mental retardation) and does not meet criteria for a Pervasive Developmental Disorder.
- C. Pathogenic care as evidenced by at least one of the following:
 1. Persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection.
 2. Persistent disregard of the child's basic physical needs.
 3. Repeated changes or primary caregivers that prevent formation of stable attachments (e.g., frequent changes in

foster care).

- D. There is a presumption that the care in Criterion C is responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).

Specific types: Inhibited Type: if Criterion A1 predominates in the clinical presentation. Disinhibited Type: if Criterion A2 predominates in the clinical presentation.

Associated features

Certain situations may cause parents to develop a way of caring, known as pathological caring. These situations may include things such as long hospitalization of the child, extreme poverty, and the inexperience of the parents or caretaker (DSM-IV-TR, 2000). Pathological care is defined as a parental caring type in which they ignore the child's basic needs; these needs may be emotional and/or physical needs. Grossly pathological care does not always cause the development of Reactive Attachment Disorder (DSM-IV-TR, 2000). Some children cared for in this manner are still able to form "normal" social attachments. Extreme neglect does however increase the risk for development of Reactive Attachment Disorder. This disorder may also be associated with developmental delays, Feeding Disorder of Infancy or Early Childhood, Pica, or Rumination Disorder (DSM-IV-TR, 2000).

Child vs. adult presentation

Reactive Attachment Disorder typically begins before the child is 5 years of age. Remission of this disorder can occur by receiving proper care and a supportive environment. If such things are not provided, the disorder will follow a continuous course, causing the individual's inability to form "normal" social attachments. Therefore Reactive Attachment Disorder can present in both children and adults, but will ultimately be diagnosed in children before age 5 years.

Gender and cultural differences in presentation

There is no research indicating that there are gender differences in Reactive Attachment Disorder. Reactive Attachment Disorder is more commonly diagnosed in the UK . Also, this disorder may be more commonly diagnosed in children who live in inner city neighborhoods and rural areas. This is due to the fact that children may be subjected to severe isolation especially for those that are part of a minority group who are not properly cared for by their parents or guardians.

Epidemiology

- There is not much information or research found on Reactive Attachment Disorder. It is believed to be a fairly uncommon disorder.
- The prevalence of reactive attachment disorder has been estimated at 1% of all children under the age

of five. Children orphaned at a young age have a much higher likelihood of this problem.

Etiology

- All children are affected differently by pathogenic caring, some go on to develop attachments despite of the pathogenic caring, others do not.
- Reactive Attachment Disorder is mainly caused by abuse or neglect of an infant's needs (for example: food, physical safety, and touching).

Empirically supported treatments

- Little research has been done for the treatment of Reactive Attachment Disorder. Teaching the caretaker proper nurturing skills may improve Reactive Attachment Disorder in some children if the caretaker implements the newly learned skills into the child's life. Holding therapy is a possible treatment for Reactive Attachment Disorder, although there has been little research confirming its effectiveness. This procedure consists of the mother or the caretaker holding the child while incorporating eye contact, touch, smiling, and talking. The anticipated end result is recreating the bond between caretaker and child that was not present when the child was an infant.
- Behavioral Management Training has been seen as

a fairly effective treatment for Reactive Attachment Disorder. Children undergoing Behavioral Management Training show decreased problematic behaviors as well as increased compliance with caregiver and teacher commands. These children also show increased play with age-appropriated peers.

LINKS:

- A story about a couple who adopted a son from a Romanian orphanage when he was seven years old. During the time he was in the orphanage, he lived in a crib with another child and never developed relationships with his caregivers. About six months after he was adopted, he began acting out and was later diagnosed with Attachment Disorder. Story begins at minute 9:30 and ends at minute 36.
 - [Attachment Disorder](#)
 - “Unconditional Love.” [This American Life](#). Chicago Public Radio. Aug. 31, 2007

Separation Anxiety Disorder (309.21)

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=331#oembed-1>

DSM-IV-TR criteria

- A. Developmentally inappropriate and excessive

anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:

- recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
- persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
- persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
- persistent reluctance or refusal to go to school or elsewhere because of fear of separation
- persistent and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
- persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
- repeated nightmares involving the theme of separation

- repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, and vomiting) when separation from major attachment figures occurs or is anticipated
- B. The duration of the disturbance is at least 4 weeks.
- C. The onset is before age 18 years.
- D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
- E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder With Agoraphobia.
- Specify if:
 - **Early Onset:** if onset occurs before age 6 years

Associated features

- When separated from the home of family, people with Separation Anxiety Disorder may exhibit sadness, apathy, social withdrawal, difficulty

concentrating on play and/or work. Also, depending on one's age, they may be scared of animals, monsters, darkness, plane travel, burglars, kidnappers and other situations that might be dangers to their family or themselves. Because the child might be scared of leaving their family, they may refuse to attend school which may cause school and academic difficulties and social avoidance. When left alone, young children may report seeing people strangers entering their room, seeing monsters and other creatures, and also seeing eyes following them around.

- Studies show that children suffering from separation anxiety disorder are much more likely to have ADHD, bipolar disorder, panic disorders, and other disorders later in life.

Child vs. adult presentation

- Separation Anxiety Disorder is seen in all age groups, but adult separation anxiety disorder is seen in about 7% of adults. Childhood separation anxiety disorder is seen in about 4% of children.
- The manifestations of the disorder may vary with age. Younger children may not express specific fears of definite threats to parents, home, or themselves. As children get older, worries or fears are often of specific dangers. Anxiety and

anticipation of separation become manifest in mid-childhood.

- Adults with this disorder are typically overly concerned about their offspring and spouses and experience marked discomfort when separated from them.
- *** The prevalence of separation anxiety disorder is slightly more frequent in females than males; the prevalence of school refusal is approximately equal between males and females.**

Epidemiology

- The prevalence of this disorder is estimated to have an average of about 4% in children and young adolescents. For children age 7-11, it is seen in about 4.1%. Children between the ages 12-14 show a prevalence of about 3.9%, and teens from 14-16 have about 1.3% that suffer from separation anxiety disorder.
- In clinical samples, the disorder is apparently equally common in males and females.
- In epidemiological samples, the disorder is more frequent in females.

Etiology

Studies have shown that children who are raised by a parent having anxiety disorders are more likely to develop anxiety disorders themselves. Experts have postulated that early and traumatic separation from the attachment figure may increase the likelihood of the child and, later on, the adolescent or adult developing separation anxiety disorder. Also traumatic experiences, a serious separation, stress in the family, a significant change, and an illness are all possible cause that might trigger Separation Anxiety Disorder.

Empirically supported treatments

One of the treatments used for this disorder is social skills training. This treatments deals with things like skill awareness, situational awareness, practice and role play. Another form of treatment is cognitive behavioral therapy, where the therapist teaches the child to challenge negative thoughts, develop new, positive thoughts, and practice alternative behaviors. Furthermore, reassurances of love, safety, and preparation for the child for upcoming separations will benefit the child in the long run.

A brief explanation of Separation Anxiety Disorder

Reading Disorder (315)

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DSM-IV-TR criteria

- A. Reading achievement, as measured by individually administered standardized tests of reading accuracy or comprehension, is substantially below that expected given the person's chronological age, measured intelligence, and age-appropriate education.
- B. The disturbance in Criterion A significantly

interferes with academic achievement or activities of daily living that require reading skills.

- C. If a sensory deficit is present, the reading difficulties are in excess of those usually associated with it.

Coding Note: If a general medical (e.g., neurological) condition or sensory deficit is present, the condition code on Axis III.

Associated Features

A reading disability is a learning disability that involves significant impairment of reading accuracy, speed, to the extent that the impairment interferes with academic achievement or activities of daily life. People with reading disabilities perform reading tasks well below the level one would expect based on their general intelligence, educational opportunities, and physical health.

Reading involves several steps, including: pronunciation, phonics, silent letters, word recognition, and so forth. People with reading deficiencies can exhibit difficulties in one or more of these areas. For people who experience a reading deficiency, there is a considerable gap between the actual level of achievement and the expected level of performance. People with reading disabilities might experience the following: slow reading speed, poor comprehension, omission of words, reversal of words or letters, difficulty

decoding syllables or single words and associating them with specific sounds (phonics), and limited sight word vocabulary.

Children who experience a reading disability tend to experience more negative emotions than children who have typical reading skills. Some negative emotions that have been associated with reading disabilities are: shame, low self-esteem, and lack of motivation. Consequently, this may have a negative effect on their academic work and achievement level, even if they are of average or normal intelligence. The deficiency can also negatively impact a person's motivation to advance in their reading abilities, which in turn leads to a lower self-esteem. Oftentimes, peers make fun of a child's reading ability, or lack thereof, because he/she often reads slowly and often needs help pronouncing what other children view as simple words, which leads to a child's feelings of shame.

Teachers can usually identify children with this disorder when doing "popcorn reading," or reading aloud. Children with reading disabilities greatly benefit from a learning environment, in which a teacher has adjusted her curriculum and teaching style to meet their specific needs. Some techniques that teachers can use to help children are: individual reading time, clapping to the rhythm of the different phonemes, tutoring, reading shorter passages, pairing with skilled readers on topic tasks, and picture and physical action association. It is very important for parents and teachers to maintain a positive attitude towards the child. Continued reassurance, maintaining frustration levels low,

providing flexibility, and providing realistic expectations are critical to reduce negative emotions and provide positive methods for children to cope with their disability. Children who receive early diagnosis and treatment for their reading disorders experience less negative emotions and negative life impacts, such as school drop out, as opposed to children who do not receive early intervention. This rate of improvement is at an astonishingly 90 to 95%.

Child vs. Adult Presentation

About 4% of school-age children in the United States are diagnosed with reading disability. Children are usually presented with a reading disability when they start kindergarten or first grade, when reading skills are first developed. Since learning disabilities, are life-long, they persist into adulthood. If a person receives adequate intervention and treatment for their disability while in school, they will usually have learned coping skills by the time they enter adulthood. In contrast, if coping skills are not learned, they could continue to struggle as adults and fall into socially unacceptable lifestyles, such as substance abuse or other crimes.

Gender and Cultural Differences in Presentation

Sixty to 80% of children who are diagnosed with reading disabilities are male. The prevalence in females with the disability may be underestimated, since males tend to be more disruptive in class and referred to special education classes

more often. Females, on the other hand, tend to quietly disassociate or daydream in expression of their disability. For the purpose of ruling out cultural differences, a random sample of the population is tested in addition to any individualized testing is performed as a diagnostic tool.

Twin Studies

- Dyslexia was found in 80% or higher of monozygotic twins. The reason the concordance is so high is because monozygotic twins have the same genotype, as opposed to dizygotic twins. In other words, monozygotic twins share the same environment and, therefore, share heritability.
- Depending on how strict the criteria is in a given country, the incidence and prevalence figures for Reading Disorder may vary from place to place.

Epidemiology

It is approximated that between five and fifteen percent of the general population has a learning disorder and about eighty percent has a reading disorder. Studies also suggest that about four percent of school-age children have a reading disorder.

Symptoms of difficulty in reading can be seen as early as Kindergarten, but they are seldom diagnosed before the end of Kindergarten or the beginning of first grade, because formal reading instruction does not begin until that time. A reading disorder may go unnoticed for a while for children

with a high IQ, because those children might function at or near their appropriate grade level in early grades. Their disorder could become more apparent, however, in fourth grade or later when the mass amount of new information makes it nearly impossible for them to hide their disorder any longer. For cases with early intervention, the prognosis is positive although the reading disorder may persist throughout their adult life.

Etiology

Reading is an intricate task, that requires eye muscle coordination, spatial orientation, visual memory, sequencing ability, an understanding of sentence structure and grammar, and the skill to categorize and analyze individual letters and a combination of letters. The brain must also be able to incorporate visual cues with memory and associate them with specific sounds. These sounds are then associated with specific meanings which must be retained while a sentence or passage is being read. When any of these processes are disrupted, a reading disorder can occur. Therefore, the cause of reading disorder is difficult to pinpoint. However, research has found that this disorder may be partially inherited. Therefore, reading disorders are more common in children that have a first-degree biological relative with a learning disability. By evaluating the reading and writing abilities of about 80 family members across four generations, researchers were able to isolate mutations in specific genes that were associated with reading and writing short comes (Davidson). Other

theories suggest that problems in certain locations of the brain may cause a reading disorder. Studies have shown that the left-hemisphere posterior brain system does not respond correctly when people with the disorder are reading. Also two different systems function to develop a reading ability; an initial system that recognizes phonetics located in the parieto-temporal region and a decoding system used by more skilled readers in the occipito-temporal region that recognizes sight vocabulary. People with a reading disorder demonstrate a low activation of both these areas and an increased activation of the frontal gyrus which causes letter to sound decoding. There may also be a visual or auditory processing deficit, such as having problems moving the eyes to follow text and moving the eyes back and forth across a line. This would not be a problem in seeing, but in processing information from the eyes and in using the eyes to get information.

Reading Disorders aggregate familiarly and is more prevalent among first-degree biological relatives of individuals with Learning Disorders.

Empirically supported treatments

Early intervention is essential to the individuals well being. Customized education plans that has a cross-disciplinary educational approach is a treatment option. Many of the successful programs all use systems that are sound or symbol based, which breaks down the words into letters and sounds. Also, they attempt to build and reinforce mental associations using visual, auditory, and kinesthetic channels of

stimulation. They simultaneously see, feel, and say the sound-symbol association by tracing the letters with their finger while pronouncing a word out loud for example. The programs are also highly structured, beginning with the sound of a single letter, working up to a pair of letters, then syllables, and then into words and sentences. By doing repetitive drill and practice, they will be able to form essential associations between sounds and symbols which may help them overcome their reading disorder (Davidson). Also, graphic organizers have a beneficial effect and are more beneficial when created by the student. These graphic organizers are visual methods of highlighting important information. They link what the student already knows with what they are trying to learn. For those with dyslexia, reading with an index card with a window cut in it is also helpful, as is reading with special colored filters.

Autistic Disorder (299.00)

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Introduction

Autism is the most commonly studied of a spectrum of developmental disorders that are believed to be neurobiologically based but which, at this point, for lack of good biomarkers, are defined purely by behavior. In the last 20 years, the definition of autism has shifted in emphasis from extreme aloofness and positive signs of abnormality in repetitive and sensorimotor behaviors to a greater awareness of the importance of more subtle reciprocal social communication deficits as core features. Standard diagnostic

instruments were developed for research purposes to acquire information both through caregiver interviews and direct clinical observation. Use of these instruments in clinical practice resulted in major improvements, which in turn affected research results. These results yielded further improvements that led to changes in clinical practice over time (Lord, 2010).

Autistic Disorder is referred to several different ways including early infantile autism, childhood autism, or Kanner's autism.

Autism is the most representative type of PDD, as well as the most researched. This subtype was first characterized by Leo Kanner in 1943 (Hoffman, 2009).

He reported several principal distinctions of the disorder, to include the following:

- inability to relate socially
- inability to convey meaning through language
- insistence on sameness in daily routines.

He also asserted that this disorder was innate, which reflects our current research on the heritability of autism.

DSM-IV-TR criteria

A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

- 1. Qualitative impairment in social interaction, as

manifested by at least two of the following:

- Impairments in social interaction may include the following (Hoffman, 2009):
 - Pronounced deficits in non-verbal social behavior
 - Lack of eye contact
 - Facial expressions
 - Body posturing
 - Gesturing
 - Lack of age-appropriate peer relationships
 - Possibly interacting with parts of people
 - Absence of spontaneous attempts to share interests or pleasure with others
 - Not pointing to or showing things to others
 - Lack of social/emotional reciprocity
 - Lack joint attention
 - Fail to share actively with other's activities

or interests

- Act as if unaware of the presence of others
 - Select solitary activities
- 2. Qualitative impairments in communication including both verbal and nonverbal communication, as manifested by at least one of the following (Hoffman, 2009):
 - Delay or absence in spoken language
 - not compensated for by attempts to communicate nonverbally
 - Inability to converse appropriately with others regardless of the presence of speech
 - Odd, stereotyped, repetitive uses of language
 - Absence of imaginative or pretend play
 - There is also a great deal of variability in communication...
 - Ranging from the absence of expressive or receptive language to fluent speech with semantic/inappropriate social uses.
 - Echolalia is the repetition of a phrase heard in the present or

the past.

- Occurs in up to 75% of individuals with PDD who are verbal
- This characteristic is a cardinal feature of autism.
- Receptive language continues to impair social communication in that individuals have difficulties in understanding abstractions.
 - Echolalia and receptive language are not utilized in a functional communicative fashion by those with autism.
- Restricted and stereotyped behavioral patterns require at least one of the following criterion (Hoffman, 2009):
 - Restricted interests that are abnormally intense
 - Can range from cars and trains to numbers and letters
 - Inappropriately intense or odd

in their content

- Rigid adherence to routines or rituals
- Repetitive motor mannerisms
 - Opening and closing doors
- Preoccupation with parts of objects
 - May become overly interested in moving parts of objects
- Compulsive behaviors
 - Lining up objects in a specific way
 - Slight alterations in routines can cause behavioral outbursts
- Motor stereotypes
 - Hand or finger-flapping
 - Rocking
 - Spinning
- Non-specific motor abnormalities
 - Toe walking
 - Unusual hand movements or body postures
- Continuous course for those with autism however, school-aged children may show improvements in social, play, and

communicative functioning, which ultimately can improve further intervention.

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

Associated features

- Children tend to be diagnosed with autism at a fairly young age due to early signs and symptoms
 - Usually, during the first three years, the child starts to exhibit autistic actions.
- Children with autism tend to have difficulties with attention, concentration, and behavior.
- Sometimes, the behavioral problems the child displays could consist of things such as self-injurious behavior (e.g. biting oneself, slapping, hair pulling, or head banging) or aggression towards others (e.g. biting others,).
 - Self-injurious behavior may be more linked to mental retardation.
 - Symptoms can generally be seen before 12 months, but at least by 24 months.

- Distinguishing between current and lifetime symptoms is very important.
 - One has to consider the developmental appropriateness of behavior.
 - Research suggests that imaging studies may be abnormal in some cases but there has been no distinct pattern to suggest this is the most valuable resource available to diagnose Autistic Disorder in an individual.
 - EEGs are often useful in detecting abnormalities in these individuals even in the absence of seizure disorders.
- Many individuals with autism might struggle with social interaction.
 - “Simple” social interactions tend to be more difficult for autistic individuals.
 - Sharing information or feelings with others are found to be very uncomfortable and uneasy for autistic individuals.
 - Individuals with Autistic Disorder often take speech literally.
 - For example, if one were to say that it is raining cats and dogs, the autistic individual would

expect for it to literally be raining cats and dogs.

- It is often difficult for an individual with autism to interpret humor in normal social conversations due to the lack of communication skills that they possess.
 - Significant impairments in eye-to-eye contact, facial expressions, body posture, and gestures make it extremely difficult for a person with autism to maintain social interactions and communication with their peers.
 - Failure to develop relationships with peers sometimes results in the formation of others that are inappropriate to the autistic individual's developmental level.
- Speech can be difficult for people with autism and may come in various forms
 - [echolalia](#) (the involuntary repetition of words spoken by another person)
 - unusual word use

- irregular syntax
 - Impairments in pitch, intonation, rate, or rhythm
 - stress placed on certain words may also be abnormal
 - Nonverbal cues tend to be misunderstood
- Related symptoms of Autism
 - Lack of eye contact
 - slow developmental skills
 - indicating needs by gestures
 - resistance to change in routine
 - hyperactivity or extreme passivity
 - resisting cuddling
 - “standoffish” attitude
 - eating disturbances
 - resisting learning
 - no fear of real dangers
 - exhibiting abnormal fears of everyday objects related to sensory experiences (e.g. trains)
 - display over and under reaction to sounds with a

hypersensitivity to certain textures

- out of place laughing or crying
- inappropriate attachment to objects
- basic difficulties
 - (e.g. sleeping)
- requiring less sleep for normal functioning
 - Lack of sleep disturbances or need for sleep seems to improve over time, but more research is needed
- not demonstrating affection easily
- savant abilities
- expression of frustration through self-injury like head banging
 - could be a closer link to mental retardation. .
- Eating disturbances
 - unusual food rituals and preferences
 - continue to adulthood
 - People with autism display over and under reaction to sounds

with a hypersensitivity to
certain textures

- High pain tolerance
- exhibit primitive reflexes, delayed development of hand dominance, and other nonspecific neurological symptoms
- Particularly in adolescence, as many as 25% of the cases diagnosed with autism may develop seizures.
- Blueeler first used the term “autism” to describe schizophrenics who had lost touch with reality.
 - Mothers and fathers are seen as responsible for the development of the disorders and are described as “refrigerators” and “freezers.”
 - Calling the parents of Autistic children “refrigerator mothers” and “freezer fathers” was in attempts to describe their personalities towards their children as cold and emotionless therefore leading to the child’s disorder.
 - There have been group deficits in affecting social, affective, linguistic, behavioral, and cognitive development.

- Prior to age three, there are delays in social interaction, language as used in social communication, and symbolic or imaginative play.
 - There are deficits in social abilities that seem to be due to impairments in understanding and responding to social information. Also impairments in imitative abilities, both immediate and deferred, have been linked to expressive language deficits later.
 - There are joint attention skills that are impaired compared to others of the same intelligence and decreased orientation to stimuli, especially social.
 - Facial perception is also impaired, and people with autism are less likely to recognize someone they have already seen.
 - A person with autism may focus on abnormal areas of the face, like looking at a

person's mouth instead of in their eyes when communicating.

- Delays in language precursors cause significant problems with language such as echolalia, abnormal prosody, and pronoun reversal or only using names later in life.
- Social or pragmatic language is most impaired such as using irrelevant details, preservation, inappropriate shifts in topics or ignoring social cues and intentions of the other person in conversation may be due to “mind-blindness.”
- People with relatives that are autistic are more likely to also ignore social cues such as being unable to detect when another person needs or wants to leave a conversation.
- Individuals with Autistic Disorder often lack the ability to interpret slang phrases in normal conversations.
 - An individual with Autism will take everything that is said in a

conversation literally which, unfortunately, makes communication even more difficult.

- Kanner and Asperger described different types of autistic children in the 1940s.
 - Asperger saw deficits in pronoun reversal, echolalia, and social interaction problems.
 - Kanner saw the same deficits with language problems added.
 - Early signs are affective, social, behavioral, and cognitive development. Impairments in understanding and responding to social information and there are secure attachment patterns that are seen in 40 to 50 percent of autism children, contrasting with 65 percent in the general population.
 - Imitative abilities have been linked to different disorders later in development.
- There has been some talk of autistic children possessing special talents and abilities due to their condition.

- Musical ability, math skills, and reading/writing abilities have all been publicized.
 - Though all of these abilities have appeared in autistic children, it is pretty rare.
 - When these skills do appear, they seem to be caused not by increased mental ability but from lack of social skills causing an increased ability to concentrate.
 - With no other distractions, the increased attention span allows the child to learn to full ability.
- People who report higher degrees of autism traits also report experiencing increased difficulties with executive control.
 - In addition, ASD and ADHD traits were associated with unique contributions to the executive control profile of individuals with subthreshold autism symptomatology (Christ, Kanne, & Reiersen, 2010).
- It is sometimes difficult to diagnose autistic

symptoms masked by intellectual disabilities.

- Research on the prevalence of autism in Iceland has indicated that one possible explanation of fewer autism cases in older age groups was due to an underestimation of autism in individuals with intellectual disabilities (IDs).
 - The study identified twice the number of autism cases than those previously recognized within the service system.
 - Autism is a prevalent additional handicap in individuals with severe ID, which should always be considered in this population (Saemundsen, Juliusson, Hjaltested, Gunnarsdottir, Halldorsdottir, Hreidarsson, et al., 2010).
- Cognitive disabilities are not part of the DSM-IV-TR criteria; however, most children with autism suffer from mild to profound mental retardation (Hoffman, 2009).
 - Nonverbal skills are superior to verbal skills
 - Irregular and variable allocation of cognitive abilities
 - Can be comorbid with conditions causing mental retardation

- Fragile X Syndrome
- Tuberous Sclerosis
- Females with autism suffer more severe mental retardation
- Seizure disorders are common in autism and other PDDs
- Evidence that head circumference is normal at birth and results in macrocephaly (larger head) by 6-12 months
 - Abnormal response to stimuli
 - Hypersensitivity to noise
 - Decreased sensitivity to pain
- Facial recognition is usually impaired (Hoffman, 2009).
 - Evidence of decreased activation of the fusiform region and amygdala when perceiving faces
 - Several studies show evidence of children diagnosed with autism spend more time focusing on individual's mouths and bodies vs. eyes, thus causing them to miss social cues.

Child vs. adult presentation

- Children tend to be diagnosed at a very young age
 - extremely rare to diagnose an adult with autism
 - Autism is a lifelong disorder.
 - The MMR vaccinations given to some children presumably caused autism
 - no concrete evidence to support that theory
 - Currently in the United States, 300,000 individuals have autism
 - 270,000 are thought to be young children
 - Approximately 14,000 older children
 - An estimated 22,000 adolescents and adults
- some other prevalence rates in the overall population for autism tend to be shown in ways such as:
 - 90% of costs are in adult services
 - 1 in 150 births are autistic
 - 1.5 million Americans may be affected

with autism

- 10-17% annual growth.
- 1 to 2 per 1,000 in children
- 60 cases per 10,000 children
- Parents often mistake autism in infants as deafness due to the following characteristics:
 - failure to cuddle
 - indifference or aversion to physical contact or facial responsiveness, or smiles
 - failure to respond to parents' voices.
- There is no period of unequivocally normal development
 - Almost 20% of parents report normal development for 1 to 2 years
 - Often appear to stagnate developmentally
 - Normal development of vocabulary is limited.
 - Young children may treat adults as interchangeable, cling to a specific person, or use a parent's hand to obtain objects without ever making eye contact
 - Over time, the child may show increased interest in social interaction, although still

treating people in the usual ways.

- In others, tasks involving long-term memory may be excellent, but the information tends to be repeated regardless of its appropriateness.
- Children and adolescents have difficulty in their ability not only to communicate verbally but also have problems with written expression.
 - It is difficult for them to interpret written language, analyze, and then respond to what they have heard which makes educating an autistic child extremely challenging.

Twin and family studies have established that there is a strong genetic basis for autism spectrum disorders. To facilitate the identification of susceptibility genes and to study pathways from gene-brain to cognition a more refined endophenotype-based approach may be useful. The neurocognitive endophenotype of autism was examined in families with multiple incidence autism. Children with autism showed weak central coherence but this “trait” could not be found in their parents nor in non-affected siblings. All family members, including the sibpairs with autism, showed deficits within executive functions, involving planning ability, but normal set-shifting. The sibpairs with autism—but

not their other family members—showed significant correlations within two visuo-spatial tasks. Deficits in executive functions (specifically planning ability) appear to characterize the broader endophenotype of autism (Nyden, Hagberg, Gousse, & Rastam, 2011).

Motor skills were assessed in toddlers and it was demonstrated that atypically developing toddlers exhibited significantly greater motor skill abilities than toddlers with autistic *disorder*. No significant difference on gross or fine motor skill abilities were found between atypically developing toddlers and toddlers with *pervasive developmental disorder—not otherwise specified* (PDD-NOS), or between toddlers with autistic *disorder* and toddlers with PDD-NOS. Gross and fine motor skills were found to be more impaired for toddlers with autistic *disorder* compared to the atypical development group. Furthermore, differences in gross or fine motor skills between the autistic *disorder* and the PDD-NOS group approached significance. (Matson, Mahan, Fodstad, Hess, J., & Neal, 2010).

There is a relationship between child symptom severity, parent broader autism phenotype (BAP), and stress and depression in parents of children with ASD. Parents reported elevated parenting stress and depression relative to normative samples. A path analysis indicated that both child symptom severity and parent BAP were positively correlated with these outcomes. The relationship between BAP and the outcome measures was partially mediated by maladaptive coping and social support and the relationship between child symptom

severity and outcomes was partially mediated by social support (Ingersoll, & Hambrick, 2011).

Gender and cultural differences in presentation

Autism is more prevalent in boys than in girls with a 3 or 4:1 ratio, although females exhibit more severe mental retardation. Autism knows no “ethnic boundaries” because it is seen throughout the World. In some studies; however, some countries have higher percentages of autism. It is noteworthy that in one study Denmark and Finland were at 29.5% and 18% as two of the highest countries with autism in that one study. Autism is found throughout an assortment of geographical locations, social groups, and ethnic groups. Females tend to have lower intellectual functioning and more severe symptoms. Higher functioning females, however, show less severe symptoms than matched males.

The rates for autism is also affected by the size of the population, with larger populations having more cases of the disorder such as the U.S.

Epidemiology

In 1996 it is reported that 1 in 10,000 people were diagnosed with autism with a rate of 10-17% annually. About 10% of those with autism are [savants](#). Autism is sometimes resembled by developmental language disorder and childhood-onset schizophrenia. Co-morbidity rates vary greatly by disorder and reveal that 40-69% have mental retardation, widely varied rates of depression and anxiety. The diagnosis of

Mental Retardation in individuals with Autism can range from mild to profound. Tic behaviors are more common than in the population and high rates of seizure disorders also. Population estimates range from 16-62 per 10,000 across all PDDs. Most parents report symptoms before 12 months, but average diagnosis is at four years. There are instruments for early screening available but have their limitations. There is a lack of transition from university based to school based intervention programs that has hampered early intervention programs.

The onset of Autistic Disorder is prior to age three. Some parents will report being worried about the child since birth or shortly thereafter. In some cases, the child may have been developing normally during the first year. Autism has a continuous course. In children, developmental gains in some areas are common, but some individuals deteriorate during adolescence. Language skills and intelligence are the strongest factors related to prognosis. Only a small percentage go on to work and live independently. In about one-third of cases, some degree of partial independence is reached. Many facilities to improve daily living skills have been developed in order to teach those with Autistic Disorder daily living skills to provide a higher quality of life and independence. The highest functioning with Autism usually continue to show problems with social interaction and communication with restricted interests.

Etiology

Genetic factors appear to have a large effect on autism. Most autistic children inherit autism from their parents. There is an increased risk for autism among siblings of the individual with this disorder. It has been found that approximately 5% of siblings are also afflicted with this condition and may also be at higher risk for developmental delays.

Environment is a huge cause of autism. Exposure to chemicals in the environment are “neurodevelopmental toxins” for the baby.

Mercury, polychlorinated biphenyls, lead, brominated flame retardants and pesticides are all chemicals that with exposure could cause harm to a child. People with relatives that have autism are more likely to be autistic. There are two courses typically seen that include a symptom onset before twelve months, and a regular development followed by a loss of skills or regression before three years, primarily language. Seventy-five percent will not live independently, even with early interventions. High IQs and early development of social communication skills are related to better prognosis. Effective programs have high levels of family involvement, strategies for generalizing learned skills with a functional approach to problem behaviors. There is also common curriculum focusing on attention/compliance, motor imitation, communication, appropriate toy use, and social skills. There are high structured environments with low student-to-staff ratio.

Contrary to widespread beliefs in certain communities,

there is **no** link between childhood vaccinations and autism. Indeed, in 2010 the British medical journal *The Lancet* [retracted](#) the original 1998 paper by Andrew Wakefield that raised the possibility of a connection, citing concerns about [ethical violations](#). In particular, Wakefield was found to have “been dishonest, violated basic research ethics rules and showed a “callous disregard” for the suffering of children involved in his research.” For more, please visit [this NY Times article](#).

Empirically supported treatments

Pivotal Response Training (PRT) has been seen as an effective treatment for children with autism. The effectiveness of PRT increases the earlier the child begins the treatment (ideally before the age of four). PRT focuses on enhancing the relationship between social communication responses and the consequent reinforcers of such responses appear to increase behaviors characteristic of motivation and improve environmental and social interactions (Kazdin, 2003).

Interventions in which the child responds to a combination of maintenance and acquisition tasks, as seen in PRT, have resulted in improved correct responding (Dunlap, 1980), increased rate of target behavior acquisition, and positive child affect (Dunlap, 1984).

In children: parents, teachers, and therapists work together in efforts to help social adjustment and speech development. Typically, autistic children that are lower functioning are

placed in a self-contained classroom in order to receive instruction which encompass daily living skills as well as general education. The education is adapted to each individual child's developmental age with the goal to reach their biological age.

Behavioral treatment therapies should include clear instructions, performance of specific behaviors, immediate praise and rewards for performing the specific behaviors, gradual increase in complexity of behaviors, and definition of when and when not to perform the behaviors. Techniques such as redirection are used to combat negative behaviors both inside and outside the classroom in order to focus an autistic individual to perform the task at hand.

A loving and supportive family is important. Parents should be involved in treatment therapies. Good communication between the family, therapists, and educators are essential. It is important for the parents to be involved in the creation of an individual education plan (IEP) in order to set goals for their autistic child. This allows both parents and educators to be on the same page as to the steps they will take in order to achieve these goals. It is vital that tasks and behavior reinforcements maintain consistency between home and school.

Empirically supported diagnostic tools

Autism can be separated into high functioning (HFA) and low functioning (LFA). Some of the instruments used to diagnose autism are the Checklist for Autism Spectrum

Disorder (designed for children with LFA and HFA), Childhood Autism Rating Scale (CARS) for children with LFA, and Gilliam Asperger's Disorder Scale (GADS) with HFA. For children with LFA, classification accuracy was 100% for the Checklist and 98% for the CARS clinician scores. For children with HFA, classification accuracy was 99% for the Checklist and 93% for the GADS clinician scores (Mayes, Calhoun, Murray, Morrow, Yurich, Mahr, et al., 2009).

Experimental Psychology and Autism

Ropar, Mitchell, and Ackroyd (2003) performed an experiment to determine if children with autism had difficulty making alternative interpretations to ambiguous figures. The researchers had participants complete three different types of tasks. One of these types was an example of a theory of mind task. Ropar et al. (2003) showed participants a picture of a flower mostly covered up with a piece of paper that had a small square cut out of it. The square window displayed only a few lines of the flower drawing. Participants were asked what they thought the picture depicted. After the participants answered, the researchers uncovered the flower and again asked participants what they thought the picture was. Next, the researchers covered the flower drawing up with the paper mask, so that the square window again only showed a small portion of the picture. Participants were then asked what a friend might think the picture was of. Participants passed the theory of mind task if they correctly

answered that another person would not know that the mostly covered picture was a flower. Participants did not pass the theory of mind task if they stated that another person would know that the picture was a flower (Ropar et al., 2003). The participants in this experiment were children with autism, children with moderate learning difficulties, and children of typical cognitive development. Results from the researchers' experiment indicated that few children with autism provided correct answers on this task, while each child in the control group answered correctly (Ropar et al., 2003). These results suggest that children with autism have difficulty perceiving others people's personal mental space.

It is important to examine practical applications of previous and current research on mental space, ambiguous figures, and theory of mind. For example, autism is a neural developmental complication characterized by constrained social interaction and communication. Research may indicate that children with autism have difficulties with ambiguous figure reversals and theory of mind tasks, which are related to impaired social skills (Gopnik & Rosati, 2001). Specifically, it has been postulated that social withdrawal in children with autism is correlated to lack of fixation on faces (Riby & Hancock, 2009). In a recent study, Riby and Hancock (2009) used a Tobii 1750 eye-tracker to record the fixation duration on faces by participants with and without autism. The researchers had participants view two kinds of pictures displayed on a computer screen. The first set of pictures depicted natural landscapes. Half of these pictures contained

only landscapes, while the other half had small faces embedded in the scene (Riby & Hancock, 2009). The second set of pictures depicted scenes with people in them that had been scrambled so that each square was a piece of the picture, but out of order (Riby & Hancock, 2009). The experimenters' results indicated that participants with autism made significantly shorter face fixations than participants that were typically developed.

Eye fixation research has many applications in psychology. Eye-tracker devices can measure eye fixations on different cognitive tasks such as processing linguistic information, reading, problem solving, processing spatial information, and processing real-world scenes (Just & Carpenter, 1976). Other research with eye-trackers has shown that adults of normal cognitive functioning fixate mostly on the eyes when viewing faces (Walker-Smith, Gale, & Findlay, 1977). However, people with autism tend to spend less time fixating on the eyes and other defining features of faces (Boraston & Blakemore, 2007). According to Boraston and Blakemore (2007) "... eye-tracking could be a way of closing the gulf between performance on cognitive tests and everyday social ability of individuals with autism" (p. 895).

Impaired performance in a range of imitation tasks has been described in children with autism spectrum disorders (ASD) and several underlying mechanism have been suggested. It has been examined whether imitation abilities are related to autism severity and to motor skills. Furthermore, the performance of children with ASD in four

imitation situations (body movements and “action on objects”, using meaningful and non-meaningful tasks) was compared. Comparison of the four imitation situations revealed that performances of meaningful actions were better than non-meaningful actions and imitation of “action on objects” was better than imitation of body movements. The current research supports the fact that socio-communication deficits and not motor abilities are linked to imitation abilities in young children with autism (Zachor, Ilanit, & Itzchak, 2010).

Atypical forms of autism may yield insights into the development and nature of the syndrome. A study of nine congenitally blind and seven sighted children who, eight years earlier, had satisfied formal diagnostic criteria for autism and had been included in groups matched for chronological age and verbal ability. A substantially higher proportion of blind (eight out of nine) than sighted (none out of seven) children now “failed” to meet formal DSM criteria for autism. Follow-up of nine congenitally blind children with autism revealed that, in adolescence, only one still satisfied diagnostic criteria for the syndrome (Hobson & Lee, 2010).

Links

- [Interview with Temple Grandin](#). After she was diagnosed with autism as a child, her parents were told to have her institutionalized, which they refused to do. Today, Temple is a professor at Colorado State University and has written multiple

books about the similarities between autistic thought-processes and animal behavior.

- “Temple Grandin: A Key To Animal Behavior.” Fresh Air. National Public Radio. January 11, 2005
- [Where are we with the Autisms?](#) on YouTube
- [Autism signs, symptoms often missed by parents.](#)
- Journal article “[Researchers pinpoint potential cause of Autism](#)“
- What does a person with autism look like? How do they act? View [this YouTube video](#) and find out.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://ffsu.pressbooks.pub/abnormalpsych/?p=335#oembed-1>

- Kim Peek was an American savant with a pervasive developmental disorder. He did not have autism, though he was the inspiration for the character with autism (Raymond Babbitt) in the film “Rain Man”. The following links are part of a five part video clip series. Only four are displayed.

STEPHANIE WEIGEL

- [Kim Peek: The Real Rain Man](#) 2/5
- [Kim Peek: The Real Rain Man](#) 3/5
- [Kim Peek: The Real Rain Man](#) 4/5
- [Kim Peek: The Real Rain Man](#) 5/5
- [Video of Stephen Wiltshire, an artistic savant with autism](#)
- [Article about the variations in autism](#)

Rett's Disorder (299.80)

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Introduction

- First discovered in 1966 by an Austrian physician (Harris, Glasberg, & Ricca).
 - Noticed two girls in his waiting room exhibiting identical hand mannerism.
 - Ultimately, he identified similar hand movements among 20 other girls diagnosed with mental retardation.
- Characteristically defined as a pattern of regression

beginning at 5-18 months old to include social, language, motor, and cognitive development (Hoffman, 2009).

- Rett's disorder is second to Down's syndrome as a cause of mental retardation in females (Hoffman, 2009).
 - Characteristically, only found in females due to being linked with the X chromosome that encodes Methyl-CpG binding protein-2 (MECP2).
 - MECP2 involved in the regulation of expression of other genes during development.
 - Mutations in MECP2 reported in 87% of females with classical Rett's disorder
 - Mutations in MECP2 reported in 50% of females with variant of the disorder
 - Mutations in MECP2 found to be lethal in males.

DSM-IV-TR criteria

- A. All of the following:
 - 1. apparently normal prenatal and perinatal development

- 2. apparently normal psychomotor development through the first 5 months after birth
- 3. normal head circumference
- B. Onset of all of the following after the period of normal development:
 - 1. deceleration of head growth between ages 5 months and 48 months
 - 2. loss of previously acquired purposeful hand skills between ages 5 and 30 months with the subsequent development of stereotyped hand movements (e.g., hand wringing or hand washing)
 - 3. loss of social engagement early in the course (although often social interaction develops later)
 - 4. appearance of poorly coordinated gait or trunk movements
 - 5. severely impaired expressive and receptive language development with severe psychomotor retardation

Associated features

Children diagnosed with Rett's Disorder present normal development and functioning until onset between 5 and 48 months. Rett's Disorder has typically been associated with

Severe or Profound Mental Retardation. There may be an increased frequency of EEG abnormalities in this particular population of individuals. Also, seizure disorder is seen in individuals with Rett's Disorder. Research suggests that the cause of Rett's Disorder may be a genetic mutation. Rett's Disorder is a genetic disorder of developmental arrest or failure of brain maturation. This is thought to happen when subsets of neurons and their synapses are disrupted during a very important time of brain development. This deviation occurs at the end of pregnancy or in the first few months of life during the important time of synapse development. A deceleration of head growth between ages 5 and 48 months is one symptom. Others are loss of previously acquired purposeful hand skills between ages 5 and 30 months, loss of social engagement early on, appearance of poorly coordinated gait movement, severely impaired expressive and receptive language development with severe psychomotor retardation. Rett's Disorder is not a degenerative disorder. It is a neurodevelopmental disorder. As long as the patient does not fall ill or suffer from complications, survival into adulthood is expected.

There are four different stages of the disorder:

- Early Onset occurs at about 6 to 18 months. The symptoms are vague and often overlooked. There are gross motor delays and less eye contact and loss of interest in toys. This stage can last for up to a year.

- Rapid Destructive stage occurs between 1 and 4 years old. Hand skills and spoken language skill are lost. It can last from a few weeks to a couple of years. Autistic-like symptoms can also occur.
- Plateau is the third stage. It is between ages 2 and 10. Motor problems and seizures are characteristic at this stage. Most girls stay at this stage during the rest of their lives. They show more interest in their surroundings.
- Late Motor Deterioration is the final stage. Reduced mobility is the most prominent feature. Girls who could walk may now not be able to walk. Cognitive abilities stay the same. This can last for years as well.

Child vs. adult development

- Although the duration of Rett's Disorder is lifelong, the onset is typically before the age of four and most often in the child's first or second year.
- Symptoms of Rett's Disorder are present in both children and adults with this disorder.
 - Progressive loss of skills is typically seen throughout the affected individual's lives.

Epidemiology

Other than two cases of boys being diagnosed with this

disease, Rett's Disorder only affects females and is much less common than Autistic Disorder. It is found in all races and ethnic groups of the world.

70-80% of females diagnosed with this disorder have the MECP2 genetic mutation. The rest of the cases are believed to have partial gene mutation.

Onset usually occurs before four years of age, usually about the first or second year. The duration is lifelong, and the loss of skills persistent and progressive. Recovery is usually quite limited, although some developmental gains may be made and there may be interest in social interaction as during late childhood or adolescence. Difficulties with communication and behavior remain constant throughout life.

Etiology

This disease is caused by a genetic mutation on the long arm of the X chromosome. These genes cause the brain to develop incorrectly by inappropriately activating other genes in the brain at the wrong time.

Empirically supported treatments

There is currently no cure for Rett's Disorder but treatment is available to alleviate the symptoms.

There are treatments available to manage their symptoms such as physical therapy or occupational therapy. Some find that medications for muscular rigidity are helpful while others gain normalcy from medications that treat things like anxiety

or irritability. A child psychiatrist should be consulted for proper medication.

While there is no cure, however, there are several treatments options. Treatment is therefore concentrated on relief of individual symptoms, compensation for physical disabilities and the provision of the best possible stimulation and quality of life. Deformities and progressive disabilities should be prevented wherever possible. Occupational therapy (in which therapists help children develop skills needed for performing self-directed activities – occupations – such as dressing, feeding, and practicing arts and crafts), physiotherapy, and hydrotherapy may prolong mobility. Treatment must always be individually structured, on the basis of the specific problem complex and point of departure of each girl, who must be offered help in utilizing her retained abilities and stimulation for further development. Special academic, social, vocational, and support services may also be required in some cases.

It has been proposed that this disorder not be included in [DSM-5](#). The rationale is that Rett's Disorder patients often have autistic symptoms for only a brief period during early childhood, so inclusion in the autism spectrum is not appropriate for most individuals.

Asperger's Disorder (299.80)

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<https://youtu.be/QWY3ntr3sdl>

Introduction

- Asperger's disorder is defined in the DSM-IV-TR to include the same social interaction and behavior impairments as those diagnosed with autism (Hoffman, 2009).
 - This subtype, however, does not include language or cognitive deficits
 - Unlike those with autism,

children with Asperger's are interested in interacting with others.

- Socially inappropriate, odd communication, or difficulty reading social cues inhibit formation of peer relationships.
- Furthering their social isolation, children with Asperger's are described as "little professors" in that they become experts in a particular area of interest often to the exclusion of other topics.
- Verbal skills are superior to non-verbal
 - Exhibit motor difficulties
 - Visual-spatial abilities
 - Fine and

gross motor
skills

- Poor coordination
 - Odd gait
 - Clumsiness
- Impairments cannot be due to another PDD or schizophrenia.
 - More common in males
 - Estimated between a 5:1 to at least 9:1 male to female ratio
 - Hans Asperger first described this disorder as being attributed to familial heredity.
 - He characterized this disorder to include the following symptoms:

- Decreased facial expression and gestures
- Peculiarities in communication
- Lack of empathy and intellectualization of feelings
- School behavioral problems
 - i.e. aggression stemming from social

DSM-IV-TR criteria

- A. Qualitative impairment in social interaction, as manifested by at least two of the following:
 - 1. marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
 - 2. failure to develop peer relationships appropriate to developmental level
 - 3. a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)
 - 4. lack of social or emotional reciprocity
- B. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
 - 1. encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus

- 2. apparently inflexible adherence to specific, nonfunctional routines or rituals
 - 3. stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
 - 4. persistent preoccupation with parts of objects
- C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.
 - D. There is no clinically significant general delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years).
 - E. There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), a curiosity about the environment in childhood
 - F. Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia.

Associated features

Asperger's Disorder has been associated with many mental disorders, such as Depressive Disorders. Also, on occasion,

Mild Mental Retardation has been seen to be associated with Asperger's Disorder. Individuals with this disorder generally seem to have strengths in verbal abilities and weaknesses in non-verbal abilities (i.e. mild motor clumsiness may be present). Overactivity and inattention are typically seen in individuals with Asperger's Disorder.

These individuals demonstrate relatively intact intellectual and language functioning accompanied by social impairments seen in autism. They tend to have appropriate but unusually intense interests, increased clumsiness and more object than people focused. There is little research to differentiate from high functioning autism such as with autism and PDD-NOS. They are considered distinct diagnoses in the DSM but instruments are hard to differentiate them effectively. Instead, diagnostic and clinical judgment must be relied on.

Children with Asperger's Disorder typically are higher functioning than those with Autism. They have difficulty interacting with peers and some children even have normal intelligence. They are often loners and are often characterized as having eccentric behaviors.

People with Asperger syndrome have difficulty recognizing faces. They do not use the eye region to a great extent in face identification. The visual search strategies in normal functioning individuals are more effective and rely on the use of the "face information triangle", i.e. the two eyes and the mouth, while individuals with Asperger syndrome have more fixations on other parts of the face suggesting a

less effective use of the “face information triangle”(Falkmer, Larsson, Bjallmark, & Falkmer, 2010).

When visual search strategies, particularly regarding the importance of information from the eye area, and the ability to recognize facially expressed emotions are compared between adults with Asperger syndrome and normal functioning individuals it is shown that adults with Asperger syndrome had greater difficulties recognizing basic emotion. Distortion of the eye area also affects the ability to identify emotions greatly for participants with Asperger syndrome (Falkmer, Bjallmark, Larsson, & Falkmer, 2011).

Controversy surrounds the distinction between high-functioning autism (HFA) and Asperger disorder, but motor abnormalities are associated features of both conditions. An examination of motor cortical inhibition and excitability in HFA and Asperger disorder using transcranial magnetic stimulation (TMS) reveals a possible distinction between the two. Cortical inhibition is significantly reduced in people with HFA compared with both the Asperger disorder (p less than 0.001) and neurotypical (p less than 0.001) people, suggesting disruption of activity at gamma-aminobutyric acid A (GABAA) receptors. Cortical inhibition deficits may underlie motor dysfunction in autism, and perhaps even relate to specific clinical symptoms (e.g. repetitive behaviours). These findings provide novel evidence for a possible neurobiological dissociation between HFA and Asperger disorder based on GABAergic function (Enticott, Rinehart, Tonge, Bradshaw, & Fitzgerald, 2010).

Physical activity is beneficial for youth with developmental disabilities. It was shown in a recent study that adolescents with Asperger syndrome scored significantly lower than the comparison group on all physical fitness subtests, including balance, coordination, flexibility, muscular strength, running speed, and cardio-respiratory endurance (p less than 0.001). Adolescents with Asperger syndrome were also less physically active (p less than 0.001)(Borremans, Rintala, & McCubbin, 2010).

Participants with autism, but not with Asperger syndrome, displayed enhanced pitch discrimination for simple tones. However, no discrimination-thresholds differences were found between the participants with ASD and the typically developing persons across spectrally and temporally complex conditions. These findings indicate that enhanced pure-tone pitch discrimination may be a cognitive correlate of speech-delay among persons with ASD (Bonnell, McAdams, Smith, Berthiaume, Bertone, Ciocca, et al., 2010).

An investigation on whether children with Asperger syndrome (AS) show superior competence in creativity, and an examination of the relationship between nonverbal creativity and nonverbal IQ and vocabulary size reveal that the participants with AS scored significantly higher in originality and elaboration, compared to their peers. Nonverbal divergent thinking was correlated to nonverbal IQ for participants with AS. It was observed that participants with AS drew the 12 incomplete figures mostly in the areas which interest them. This result may indicate better

performances in originality and lesser performances in flexibility (Liu, Shih, & Ma, 2011).

Child vs. adult presentation

Different ages may present differently for Asperger's Disorder. Often the social disability of individuals with Asperger's Disorder can become more striking over time. By adolescence some people with the disorder may use areas of strength to compensate for weaker areas. Individuals with the disorder may feel victimization from others. Feelings of social isolation and an increasing understanding of self-awareness can lead to the development of depression and anxiety in adolescents and young adults.

Gender and Cultural Differences in Presentation

Asperger's Disorder is at least 5 times more likely to be diagnosed in males than females. Asperger's Disorder has no ethnic boundaries, Asperger's is seen all around the world. Rates seem to be higher with the greater rates of populations. There has been no conclusive evidence to support that Asperger's Disorder shows cultural differences.

Epidemiology

It is estimated that between 0.024% and 0.36% of the general population in North America and northern Europe have Asperger's Disorder and it is more common in boys. Anxiety disorder and major depressive disorder are likely to be

comorbid with Asperger's disorder. It is estimated that 65% of people with Asperger's also have one of them

With effective treatment, children with AS can learn to cope with their disabilities, but they may still find social situations and personal relationships challenging. Many adults with AS are able to work successfully in mainstream jobs, although they may continue to need encouragement and moral support to maintain an independent life.

Generally, there is about 5 to every 10,000 children that have Asperger's Disorder.

Asperger's follows a lifelong course. Good verbal abilities may mask social dysfunction and mislead teachers→

Etiology

The etiology of Asperger's Disorder is not known but current studies suggest that the condition may run in families, particularly with histories of depression and bipolar disorder. Also, about fifty percent of patients with Asperger's Disorder have a history of oxygen deprivation during birth, which leads to the hypothesis that it is caused by damage to the brain before or during childbirth.

Empirically supported treatments

Treatment for Asperger's Disorder addresses the three main symptoms: reduced communication skills, obsessive or repetitive routines, and clumsiness. Most agree the earlier the intervention, the better. An effective treatment program takes the child's interests into account, offers a predictable schedule,

teaches tasks as simple steps, holds their attention, and helps strengthen behavior. The treatment may include social skills training, cognitive behavioral therapy, and medication for co-existing conditions. Individual psychotherapy to help process feelings of being “socially handicapped”. There are also specific medications for problems such as: hyperactivity, impulsivity, inattention, irritability, aggression, preoccupations, rituals, compulsions, and anxiety.

DSM-5 is proposing that this disorder be subsumed into the existing, Autistic Disorder. [There is some objection](#) regarding the proposal among some people in the Asperger's/Autism community.

Links

- [What Is Asperger's Syndrome?](#) on YouTube
- [About Autism and Asperger's, Child Psychology Information](#) on YouTube
- [Australian Doctor Discusses Asperger's Syndrome](#) on YouTube
- A young man with [Asperger's Syndrome](#) shares what it is like to have Asperger's and describes how it influences his day to day life.
- The following is a documentary of a young man with Asperger's Syndrome:



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=339#oembed-1>

Pervasive Developmental Disorder Not
Otherwise Specified or PDD-NOS
(299.80)

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Children diagnosed with PDD-NOS fall into at least one of two categories, if not both:

- They do not meet the criteria of symptoms utilized by clinicians to diagnose any of the four previously mentioned types of PDD
- They do not have the degree of impairments outlined in the four types of PDD (Tsai, 1998).

This category should be utilized when there is a severe and pervasive impairment in the development of social interaction or verbal and nonverbal communication skills, or when stereotyped behavior, interests, and activities are present, but the criteria are not met for a specific Pervasive Developmental Disorder, Schizophrenia, Schizotypal Personality Disorder, or Avoidant Personality Disorder” (Tsai, 1998).

- For example, this category includes “atypical autism”— presentations that do not meet the criteria for Autistic Disorder because of late age of onset, atypical symptomatology, or sub-threshold symptomatology, or all of these.
- PDDNOS is the result of a neurological abnormality; however there is no explanation for its cause(s) (Tsai, 1998).
 - The components used to define this disorder could be the culprit of the failed causal relationships, because PDDNOS includes behavioral symptoms rather than genetic testing.

Children generally reach age 3–4 years old before they portray enough symptoms to cause a parent or caregiver to worry about a diagnosis (Tsai, 1998).

Symptoms for PDDNOS lie on a continuum and vary per child in the degree and intensity of impairments:

- Social behaviors (Tsai, 1998)
 - Infants may avoid eye contact and exhibit little, if any interest, in human voices.
 - Infants do not usually raise their arms to indicate wanting to be picked up, as normal children do.
 - Young children do not develop typical attachment behaviors and do not exhibit separation or stranger anxiety.
 - Young children lack interest in playing with other children, to the point of actively avoiding others.
 - Middle aged children may show greater attachments towards family members, friends, and peers; however, they still have social impairments.
 - These children lack correct responses towards others' interests and emotions and may lack the comprehension of humor.

- Nonverbal communication (Tsai, 1998)
 - Even if children exhibit the normal pulling of adults' hands toward a desired object, they may do so without exhibiting the proper facial expressions.

- Children with PDDNOS do not seem to participate in imaginative games and are less likely to imitate their parents' activities.
 - Some children do participate in imaginative play; however, they tend to exhibit repetitive behaviors.
- Individuals in middle to late childhood tend not to utilize gestures.
- Children with PDDNOS do know how to exhibit emotion.
 - The emotions exhibited are extremes. They do not ordinarily portray subtle facial expressions.
- Speech (Tsai, 1998).
 - Infants tend not to babble. If they do, the babbling halts within the first year.
 - Echolalia may be the only type of speech acquired.
 - Even if echolalic speech is accurately produced, comprehension may be limited.
 - Echolalia serves several

functions

- self stimulation
 - the step between being nonverbal and verbal
 - sufficient communication
- Some develop efficient phrase usage; however, is accompanied by pronoun reversal.
 - Impairments in speech production are evident, to include monotonous, flat, robotic sounds that lack pitch change, emphasis, or emotion.
 - Odd speech characteristics exhibited by children with PDDNOS include singsong speech, question-like statements, odd breathing rhythms, etc.
 - Abnormal grammar in verbal children results in:
 - distorted phrases
 - muddled sounding synonyms or similar sounding words
 - labeling objects by their use
 - inventing new words

- incorrect usage of prepositions, conjunctions, and pronouns.
- Speech lacks imagination, abstraction, or subtle emotion
- Children have difficulties discussing things outside of immediate contexts and ordinary “to-and-fro” conversations.
- Behavioral Patterns (Tsai, 1998)
 - Children with PDDNOS are resistant to change.
 - They exhibit frustration when their line of toys are disrupted
 - New activities are resisted
 - They exhibit ritualistic/compulsive behaviors.
 - Can involve rigid routines, repetitions, or preoccupations
 - Attachments and behaviors are abnormal.
 - Exhibit intense attachments to odd objects
 - Preoccupation with select features of objects
 - Unusual responses to sensory experiences
 - Under or overresponsive to

certain stimuli

- Some avoid tender contact and enjoy rough play
- Movement (Tsai, 1998)
 - Motor skills can be delayed; however, lie within the normal range.
 - If they are overactive as young children, they tend to be less so in adolescence.
 - The following behaviors may be continuous or sporadic: grimacing, hand flapping, toe walking, jumping, pacing, swaying, head banging, etc.
- Cognitive Impairments (Tsai, 1998)
 - Children do well on tests involving manipulative and visual skills or immediate memory, while scores are inadequate when asked to implement logic and abstract thought.
 - Development is impaired in regards to imitation, comprehension, inventiveness, applying rules, and utilizing information.
 - Development excels in rote memory and skills in music, math, and reading.
 - Children diagnosed with PDDNOS who also have a low IQ score tend to lack

social skills and exhibit inappropriate social responses (i.e. touching or smelling people).

Testing for PDDNOS (Tsai, 1998)

- Currently no objective biological assessments to confirm diagnosis
 - Diagnosis reflects clinician's "best guess"
 - To gain an accurate diagnosis requires a thorough assessment by a trained professional
 - child psychiatrist
 - developmental pediatrician
 - pediatric neurologist
 - child psychologist
 - developmental psychologist
 - neuropsychologist

Assessments, conducted by local public school or private practitioner, are implemented to gather information to determine an accurate diagnosis and to provide information to aid in the appropriate intervention for the child and family.

Medical Assessment

- Thorough birth, development, medical, and family history

Abnormal Psychology

- Full physical and neurological exam
- Laboratory tests and/or brain scans (at the physician's discretion)

Genetic and Family Studies

- Indicates the relationship between PDD-NOS and autism exists by noting the possibility of diagnosis of either genetic disorder in siblings of the diagnosed person (Hoffman, 2009).
- Immediate relatives of an individual with PDD-NOS may be in a group called the “broader autism phenotype.” This group may exhibit features of PDD-NOS but do not portray enabling features to carry the diagnosis of PDD-NOS (Hoffman, 2009).

Interviews

- Child him/herself
- Parent
- Teacher
- Child may behave differently per setting/situation
- Rate Behavior
- Direct Behavioral Observations
- Psychological assessment

- Utilize standard instruments to evaluate the following areas
 - Cognitive
 - Social
 - Emotional
 - Behavior
 - Adaptive Function

Educational Assessment

- Formal and informal tests to evaluate:
 - Preadademic skills
 - Academic skills
 - Daily living skills
 - Learning style and problem solving approaches

Communication assessment

- Formal testing
- Observation
- Parental/Caregiver interviews
- Assess range of communication skills:
 - Personal interest in communication
 - Purpose for communication

Abnormal Psychology

- Content and context
- Nonverbal communication
- Comprehension of communication

Occupational assessment

- Determine nature of sensory function
- Assess fine and gross motor skills

Evaluation Summary

- Utilize all information gathered to determine diagnosis

Treatment for PDDNOS (Tsai, 1998)

- Behavioral Issues
 - Keep environment organized with clear, concise, and consistent rules.
 - Structure and predictability are essential.
 - Problem behaviors could be a form of communication.
 - Remember in positive behavioral support strategies:
 - Programs are individually based
 - Children with PDDNOS have trouble generalizing from one

environment to the next

- Implementing home-community based approaches can maximize results
- Adapting to classroom environments can be difficult, therefore:
 - Knowledgeable teachers are essential;
 - Structure, consistency, and predictability should be utilized;
 - Information should be presented visually and verbally;
 - Interaction with nondisabled peers is vital for appropriate language, social, and behavioral skills;
 - Communication devices aid in improving communication skills;
 - Reduced class size and appropriate seating

arrangements help to eliminate distractions;

- Curriculum should be modified depending on the child's strengths and weaknesses;
 - Combining positive behavioral supports with educational interventions provide better results;
 - Continuous and regular communication between teachers, parents, and primary care physicians is a must.
- Medical Treatment
 - Medical treatment is to ensure good physical and psychological health.
 - Regular checkups to monitor growth, vision, hearing, blood pressure, dental, diet, and hygiene allow for preventative measures.
 - There is not one specified medication for

all children with PDDNOS.

- Levels of medication require experimentation to determine the optimal dosage
 - Medication regimens are individualistic and are a last resort.
 - If medications are prescribed, they should be taken in conjunctions with other therapies and thoroughly monitored.
- Psychological treatment
 - Counseling is beneficial in assisting adjustment for the family.
 - Psychologists provide ongoing assessment, school consultation, case management, and behavioral training.
 - Family teamwork eases the burden on the primary caregiver.
 - Additional Options
 - Facilitated Communication encourages individuals with communication impairments to express themselves by utilizing a facilitator to assist in spelling

words on a keyboard, typewriter, or computer.

- Auditory Integration Therapy (AIT) sends randomly selected frequencies from a CD player to the child with PDDNOS, resulting in
 - diminished sensitivity to sounds
 - spontaneous speech
 - development of complex language
 - answering questions
 - increased interaction with peers
 - appropriate social behavior
- Sensory Integration Therapy sets out to improve how a child's senses process stimulation and work together to respond efficiently.
- The Lavaas Method is considered an Applied Behavior Analysis and intended for preschool aged children with autism.
 - Behaviors are molded by rewarding desired behaviors and ignoring undesired behaviors in 4-6 hours per day of one on one training between 5-7 days per

week.

- Vitamin therapy adds B6 and magnesium to the child's diet to help form malfunctioning neurotransmitters.
- Dietary intervention may be necessary for some children with PDDNOS because of food sensitivities or allergies.
- Anti-yeast therapy is assumed by some to reduce negative behaviors.
 - Antibiotics provided to toddlers for ear infections can cause “yeast overgrowth,” which may or may not be a coincidence of the existence of higher yeast levels in children diagnosed with autism and PDDNOS.

[DSM-5](#) is proposing that this disorder be subsumed into the existing Autistic Disorder.

The following video gives insight to an everyday outing with a child with Autism.



One or more interactive elements has been excluded from this version of the text. You can

view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=341#oembed-1>

Introduction to Disruptive Behavior Disorders

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

A DISORDER THAT CAUSES BEHAVIOR THAT IS
SIGNIFICANTLY DISTURBING TO OTHERS (SUCH
AS AGGRESSIVE, IMPULSIVE, ARGUMENTATIVE
BEHAVIORS, ETC.).

The disruptive behavior disorders are abnormal behaviors that are expressed in many different forms. Such behaviors are usually portrayed as inappropriate among most individuals in a society. They are also called Behavioral Disorders. These behaviors also violate the social norms of others and especially

towards their siblings. People “break the rules” a little all the time and children also, and especially the rules that they believe are not as important. Over time, children tend to mature and outgrow these disruptive behaviors. When they do not, psychological evaluation is usually advised as this behavior can lead to other more serious disorders (antisocial personality disorder, etc). Several things can lead up to the disorder, including both a biological and environmental basis. Initially, there was much debate over whether or not oppositional defiant disorder (ODD) and conduct disorder (CD) should be classified as one disorder, with ODD being a milder precursor to CD. However, it was found that 75% of children with ODD do not develop CD. Although these are found to be separate disorders, they do share many common features such as defiance, aggression, and rule breaking behaviors.

There are three main Disruptive Behavior Disorders:

- Oppositional Defiant Disorder
- Conduct Disorder
- Attention Deficit Hyperactive Disorder (ADHD)

Parenting and Epidemiology for Disruptive Disorders

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PARENTS

- Parents need an arsenal of coping strategies to reduce the behavioral problems at home. The first step is effective diagnosis and treatment by a practitioner with experience in mental disorders of childhood. Nearly all of the behaviors associated with the Disruptive Behavior Disorders (DBD) may be seen in normal children from time to time. The Disruptive Behavior Disorder (DBD)

diagnosis is made when the frequency and persistence of these symptoms result in clinical impairment in social, academic or occupational functioning. Ongoing supervision by a competent mental health practitioner is crucial because the disruptive behavior disorders are frequently accompanied by other disorders such as ADHD, Anxiety, and Mood Disorders.

- Children with DBD's need a higher level of supervision than other children of the same age. However, supervision does not always have to be by the parent. In fact, because defiant behavior is often directed primarily at parents and teachers, parents may find that alternative caregivers, such as competent babysitters or aides, are able to develop good relationships with the child that provide social learning for the child and valuable respite for parents.
- Respite and parent support are important because parents need to be in control of their own emotions during difficult episodes with the child. These kids enjoy making you mad, and they are good at it. Parents need to maintain an emotionally neutral stance when giving instructions or consequences to the disruptive child. This skill does not come naturally and must be practiced and perfected over time. If parents don't learn to control their own emotions when disciplining the

child, the result is often violence and escalation of the disorder.

- Find ways to maintain a positive relationship with your child. Pay attention to his good qualities and find joy in the moments of closeness. We naturally avoid people who cause us anxiety and are angered when they hurt us. But, we love our children and that drives us forward to seek healing for them and for us. You need an outlet for your own feelings, so seek out support to help you cope. Many parents also find that they need support to maintain a healthy, supportive marriage in difficult situations.
- [Get a plan and stick with it.](#) Learn all you can about how to effectively manage your child's behavior; find what works for you; and then use those strategies in a consistent and structured way. Routines and clear expectations for behavior benefit all children. They are vital to the healthy development of the disruptive child.
- **Resources for common behavioral problems associated with the diagnosis of Disruptive Behavior Disorder and strategies for parents:**
 - [My Child Has a Problem – Aggression](#)
 - [How to Handle Temper Tantrums](#)
 - [How to Handle Lying and Stealing](#)
 - [Effective Discipline Strategies](#)

- Instead of feeling anger, frustrated, and becoming overwhelmed when children display disruptive behavior, as a parent, role models, and educators we need to be empathetic and feel compassion and love for these children. We love those children, just not their disruptive behaviors. One main reasons children are disruptive, is due to a lack of boundaries and goals not being set clearly at an early stage of life, this lack can lead to disruptive behavior in and outside the home. We need to be specific and concrete on what needs to take place in the home, outside the home, in school, ect. We must model what success and appropriate behaviors look like and show children how to exhibit these positive behaviors.
- When talking to your children, let them know exactly what and how good behavior needs to be implemented. Remember to be specific; don't just say "be good today" but state "be good today by not disrupting the classroom and listening to your teacher." Talk about these goals and objectives each day with your child, and if inappropriate behavior follows, consequences need to immediately be followed through as well. Reward immediately and efficiently when your child is effective and responsive. Use eye contact when giving requests, and have your child repeat back to you what you have said in order to ensure that he

really understands what needs to be accomplished. Make realistic and achievable goals for your children, and let them know the consequences beforehand to reinforce good behavior. This allows the child to stop and think about actions before reacting. By setting expectations too high for your child, you are setting them up for failure, and they respond by feeling overwhelmed and frustrated.

- It is also very important to remember not to look at your child's "C" grade, but to look at the progress from a failing class. Successful treatment does not happen overnight. So many parents want results immediately and get anxious, which causes the child to feel "anxious." This system does not work. This progress needs to be slow but steady. If a child acts up less each week, that is an example of slow but successful and steady progress, and children need to be acknowledged and rewarded. Gauge success by your own child's standards, not by what is considered "the norm" or someone else's standards. Focus on your child, we will be not be set up for failure if we are not constantly comparing our children or ourselves to others. Remember that each child is special, unique, and responds differently.
- I highly recommend star charts or success charts to gauge students' progress in specific behavior, but be sure to include your child in this process. It is

important the child sees progress daily to focus on the behaviors and positive feedback and be part of this process. Reward systems work well for students of all ages, not just the younger ones. Success charts benefit the child and get the whole family involved. Older children can also use privileges such as pagers, driving the car, cell-phone usage, etc. The family must be supportive and consistent in reinforcing positive responses and outcomes when they occur. Remember: it is essential to set specific, measurable, achievable, realistic, and time efficient goals. This will make a big difference to help disruptive behaviors become deserving behaviors ! This is what we want!

- We must avoid being reactive towards this resistant behavior from our children. Show your child who's in control by demonstrating self-control and restraint. Always stay calm, controlled, and collected when your child acts up. Remember: act rational to create rational behavior and responses from your child. Time-outs are highly effective for younger children, and a good formula to use is one minute per one year of age, e.g. 6 minutes for a sixyear old. The child needs to have time out to understand what was done wrong, and what he can do better next time, and should resolve the issue with an apology.

EPIDEMIOLOGY FOR DISRUPTIVE DISORDERS:

- Conduct problems are one of the most frequent reasons for referral to child and adolescent treatment services. Prevalence rates are estimated to be 2-5%.
- These problems are more often diagnosed in boys than in girls: 3-4:1 ratio, perhaps because of the emphasis on male expressions of aggression.
- Contextual factors (poverty, high-crime neighborhoods) increase conduct problems.
- ODD is often a precursor of CD, although the child cannot receive both diagnoses.
- Average onset for ODD: six years old; for CD: nine years old.
- Most children (75% in one study) do not progress from ODD to CD
- Co-occurring disorders include ADHD (35-70%); ADHD often comes first.
- Profile of children with disruptive disorders includes peer rejection, lower school achievement, verbal/language deficits, deficits in executive functions.
- Co-occurring disorders also include anxiety disorders (19-53%) and depression (12-38% of community samples, 33% of clinical samples; boys

show greater co-occurrence than girls).

- Some but not all (estimates of 25%) children continue a course of aggressive and antisocial behaviors into adolescence; early childhood onset is related to more serious and persistent antisocial behaviors; this early onset pattern is less common than the adolescent-onset pattern (3-5% of the general population). These children have often been described as having a “difficult temperament during infancy”.
- Adolescent-onset pattern is the more common developmental pathway, with slightly more females than males; problematic behaviors often stop after adolescence and are referred to as adolescent-limited.
- A developmental triple pathway model is provided by the research of Loeber and colleagues: the overt pathway, the covert pathway and the authority conflict pathway.

Oppositional Defiant Disorder (313.81)

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- Classified as an externalizing disorder

DSM-IV-TR criteria

- A pattern of negativism, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:
 - (1) often loses temper
 - (2) often argues with adults

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- (3) often actively defies or refuses to comply with adults' requests or rules
- (4) often deliberately annoys people
- (5) often blames others for his or her mistakes or misbehavior
- (6) is often touchy or easily annoyed by others
- (7) is often angry and resentful
- (8) is often spiteful or vindictive
 - Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.
 - More diagnostic information can be found on the following link from the American Academy of Child & Adolescent Psychiatry: [AACAP](#)
- The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.
http://www.wikispaces.com/_/ad4b0f60/i/c.gif
- The behaviors do not occur exclusively during the

course of a Psychotic or Mood Disorder.

- Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.
- Recurrent pattern of negativistic, defiant, disobedient, and hostile behavior towards authority figures.
- Occurs outside of normal developmental levels and lead to impairment in functioning.

Peers

Children with oppositional defiant disorder (ODD) have substantially impaired relationships with parents, teachers, and peers. These children are not only impaired in comparison with their peers, scoring more than two standard deviations below the mean on rating scales for social adjustment, but they also show greater social impairment than do children with bipolar disorder, major depression, and multiple anxiety disorders. When compared with oppositional defiant disorder, only conduct disorder and pervasive developmental disorder had nonstatistical differences in social adjustments.

Associated features

Oppositional Defiant Disorder (ODD) is characterized by hostile and defiant behaviors, such as negativity, defiance, hostility, frequent outbursts of rage, an excessive need to

argue and swear, avoidance, and disobedience that begin by age six and is followed by Conduct Disorder (CD) that has an early onset around age nine. Those who develop CD in adolescence have problems that persist through adolescence, but are not seen in adulthood. These children seem to be most comfortable when pushing the boundaries of familiar territory.

According to the DSM-TR-IV, Oppositional Defiant Disorder (ODD) is more common in households where the child's upbringing has been very inconsistent or even neglectful and tends to shift into the school environment. The child's caregiver might also change often during their life. Children with Oppositional Defiant Disorder (ODD) might also have Attention-Deficit/ Hyperactivity Disorder (ADHD) or other Learning Disorders (LD) and Communication Disorders. Males in their preschool years tend to have higher motor activity or a more problematic temperament. During school years children with Oppositional Defiant Disorder (ODD) may have lower self-esteem and low frustration tolerance. They may also swear and use alcohol, tobacco, or illegal drugs. They may often invoke conflict with teachers, parents, and even peers. Difficulty maintaining friendships and academic problems are also seen quite frequently with this disorder.

ODD usually begins in the child's home and often carries over to familiar adults in the child's life such as his/her parents. With these adults they will push the boundaries and test their limits. Children with ODD may present either a low

self-concept or an inflated self-esteem. They often engage their parents or caregivers in fights that may escalate into emotional turmoil on both child and parents which can lead parents to start a negative style of parenting that often only serves to perpetuate the problem. ODD behaviors may not be evident in the school or community and are not likely to be evident in the clinical interview.

It occurs outside of normal development levels and leads to impairment in functioning.

Child vs. adult presentation

Oppositional behavior is common in preschool children and adolescents, therefore, the caution should be determined for an adequate diagnosis. The number of symptoms tends to increase with age. Children tend to display disruptive and aggressive behaviors for longer than 6 months. There is a pattern of ongoing defiant, uncooperative, and hostile behaviors. Children usually have frequent temper tantrums, deliberate attempts to upset or annoy people especially adults, and they seek revenge often. If the Oppositional Defiant Disorder (ODD) does not progress into Antisocial Personality Disorder (ASPD), then the problems continue through adolescence, but will not be seen in adulthood. Research has demonstrated that children, who have Oppositional Defiant Disorder (ODD), especially at an early age, are more likely to develop Antisocial Personality Disorder (ASPD), psychopathy, or other serious mental illness when they reach adulthood.

Gender and cultural differences in presentation

Before puberty, males seem to have Oppositional Defiant Disorder (ODD) more often than females. It is a 4:1 average ratio that males have ODD more than girls. After puberty, the rates will equal out. Symptoms for both genders are very similar, except that males will sometimes be more confrontational or have more persistent symptoms. The presentation of ODD symptoms may be seen differently across cultures.

Epidemiology

Oppositional Defiant Disorder (ODD) seems to be more common in families where at least one parent has had a history of Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), Mood Disorder, Attention Deficit/Hyperactivity Disorder (ADHD), Substance-Related Disorder, or Antisocial Personality Disorder. Also, some studies have shown that children that have mothers with Depressive Disorder are more likely to have oppositional behavior. It is unknown as to how much the mother's depression results from or causes the child's oppositional behavior.

Rates of 2% to 16% have been reported.

Symptoms usually become evident before eight years of age and not later than early adolescence. Oppositional symptoms often emerge at home but may emerge elsewhere as well over time. Onset is usually gradual, over months

or years. Oppositional Defiant Disorder (ODD) may be a precursor to Conduct Disorder (CD).

Etiology

- There are many different theories that try to explain both Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD):
 - A psychodynamic oriented therapist would interpret the aggressive and defiant behaviors of Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) as manifestations of a deeply-seated feeling of lack of parental love, the inability to trust, and an absence of empathy. This is related to the Psychodynamic disorders.
 - Behavioral Theories suggest that the defiant behaviors are caused by the defiant behavior not being punished and good behavior being reinforced. The parents repeatedly giving into demands is a reinforcement of the bad behavior.
 - Cognitive Theories suggest that the child feels hostility in their lives, and they responded to it with their own hostility.
 - Family Patterns, Attachment, and Parenting a Family System Clinician

would say that the child's aggression is their way of attempting to control the balance of power because of the parents inconsistent, or extreme boundaries and limit setting.

- There is also evidence of low levels of [DBH](#) (which converts dopamine to noradrenaline) may produce higher thresholds for sensation-seeking behaviors in some children.

Empirically supported treatments

Problem-Solving – Skills-Training programs teach children to solve problems in a logical and predictable manner. The second, The Coping Power, promotes anger control. The down side to both is the time with Problem-Solving – Skills-Training being a 20 session program and The Coping Power being even longer at 33 sessions. There is also research being done in parenting training to help parents improve skills in targeting behaviors that should be changed and developing a reward program to reduce unwanted behaviors while increasing the wanted ones.

Parent Management Training (PMT) can allow the parents learn to develop and implement structured contingency management programs at home. It can improve interactions between the parents and child, change antecedents to problem behaviors, improve the parent's monitoring skills of the child's behavior, and give them more effective discipline

strategies. A few examples of the techniques suggested towards parents during this training, are to acknowledge and praise children when they perform positive behaviors, establish schedules and stick to them, maintain effective timeouts, and try to circumvent corrivalry.

Individuals raising children with Oppositional Defiant Disorder (ODD) must find ways to accomplish their daily routines and errands despite the behavior of their children. Without the perspective of being a parent of a child with ODD it can be difficult to understand the challenges they face. See video http://www.youtube.com/watch?v=c-KC9rkn0_Y

Recent studies demonstrate that certain medications can help with Oppositional Defiant Disorder (ODD). The research is preliminary, but the studies show that under certain circumstances medical treatments may help.

In one study, [Ritalin](#) (**[methylphenidate](#)** hydrochloride) was used to treat children with both ADHD and ODD. Researchers found that when treated with Ritalin, 90% of the children no longer had the ODD. However, this was a poorly executed study. The researchers dropped a number of children from the study because they were too defiant to take their medication as scheduled. Still, even if these children are included as treatment failures, the study still showed a 75% success rate with Ritalin (Kane, 2010). For children that are over 6 years old take Ritalin starting out with 5mg tablets twice a day. It should be taken in the morning before breakfast and in the afternoon before dinner to avoid stomach

problems. If necessary, your child's healthcare provider may slowly increase the dosage up to Ritalin 60 mg per day. For adults with narcolepsy, the total dosage of Ritalin per day is usually 20 mg to 30 mg (divided into two or three doses). Some people may need less Ritalin, while others may need as much as 60 mg per day.

As with any medicine, side effects are possible with [**Ritalin**](#) ([**methylphenidate**](#) hydrochloride). However, not everyone who takes the drug will experience side effects. In fact, most people tolerate it quite well. If side effects do occur, in most cases, they are minor, meaning they require no treatment or are easily treated by you or your healthcare provider. Common Side Effects of Ritalin has been studied thoroughly in clinical trials, with many people having been evaluated. In these studies, side effects occurring in a group of people taking the drug are documented and compared to side effects that occurred in a similar group of people not taking the medicine. This way, it is possible to see what side effects occur, how often they appear, and how they compare to the group not taking the medicine. Based on these studies, the most common Ritalin side effects include: nervousness, [**Insomnia**](#), loss of appetite, nausea, dizziness, headache, drowsiness, abdominal pain (stomach pain), and weight loss (see [**Ritalin and Weight Loss**](#)). Ritalin can also temporarily stunt the growth of children. This slowing down of growth is usually small (less than an inch and less than two pounds), and children usually catch up to their normal growth rate with time.

DON'T FORGET: A diagnosis of ODD must occur before the age of 18, and symptoms must not be better accounted for by either conduct disorder or antisocial personality disorder.

Conduct Disorder (CD), Childhood-Onset Type (312.81)

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- Classified as an externalizing disorder. More severe than oppositional defiant disorder.

Children with Conduct Disorder (CD) are usually rejected by their peers and usually have a hard time making friends.

DSM-IV-TR criteria

- Conduct disorder is a more extreme form of ODD and involves more serious incidents of aggression and defiance.

- A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules that are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months.
 - Aggressive conduct that threatens physical harm.
 - Nonaggressive conduct that causes property damage.
 - Deceitfulness or theft.
 - Serious violations of rules.
- The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.
- If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.
- **Coding note:** Onset of at least one criterion characteristic of Conduct Disorder (CD) prior to age 10 years.
- Aggression to People and Animals:
 - Often bullies, threatens, or intimidates others.
 - Often initiates physical fights.

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- Has used a weapon that can cause serious physical harm to others.
 - A bat, brick, broken bottle, knife, gun
- Has been physically cruel to people.
- Has been physically cruel to animals.
- Has stolen while confronting a victim.
 - Mugging, purse snatching, extortion, armed robbery
- Has forced someone into sexual activity.

CD Subtypes

- Child-Onset Type:
 - Onset of at least one criteria before age 10.
- Adolescent-Onset Type:
 - Absence of any criteria before age 10.
- Unspecified Onset
- Code Severity:
 - Mild, Moderate, and Sever.

Associated features

Children with Conduct Disorder (CD) show acts of aggression towards others and animals. Children with

conduct disorder (CD) usually show little to no compassion or concern for others or their feelings. Also, concern for the well-being of others is at a minimum. Children also perceive the actions and intentions of others as harmful and threatening than they actually are and respond with what they feel is reasonable and justified aggression. They may lack feelings of guilt or remorse. Since these individuals learn that expressing guilt or remorse may help in avoiding or lessening punishment, it may be difficult to evaluate when their guilt or remorse is genuine. Individuals will also try and place blame on others for the wrong doings that they had committed. Children with conduct disorders (CD) tend to have lower levels of self-esteem. Children diagnosed with conduct disorders (CD) are typically characterized as being easily irritable and often reckless, as well as having many temper tantrums. These children may force sexual activity and theft while confrontation (e.g. mugging).

Individuals may have low self-esteem despite their projected “tough” image portrayed to society. Conduct Disorder (CD) often accompanies early onset of sexual behavior, drinking, smoking, use of illegal drugs, and reckless acts. Illegal drug use may increase the risk of the disorder persisting. The disorder may lead to school suspension or expulsion, problems at work, legal difficulties, STD’s, unplanned pregnancy, and injury from fights or accidents. Suicidal ideation and attempts occur at a higher rate than expected.

They show aggressive conduct that threatens physical

harm, and non-aggressive conduct that causes property damage. They display deceitfulness or theft, and serious rule violations. Rule violations sometimes include staying out all night, running away, and frequently playing truant. There are behavior problems that cause significant impairment in social, academic, or occupational functioning. There is a deliberate engagement in fire setting, with the intention of causing serious damage. They have deliberately destroyed others' property by means other than fire setting. Often children with this disorder will lose their temper easily, argue with adults, and deliberately annoy others.

Conduct Disorder (CD) may be accompanied by a lower-than-average intelligence, particularly regarding verbal IQ. Attention-Deficit/Hyperactivity Disorder (ADHD) is common in individuals with this disorder, and the disorder may be comorbid with Learning Disorders (LD), Anxiety Disorders, Mood Disorders, and Substance-Related Disorders.

Research has suggested that parents of children with conduct disorder (CD) frequently lack several important parenting skills. Parents have been reported to be more violent and critical in their use of discipline, more inconsistent, erratic, permissive, less likely to monitor their children, as well as more likely to punish pro-social behaviours, and to reinforce negative behaviours. A coercive process is set in motion during which a child escapes or avoids being criticised by his or her parents through producing an increased number of negative behaviours. These behaviours

lead to increasingly aversive parental reactions which serve to reinforce the negative behaviours (Duff, 2005).

Differences in affect have also been noted in conduct disorder (CD) in children. In general their affect is less positive, they appear to be depressed, and are less reinforcing to their parents. These attributes can set the scene for the cycle of aversive interactions between parents and children (Duff, 2005).

Child vs. adult presentation

The presentation of symptoms differ among age. As the individual matures, behaviors intensify and become more physical. Less severe behaviors tend to appear first while others emerge later. The most severe appear last. In comparison, childhood-onset presentation involves more behavioral problems. Lying, shoplifting, and burglary are just a few examples of symptoms present among adults.

Gender and cultural differences in presentation

Boys tend to display behavioral problems that are associated with conduct disorders than girls. Studies show findings that there is a 4:1 prevalence ratio of CD in boys to girls. However, this ratio may fluctuate throughout the child's development. For example, the difference in prevalence among boys and girls may be small to nonexistent in preschool children, but the difference usually becomes more dramatic throughout childhood. The ratio then seems to drop to 2:1 (males to females) during adolescence. There

is a bit of controversy about the difference in prevalence rates among boys and girls. Some argue that girls are less likely to be diagnosed with CD because they may exhibit more indirect or relational aggression. Others argue that girls showing possible symptoms of CD should be diagnosed using more lenient criteria that compares a girl to other girls, instead of a sample of both girls and boys.

There is some research that has indicated that certain social factors can influence the development of this disorder. For example, the high rate of violence in the United States (compared to other industrialized nations), and the marginalization of ethnic minorities have been noted to increase the risk of delinquent and antisocial behavior among those without the means to obtain goods through socially accepted methods. However, the findings of these studies are not conclusive.

Boys diagnosed with CD tend to display more serious acts such as vandalism and theft. Whereas girls tend to display acts such as running away, truancy, and prostitution.

Epidemiology

The diagnosis range of individuals with conduct disorder are anywhere from 1% to no more than 10%. Also, conduct disorder (CD) ranges in 9 to 17 year old kids at about 1% to 4%.The prevalence rate of males is higher than that of females. Research has showed that the prevalence of CD has increased.

Onset may occur as early as preschool, but the most

significant symptoms usually appear from middle childhood through middle adolescence. Oppositional Defiant Disorder (ODD) is a common precursor to Conduct Disorder (CD). Onset after 16 years of age is rare. The course varies; in the majority of individuals, it remits by adulthood. A large portion continues to show that meet criteria for Antisocial Personality Disorder. Many achieve adequate social and occupational adjustment as adults. Early onset predicts a worse prognosis and an increased risk for Antisocial Personality Disorder and Substance-Related Disorders. Those with Conduct Disorder (CD) are at risk for Somatoform Disorders, Mood Disorders, and Anxiety Disorders as well.

Etiology

The etiology of conduct disorders (CD) is thought to be mostly family influenced and morally developed. Studies have shown that there is a high incidence rate of deviant behavior among families of children with conduct disorder. Also, moral development relates to the violating of rules and norms that is portrayed among conduct disorder. These behavioral characteristics pertain to moral development.

Social problems and peer group rejection have been found to contribute to delinquency. Low socioeconomic status has been associated with conduct disorders. Children and adolescents exhibiting delinquent and aggressive behaviors have distinctive cognitive and psychological profiles when compared to children with other Mental Health Disorders problems and control groups.

A decrease of activity in frontal lobe functioning has been associated with poor ability to inhibit behavioral responses. This also leads to a weakness in planning ability.

Empirically supported treatments

Educating the parents of children with conduct disorders (CD) and providing them with information on the disorder are well-established treatments. Also, modifying the behavior in the classroom can be an effective treatment modality in children with conduct disorder (CD).

Certain cognitive-behavioral approaches have been proven to be effective when working with children that have CD. It has been documented that children with CD have problems processing social information. This may include difficulty encoding social cues, interpreting these cues, developing social goals, and developing appropriate social responses. These cognitive-behavioral techniques are designed specifically to help children overcome these deficiencies in social cognition and social problem solving.

Family therapy helps families gain an understanding of the problems with conduct disorder and how they can be corrected. Therapists evaluate how different family members interact in a therapy type environment. Typically, family therapy is directed towards helping parents work together as a whole, help them cope more efficiently, and to equip parents with better disciplinary skills.

Note: CD with childhood-onset-type applies if at least one criterion symptom was present prior to 10 years of age, while

CD with adolescent-onset-type is used if no symptoms were evident prior to 10 years of age.



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Summary

Conduct disorder (CD) is very common among children and adolescents in our society. This disorder not only affects the individual, but his or her family and surrounding environment. Conduct disorder (CD) appears in various forms, and a combination of factors appear to contribute to its development and maintenance. A variety of interventions have been put forward to reduce the prevalence and incidence of conduct disorder (CD). The optimum method appears to be an integrated approach that considers both the child and the family, within a variety of contexts throughout the developmental stages of the child and family's life (Duff, 2005).

Attention-Deficit/Hyperactivity Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE



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There are two types of **ADHD**: 1) **Inattentive Type**, and 2) **Hyperactive-Impulsive Type**.

DSM-IV-TR criteria

Inattentive Type

- Six or more of the following symptoms of inattention have been present for at least 6 months to a point that is disruptive and inappropriate for developmental level:
 - 1) Often does not give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
 - 2) Often has trouble keeping attention on tasks or play activities.
 - 3) Often does not seem to listen when spoken to directly.
 - 4) Often does not follow instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).
 - 5) Often has trouble organizing activities.
 - 6) Often avoids, dislikes, or doesn't want to do things that take a lot of mental effort for a long period of time (such as

schoolwork or homework).

- 7) Often loses things needed for tasks and activities (e.g. toys, school assignments, pencils, books, or tools).
- 8) Is often easily distracted.
- 9) Often forgetful in daily activities.
- Attention can mean a number of different things.
- In ADHD, the main problem is the inability to have sustained attention or persistence on tasks, remember and follow rules and resist distractions.
 - May be more related to working memory than true “attention” problems.
- People with ADHD exhibit more “off-task” time and less productivity.
- Even occurs during things like television.

Hyperactive-Impulsive Type

- Six or more of the following symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for developmental level:
 - Hyperactivity:
 - 1) Often fidgets with hands or feet or squirms in seat.
 - 2) Often gets up from seat when

remaining in seat is expected.

- 3) Often runs about or climbs when and where it is not appropriate (adolescents or adults may feel very restless).
- 4) Often has trouble playing or enjoying leisure activities quietly. Is often “on the go” or often acts as if “driven by a motor”.
- 5) Often talks excessively.

◦ Impulsiveness:

- 6) Often blurts out answers before questions have been finished.
- 7) Often has trouble waiting one’s turn.
- 8) Often interrupts or intrudes on others (e.g., butts into conversations or games).

- Some symptoms that cause impairment were present before age 7 years. There has to be an onset of symptoms prior to 7 years old, but a diagnosis can occur much later.
- Some impairment from the symptoms is present in

two or more settings (e.g. at school/work and at home).

- There must be clear evidence of significant impairment in social, school, or work functioning.
- The symptoms do not happen only during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder. The symptoms are not better accounted for by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Don't forget: Children who meet the criteria for both inattentive type and hyperactive-impulsive type meet the criteria for ADHD Combined Type.

ADHD Subtypes

- ADHD, Combined Type:
 - If both criteria for inattentive and hyper-impulsive symptoms are met for the past 6 months.
- ADHD, Predominantly Inattentive Type:
 - If criterion for inattentive is met but criterion for hyper-impulsive is not met for the past 6 months.
- ADHD, Predominantly Hyperactive-Impulsive

Type:

- If criterion for hyper-impulsive is met but criterion for inattentive is not met for the past 6 months.
- Evidence mounting that predominately inattentive type is a separate disorder:
 - Sluggish cognitive style, selective attention deficits.
 - Lower rates of co-morbidity with ODD and CD.
 - Memory retrieval problems.
 - Different development course.

Peers

One effect Attention-Deficit/Hyperactivity Disorder (ADHD) can have on a child's life is to make childhood friendships, or peer relationships, very difficult. These relationships contribute to children's immediate happiness and may be very important to their long-term development.

Research suggests that children with difficulty in their peer relationships, like being rejected by peers or not having a close friend, may in some cases have higher risk for anxiety, behavioral and mood disorders, substance abuse and delinquency as teenagers.

Parents of children with ADHD may be much less likely to report that their child plays with groups of friends or is

involved in after-school activities, and half as likely to report that their child has many good friends. Parents of children with ADHD may be more than twice as likely than other parents to report that their child is picked on at school or has trouble getting along with other children.

Associated features

There are three core features of ADHD. They are inattention, hyperactivity and impulsivity. Attention Deficit/Hyperactivity Disorder (ADHD) can be seen in both children and adults even though it is more prevalent in children. The onset of ADHD is usually before the age of seven. People with ADHD have to demonstrate at least one of three core features of the disorder: inattention, hyperactivity, and impulsive. Given these features, there are three subtypes of ADHD: Primarily Inattentive Type, Primarily Hyperactive-Impulsive Type, and Combined Type. Due to random cases and unique patients, the DSM-IV-TR includes an additional category, ADHD NOS (Not Otherwise Specified). This category is most often used in cases where the onset of ADHD occurs after seven years of age or when hypo-active behaviors accompany inattentive symptoms. The Inattentive Type of ADHD is characterized by poor organizational skills, poor ability to maintain mental focus, poor attention to details, forgetfulness, etc. Also the Inattentive type is the criterion for predominately inn-attentive type is met but not the hyperactive impulsive type for the past six months. The Hyperactive-Impulsive Type of ADHD is characterized by

fidgety behavior, non-stop motion, excessive talking, blurting out thoughts and answers, impatience, etc. This type is predominately met if criterion for hyper impulsive type is met but inattentive criterion is not met for the past six months. The DSM-IV-TR requires six of the nine listed symptoms for a diagnosis of Inattentive Type or Hyperactive-Impulsive Type. In addition, the DSM requires the child to meet four other conditions: symptoms must be present for at least six months, symptoms must cause problems with everyday life, symptoms must stay steady over different situations, and symptoms must occur before seven years of age. Children with this type of ADHD have difficulties with certain impulses, such as waiting their turn, which puts them at a greater risk socially with their peers. These children often have trouble maintaining friendships and tend to gravitate towards other children who exude disruptive behavior. Children who meet the qualifications and symptoms for the past six months for both Inattentive Type and Hyperactive-Impulsive Type ADHD are diagnosed with Combined Type ADHD.

The main problem is the inability to have sustained attention or persistence on tasks, remembering and following rules, and resisting distractions. This may be more related to working memory than true attention problems. These individuals display more off-task time and less productivity, even with television. In ADHD, thought to involve problems with voluntary inhibition of responses, not impulsively due to motivators. Some impairment from the symptoms is present

in two or more settings, at school or work and home. There must be clear evidence of significant impairment in social, school, or work functioning.

There are subtypes of ADHD that need to be recognized: Combined Type (if both criteria for inattentive and hyper-impulsive symptoms are met for past 6 months), Predominantly Inattentive Type (criteria for inattentive is met, but not hyper-impulsive criteria met for past 6 months), and lastly Predominantly Hyperactive-Impulsive Type (vice versa criteria as for Inattentive Type).

Child vs. adult presentation

ADHD is more prevalent in children, but it can also occur in adults. When present in adults, it is categorized as Adult Attention Deficit Disorder (AADD). The symptoms for AADD and ADHD are fairly similar. For example, AADD is characterized as having low self-motivation and low self-regulation due to procrastination, organization problems, problems being easily distracted, etc. Studies show that 70 percent of children diagnosed with ADHD will continue to have related symptoms into and possibly throughout adulthood. At some level, all of the core symptoms are present in all children. It is a very normal thing to be a kid and that involves a lot of random behaviors and spurts of likes and dislikes. The degree of the symptoms and the impairment they cause separates ADHD from ordinary exuberance. Symptom thresholds may not apply outside 4 to 16 year old range. The behavior of hyperactivity can be seen in 22% to

57% of children and only 4.2% to 6.3% meet criteria for the actual disorder. Parent reports are much lower than the reports by the teachers.

Gender and cultural differences in presentation

Regarding ratios of male to female, there have been assorted reports of ADHD ranging from 2:1 to 9:1. In other words, ADHD is seen two to four times more in boys than girls. Males are 2.6% to 5.6% time more likely to be diagnosed as females. Clinic referred samples have an even higher ratio due to co-morbid ODD/CD. Males and females tend to have the same functional deficits and impairments. Although recent studies have shown that children who express Inattentive Type ADHD symptoms are more likely to be female, experts are still debating whether prevalence rates indicate gender differences. ADHD is viewed differently across cultures. For example, some cultures view ADHD as it is described in the DSM-IV-TR. On the other hand, some cultures see it on a biological level and portray ADHD symptoms as character flaws. Studies show that Africa and the Middle East have lower prevalence rates of children diagnosed with ADHD than children diagnosed in North America.

Epidemiology

Attention Deficit/Hyperactivity Disorder (ADHD) is one of the most common childhood mental disorders. Prevalence rates of ADHD in school-aged children, according to the DSM-IV-TR, runs from three to seven percent of the total

population. In other words, three to seven percent of school-aged children will be diagnosed with one of the three types of ADHD. The Hyperactive-Impulsive Type of ADHD consumes ninety percent of these children. This could be due to the fact that most children showing symptoms of the Inattentive Type of ADHD are undiagnosed because of their passive and subtle behavior. Children with ADHD usually experience academic problems as well. It is estimated that comorbid rates between ADHD and specific learning disabilities are anywhere from 16 to 21 percent. It is important to note that symptoms of childhood depression and Bipolar Disorder often overlap with symptoms of ADHD. For example, irritability is one of the most common symptoms of childhood depression. Irritability can cause problems concentrating, agitation, frequent squirming, etc. Studies show that 70 percent of depressed children and 90 percent of younger children and 30 percent of adolescent children with Bipolar Disorder have co-morbid ADHD. ADHD and externalizing disorders also have co-morbid rates. Studies show that co-morbid rates between children with ADHD and ODD (Oppositional Defiant Disorder) range from 35 to 60 percent. Also, almost half of the children diagnosed with ADHD will develop CD (Conduct Disorder) later in life. Studies show that hyperactive teens with ADHD are significantly more likely to use cigarettes and alcohol. Lastly, ADHD causes its inhabitants to develop problematic relationships with their peers. This can cause social anxiety along with many other problems. Anxiety symptoms

resemble ADHD symptoms and most children with ADHD have sleeping problems.

ADHD fits the criterion such as engender substantial harm, and incur dysfunction of mechanisms that have been selected for survival value, and these back up ADHD's realness or validity.

The earliest age at which a diagnosis of ADHD might be possible is about three years; symptoms of inattention are not likely to be noticed until much later. About two-thirds of elementary school children diagnosed with ADHD have an additional diagnosable disorder. The course of this disorder is particularly prone to bad outcomes because of high rates of comorbidity with internalizing and externalizing disorders.

Etiology

The exact cause of ADHD is still debated among experts even though it is one of the most prevalent childhood disorders. The occurrence of ADHD is most likely due to a combination of environmental and biological factors. The biological factors pertain to abnormal brain activity and genetic factors. In children with ADHD, functional resonance imaging (fMRI) and [single photon emission computed topography \(SPECT\)](#) shows that the cingulate gyrus is more active. The cingulate gyrus is responsible for directing response selection and the ability to focus one's attention. On the other hand, brain scans show that frontal brain activities are less frequent than normal. The frontal brain system is in charge of executive and motor functioning.

Another area of abnormal brain activity for children with ADHD is neurotransmission. Studies show that these children have low levels of catecholamines (nor epinephrine, dopamine, and epinephrine). These neurotransmitters are responsible for motor activity and attention. In addition to abnormal brain activity, there are genetic factors in ADHD. Nearly 50 percent of parents who have ADHD have children with this disorder.

- There is much debate over the symptoms and name for what is now called or referred to as ADHD. Some other names and symptoms are explosive will, minimal brain dysfunction, volatile inhibition, and hyperactive child syndrome. In the DSM III, ADHD was called simply Attention Deficit Disorder.
- Evidence is mounting that the predominately inattentive type is a separate disorder such as a sluggish cognitive style, lower rates of co-morbidity with ODD and CD., memory retrieval problems, more passive social relationships and a different developmental course.
- As infants, children with difficult temperaments tend to be at greater risk for developing ADHD later in life.
- Other early risk factors include excessive activity, difficult sleeping (insomina), and irritability.

Empirically supported treatments

Treatments for ADHD can vary between patients according to their comorbid features. Recent studies show that stimulant medication is more effective in reducing the core symptoms of ADHD than behavior therapy. Given this, medication should still be a short-term fix. There are many forms of stimulant medication. For example, [Ritalin](#) (Methylphenidate) and Dexedrine are short-acting medications, Ritalin-SR is a slow release medication, and Ritalin-LA is a long-acting medication. Also, stimulant medications such as Ritalin, [Cylert](#) (Pemoline), and Dexedrine increase the number of neurotransmitters that ADHD inhibits.

Cylert (pemoline) is supplied as tablets containing 18.75 mg, 37.5 mg or 75 mg of pemoline for oral administration. Cylert is also available as chewable tablets containing 37.5 mg of pemoline. Cylert side effects cannot be anticipated. If any develop or change in intensity, inform your doctor as soon as possible. The most common Cylert side effect may include insomnia. Less common Cylert side effects may include depression, dizziness, drowsiness, hallucinations, headache, hepatitis and other liver problems, increased irritability, involuntary, fragmented movements of the face, eyes, lips, tongue, arms, and legs, loss of appetite, mild depression, nausea, seizures, skin rash, stomachache, suppressed growth, uncontrolled vocal outbursts, weight loss, and yellowing of skin or eyes. Rare Cylert side effects may include a rare form of anemia with symptoms such as

bleeding gums, bruising, chest pain, fatigue, headache, nosebleeds, and abnormal paleness.

Methylphenidate or Ritalin is a central nervous system stimulant. It affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. Methylphenidate is used to treat attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), and narcolepsy. Methylphenidate may also be used for purposes not listed in this medication guide. If a child is taking Ritalin it should be taken 2 times a day; morning before breakfast and at night before dinner. Usually children start out at 6mg tablets and then can move up to at least 60mg a day. Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established. Sufficient data on safety and efficacy of long-term use of Ritalin in children are not yet available. Although a causal relationship has not been established, suppression of growth (ie, weight gain, and/or height) has been reported with the long-term use of stimulants in children. Therefore, patients requiring long-term therapy should be carefully monitored. Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative. Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parental abuse. Careful supervision is required during drug withdrawal, since severe depression as

well as the effects of chronic over activity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

The dose of **Dexedrine**® (**dextroamphetamine** sulfate) prescribed by your healthcare provider will vary depending on a number of factors, including: the condition being treated (**ADHD** or **narcolepsy**), your age, other medical conditions you may have, other medications you may be taking. As is always the case, do not adjust your dose unless your healthcare provider specifically instructs you to do so. Dexedrine Dosing for ADHD; refer to the following table for the Dexedrine dosing for children and teenagers with ADHD:

Age	Dexedrine Dosage	Maximum Dexedrine Dosage
3 to 5 years old	2.5mg once daily (tablet only)	40mg total daily (rarely, dosages may need to be higher)
6 years and older	5 mg once or twice daily (tablets), or 5 10 mg once daily (spansules)	40 mg total daily (rarely, dosage may need to be higher)

Generally, the lower dosage of Dexedrine should be tried first. The dosage should be increased slowly and only if necessary.

As with any medicine, there are possible side effects with **Dexedrine**® (**dextroamphetamine** sulfate). However, not everyone who takes this medicine will have problems. In fact, most people tolerate it well. When side effects do

occur, in most cases they are minor, meaning they require no treatment or are easily treated by you or your healthcare provider. Most common side effects of Dexedrine include: overstimulation, restlessness, or [**insomnia**](#), dizziness, [**Headache**](#), dry mouth, unpleasant taste, [**Diarrhea**](#), [**Constipation**](#), loss of appetite and decreased eating, weight loss (see [**Dexedrine and Weight Loss**](#)), and [**Erectile dysfunction**](#) ([**ED**](#) or [**impotence**](#)) or changes in sex drive (see [**Dexedrine Sexual Side Effects**](#)). Dexedrine can also cause a temporary slowing of growth in children. This slowing of growth is usually small (less than an inch and less than two pounds), and children usually catch up to within normal limits in time.

There are behavioral benefits to stimulant medication too. Studies show that improvements in parent-child interactions and decreases in aggressive behaviors can result from stimulant medications. Studies also show that Parent Training Programs (PT) are effective in that they improve parenting skills while reducing parent stress. Behavior treatment is used and can show improvements in areas such as parent-child interactions, aggressive responses, and social skills. Given the above information, medication is still the most effective treatment for ADHD.

Critics

- Symptom thresholds may not apply outside 4-16 year old range.
- Research has found the following recommended

levels for different age groups:

- 4/9 and 5/9 for age 17-29.
- 4/9 and 4/9 for age 30-49.
- 3/9 and 3/9 for ages 50+.
- No research on below age 4.
- Appropriateness of items sets for different ages and genders.
 - Inattention seem more geared for school-age or adolescents.
 - Hyper/Impulsive seem more applicable to younger children.
- Could influence rates of diagnosis across age groups, resulting in more false-negative as one gets older.
- Onset before age 7 not research supported.
 - No other mental disorder has a precise an age of onset.
- No lower-age or IQ boundary in DSM-IV-TR.
- No research support for symptom duration of 6 month; some support for a 12 month period.
- Requirement of impairment 2/3 environments.
 - Situational specificity
 - Lack of parent-teacher agreement

Abnormal Psychology

- Problems likely to be addressed in DSM-V, but can be used for more effective diagnosis now.
- Many critics of the reality of ADHD, say that it is merely pathologizing normal behavior.
 - Includes Rush Limbaugh, Psyllis Schaffly, George Will, Ariana Huffington, Hillary Clinton, and even some actual scientists.
- If this is true, differences would not be found between ADHD and non-ADHD children.
 - Obviously not the case, 30 years of research on the differences.

The MTA study

The Multimodal Treatment Study of Children (MTS) with ADHD is the largest and most comprehensive study done on children with ADHD. A summary of the study is summarized by Dr. David Rabiner, Ph.D at the following link: [MTA study](#).

Links

- Robert Jergen, author of *Little Monster: Growing Up with ADHD* and professor at the University of Wisconsin, tells about his life as an adult with ADHD:
 - [“Dealing with ADHD as an Adult.”](#) *Talk of the Nation*. National Public Radio.

July 12, 2005.

Barkley's model

- focuses on how behavioral disinhibition impacts four primary executive functions:
 - Poor working memory
 - Delayed interalization of speech
 - Immature regulation of affect/ motivation/ arousal
 - Impaired reconstitution


Barkley's Assumptions

- Behavioral inhibition (BI) develops ahead of these four executive functions (EF).
- Each EF emerges at different times and has a different developmental trajectory.
- ADHD impairs the BI, which in turn impairs the EF.
- Deficit in BI due to biological factors.
- Deficits in self-regulation are caused by the primary BI, but in turn feed back to cause even poorer BI.
- Model does not apply to the inattentive type of ADHD.

- With approximately four million children in the United States it can be difficult to realize the individual nature of ADHD symptoms in children. Each child presents a unique case. See video <http://www.youtube.com/watch?v=z2hLa5kDRCA>.
- Journal article: [Social cognition in ADHD](#).
- Journal article: [Genetics of ADHD](#).
- A report done by CNN on the over diagnosis of ADHD: [CNN report on ADHD](#).
- A satirical view of ADHD as shown on Comedy Centrals “The Daily Show”, with John Stewart but refer back to the previous information to see correct symptoms and diagnostic criteria for ADHD: [Daily Show ADHD](#).
- To learn more about the effects ADHD can have on children with peer interactions, click [here](#).
- Below is a YouTUBE video of a young boy with ADHD. It shows how even though he has a mental illness he can still perform with music. ADHD does not affect this kid with his music ability.



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Oppositional Defiant Disorder (ODD) & Conduct Disorder (CD)

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

Antisocial and aggressive behavior

Antisocial behavior (ASB) in children and adolescents can fall into two primary categories in the DSM-IV-TR, which are Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). Official rates of antisocial behavior have fallen since the 1990's, but still are much higher in the United States than in any other industrialized nation.

Defining the problem

From a legal perspective, delinquency involve children, while criminal acts involve adults. It refers to one act and not a series of acts. Also, it is official if they are caught for the act and self-reported if they only admit to doing it.

From an empirical, psychological perspective, externalizing behaviors are acting out while internalizing behaviors are acting in. Antisocial behaviors would be an externalizing, disruptive, acting out behavior. This does not refer to ADHD-type behaviors though. Aggression and antisocial behaviors frequently co-occur but are very different.

From the diagnostic perspective, ODD and CD are disruptive behavior disorders in children and adolescents and antisocial personality disorder (ASPD) is a disorder found in adults. There is a backwards trend—children with ODD or CD will not necessarily have ASPD when they get older. Many children drop out of their disorders. There is not a forward trend to this though.

From the developmental perspective, they examine development of callous, unemotional traits in childhood, and how it relates to traits of psychopathy in adults. The callous/unemotional trait may be a downward extension of the affective/interpersonal factor of psychopathy (Mash & Barkley, 2003).

Subtypes of aggression and antisocial behavior

There is verbal versus physical. Physical emerges earlier with

a peak during preschool years, verbal shows later onset. There are high levels of physical during middle childhood that may warrant clinical attention, as may early emergence of verbal aggression. Physical aggression may become violent in later development. There is a difference between aggression and violence. Violence has an intent to harm while aggression is used to get their way (Lack, 2010).

Another subtype of aggression and antisocial behavior, is instrumental (goal-directed) versus hostile (inflicting pain is the goal). For the latter type, the inflicting of pain is characterized as the intent of the behavior observed (Mash & Barkley, 2003). Some levels of instrumental aggression are normative for toddlers, but extreme levels of hostile aggression demand further assessment for any age group (Mash & Barkley, 2003).

The third subtype group is proactive (bullying) versus reactive (retaliatory). Both types of aggression are highly related to each other, but they use different kinds of social-cognitive information-processing deficits and distortions (Mash & Barkley, 2003).

The fourth subtype group is direct versus indirect/relational. Direct can be described as verbal and physical manifestations, while indirect or relational are described as “getting even” by having a third party retaliate which can occur through rumors (Mash & Barkley, 2003). Indirect aggression is seen more often in females (Lack, 2010).

The final subtype is broadly, overt versus covert. Overt is exemplified by most of the types of physically aggressive

actions noted throughout this section. Covert refers more to non-aggressive behaviors such as lying, stealing, destroying property, etc.

ASB diagnostic history

There has been research on differences in ASB children for over 60 years. The earlier research focused on “under-socialized” versus “socialized” behaviors (Lack, 2010). The DSM-III changes included operational criteria for CD, four subtypes (socialized versus under-socialized and aggressive versus non-aggressive), and introduced a mild version called “oppositional disorder”. The DSM-III-R changed it significantly by increasing the number of symptoms needed, the subtypes became groups/socialized type, solitary/aggressive, and undifferentiated and “oppositional disorder” was renamed ODD. The DSM-IV-TR kept these two categories separated and introduced several other differences (Lack, 2010).

ODD features

There is a recurrent pattern of negative, defiant, disobedient, and hostile behavior toward authority figures. It is important to remember that this is toward authority figures and not their peers. This occurs outside of normal developmental levels and leads to impairment in functioning (Lack, 2010).

DSM-IV-TR CRITERIA

- Displaying four (or more) of the following

behaviors consistently over at least a six month period;

- often loses temper
 - often argues with adults
 - often actively defies or refuses to comply with adults' requests or rules
 - often deliberately annoys people
 - often blames others for his or her mistakes or misbehavior
 - is often touchy or easily annoyed by others
 - is often angry or resentful
 - is often spiteful or vindictive
- Behavior problems cause clinically significant impairment in social, academic, or occupational functioning. The behaviors are not part of a psychotic or mood disorder. Criteria not met Conduct Disorder or Antisocial Personality Disorder (Lack, 2010).

CD features

Repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. There are four main categories of symptoms' aggressive conduct that threatens physical harm, non-aggressive conduct that causes property damage,

deceitfulness or theft, and serious violation of rules (Lack, 2010).

DSM-IV-TR CRITERIA

Have to have three (or more) symptoms in the past 12 months, with at least one in the last six months. The behavior problems cause clinically significant impairment in social, academic, or occupational functioning. Criteria not met for Antisocial Personality Disorder if above age 18.

Aggression to people and animals

- often bullies, threatens, or intimidates others
- often initiates physical fights
- has used a weapon that can cause serious physical harm to others (such as a bat, brick, broken bottle, knife, gun)
- has been physically cruel to people
- has been physically cruel to animals
- has stolen while confronting a victim (mugging, purse snatching, extortion, armed robbery)
- has forced someone into sexual activity

Destruction of property

- has deliberately engaged in fire setting with the intent of causing serious damage

- has deliberately destroyed others' property (by means other than fire setting)

Deceitfulness or theft

- has broken into someone else's house, building, or car
- often lies to obtain goods or favors or to avoid obligations (cons others)
- has stolen items on nontrivial value without confronting a victim (shoplifting, but without B&E, forgery)\

Serious violations of rules

- often stays out at night despite parental prohibitions (beginning before the age of 13 years)
- has run away from home overnight at least twice while living in a parental home.
- is often truant from school (beginning before the age of 13 years)

CD subtypes

- Child-Onset Type: onset of at least one criteria before age 10.
- Adolescent-Onset Type: absence of any criteria before age 10.
- Unspecified Onset

- Code severity: mild, moderate, severe

Viability of CD and ODD

Both disorders are divergent from ADHD, but still distinct from ADHD. They do show significant overlap in behavioral pattern and risk factors (Lack, 2010). The difference is that those with ADHD do not mean to perform those behaviors. There is a difference developmental course for those diagnosed with ODD only, diagnosed with ODD and then CD, and those diagnosed only with CD. There is currently no strong evidence for discontinuity of symptoms in CD predicting course. ODD is characterized by normal, developmentally appropriate behaviors and is often criticized for this fact in the popular press. Most with CD have ODD, but not all. Most with ODD do not have CD. The number of possible symptoms in CD diagnosis guarantees heterogeneity of the disorder. It can have overt, covert, or mixed presentation. The DSM-IV has included warnings not to ignore environmental context of aggressive behaviors (Lack, 2010). In some situations a behavior can be beneficial or adaptive, such as running away from an abusive home is beneficial.

Prevalence rates

With shifting diagnostic criteria over the past 20 years it was hard to get good long-term data. The median estimates of 3% for ODD. There are higher rates of self-report and

about 1-3% from parent-report. CD estimates from 1-10%, depending on criteria (Lack, 2010).

Sex differences

There are initially no sex differences in activity level, noncompliance and other types of difficult temperament traits. By elementary school, evident sex differences occur, with males showing more of every type of aggression. This may be that females' developmental course steers them more toward internalizing problems and may also be the differences in externalizing symptoms in females (such as sexual promiscuity, substance use, and somatization). ODD rates are equal in early childhood, but males predominate by early elementary years. CD rates in childhood and preadolescence show a 4:1 male-female ratio. Sex differences seem to disappear by adolescence. The differences are notable in indirect/relational aggression, where females show much higher rates (Lack, 2010).

Comorbidity

Large amounts of co-morbid problems appear in both ODD and CD. There is a co-morbidity with ADHD that is associated with worse outcomes, such as ASPD and higher levels of aggression. Also, there is a co-morbidity with academic problems. They are mediated by presence of ADHD in middle childhood. The snowball effect can be seen in this situation. It is also co-morbid with internalizing problems. Social withdrawal forms of anxiety appear to be

predictive of more aggression, while fear and inhibition are related to less aggression. There is a high co-morbidity with depression, but the relationship between them is uncertain.

Risk factors

Child factors:

- difficult temperament from birth
- hyperactivity (if co-occurs with CD)
- impulsivity
- substance use
- aggression
- early-onset of disruptive behaviors
- withdrawal
- low intelligence/executive function/information processing problems

Family factors:

- parental substance abuse
- modeling of antisocial/delinquent behavior by parents
- parental history of mental problems, particularly father's ASB and mother's depression.

Peer factors:

- Rejection by peers
- association with delinquent peers/siblings

Parenting practices:

- poor parent-child relations
- poor supervision/communication
- physical punishment
- parental neglect/abuse
- maternal nicotine use during pregnancy
- teenage/single parenthood
- disagreement on discipline among parents
- high turnover of caretakers
- carelessness in allowing access to weapons

School factors:

- poor academic performance
- being older than classmates
- weak bonding to school
- low educational aspirations
- low school motivation
- poor school system

Neighborhood factors:

- neighborhood disadvantage or poverty
- disorganized neighborhood
- availability of weapons
- media portrayal of violence

Assessment and diagnosis

Structured or semi-structured clinical interview that should cover developmental and family history, DSM-IV ODD/CD symptoms, and symptoms of typical co-morbid problems (such as ADHD, LDs, anxiety/mood disorders, etc.). There should also be parent, teacher and self-reports of behaviors. Some good scales to use include BASC and CBCL for overall screeners. This is due to a high co-morbidity with ADHD, that some may want to use specific measures.

Treatment

Treatment outcomes are much better for ODD than for CD. Effective treatments are based on operant conditioning and social-cognitive learning principles.

There are four empirically supported treatments:

- 1.) Contingency management programs: they establish clear behavioral goals to shape towards appropriate behavior, monitor the child's progress toward goals, reinforce appropriate steps toward these goals, and provide consequences for inappropriate behavior.
- 2.) Parent Management training (PMT): the goal is to teach the parents how to develop and implement structured

contingency management programs at home. It also focuses on improving parent-child interactions, changing antecedents to problem behaviors, improving parent's monitoring of child's behavior and using more effective discipline strategies. It is a very Skinnerian technique.

3.) CBT approach: the goal is to overcome deficits in social cognition and problem solving. Also includes role-playing and modeling. Also there is stimulant medication which is useful in children with ADHD who have co-occurring behavior problems.

4.) Multisystemic therapy (MST): it grows out of a family systems approach. Intensive treatments that see problems in children's behavior as stemming from a larger family context. It focuses on the role of the misbehavior in the family, then adjusting how the family responds and reacts to both the child and each other.

References for ODD & CD

Lack, C. W. (2010). *Abnormal Psychology*. Retrieved 2010, from Caleb W. Lack, Ph.D: <http://www.caleblack.com/psy4753.html>

Mash, E. J., & Barkley, R. A. (2003). *Child Psychopathology* (2 ed.). New York, NY: The Guilford Press.

Attention-Deficit/Hyperactivity Disorder (ADHD)

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COLLEGE

History

There has been a lot of debate over symptoms and what the name should be before it was decided to be called ADHD. William James referred to it as ‘explosive will’ and George Still called it ‘volitional inhibition’. ADHD has also been referred to as minimal brain dysfunction and hyperactive child syndrome. The DSM-II called it ‘hyper-kinetic reaction of childhood’, which was the first childhood disorder in the DSM. DSM-III referred to it as Attention Deficit Disorder

(ADD) and it had much more information on it. It was classified as with or without hyperactivity. The DSM-IV calls it ADHD. DSM-V will also refer to it as ADHD.

Features

There must be a persistent pattern of inattention and/or hyperactivity-impulsivity more severe and more frequent than in same-age peers. There has to be an onset of symptoms prior to seven years old, but diagnosis can occur much later. A child must display six or more symptoms of either inattention or hyperactivity-impulsivity for at least six months. Adults can have less. There must be some impairment from the symptoms present in two or more settings (e.g., at school/work and at home) and a clear impairment in social, school or work functioning. The symptoms cannot be accounted for by another mental disorder such as pervasive developmental disorder, schizophrenia, or any other psychotic disorder. The problems with inhibition (hyperactive-impulsive behavior) arise first, usually at ages 3-4, ahead of those related to inattention, with arise are 5-7 years old and then slow cognitive tempo arises at ages 8-10 (Mash & Barkley, 2003). Those with inattention are frequently diagnosed later in life due to the less disruptive nature of the problems. It will not go away with adulthood, but presentation does typically change.

Symptoms

Inattention symptoms:

- often does not give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
- often has trouble keeping attention on tasks or play activities.
- often does not seem to listen when spoken to directly.
- often does not follow instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).
- often has trouble organizing activities.
- often avoids, dislikes, or does not want to do things that take a lot of mental effort for a long period of time (such as schoolwork or homework).
- often loses things needed for tasks and activities (e.g., toys, school assignments, pencils, books, or tools).
- often easily distracted.
- often forgetful in daily activities.
- inability to have sustained attention or persistence on tasks, remember and follow rules, and resist distractions (may be more related to working memory than true “attention” problems).
- exhibit more “off-task” time and less productivity

(even occurs while watching television).

- slower and less likely to return to an activity once interrupted.
- less attentive to changes in the rules governing a task.
- less capable of shifting attention across tasks flexibly.

Hyperactivity symptoms:

- often fidgets with hands or feet or squirms in seat.
- often gets up from seat when remaining in seat is expected (such as in school).
- often runs about or climbs when and where it is not appropriate (adolescents or adults may feel very restless).
- often has trouble playing or enjoying leisure activities quietly.
- often “on the go” or often acts as if “driven by a motor”.
- often talks excessively.
- greater touching of objects.

Impulsive symptoms:

- often blurts out answers before questions have been finished.

- often has trouble waiting one's turn.
- often interrupts or intrudes on others (e.g., butts into conversations or games).

The 3 Subtypes

1. Combined type: if both criteria for inattentive and hyper-impulsive symptoms are met for the past 6 months. There must be 6 symptoms present from each. Combined is the most common of the subtypes.
2. Predominately Inattentive type: If criteria for inattentive is met but criterion for hyper-impulsive is not met for the past 6 months.
3. Predominantly Hyperactive-Impulsive type: If criterion for hyper-impulsive is met but criterion for inattentive is not met for the past 6 months.

Criticisms

Some say that the child is “just being a kid”. There is some level of all of the core symptoms is present in all children which is very normal. ADHD is separated from ordinary exuberance and “being a kid” by the degree of the symptoms and the impairment they cause.

Symptoms thresholds may not apply outside of 4-16 year old range. Fewer symptoms are needed to qualify for ADHD as age increases.

Appropriateness of item sets for different ages and genders. Inattention seems more geared for school-aged or

adolescents. Hyper/Impulsive seems more applicable to younger children. This could influence the rates of diagnosis across age groups, resulting in more false-negatives as one gets older.

There is little if any research for the onset before age 7. No other mental disorder has this precise an age of onset. There is also no lower-age or IQ boundary in the DSM-IV-TR.

No research support for symptom duration of 6 months. There is some support for a 12 month period, though.

The requirement of impairment in 2/3 environments is situation specific and lacks parent-teacher agreement.

Some say that ADHD is not real and it is merely pathologizing normal behavior, which is not the case; research indicates that there are a large number of differences between ADHD and non-ADHD children.

Prevalence

The behavior of hyperactivity can be seen in 22-57% of children. Only 4.2-6.3% meet criteria for the action disorder, which is 5% nationwide. Parent-reports gives much lower figures than teacher-reports, which only seems to support the idea that environmental context is very important.

Sex differences

Males are 2.6-5.6 times more likely to be diagnosed as females within epidemiological samples; average ratio of 3:1. The clinic-referred samples have even higher ratios due to comorbid Oppositional Defiant Disorder/Conduct Disorder

seen in boys. This holds true even though research show that females have as great of functional impairments and deficits as the males.

Socioeconomic and cultural differences

There is little research on the relationship between socioeconomic status (SES) and ADHD rates. However, using the DSM criteria, there are higher rates of ADHD found outside the United States. This is most likely due to cultural differences in expectations or interpretations of symptoms. There are higher rates in the US reported for non-whites, yet they are from poorly controlled studies that had no correction for co-morbidity. It seems that ADHD occurs across all socioeconomic levels, although there are variations across all SES levels.

Co-morbid psychiatric disorders

There are high rates of co-morbidity in ADHD; 44% in community samples and 87% for clinic-referred samples. The most common of those disorders are Oppositional Defiant Disorder (54%-67%), Conduct Disorder (26% by adulthood), Antisocial Personality disorder (12-21%), learning disorders (30-50%), anxiety disorders 25% in childhood), and mood disorders (20-30%). Up to 18% of children may develop a motor tic in childhood (a symptom of Tourette's), but this declines at a base rate of 2% by mid-adolescence and less than 1% by adulthood. Individuals with obsessive-compulsive disorder or Tourette's disorder have a marked elevation in

risk for ADHD, averaging 48% or more (Mash & Barkley, 2003).

Developmental impairments

- There are many concurrent developmental difficulties that are seen with ADHD:
- Physical problems: gross and fine motor control, motor sequencing.
- Working memory impairments
- Poor planning and anticipation
- lack of verbal fluency
- Inefficient self-monitoring
- Poor regulation of emotion
- Impaired academic functioning: the snowball effect-as you go on you get further behind. Between 19% and 26% of children with ADHD are likely to have any single type of learning disability, which, conservatively, is defined as a significant delay in reading, arithmetic, or spelling relative to intelligence and achievement in one of these three areas at or below the 7th percentile (Mash & Barkley, 2003).
- Reduced intelligence. These children often have lower scores on intelligence tests, especially in verbal intelligence, when compared to children

without ADHD (Mash & Barkley, 2003).

- Poor social skills. Fellow classmates may not deem a child with ADHD as someone they would want to become friends with since they usually interrupt or join conversations without being invited into them. They are also seen as disruptive.
- Motor in-coordination: as many as 60% of children with ADHD, compared to up to 35% of normal children (Mash & Barkley, 2003). All of the listed impairments can fall under the domain of “executive functioning” since they are processes that assist with self-regulation, behaviors that modify the probability of a subsequent behavior so as to change the probability of a later consequence. They are mediated by the prefrontal cortex.

Health Outcomes

Studies have concluded that children with ADHD are more accident-prone and get injured more often than children without the disorder. About 16% of a sample of hyperactive children from a study had at least four or more serious accidental injuries (broken bones, lacerations, head injuries, severe bruising, lost teeth, etc.), compared to the 5% of children in the control group (children without ADHD) (Mash & Barkley, 2003). Teenagers with ADHD have a higher frequency of vehicular crashes and a history of citations for speeding than children without ADHD (Mash

& Barkley, 2003). This may be due to the inattention and/or hyperactive-impulsive behavior of a teenager with ADHD. Children with ADHD also have more sleep problems than a child without; they experience a longer amount of time to fall asleep, instability of sleep duration, tiredness at waking, or frequent waking during the night (Mash & Barkley, 2003).

Etiology

ADHD arises from a combination of environmental, genetic, and neurological factors, meaning that there is no one true developmental pathway. Whatever pathway it takes, it often ends up disrupting prefrontal cortical-striatal network, which is smaller and less active in people with ADHD. Social factors may play a role in expression, but would not be purely responsible for this disorder.

Theoretical framework

Barkley's model focuses on how behavioral disinhibition impacts four primary executive functions; poor working memory, delayed internalization of speech, immature regulation of affect/motivation/arousal, and impaired reconstruction. These impairments in executive function in turn impair social self-sufficiency. Barkley's assumptions were; 1.) behavioral inhibition develops ahead of these four executive functions, 2.) each executive function emerges at different times and has a different developmental trajectory, 3.) ADHD impair the behavioral inhibition, which in turn impairs the executive function, 4.) deficit in behavioral

inhibition is due to biological factors, 5.) deficits in self-regulation are caused by the primary behavioral inhibition, but in turn feedback to cause even poorer behavioral inhibition, and 6.) model does not apply to inattentive types of ADHD (this is the model's biggest problem).

Diagnosis

A typical battery for an ADHD assessment would include; a structured or semi-structured clinical interview that should cover developmental and family history, DSM-IV ADHD symptoms, and symptoms of typical co-morbid problems, intelligence and achievement testing to rule out learning disabilities since ADHD is highly co-morbid with them, parent, teacher and self-reports of behavior, and one could also use continuous performance measures but they have less diagnostic validity than parent or teacher report measures.

Treatment(s)

Medication is very effective at treating core symptoms. Central nervous system stimulants such as amphetamine and methylphenidate help in 70-80% of children. Another treatment is behavioral therapy, which cannot reduce the core symptoms, but it can help treat co-occurring problems such as; social skills training, parent training for oppositional behavior, helping parents shape home environment, working with teachers to shape school environment, etc. Behavioral therapy has the best long-term outcomes. A combination of medication and behavioral therapy has been found as most

effective for longer-term outcomes No other treatments have been found to be effective. There are many out there that say they are, but they are basically aimed at taking people's money such as changing diets, biofeedback and vitamins.

Changes proposed for DSM-5

DSM-5 changes the symptoms from inattention **or** hyperactivity and impulsivity to inattention **and/or** hyperactivity and impulsivity. There will also be more symptoms for hyperactivity and impulsivity added. Inattentive Presentation (Restrictive) will be added among the types of presentations of ADHD (American Psychiatric Association, 2010).

ADHD References

- American Psychiatric Association. (2010). *Proposed Draft Revisions to DSM Disorders and Criteria*. Retrieved 2010, from DSM-5 Development: <http://www.dsm5.org/ProposedRevisions/Pages/Default.aspx>
- Lack, C. W. (2010). *Abnormal Psychology*. Retrieved 2010, from Caleb W. Lack, Ph.D: <http://www.caleblack.com/psy4753.html>
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Dissociative Identity Disorder (300.14)

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

This is a video of a man named Tony who has Dissociative Identity Disorder. It is believed that Tony has 53 or more distinct identities or personality states.

The video above is an interview with former NFL running back Herschel Walker. In the interview he briefly discusses his experience with Dissociative Identity Disorder.

DSM-IV-TR CRITERIA

A. The presence of two or more distinct identities or

personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these identities or personality states recurrently take control of the person's behavior.

C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

D. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

Associated features

Several symptoms are characteristic:

- Fluctuating symptom pictures
- Fluctuating levels of function from highly effective to disabled
- Severe headaches or other pains
- Time distortions, time lapses, and amnesia
- Depersonalization and Derealization –
Depersonalization occurs when a person feels unattached to him or herself. During this phenomenon, it is almost as if you can see yourself from another view point. Derealization is when

you experience surroundings or people as if they are new, eccentric, or dreamlike when they are clearly not.

- Patients can lose time; they can end up in places and not know how they arrived there or why. They also may find objects that they do not identify or handwriting that they do not think they wrote.
- Individuals with Dissociative Identity Disorder frequently report having experienced severe physical and sexual abuse, especially during childhood. However, children's minds can produce distorted images or memories, so it is hard to tell how accurate they are. Some past experiences can be cleared up through objective evidence. Some individuals may have post traumatic symptoms such as nightmares, flashbacks, and startle responses.
- Certain identities can control their pain levels or other physical symptoms, which some individuals will self-mutilate and have suicidal thoughts. They may also experience relationships that contain both sexual and physical abuse. The identities or personality states persistently take control over the person's behavior. These alternate identities are frequently diverse from the individual's personality. Also, it could be of a different name, age, gender,

or even race.

- Comorbidity occurs with Post- Traumatic Stress Disorder.

Child vs. adult presentation

There are no reliable figures on the diagnosis of children. However, it has increased during the 1990s. A child acting like someone else is perfectly normal. They are trying to get a sense of self. Of course, if some trauma happens in a child's life, the result may go beyond simply mimicking another person. It may go as far as to creating alter personality states so they can create a fantasy world in order to escape real life. The average age is in early childhood, generally by the age of four. The average time period for the first symptom to occur to diagnosis is 6-7 years. The disorder may go dormant after 40 years of age but may reappear during episodes of stress or trauma or with substance abuse.

Gender and cultural differences in presentation

Dissociative Identity Disorder has been found in individuals from a several different cultures all around the world. It is diagnosed 3 to 9 times more often in adult females than in adult males; in childhood, the female-to-male ratio may be even more, but the data is limited. Males tend to have fewer identities than females. Males have approximately 8 identities. Females tend to have around 15 or more.

Epidemiology

- The studies do not give an exact estimate, however the numbers have increased drastically. A reason for this is because it could have been misdiagnosed as schizophrenia or bipolar disorders. Also, people have become more aware of child sexual abuse, which is a leading cause of DID. DID may be present in about 1% of the general population. India, Switzerland, China, and Germany's prevalence rates range from 0.015% to 0.9%. The Netherlands is 2%. The U.S. ranges from 6 to 10% and Turkey at the highest with 14%.
- However, scientists claim that a person having multiple personalities is bizarre, and the support for it is not credible. Some therapists maintain that using hypnosis and frequent prompting of alters bring about the indwelling identities. Even though, some patients do not show symptoms before the treatment has occurred. There is substantial support for the claim that therapists and the media are creating alters rather than discovering them.

Etiology

The causes are not yet confirmed, but there are some theoretical predictions of what causes DID. They are overwhelming stress, physical and sexual abuse especially in

childhood, inadequate childhood nurturing, and the disability to separate recollections with what actually happens. The most common reason is childhood abuse; most of the cases reported deal with abuse. Some children tend to make up “happy places” that they can disappear to, to get away from the violence. If it happens often enough, the children may not be able to tell the difference between that and reality. It is also more common when an individual has biological relatives that also have the disorder.

Empirically supported treatments

Treatment is done to try to reconnect the different personalities to one functional identity. Sometime if that does not work, a clinician may try to do something to help with the symptoms. Some of the things are long-term psychotherapy, cognitive and creative therapies, and medications for comorbid disorders or doing some kind of behavioral therapy. Some may face a longer, slower process which may only help with symptom relief. However, the ones that are still attached to the abusers may have the most difficult time. Some medications for Dissociative Identity Disorder are antidepressants, anti-anxiety drugs, or tranquilizers to help reduce the symptoms.

PROPOSED DSM-5 CHANGES (DSM5.ORG)

Dissociative Identity Disorder

A. Disruption of identity characterized by two or more

distinct personality states or an experience of possession, as evidenced by discontinuities in sense of self, cognition, behavior, affect, perceptions, and/or memories. This disruption may be observed by others or reported by the patient.

B. Inability to recall important personal information, for everyday events or traumatic events, that is inconsistent with ordinary forgetfulness.

C. Causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The disturbance is not a normal part of a broadly accepted cultural or religious practice and is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol intoxication) or a general medical condition (e.g., complex partial seizures). NOTE: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

Specify if:

a) With non-epileptic seizures or other conversion symptoms

b) With somatic symptoms that vary across identities (excluding those in specifier a)

The workgroup is still considering whether Criterion C is necessary. The specifiers are still under consideration.

Rationale for Change

A. Clarification of language, including indicating that different states can be reported or observed, reducing use

of Dissociative Identity Disorder Not Otherwise Specified. Including Trance and Possession Disorder by mentioning “experience of possession” increases global utility.

B. Noting that amnesia for everyday events is a common feature.

C. This criterion is included in DSM-IV Dissociative Identity Disorder. Including it may help differentiate normative cultural experiences from psychopathology.

D. Addition from DSM-IV Dissociative Trance Disorder to increase cross-cultural applicability

Specifiers:

a) A substantial proportion of patients with Dissociative Identity Disorder have conversion symptoms, which are related to their dissociative disorder and require special clinical attention and treatment.

b) Some Dissociative Identity Disorder patients have dissociative variations in somatic symptoms that require clarification for differential medical diagnosis and treatment.

DSM-5 Changes for Dissociative Disorder not Otherwise Specified (300.15)

This category is for disorders in which the predominant feature is a dissociative symptom (i.e. *a subjective loss of integration of information or control over mental processes that, under normal circumstances, are available to conscious awareness or control, including memory, identity, emotion, perception, body*

representation, motor control, and behavior) that does not meet the criteria for any specific Dissociative Disorder. Examples include:

1. Clinical presentations similar to Dissociative Identity Disorder that fail to meet full criteria for this disorder. Examples include presentations in which a) there are not two or more distinct personality states, or b) amnesia for important personal information does not occur.
2. States of dissociation that occur in individuals who have been subjected to periods of prolonged and intense coercive persuasion (e.g., brainwashing, thought reform, or indoctrination while captive).
3. Dissociative trance, characterized by narrowing of awareness of immediate surroundings or stereotyped behaviors or movements that are experienced as being beyond one's control. The dissociative trance is not a normal part of a broadly accepted collective cultural or religious practice.
4. Loss of consciousness, stupor, or coma not attributable to a general medical condition.
5. Ganser syndrome: the giving of approximate answers to questions (e.g., 2 plus 2 equals 5) when not associated with Dissociative Amnesia.
6. Acute reactions to stressful events, lasting less than one month, that are characterized by mixed

dissociative symptoms, such as depersonalization, derealization, amnesia, disruptions of consciousness, and/or stupor that cause marked distress or impairment and are not restricted to the symptoms of another mental disorder, e.g., Acute Stress Disorder, Delirium, or another dissociative disorder.

7. Acute states, lasting less than one month, characterized by mixed dissociative symptoms (e.g., amnesia, dissociative flashbacks, disruptions of consciousness) and psychotic symptoms (e.g., catatonia, auditory or visual hallucinations, delusions, grossly disturbed behavior) that cause marked distress or impairment and do not meet criteria for Acute Stress Disorder, a Psychotic Disorder, Delirium, or another dissociative disorder.

An additional example of acute presentations with mixed dissociative symptoms that do not fulfill criteria for the specified dissociative disorders is being considered for inclusion in Dissociative Disorder Not Otherwise Specified.

Rationale

Changes to be consistent with alterations in Dissociative Identity Disorder and the definition of dissociation.

Somatization Disorder (300.81)

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In the video above Dr. Soheil Ahaddian explains what Somatization Disorder is and the symptoms that appear with it.

DSM-IV-TR CRITERIA

A history of many physical complaints beginning before age 30 years that occur over a period of several years and result in treatment being sought or significant impairment in social, occupational, or other important areas of functioning.

Each of the following criteria must have been met, with

individual symptoms occurring at any time during the course of the disturbance:

(1) four pain symptoms: a history of pain related to at least four different sites or functions (e.g., head, abdomen, back, joints, extremities, chest, rectum, during menstruation, during sexual intercourse, or during urination)

(2) two gastrointestinal symptoms: a history of at least two gastrointestinal symptoms other than pain (e.g., nausea, bloating, vomiting other than during pregnancy diarrhea, or intolerance of several different foods)

(3) one sexual symptom: a history of at least one sexual or reproductive symptom other than pain (e.g., sexual indifference, erectile or ejaculatory dysfunction, irregular menses, excessive menstrual bleeding, vomiting throughout pregnancy)

(4) one pseudo-neurological symptom: a history of at least one symptom or deficit suggesting a neurological condition not limited to pain (conversion symptoms such as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or a lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, seizures; dissociative symptoms such as amnesia; or loss of consciousness other than fainting.

C. Either (1) or (2):

(1) after appropriate investigation, each of the symptoms in Criterion B cannot be fully explained by a known general

medical condition or the direct effects of a substance (e.g., a drug of abuse, a medication)

(2) when there is a related general medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected from the history, physical examination or laboratory findings

D. The symptoms are not intentionally produced or feigned (as in Factitious Disorder or Malingering)

Associated features

- Associated features of Somatization Disorder (SD) include: vomiting, chest pain, dizziness, headaches, stomachaches, pain during sex, diminished sex drive, pain while passing urine, erectile dysfunction, irregular menstruation, joint pain, and back pain. Other types of symptoms are possible, but these are the most common. These symptoms are usually severe enough to interfere with patients' daily lives and relationships. They are not to be taken lightly.
- Individuals diagnosed with Somatization Disorder make colorful, often exaggerated complaints. The complaints are often lacking in specific factual information. A checklist approach to diagnostic interviewing may be less effective than a thorough review of medical treatments and hospitalizations in documenting the pattern of frequent somatic complaints.

Child vs. Adult presentation

Children experience many of the same symptoms adults suffer from. The age of onset is typically during adolescence and the diagnosis criteria needs to be met by the 20s. If chronic, individuals rarely remit completely. Boys and girls experience symptoms equally until adolescence is reached. Once adolescence is reached, more girls report having somatization disorder than boys. Children tend to experience somatization disorder after a traumatic event in their life has taken place, such as divorce or death of a loved one.

Gender and cultural differences in presentation

- Somatization disorder is more prevalent in women than it is in men. Some studies provide that as much as two percent of women suffer from somatization disorder. The ratio of men to women that suffer from somatization disorder is about ten to one.
- Somatization disorder is found all over the world. Many cultures present with the same symptoms that are mentioned above, but others are different. Cross-cultural studies indicate that the symptoms people with somatization disorder experience may vary greatly from culture to culture. Some symptoms specific to South Asia and Africa include burning sensations in the hands and feet and the feeling of worms crawling or ants crawling under

the skin, respectively. Prevalence is about 0.2% to 2% in women and less than 2% in men.

Epidemiology

Somatization Disorder is not commonly found in the population. About 2% of women have it and 0.2% of men have it. Many people that suffer from somatization disorder also have anxiety disorders or depression or both.

Etiology

Somatization disorder is caused by stress. The patient does not want to feel stress or anxiety so the patient transmits these feelings into physical symptoms. Some people also associate a stigma onto psychological therapy and if they feel pain or other symptoms they can go to a medical doctor and not a psychologist.

Empirically supported treatments

- There is not a known treatment for somatization disorder, but there are ways to manage symptoms. Cognitive behavioral therapy is used to help the patient change and manage their thoughts. Patients are also encouraged to become more active. Anti-depressants can also be used to manage symptom, these treat by alleviating the depression or dysthymia. It is extremely difficult to treat but a combination of medical management and

cognitive-behavioral therapy may be helpful.

- While empirical support may be lacking, there is a growing consensus that suggests that somatization disorder should be managed instead of treated. This simply means that primary care physicians, therapists, or any other caregivers should help patients control the behavior caused by SD instead of trying to cure it. An important goal of this method is preventing any unnecessary medical or surgical investigations. This could be accomplished by following five recommendations:
 1. One long-term and supportive relationship with a primary care physician that understands the situation should be established. This can prevent doctor shopping and lead to more coordinated support.
 2. Establish an appointment schedule for check-ups rather than seeing the patient on demand. This is done to avoid the reinforcement of abnormal behaviors caused by the disorder.
 3. A caregiver may regard certain physical complaints as a form of communication as well as possible evidence of a disease.
 4. The use of psychotropic drugs and analgesic medication should be minimized.
 5. Adaptive and positive behavior should be

encouraged and promoted while sick role behavior is ignored whenever possible.

PROPOSED DSM5 CHANGES (DSM5.ORG)

Reclassification to Complex Somatic Symptom Disorder

Complex Somatic Symptom Disorder includes: previous diagnoses of Somatization Disorder, Undifferentiated Somatoform Disorder, Hypochondriasis, Pain Disorder Associated With Both Psychological Factors and a General Medical Condition, and Pain Disorder Associated with Psychological Factors

To meet criteria for CSSD, criteria A,B, and C are necessary.

A. Somatic Symptoms

One or more somatic symptoms that are distressing and/or result in significant disruption in daily life.

B. Excessive Thoughts, Feelings, and Behaviors related to these somatic symptoms or associated health concerns:

At least two of the following are required to meet this criterion:

- (1) High level of health-related anxiety.
- (2) Disproportionate and persistent concerns about the medical seriousness of one's symptoms.
- (3) Excessive time and energy devoted to these symptoms or health concerns

C. Chronicity: Although any one symptom may not be continuously present, the state of being symptomatic is chronic (at least 6 months).

For patients who fulfill the CSSD criteria, the following optional specifiers may be applied to a diagnosis of CSSD where one of the following dominates the clinical presentation:

1. Predominant somatic complaints (previously, somatization disorder)
2. Predominant health anxiety (previously, hypochondriasis). If patients present solely with health-related anxiety with minimal somatic symptoms, they may be more appropriately diagnosed as having an anxiety disorder.
3. Predominant Pain (previously pain disorder). This classification is reserved for individuals presenting predominantly with pain complaints who also have many of the features described under criterion B. Patients with other presentations of pain may better fit other psychiatric diagnoses such as adjustment disorder or psychological factors affecting a medical condition.

For assessing severity of CSSD, metrics are available for rating the presence and severity of somatic symptoms (see for instance PHQ, Kroenke et al, 2002). Scales are also available for assessing severity of the patient's misattributions, excessive concerns and preoccupations (see for instance Whiteley inventory, Pilowsky , 1967).

Rationale:

Major Change #1: Rename Somatoform Disorders to Somatic Symptom Disorders and combine with PFAMC and Factitious Disorders

The workgroup suggests combining Somatoform Disorders, Psychological Factors Affecting Medical Condition (PFAMC), and Factitious Disorders into one group entitled “Somatic Symptom Disorders” because the common feature of these disorders is the central place in the clinical presentation of physical symptoms and/or concern about medical illness. The grouping of these disorders in a single section is based on clinical utility (these patients are mainly encountered in general medical settings), rather than assumptions regarding shared etiology or mechanism.

Major Change #2: Combine Somatization disorder, hypochondriasis, undifferentiated somatoform disorder, and pain disorder into a new category entitled “Complex Somatic Symptom Disorder” (CSSD)

Combine somatization disorder, hypochondriasis, undifferentiated somatoform disorder, and pain disorder into a new category entitled “Complex Somatic Symptom Disorder” (CSSD) which emphasizes the symptoms plus the patients’ abnormal cognitions (Barsky, Lowe, Rief). The term “complex” is intended to denote that in order for this diagnosis to be made, the symptoms must be persistent and must include both somatic symptoms (criterion A) as well as cognitive distortions (criterion B).

This is a major change in the diagnostic nomenclature, and it will likely have a major impact on diagnosis. It clarifies that a diagnosis of CSSD is inappropriate in the presence of only unexplained medical symptoms. Similarly, in conditions such as irritable bowel syndrome, CSSD should not be coded

unless the other criterion (criterion B—attributions, etc) is present.

It is unclear how these changes would affect the base rate of disorders now recognized as somatoform disorders. One might conclude that the rate of diagnosis of CSSD would fall, particularly if some disorders previously diagnosed as somatoform were now diagnosed elsewhere (such as adjustment disorder). On the other hand, there are also considerable data to suggest that physicians actively avoid using the older diagnoses because they find them confusing or pejorative. So, with the CSSD classification, there may be an increase in diagnosis.

The proposal is to group together these heretofore separately recognized disorders because in fact, there are 3 diverse sources suggesting considerable overlap among them.

1. A 2009 study found that 52% of physicians surveyed indicated that there was “a lot of overlap” and an additional 38% thought that there was “some overlap” across these disorders. In contrast, less than 2% of physician respondents felt that these were “distinctly different disorders (Dimsdale, Sharma, & Sharpe, unpublished).

2. There are limited data regarding overlap in clinical settings. One primary care study, for instance, found that 20% of somatization disorder patients also had hypochondriasis (Escobar, 1998). In primary care patients, somatization disorder was 5 times (Fink et al 2004) to 20 times (Barsky et al 1992) more common in hypochondriasis patients as compared to primary care patients without

hypochondriasis.

3. Treatment interventions are similar in this group of disorders. Cognitive behavior therapy (CBT) and antidepressant medications appear to be the most promising therapeutic approaches for hypochondriasis, somatization disorder, and pain disorder (Kroenke 2007; Sumathipala 2007). Although several variations of CBT have been employed, they share many elements in common. These include the identification and modification of dysfunctional and maladaptive beliefs about symptoms and disease, and behavioral techniques to alter illness and sick role behaviors and promote more effective coping. The literature on the use of antidepressants is more limited, but it too does not suggest any major distinctions in therapeutic response across these different disorders. In addition to these patient centered commonalities of treatment, all of these disorders benefit from specific interventions with the patient's non-psychiatric physician (e.g. scheduling regular appointments as opposed to prn appointments, limiting testing and procedures unless clearly indicated) (Allen 2002).

A key issue is whether the guidelines for CSSD describe a valid construct and can be used reliably. A recent systematic review (Lowe, submitted for publication) shows that of all diagnostic proposals, only Somatic Symptom Disorder reflects all dimensions of current biopsychosocial models of somatization (construct validity) and goes beyond somatic symptom counts by including psychological and behavioral symptoms that are specific to somatization (descriptive

validity). Predictive validity of most of the diagnostic proposals has not yet been investigated.

Trichotillomania (Hair-Pulling
Disorder) (F63.3)

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

DSM-IV-TR CRITERIA

- A. Recurrent pulling out of one's hair resulting in noticeable hair loss.
- B. An increasing sense of tension immediately before pulling out the hair or when attempting to resist the behavior.
- C. Pleasure, gratification, or relief when pulling out the hair.
- D. The disturbance is not better accounted for by another

mental disorder and is not due to a general medical condition (e.g., a dermatological condition.)

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Associated Features

Individuals with Trichotillomania are often seen by the public as having a habit of playing with their hair. The individual will examine the hair root, twirl it off, pull the strand of hair between their teeth, or may eat their hair. They usually do not pull their hair out in the presence of anyone except family members. The individual suffering from this disorder will deny that they pull out their hair, and will attempt to hide the resulting baldness. If the case is extreme, the individual may have urges to pull others hair, but often can refrain. Dolls, pets, carpet, and sweaters are often pulled on like hair, and nail biting, scratching, gnawing, and excoriation are often associated with this disorder.

Child vs. Adult presentation

The mean age of onset is 9 to 14 years old. It is more common during the first 20 years of someone's life. There is not a difference in presentation between child and adults, however.

Gender and cultural differences in presentation

When presented in children, the rates between genders tend

to be relatively equal. However, when Trichotillomania is present in an adult, it is more common in females. It has been found that 70-90% of pre-adolescents and adults that have this are female. This finding of an off-balance male-to-female ratio may be a result of the true gender ratio of the condition, or it could be due to treatment seeking curve formed due to cultural or gender based attitudes regarding acceptance of the associated features of this disease.

Epidemiology

Trichotillomania is now believed to be more common than it once was. Studies show that today the lifetime prevalence rate of this disorder is 0.6%.

Etiology

- There is evidence of a genetic predisposition, in which mutations found in a gene known as SLITRK1 have been linked to trichotillomania as well as to Tourette syndrome, a neurological disorder that causes a person to make unusual movements and sounds
- Neurochemical problems can also play a role in Trichotillomania. Some studies suggest that abnormalities in the natural brain chemicals serotonin and dopamine may play a role in trichotillomania.

Empirically supported treatments

PROPOSED DSM5 CHANGES (DSM5.ORG)

The work group is recommending that this disorder be reclassified from Impulse Control Disorders Not Elsewhere Classified to Anxiety and Obsessive-Compulsive Spectrum Disorders

- A. Recurrent pulling out of one's hair resulting in hair loss.
- B. The hair pulling causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The hair pulling is not due to a general medical condition (e.g., a dermatological condition).
- D. The hair pulling is not restricted to the symptoms of another mental disorder (e.g., hair pulling due to preoccupation with appearance in Body Dysmorphic Disorder).

The work group is considering an additional criterion that addresses urges to pull one's hair or attempts to resist hair pulling.

Rationale for Change

Name: The term "mania" seems inappropriate for trichotillomania. However, changing too rapidly to a more descriptive term (eg hair-pulling disorder) may be confusing for clinicians, hence we propose to retain trichotillomania in parentheses

A: Hair loss may not always be noticeable in those suffering from this disorder.

B and C: Patients with chronic hair-pulling may or may not meet criteria B or C. Those who do and do not meet these criteria do not appear distinguishable on a range of clinical validators.

D: The exclusion criterion may be more clinically useful if it lists disorders that may be misdiagnosed as trichotillomania. For purposes of clarity and consistency, we have used the phrase “not restricted to” in the hierarchy criterion of other disorders in our section.

Severity

Massachusetts General Hospital Hairpulling Scale (MGH-HPS) (Keuthen et al., 1995)

Intermittent Explosive Disorder (312.34)

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

This is a short video by Dr. Gary Solomon explaining what Intermittent Explosive Disorder is and the symptoms that go along with the disorder.

DSM-IV-TR CRITERIA

A. Several discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.

B. The degree of aggressiveness expressed during the

episodes is grossly out of proportion to any precipitating psychosocial stressors.

C. The aggressive episodes are not accounted for by another mental disorder (e.g., Antisocial Personality Disorder, Borderline Personality Disorder, a Psychotic Disorder, a Manic Episode, Conduct Disorder, or Attention-Deficit/Hyperactivity Disorder) and are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma, Alzheimer's disease)

Associated features

- Some individuals see their impulses as stressful and destructive before, during and after they react to these impulses. These reactions can cause problems socially in their relationships, school, and/or jobs. Individuals with Intermittent Explosive Disorder can sometimes suppress their anger, to an extent, and react in a less destructive manner. Individuals with narcissistic, obsessive, paranoid, or schizoid traits may be especially prone to having explosive outbursts of anger when under increased stress. Some individuals may also report that their aggressive episodes are often preceded or accompanied by symptoms such as tingling, tremor, palpitations, chest tightness, head pressure, or hearing an echo. Individuals may describe their aggressive impulses as extremely distressing. The

disorder may result in job loss, school suspension, divorce, difficulties with interpersonal relationships or other impairment in social or occupational spheres, accidents, hospitalization, financial problems, incarcerations, or other legal problems.

- Signs of generalized impulsivity or aggressiveness may be present between explosive episodes. Individuals with Intermittent Explosive Disorder may report problems with chronic anger and frequent “sub threshold” episodes, in which they experience aggressive impulses but either manage to resist acting on them or engage in less destructive aggressive behaviors.

Child vs. adult presentation

- In children, they may react with a temper, hyperactivity, or destructive actions such as tearing up objects, setting objects on fire, or taking from others. There is no exact age of when Intermittent Explosive Disorder begins, however it is believed to occur from childhood to late teens or twenties.
- Intermittent explosive behavior or episodic aggressive outbursts often begin in childhood, adolescence or early adulthood and follow a chronic course. In a study of 27 patients who were diagnosed with IED, 75% of those reported that their explosive behavior began in adolescence, with

a mean age of onset of 14 years old, and a mean duration of 20 years old (Olvera 2002).

Gender and cultural differences in presentation

The episodic violent behavior is more frequent in men than women. Amok is uncontrolled, severe violent behavior where a person would declare it was amnesia. This is known to be seen more in the southeastern area of Asia. But, has also been seen in Canada and the United States. However, Amok does not occur frequently, but in a single episode.

Epidemiology

Very little is known about Intermittent Explosive Disorder; it is seen as a very rare disorder. Most studies, however, indicate that it occurs more frequently in males. The most common age of onset is the period from late childhood through the early 20s. The onset of the disorder is frequently abrupt, with no warning period. Patients with IED are often diagnosed with at least one other disorder—particularly personality disorders, substance abuse (especially alcohol abuse) disorders, and neurological disorders.

Etiology

- Some studies suggest that abnormalities of the brain that are responsible for regulating behavioral arousal and inhibition could be the cause. Developmental problems or Neurological

symptoms maybe a cause. There may be an imbalance of serotonin or testosterone levels. However, if a physician believes it is due to physiological problems, it may be diagnosed as a General Medical Condition instead. It may also be a cause of exposure in family situations at a young age, or a genetic factor. Also, lower levels of brain glucose (sugar) metabolism in patients who act in “impulsively aggressive” ways.

- Impulsive aggression is thought to be mainly defensive in nature, driven by fear, anger and a cognitive distortion of environmental conditions, with extremely high autonomic arousal (Olvera 2002).
- Neurobiological studies of aggression suggest that numerous neurotransmitters are disrupted. A disruption in the serotonergic system, in particular, low cerebral spinal fluid levels of 5-hydroxyindoleacetic acid, a serotonin metabolite, have been found in IED individuals (Olvera 2002).

Empirically supported treatments

Some treatments are seen in certain medications such as anti-convulsion, anti-anxiety, mood regulators, or anti-depressants. Also, some forms of group therapy such as anger management have been seen as helpful. Some medications include: carbamazepine (an antiseizure medicine),

STEPHANIE WEIGEL

propranolol (a heart medication), and lithium (used to treat Bipolar type two manic-depression disorder).

Kleptomania (312.32)

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

This is a short clip of Dr. Gary Solomon explaining what activities a person diagnosed with kleptomania might do.

DSM-IV-TR CRITERIA

A. Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value.

B. Increasing sense tension immediately before committing the theft.

C. Pleasure, gratification, or relief at the time of committing the theft.

D. The stealing is not committed to express anger or vengeance and is not in response to a delusion or a hallucination.

E. The stealing is not better accounted for by a Conduct Disorder, a Manic Episode, or Antisocial Personality Disorder.

Associated features

Kleptomania is an irresistible impulse to steal, stemming from emotional disturbance rather than economic need. It is also said that it is a recurrent failure to resist stealing. It is most observed in patients who are “chemically dependent” or also have mood, anxiety, or eating disorders. It is possible that people with kleptomania could also be dealing with major depression, panic attacks, social phobia, anorexia nervosa, bulimia nervosa, substance abuse, and obsessive compulsive disorder. People with this disorder get a thrill from stealing and randomly have an overwhelming urge to do so. Strangely enough, they often feel guilty after committing theft and surreptitiously return the stolen items. If the items, usually of lesser importance, aren’t returned they are hoarded, discarded, or given away. In less severe instances of kleptomania, things are borrowed and not returned.

Kleptomania is not to be confused with the regular act of stealing. Whether planned or impulsive, a normal thief steals for the objects value or usefulness. Many times they are teenagers or gang members that view theft as a rite of passage, form of rebellion, or commit them just for a dare.

Child vs. adult presentation

It is difficult to assess the differences in presentation of Kleptomania among children and adults. This is because Kleptomania typically presents itself during late adolescence or early adulthood. It is rare for Kleptomania to manifest itself during a person's early childhood or late in their life. This is because it is hard to distinguish if children are stealing because of a disorder or if it is because they do not know any better.

Gender and cultural differences in presentation

In preliminary evidence, clinical samples suggest that approximately two-thirds of individuals with Kleptomania are female. Kleptomania in cultural differences are not stated.

Epidemiology

Kleptomania is a rare condition that appears to occur in fewer than 5% of identified shoplifters. Studies suggest that the prevalence in the general population may be around 0.6%. Studies also suggest that it is more prominent in females. Other studies, interestingly, have found an exceptionally high correlation of kleptomania in patients with bulimia of 65%. Also, approximately 7% of patients have a correlation with histories of OCD.

Etiology

- One theory suggests that receiving the thrill of

stealing can aid in alleviating symptoms in people who are clinically depressed. They never seek aid in the act of theft and never plan to steal with others. There can be favored objects or environments where theft occurs, but detection of kleptomania, even by family, is difficult and the problem mostly goes undetected.

- There is no known cause for kleptomania. It is possible that it is genetically related especially from first-degree relatives. There also tends to be a sharp inclination for kleptomania to coexist with OCD, bulimia nervosa, and clinical depression.

Empirically supported treatments

Actually finding a diagnosis is typically difficult given that patients do not seek medical help for this complaint. It is also difficult to detect in the initial psychological assessments. It is most commonly addressed when one comes in for other reasons like depression, bulimia, or are simply emotionally unstable. They may prefer certain objects and settings, but these may not be described by the patient. Initial psychological evaluations may reveal a past of inadequate parenting, conflicting relationships, or a point of severe stressors such as having to make a move from one home to another.

There tends to be little or no system on the course of Kleptomania. There are, however, three typical courses that can be described as: “sporadic with brief episodes and long

periods of remission; episodic with protracted periods of stealing and periods of remission; and chronic with some degree of fluctuation.” Though they are convicted numerous times for shoplifting, the disorder could go on for years.

Treatments will vary concerning this disorder. It starts with an extensive psychological assessment. The patient will undergo therapy that targets impulse control and any and all coexisting mental disorders. They gain a comprehensible understanding of their specific triggers in order to prevent relapse. Psychotherapies, such as cognitive-behavioral therapy and rational emotive therapy, will be included in the treatment. Other psychotherapies include covert sensitization, aversion therapy, and systematic desensitization.

Several medications have been shown to work, but the possibility of the patient having another mental disability should also be taken into account. Antidepressants are the most widely used medicine to treat kleptomania, which includes Prozac. These are serotonin reuptake inhibitors. Side effects often occur, so patients should consult doctor if any occur. Mood stabilizers can also be used to even out the patient's mood. This will help the patient not have rapid or uneven mood changes that may trigger them to steal something. An example of this includes lithium which is shown to possibly be helpful. Benzodiazepines can also be used but the effectiveness often varies patient to patient and they may cause the patient to become dependent on the drug. These medications are central nervous system depressants, also known as tranquilizers. Examples of these include Xanax

and Klonopin. Lastly, there are addiction medications. Revia falls into this category. Revia is known as an opioid antagonist and is most commonly prescribed for kleptomania. This particular drug blocks the part of the brain that feels pleasure with certain addictive behaviors, which in turn should reduce the patients urge to steal.

Pathological Gambling (312.21)

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

DSM-IV-TR criteria:

- A. Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:
 - (1) is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to

get money with which to gamble)

- (2) needs to gamble with increasing amounts of money in order to achieve the desired excitement
- (3) has repeated unsuccessful efforts to control, cut back, or stop gambling
- (4) is restless or irritable when attempting to cut down or stop gambling
- (5) gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)
- (6) after losing money gambling, often returns another day to get even (“chasing” one’s losses)
- (7) lies to family members, therapist, or others to conceal the extent of involvement with gambling
- (8) has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling
- (9) has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling
- (10) relies on others to provide money to

relieve a desperate financial situation
caused by gambling

- B. The gambling behavior is not better accounted for by a Manic Episode.

Associated features

Pathological gambling (PG) is characterized as a chronic, progressively maladaptive, impulse control disorder that is distinguished by continued acts of PG despite compounding severe negative consequences. Individuals who suffer from PG often have problematic interpersonal relationships. These relationships become increasingly strained during the progression of the disorder. In one extreme, individuals with PG may try to legally finance gambling and living expenses through loans. To a higher extreme, individuals may also commit illegal acts such as forgery, fraud, theft, or embezzlement in order to gain financing. There is evidence to support comorbidity of PG and alcohol and depression. A 1992 study showed that 12.9% of heavy drinkers had a gambling problem as compared to 5% of nondrinkers. Comorbidity rates of PG and major depressive disorder can reach as high as 76%. Other associated features of PG include: unemployment, substance abuse, and suicide attempts. Most pathological gamblers tend to deny their problem and therefore do not get help. The South Oaks Gambling Screen (SOGS) is a very common and validated tool used to assess gamblers. Associated features also include repetitive behaviors which shares features with obsessive compulsive disorder.

Child vs. adult presentation

Historically, PG has been stereotyped as an adult disorder, but with the vast growth of casino expansion and the creation of internet gambling, adolescent rates of PG have superseded adult prevalence rates by two to four times. According to a 2006 *Adolescent Psychiatry* article written by Timothy W. Fong, gambling is a media-driven, socially acceptable form of behavior. Fong also states that 86% to 93% of all adolescents have gambled for money at least once, 75% of those did it within the confines of their home, while 85% of parents did not care. He states that adolescent gambling is the most popular risk taking behavior seen in adolescents, trumping cigarettes, alcohol, drugs, and sex. The reasons why adolescents start gambling vs. reasons why adults start gambling are very different. Adolescents start because: it is a form of excitement and relief of boredom, a need to keep playing for spectator success, use gambling as a coping mechanism or relief from daily stress, and lastly, it is a socially acceptable form of competition.

Gender and cultural differences in presentation

More men are typically diagnosed with pathological gambling than women, and men tend to start sooner. The gender ratio is 2:1 with men being twice more likely than women. Culturally, PG is more prevalent in minority groups. Socioeconomic status also strongly correlates to PG and it is more prevalent in the lower class, who cannot afford to

gamble. Pathological gambling affects 2%–5% of Americans, where symptoms and means of gambling vary.

Epidemiology

As gambling facilities become more prevalent, so do PG prevalence rates. In fact, 2 million Americans are considered to be pathological gamblers, with another 3 million considered being “problematic gamblers,” and 15 million more considered to be at risk. There is a 4% prevalence rate in America, while prevalence rates vary in other countries. Worldwide rates vary from 2% to 6%. Gambling usually begin in early adolescence in men, and from ages 20–40 in women.

Etiology

- The causes do not seem to be biologically related due to the lack of evidence. A psychological cause, however, is more likely. A pathological gambler typically has symptoms of depression or alcoholic tendencies. They usually turn to gambling to get the “high” of winning to escape from everyday problems or more serious life problems.
- PG is consistently associated with blunted mesolimbic–prefrontal cortex activation to nonspecific rewards, whereas these areas show increased activation when exposed to gambling-related stimuli in cue exposure paradigms. Very

little is known, and hence more research is needed regarding the neural underpinnings of impulsivity and decision making in PG (van Holst, van den Brink, Veltman, & Gourdriaan, 2010).

Empirically supported treatments

- Treatment consists of therapy. He/she must first realize that they do indeed have a problem and that they need help. Announcing this to friends and family is usually best. Treatment is based on behavior changes. The counselor will usually start by uncovering the underlying cause of the gambling addiction. If the patient is depressed then the depression is treated accordingly. For the 85% who stay in treatment, it is successful. On average, however, 50% drop out. Aversion therapy is an option. Here the patient is exposed to the stimulus while also being exposed to something that would cause them discomfort. Treatments usually try to help the patient overcome their impulses and learn to control urges. Also, the gambler must learn to overcome the illusion that they will “win the next time.” There are also self-help groups like gamblers anonymous that the patient can join. Groups for the family like Gam-Anon are also available. It is often recommended that he/she never return to gambling. It is also recommended that he/she does not return even to the places that they have

gambled. Returning could cause a relapse. Medications such as antidepressants and opioid antagonists (naltrexone) may help also.

- Includes schizophrenia, mood problems, antisocial personality disorder, alcohol, or cocaine addiction.
- Brief intervention, motivational interviewing and cognitive and behaviour therapy are effective treatments. Treatment could be delivered in individual or group-format. Most studies proposed abstinence-based treatments (Khazaal, 2010).

Dsm5 Proposed Changes

The work group has proposed that this diagnosis be reclassified from Impulse-Control Disorders Not Elsewhere Classified to Substance Related Disorders which will be renamed to Addiction and Related Disorders

Disordered Gambling:

- A. Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:
 1. is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble

2. needs to gamble with increasing amounts of money in order to achieve the desired excitement
 3. has repeated unsuccessful efforts to control, cut back, or stop gambling
 4. is restless or irritable when attempting to cut down or stop gambling
 5. gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)
 6. after losing money gambling, often returns another day to get even (“chasing” one’s losses)
 7. lies to family members, therapist, or others to conceal the extent of involvement with gambling
 8. has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling
 9. relies on other to provide money to relieve a desperate financial situation caused by gambling
- B. The gambling behavior is not better accounted for by a Manic Episode.

Rationale for Change:

- Pathological (disordered) gambling has commonalities in clinical expression, etiology, comorbidity, physiology and treatment with Substance Use Disorders
Lowered Threshold for Pathological (Disordered)

Gambling Diagnosis

- Several empirical studies have supported lowering the threshold for a diagnosis of pathological (disordered) gambling. Statistical analyses bearing on this issue are also in progress.

Eliminate Illegal Act Criterion for Pathological (Disordered) Gambling Diagnosis

The illegal act criterion of pathological (disordered) gambling has been shown to have a low prevalence with its elimination having little or no effect on prevalence and little effect on the information associated with the diagnosis in the aggregate.

Severity:

Recommendations for severity criteria for this disorder are forthcoming

Body Dysmorphic Disorder (300.7)

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

DSM-IV-TR CRITERIA

A. Preoccupation with an imagined defect in appearance. If slight physical abnormality is present, the person's concern is markedly excessive.

B. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The preoccupation is not better accounted for by

another mental disorder (e.g., dissatisfaction with body shape and size in Anorexia Nervosa).

Associated features

The preoccupations associated with body dysmorphic disorder (BDD) are commonly described as being repetitive, excessive, obsessive, compulsive, ritualized, distressing, impairing, time-consuming, and somewhat less often, delusional. Symptoms usually appear suddenly, with onset during times of extreme psychosocial stress. The similarities in descriptions of preoccupation frequently cause a misdiagnosis of obsessive-compulsive disorder (OCD), however, the comorbidity of OCD and BDD is relatively common. Other common comorbidities include, but not limited to; mood disorders (major depressive disorder), anxiety disorders (social phobia), substance use, eating disorders (anorexia nervosa), and personality disorders (borderline personality disorder). Examples of preoccupations include behaviors that seek to examine, improve, or hide perceived defects leading to time consuming functional impairments. Activities associated with preoccupations include obsessions in: grooming; mirror checking, hair brushing, hair styling, hair cutting, shaving, washing, and application of makeup. Camouflaging: wearing wigs, hats, make-up, sunglasses, extra clothing and changing body position to hide perceived defect. Medical procedures: numerous dermatological visits, and multiple cosmetic surgeries. Need for reassurance: mirror checking, asking

others opinion, and excessive comparison to other people. Diet and exercise: excessive exercise, muscle dysmorphia, steroid usage; excessive diet, anorexia nervosa, and bulimia nervosa (eating disorders). The most common preoccupations of the body focus primarily on the skin, hair, and nose. People diagnosed with BDD typically have poor self-image/esteem, express shame in appearance, feel ugly, unlovable, and have a strong fear of rejection. Suicide ideation, attempts, and completion are significantly high in comparison to other mental disorders; however, the studies are few and only preliminary. Reasons for results suggest that suicidal risk is higher in patients with BDD. High suicidal risks are due to high rates of psychiatric hospitalization, comorbidity prevalence, being single and divorced, low self-esteem, poor social support, and having high levels of anxiety, depression, and hostility.

Child vs. adult presentation

Most research suggests that the onset of BDD begins in early adolescents, although, little research has been done regarding definite onset. The role of body image during pubertal change increases body focus and dissatisfaction. Adolescents typically present more often with body shape and weight concerns related to distress, as opposed to adult presentation of dissatisfaction of specific body parts (i.e., face and hair).

Gender and cultural differences in presentation

Most research suggest BDD in non-discriminative across

gender lines. Some research suggests females are more likely to present with associated features resembling weight and shape concerns, eating disorders, and depressive disorders. Sociocultural influences include appearance related pressures. Socially constructed conceptions of perfection and/or beauty portrayed through the media affect both genders without bias. BDD exists in many cultures around the world. The areas having the most research conducted include the United States, Italy, and the United Kingdom. Studies pertaining to prevalence rates cross-cultures have been insignificant in number; the studies done suggest prevalence rates to be very similar.

Epidemiology

Several sources of research agree prevalence rates in the general population vary from 1% – 2%. Prevalence rates tend to increase in clinical settings. Prevalence rates in the medical population of dermatology increase to 11.9%, and in the cosmetic surgery population, an increase of 2% – 7%. People suffering with BDD typically present to cosmetic surgeons for correction of perceived bodily flaw, and inevitably receive no satisfaction or relief from the disorder.

Etiology

The onset of BDD generally begins around the pubertal time of adolescents. The disorder is more commonly chronic and unremitting than it is not. The course of this disorder follows a continuous lifetime course, in that; it is very unlikely for full

remission to occur with treatment. Suicidal ideation is higher for this disorder than other mental disorders.

Empirically supported treatments

- Serotonin deregulation seems to be common among patients with BDD. Selective serotonin reuptake inhibitor (SSRI) (i.e., fluoxetine hydrochloride) drugs have been empirically proven to decrease the symptoms associated with BDD. Another empirically supported approach is cognitive behavioral therapy (CBT). A combination of SSRI and CBT is the common approach to BDD.
- Behavioral and/or cognitive-behavioral techniques are typically used to change abnormal activities like avoidance behavior, reassurance seeking, checking, and excessive grooming. For example, exposure in vivo can be used to help people with BDD become more comfortable exposing themselves to social situations.

Links:

- Article about [Body Dysmorphic Disorder](#) in American population (Need UCO login and password to access article).

PROPOSED DMS-5 CHANGES

The work group is recommending that this disorder be reclassified from Somatoform Disorders to Anxiety and Obsessive-Compulsive Spectrum Disorders

A. Preoccupation with a perceived defect(s) or flaw(s) in physical appearance that is not observable or appears slight to others.

B. At some point during the course of the disorder, the person has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, or reassurance seeking) or mental acts (e.g., comparing their appearance with that of others) in response to the appearance concerns.

C. The preoccupation causes clinically significant distress (for example, depressed mood, anxiety, shame) or impairment in social, occupational, or other important areas of functioning (for example, school, relationships, household).

D. The appearance preoccupations are not restricted to concerns with body fat or weight in an eating disorder.

Specify if:

Muscle dysmorphia form of body dysmorphic disorder (the belief that one's body build is too small or is insufficiently muscular)

Specify whether BDD beliefs are currently characterized by:

Good or fair insight: Recognizes that BDD beliefs are definitely or probably not true, or that they may or may not be true

Poor insight: Thinks BDD beliefs are probably true

Absent insight (i.e., delusional beliefs about appearance):
Completely convinced BDD beliefs are true

Rationale:

Criterion A: Changes clarify the criterion's meaning and aim to make it more acceptable to patients. The changes are not intended to change caseness.

Criterion B: Examples are added to increase awareness of some of the common types of distress or impairment in functioning.

Criterion C: It is recommended that this criterion be limited to eating disorders, as to our knowledge, there are no other disorders that might easily be misdiagnosed as BDD. Before a final recommendation is made, it will be important to examine the DSM-V criteria for eating disorders, and examples of eating disorder NOS, to determine whether criterion C should or should not include eating disorder NOS.

The phrase "not better accounted for" appears to be confusing to some DSM users (for example, it is sometimes misconstrued to mean that BDD cannot be diagnosed if the patient also has an eating disorder, even if the patient also meets criteria for BDD). We recommend alternate wording, such as "is not restricted to," which may be clearer.

Specifiers:

The muscle dysmorphia form of BDD appears to have several important differences from other forms of BDD (e.g., higher rates of suicidality and substance use disorders), and the

treatment approach may require some modification. Thus, adding this specifier may have clinical utility.

There appear to be far more similarities than differences between delusional and nondelusional BDD, and thus it is recommended to combine BDD's delusional and nondelusional variants into a single disorder and to eliminate the delusional variant from the psychosis section. The proposed specifier reflects the broad range of insight (including delusional thinking) that can characterize BDD beliefs. The proposed levels of insight are similar to categories in widely used scales for BDD, and they are the same as those proposed for OCD and olfactory reference syndrome.

Severity:

Yale-Brown Obsessive-Compulsive Scale Modified for BDD (BDD-YBOCS) (Phillips et al., 1997)

Insight dimensions (proposed for OCD, BDD, ORS, Hoarding Disorder): Brown Assessment of Beliefs Scale (BABS) (Eisen et al., 1998)

Conversion Disorder (300.11)

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

DSM-IV-TR CRITERIA

A. One or more symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition.

B. Psychological factors are judged to be associated with the symptom or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflict or other stressors.

C. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).

D. The symptom or deficit cannot, after appropriate

investigation, be fully explained by a general medical condition, or by the direct effects of a substance, or as a culturally sanctioned behavior or experience.

E. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of function or warrants medical evaluation.

F. The symptom or deficit is not limited to pain or sexual dysfunction, does not occur exclusively during the course of Somatization Disorder, and is not better accounted for by another mental disorder.

Associated features

- Some people with Conversion Disorder may display la belle indifférence. This is a relative lack of worry about their condition or its implications. Other people may act in a dramatic or histrionic manner though.
- Individuals being treated for Conversion Disorder may develop dependency issues and embrace an ailing role during the course of their treatment.
- Symptoms caused by Conversion Disorder usually conflict with established anatomical or physiological knowledge and explanations. Therefore, objective signs that indicate the presence of a traditional abnormality are frequently absent.
- Laboratory analysis of the condition typically do

not yield any findings as well. The absence of any findings is a feature that may indicate that Conversion Disorder is the actual source of the problem(s).

- Dissociative Disorders, Major Depression, and Histrionic, Antisocial, Borderline, and Dependent Personality Disorders are mental disorders than can be associated with Conversion Disorder.
- Most conversion symptoms are neurological and usually relate to the loco-motor system. The motor symptoms include convulsions, paralysis, weakness, and dyskinesia. Sensory symptoms include paraesthesia or anesthesia, blindness or speech disorders (Heruti, Levy, Adunski and Ohry, 2002).

Child vs. adult presentation

The symptoms that children with conversion disorder experience are frequently limited to seizure or gait problems. There is a wide range of symptoms that adults with Conversion Disorder may experience. These symptoms may include the loss of sensation, paralysis, blindness, seizures, or a mixed presentation.

Conversion Disorder appears in adolescence or early adulthood. Presentation before the age of 10 or after the age of 35 is rare, though some cases have been reported around age 90. Conversion Disorders before the age of 10 are usually

limited to walking impairments or convulsions (Heruti, Levy, Adunski and Ohry, 2002).

Gender and cultural differences in presentation

Conversion disorder is diagnosed more frequently in women than in men. An exact ratio has not been established, but most studies indicate that the ratios range between 2:1 and 10:1. It is more common for women with Conversion Disorder to eventually develop Somatization Disorder, but there is a strong relation between Conversion Disorder and Antisocial Personality Disorder among men. It is common for men who experience Conversion Disorder to have suffered an industrial accident or to have been in the Military. It is much more common for women to experience symptoms on the left side of their body than in their right side.

There are various links between Conversion Disorder and cultural factors. People in rural settings, lower socioeconomic levels, and with relatively less knowledge of psychology and medicine are diagnosed with Conversion Disorder more frequently than other populations. There is a higher incidence of Conversions Disorder in developing regions than in developed regions, and reports from the developing regions decrease as further development occurs. The conversion symptoms displayed by patients may vary based on their culturally accepted means of demonstrating distress. One must be aware that the religious and healing rituals of certain cultures may include characteristics that could be confused with symptoms of Conversion Disorder.

Some symptoms that might be linked to a conversion disorder in the United States may be a “normal expression” of anxiety in other cultures. In London at the National Hospital, the diagnosis of 1% of inpatients. In Iceland, the report is 15 cases per 100,000 persons.

Epidemiology

The prevalence of Conversion Disorder varies according to multiple reports, but the rates generally range from 11/100,000 to 500/100,000 in samples from the general population. About 3% of mental health clinic referrals are due to Conversion Disorder. Conversion Disorder is more likely to develop among older adolescents or young adults, women, and people from lower socioeconomic classes. According to one study, there was 1.2%– 11.5% of psychiatric consultations for hospitalized medical and surgical patients.

Etiology

The exact cause of Conversion Disorder has not been established by empirically supported data, but there are some theories about its development. Many contemporary theories claim that the development of Conversion Disorder is often sudden, and it is triggered by subconscious conflict, unresolved grief, sexual trauma, or other stressful situations. In essence, these theories state that people with Conversion Disorder convert their psychological distress into physical symptoms to avoid any further mental anguish. Disturbances

in the central nervous system may increase the likelihood and/or severity of any somatic symptoms.

Other factors may influence the development of Conversion Disorder. There is some evidence that Conversion Disorder may be genetically transmitted, but there is not enough data to prove this conclusively. Socioeconomic factors are also known to influence the development of this disorder, but the exact manner in which they impact an individual has not been definitively identified.

According to Freud, suppression is the major defense mechanism involved in conversion because of the close relation between conversion conditions and traumatic events in the individual's life. Freud states that an impulse, or a wish, that cannot be fulfilled due to negative connotations such as fear, shame, guilt, or anger is converted into physical expression (Heruti, Levy, Adunski and Ohry 2002).

Empirically supported treatments

There are no empirically supported treatments for Conversion Disorder, but there are a couple of methods that are believed to help people with this disorder. The most common methods are behavioral or cognitive behavioral treatments. Treatment plans need to be individualized due to the varying symptoms of each person, but there are some general guidelines. It is important to discover any psychological stressors an individual may have that precipitate somatic symptoms to cope with them. It is vital to help individuals recognize these stressors and to help them learn

more adaptive methods for dealing with them. Manipulation of the patient's social environment may be necessary in order to reinforce the patient's non-symptomatic behavior.

Physical rehabilitation, due to motor functional imparities, should be considered an option as soon as possible, after physiological etiologies have been ruled out. Physical rehabilitation addresses the prevention of secondary disabilities due to the disorder.

Proposed Changes in DSM-5 (dsm5.org)

The work group is recommending this disorder be renamed from Conversion Disorder to Functional Neurological Symptoms.

Criteria A, B, and C must all be fulfilled to make the diagnosis:

A. One or more symptoms are present that affect motor or sensory function or seizure-like episodes.

B. The symptom, after appropriate medical assessment, is found not to be due to a general medical condition, the direct effects of a substance, or a culturally sanctioned behavior or experience.

C. Physical signs or diagnostic findings that provide evidence of internal inconsistency or incongruity with recognized neurological or medical disorder.

D. The symptom causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Both the Somatic Symptom Disorders Work Group and

the Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group are discussing how conversion disorder relates to the Dissociative Disorders

Rationale:

Major Change #1: Rename Somatoform disorders to Somatic Symptom Disorders and combine with PFAMC and Factitious Disorders

The workgroup suggests combining Somatoform Disorders, Psychological Factors Affecting Medical Condition (PFAMC), and Factitious Disorders into one group entitled “Somatic Symptom Disorders” because the common feature of these disorders is the central place in the clinical presentation of physical symptoms and/or concern about medical illness. The grouping of these disorders in a single section is based on clinical utility (these patients are mainly encountered in general medical settings), rather than assumptions regarding shared etiology or mechanism.

Major Change #2: De-emphasize medically unexplained symptoms

Remove the language concerning medically unexplained symptoms for reasons specified above. The reliability of such judgments is low (Rief, 2007). In addition, it is clear that many of these patients do in fact have considerable medical co-morbidity (Creed, Ng). Medically unexplained symptoms are 3 times as common in patients with general medical illnesses, including cancer, cardiovascular and respiratory

disease compared to the general population (OR=3.0 [95%CI: 2.1 to 4.2] (Harter et al 2007). This de-emphasis of medically unexplained symptoms would pertain to somatization disorder, hypochondriasis, undifferentiated somatoform disorder, and pain disorder. We now focus on the extent to which such symptoms result in subjective distress, disturbance, diminished quality of life, and impaired role functioning.

Major Change 3: Modify Criteria for Conversion Disorder

Changes are made in an effort to simplify the criteria for conversion disorder. First, we suggest removing the requirement that the clinician actively establish that the patient is not feigning. This is because (a) it is probably clinically impossible to prove that a patient is not feigning (Sharpe, 2003) and (b) there is no evidence that feigning of conversion symptoms is more common than feigning of other mental disorders. However as with other disorders positive evidence of feigning remains an exclusion, thereby differentiating conversion from factitious disorder and malingering.

Second, we suggest removing the requirement that the clinician has to establish that there are associated psychological factors . This is because (a) as with feigning, it is very difficult to reliably establish that relevant psychological factors are present in all cases and (b) the research evidence suggests that psychological factors can often be found but are not specific and have only a weak association with the

diagnosis (Roelofs, 2005). The association with psychological factors has therefore been relegated to accompanying text rather than remaining a clinical requirement for diagnosis.

Third, we emphasize the importance of obtaining positive evidence of the diagnosis from appropriate neurological assessment and testing. Current diagnostic criteria require that the symptom, after appropriate medical assessment, is found not to be due to a general medical condition. In contrast to most other somatic symptoms, it can be usually be reliably determined whether neurological symptoms are due to an organic disease (Stone et al 2009). Additionally there are also findings on neurological assessment and investigation that positively suggest the symptoms are those of conversion (such as Hoovers sign for motor weakness or absence of seizure activity on an EEG during apparent seizures for seizures) (Hallett 2005; Reuber 2004; Stone 2005).

We suggest retaining Conversion Disorder in the Somatic Symptom Disorders section of the DSM. Conversion remains a condition defined by a somatic symptom that causes disability or distress and therefore sits comfortably in the new Somatic Symptom Disorders category that replaces somatoform disorders on grounds of utility. The alternative placement of this diagnosis is with dissociative disorders. The argument for moving conversion there is that the mental mechanisms involved are similar. However dissociation is a hypothetical process and moving conversion would (a) risk making an unjustified assumption about cause (b) lose the

utility of grouping with other conditions that present with a somatic symptom.

Severity

There are few widely employed measures of severity in factitious disorder or conversion disorder.

For conversion disorder, the severity scoring might best be based on the severity of the associated disability (using a simple rating of mild, moderate and severe)

Dissociative Fugue (300.13)

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

DSM-IV-TR CRITERIA

A. The predominant disturbance is sudden, unexpected travel away from home or one's customary place of work, with inability to recall one's past.

B. Confusion about personal identity or assumption of a new identity (partial or complete).

C. The disturbance does not occur exclusively during the course of Dissociative Identity Disorder and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., temporal lobe epilepsy).

D. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Associated features

Dissociative Fugue was formerly known as Psychogenic Fugue, it is comorbid with Bipolar Disorder, Major Depressive Disorder, and Schizophrenia, as well as PTSD, Substance Related disorders, Panic and Anxiety Disorders, Eating Disorders, and Somatoform Disorders. Note: Dissociative Fugue is often mistaken for malingering. This happens because the disorder enables people to escape their responsibilities or undesirable or dangerous situations; therefore it is seen as if a person is taking the 'easy-way-out'. A person in the midst of a Dissociative Fugue episode may appear only slightly confused or they may appear to have no symptoms at all and attract no attention. Eventually, however, the person will begin to show significant signs of confusion or distress as they become aware of memory loss or confusion about their identity. This amnesia is characteristic of the disorder. When the fugue ends, the person may experience depression, grief, shame, and suicidal impulses.

Child vs. adult presentation

Dissociative Fugue usually begins in adulthood. There is little information about the presentation of this disorder in children. When it does affect children, it is most commonly

due to severe trauma such as sexual abuse, but even then it does not usually present until adulthood.

Gender and cultural differences in presentation

Some research revealed that this condition most often occurs in females, but the reason is unknown. One source stated that females are at a rate six to nine times higher than males, and it increases as age increases. This pattern is most likely associated with the stresses on a woman to be both mother and a family provider and caretaker, in conjunction with the societal pressures and gender prejudices. Most studies however, believed that Dissociative Fugue is equally prevalent across genders.

There is little information on the cultural differences in presentation of Dissociative Fugue. It is important to remember that what may be considered dissociative in one culture may be seen as normal in another. Cultures prone to warfare are more likely to experience the distressing pressures of war, which is a common causal traumatic event of this disorder. Various cultures with defined “running” syndrome may have symptoms that meet diagnostic criteria for Dissociative Fugue, such as the amok in Western Pacific cultures.

Epidemiology

This is a relatively rare disorder, actually the rarest of the dissociative disorders, affecting about only 2 in 1000 people in the United States. The prevalence rate is estimated at 0.2%.

It is much more common however among people who have been in wars, accidents, natural disasters, or other highly traumatic or stressful events.

Etiology

Episodes of Dissociative Fugue are usually triggered by very stressful events. Traumatic experiences such as war, natural disasters, accidents, and sexual abuse during childhood, often increase the incidence of the disorder. More personal types of stress, like the shocking death of a loved one or unbearable pressures at work or home, might also lead to the unplanned travel and amnesia that is characteristic of Dissociative Fugue.

Empirically supported treatments

Most fugues last for only hours or days, and then often disappear on their own. The goal of treatment is to assist the person to come to terms with the trauma or stress that triggered the fugue in the first place. Another goal of treatment is to help develop new coping methods to prevent further fugue episodes. As with most disorders, the particular treatment approach depends on the individual and the severity of his or her symptoms. The most likely treatment however will include a combination of psychotherapy, cognitive therapy, medication, family therapy, creative therapy, and clinical hypnosis. Psychotherapy is the main treatment for dissociative disorders such as Dissociative Fugue. Such treatments aim to increase insight into problems. Cognitive therapy focuses on changing dysfunctional

thinking patterns. Medication is useful when the person also suffers from depression or anxiety. Family therapy aims to teach the family more about the disorder and learn about the symptoms of recurrence. Creative therapies, such as music therapy and art therapy, let the person express themselves in safe manners. Clinical hypnosis uses intense relaxation, concentration, and focuses attention to achieve an altered state of awareness. This is risky however because of the risk of creating false memories. The prognosis for Dissociative Fugue is often very good because the episodes do not usually last longer than a few months and people generally recover quickly. Efforts to restore the memories of what happened during the fugue are usually unsuccessful or take a long time to be recovered.

Illustrative case

A case study was reported in *Psychology Today* (Drawing a Blank, October 2007) and was also reported in *Macleans Magazine* (The Man Who Lost Himself, May 2007) about a man named Jeff Ingram. A short summary of this case goes as follows: Ingram, 40, is a former mill worker in Olympia, Washington. He left his home one morning headed for Alberta to visit a terminally ill friend. A few days later he woke up on a street in Denver with no idea of who he was. Ingram became confused, angry, and worried when he was being questioned by the hospital's receptionist because he had no knowledge of his identity. Even months after being reunited with his family, Ingram still had no pre-

fugue memories, including that of his three year relationship with then-fiancée. In order to prevent such confusion in the future, Ingram ordered GPS shoes and had his identity information tattooed on him. He also wears a zip disk with medical information around his neck. It is believed that the possible trigger of Ingram's fugue episode was the stress of his friend's battle of cancer. A more detailed article can be found in Maclean's magazine (May 2007).

PROPOSED DSM-5 CHANGES: (dsm5.org)

The DSM-5 workgroup is proposing that this disorder be subsumed into an existing disorder. **Dissociative Amnesia**(to become a subtype of Dissociative Amnesia).

Rationale:The literature, reviewed in the Dissociative Disorders literature review, makes it clear that dissociative amnesia, usually for identity, is the primary feature, and travel is an inconsistent one. Also, the disorder is extremely rare, so inclusion as a subtype of Dissociative Amnesia seems reasonable.

Factitious Disorders (300.19)

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

DSM-IV-TR CRITERIA

- A. The patient is intentionally producing or pretending to have physical or psychological symptoms or signs of illness.
- B. The patient's motivation is to assume the role of a sick person.
- C. There are no external motives that explain the behavior.

Associated Features

- Includes intentionally fabricating physical or

psychological symptoms without having any actual illnesses. Motivation must lie in assuming the sick role and not for personal gain as in malingering.

- It can have predominantly psychological signs and symptoms, or predominantly physical signs and symptoms or a combination of psychological and physical signs and symptoms.
- Patients may do things to make it look like they are ill and need medical attention such as; contaminating urine sample, ingesting harmful substances like bacteria to invoke some sort of physical proof that they need care, taking hallucinogens, purposefully infecting minor cuts or scrapes to increase the severity and increase the medical attention administered. Can be seen in patient who seeks attention, sympathy, or leniency in some situations.
- Patients may have long medical histories with many hospital admissions. Their records are usually vague and inconsistent.
- The patient may have an unusual knowledge of the supposed disease as if they just had definitions to go off of without any true experience.
- They could be employed in a medical setting.
- Their hospital visits are usually around hospitals and weekends when the experienced staff is not

working so they will have a less likely chance of being caught but still get the same treatment.

- The person will probably receive few hospital visits even if they claim to be an important figure.
- The patient may be unusually comfortable with invasive procedures, uncomfortable surgeries, or a drastic diagnosis.
- Their hospital behavior could be classified as controlling, hostile, attention-seeking, or disruptive.
- They may only present symptoms when they think they are being watched or when thought to be under surveillance and may disprove of surveillance.
- They are abusing medications, most commonly pain-killers.
- The illness that is being played out fluctuates, often with rapid progression.
- Self-inflicted wounds are most abundant.

Munshausen

- Munchausen Disorder is another term for Factitious Disorder.
- This is also known as Hospital Addiction Syndrome or Hospital Hopper Syndrome.

- This has the same diagnostic criteria as Factitious Disorder, seeking attention for being sick. Most often seeking sympathy and care. Sometimes multiple surgeries are performed before diagnosing this disorder.

Munchausen Syndrome by proxy

- Referred to in the DSM-IV-TR as Factitious Disorder by proxy, is a disorder in which someone delivers harm to someone else, most often a child, in order to gain attention. Its been described as an extended form of child abuse; it's only difference is that it's done for some sort of gain.
- Münchausen syndrome by proxy (MSBP), is a psychiatric disorder, a particular form of child abuse. An impaired emotional relationship exists mainly between the mother and her child. According to the variety of victims' symptoms, all medicine doctors may deal with this syndrome in every day clinical practice. Still insufficient knowledge about the syndrome and its' rare consideration in the differential diagnosis result in only severe, potentially lethal cases recognition. For many years the rest remains a source of a long-term physical and mental injuries in victims (Berent, Florkowski, & Galecki, 2010).
- Brief overview of [Munchausen by Proxy](#)

Ganser Syndrome

Ganser Syndrome is a separate type of Factitious Disorder. This disorder involves a patient giving absurd or exaggerated responses to simple questions. It can also be when a patient gives approximate answers to simple questions. The symptoms include clouded consciousness, altered reality, confusion, stress, loss of identity, etc.

Epidemiology

- FD often goes undetected therefore making it difficult to accurately determine how many people are afflicted.
- It has been shown that there is a much higher prevalence of physical factitious symptoms than psychological factitious symptoms.
- Only a few select studies have been done to show its prevalence. A large teaching hospital in Toronto reported that 10 of 1,288 patients referred to a consultation service had FD (0.8%). The National Institute for Allergy and Infectious Disease reported that 9.3% of patients referred for fevers of unknown origin had factitious disorder. A clinic in Australia found that 1.5% of infants brought in for serious illnesses by parents were cases of Munchausen syndrome by proxy.

Etiology

- Little is known about the true causes of FD because of poor follow up after hospital visits. There are a few theories; brain imaging has shown some biological associations with FD especially with Gasner Syndrome.
- FD might be attempted to re-enact some unresolved parental issues, or to re-enact a particularly enjoyable hospital visit.
- It also might be a form of masochism.
- It could just be attention seeking behavior or a need for care and nurturance
- It's been speculated that FD may be an attempt to gain control over an authority figure such as a doctor.
- FD is often common amongst people who received extensive medical treatment as children for real physical disorders, experienced extreme family problems or abuse during childhood,

Treatment

- Medication has yet to prove successful in treating FD, some mood disorder medications have proven effective if they have other personality disorders.
- Most long term treatment is dropped by someone

with FD.

- Psychotherapy and Family Therapy are some of the only treatments that have shown benefit, these often require what the patient doesn't have that caused this disorder, such as a caring family or someone willing to go through long term therapy with them.

DSM5 CHANGES (DSM5.ORG)

The work group proposed that Factitious Disorder be reclassified to Somatic Symptom Disorders.

Factitious Disorder

To make this diagnosis, all 4 criteria must be met.

1. A pattern of falsification of physical or psychological signs or symptoms, associated with identified deception.
2. A pattern of presenting oneself to others as ill or impaired.
3. The behavior is evident even in the absence of obvious external rewards.
4. The behavior is not better accounted for by another mental disorder such as delusional belief system or acute psychosis.

Major Change #1: Rename somatiform disorders to Somatic Symptom Disorders and combine with PFAMC and Factitious Disorders

The workgroup suggests combining Somatoform Disorders, Psychological Factors Affecting Medical Condition (PFAMC), and Factitious Disorders into one group entitled "Somatic Symptom Disorders" because the

common feature of these disorders is the central place in the clinical presentation of physical symptoms and/or concern about medical illness. The grouping of these disorders in a single section is based on clinical utility (these patients are mainly encountered in general medical settings), rather than assumptions regarding shared etiology or mechanism.

Major Change #2: De-emphasize unexplained symptoms

Remove the language concerning medically unexplained symptoms for reasons specified above. The reliability of such judgments is low (Rief, 2007). In addition, it is clear that many of these patients do in fact have considerable medical co-morbidity (Creed, Ng). Medically unexplained symptoms are 3 times as common in patients with general medical illnesses, including cancer, cardiovascular and respiratory disease compared to the general population (OR=3.0 [95%CI: 2.1 to 4.2] (Harter et al 2007). This de-emphasis of medically unexplained symptoms would pertain to somatization disorder, hypochondriasis, undifferentiated somatoform disorder, and pain disorder. We now focus on the extent to which such symptoms result in subjective distress, disturbance, diminished quality of life, and impaired role functioning.

Minor Change: Factitious Disorders

The work group proposes minor modifications to factitious disorders. Most importantly, it eliminates the distinction between factitious disorders involving physical vs psychological symptoms. It clarifies who is the patient in circumstances previously diagnosed as “factitious disorder by

proxy.” This is now termed “factitious disorder on other.” Additional minor changes in the factitious disorder descriptions were made to emphasize objective identification rather than inference about intentionality or possible underlying motivation. “Intentional production or feigning” was thus removed and replaced with “a pattern of falsification”. The wording “pattern of falsification” attempts to emphasize that the diagnosis should follow an objective characterization of a set of behaviors, without perceived inference about the intentionality or possible underlying motivation for these behaviors. “...associated with identified deception” was inserted to state that the behaviors showed evidence of deception as identified by the observer. Again, this wording emphasizes behaviors being observed, rather than inference about intent. Finally, item A4 was added to clarify that factitious disorder is not diagnosed when it is accounted for by another mental disorder such as an acute psychosis.

Severity:

There are few widely employed measures of severity in factitious disorder or conversion disorder.

For factitious disorder, one might grade severity levels as “1” when symptoms alone are reported (“bright red blood in stool”), as “2” when a lab test was modified (e.g. introducing blood into a urine sample), as “3” when patients make themselves sick or as “4” when patients’ actions lead to life threatening illness.

100

Intermittent Explosive Disorder
(312.34)

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COLLEGE

Intermittent explosive disorder, also known as IED, is characterized by the failure to resist aggressive impulses, which result in serious assaults or property destruction (American Psychological Association, 2000). The degree of aggression displayed during these outbursts is grossly out of proportion with the events that provoke them. (Bayer, 2000). The short-lived episodes of aggression provide a way for the person with IED to vent his or her anger and frustration (Bayer, 2000). These verbal or physical outbursts are much more intense than normal anger, and the individual with

IED is unable to control them (Bayer, 2000). The aggression the individual feels is often ego-dystonic, so they may feel regret or guilt after committing the aggressive act (Bayer, 2000; Blankenship, 2008). IED is not the same as aggression that is purposeful and premeditated, and it does not arise out of personal motives, such as revenge, social dominance, or monetary gain (Blankenship, 2008).

History of IED:

- The name of this disorder has changed over time and so has the diagnostic criteria listed in the DSM. In the DSM-I, IED was called passive aggressive personality, aggressive type; in the DSM-II, it was renamed explosive personality disorder.
- The term intermittent explosive disorder was first used in the DSM-III, and the diagnostic criteria excluded individuals with antisocial personality disorder and generalized aggression or impulsivity (Blankenship, 2008).
- In the DSM-III-R, individuals with borderline personality disorder were also excluded (Blankenship, 2008).
- The current diagnostic criteria for IED no longer excludes generalized aggression or impulsivity (Blankenship, 2008).
- For an individual to be diagnosed with IED, the outbursts cannot be triggered by other disorders or

medication. However, people with IED very likely to abuse drugs (Bayer, 2000).

IED and suicide:

- A study assessing the prevalence rates of suicidal and self-injurious behavior among individuals with IED found that approximately 17% of patients exhibited self-aggressive behavior, 12.5% had attempted suicide, and 7.4% had performed non-suicidal, self-injurious behavior (McCloskey, Benzeev, Lee & Coccaro, 2008).
- It was also found that women were at an increased risk for self-injurious behavior overall (McCloskey et al., 2008).
- Furthermore, individuals with major depressive disorder were found to be at a higher risk of self-aggressive behaviors, including suicide attempts (McCloskey et al., 2008).

DSM-IV-TR criteria

- A. Several discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.
- B. The degree of aggressiveness expressed during the episodes is grossly out of proportion to any precipitating psychosocial stressors.

- C. The aggressive episodes are not better accounted for by another mental disorder (e.g., [Antisocial Personality Disorder](#), [Borderline Personality Disorder](#), [a Psychotic Disorder](#), [a Manic Episode](#), [Conduct Disorder](#), or [Attention-Deficit/Hyperactivity Disorder](#)) and are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma, Alzheimer's disease)

Associated features

Some individuals see their impulses as stressful and destructive before, during, and after they react to these impulses. Episodes may be associated with affective symptoms (racing thoughts, rage, etc.) during the aggressive acts and rapid onset of depressed mood after the acts. Some episodes may be preceded by tingling, tremors, palpitations, chest tightness, hearing an echo, or head pressure (Bayer, 2008). These reactions can cause problems socially in their relationships, school, and/or jobs. Individuals with IED can sometimes suppress their anger, to an extent, and react in a less destructive manner. Signs of impulsivity or aggressiveness may be present between episodes (Bayer, 2008). They may report problems with anger and “sub-threshold” episodes. Individuals with narcissistic, obsessive, paranoid, or schizoid traits may be especially prone to having explosive outbursts of anger when under increased stress.

Child vs. adult presentation

Children may react with a temper, hyperactivity, or destructive actions such as tearing up objects, setting objects on fire, or taking from others. There is no exact age of when IED begins, however it is believed to occur from childhood to late teens or twenties.

Gender and cultural differences in presentation

This episodic violent behavior is more frequent in men than women (Bayer, 2008). One form of aggression, known as *amok*, is characterized by acute, unrestrained violence, typically associated with amnesia. This is primarily seen in southeastern Asia but has also been seen in Canada and the United States. Unlike IED, *Amok* does not occur frequently but in a single episode.

Epidemiology

- Very little is known about the epidemiology of intermittent explosive disorder.
- Studies have found that IED may be present in over 5% of the population (Kessler, Coccaro, Fava, Jaeger, Jin & Walters, 2006).
- One study found that from 3.4% to 10.4% of patients in a psychiatric facility had IED characteristics at some point in their lives (Grant, Levine, Kim & Potenza, 2005).

- There is limited data on age at onset, but it appears to be between childhood and the early twenties (Bayer, 2008). The onset may be abrupt with no prodromal period, and the course varies (Bayer, 2008). The course is chronic in some individuals and episodic in others (Bayer, 2008).

Etiology

Developmental problems or neurological symptoms maybe a cause. There may be an imbalance of serotonin or testosterone levels. However, if a physician believes it is due to physiological problems, it may be diagnosed as a general medical condition instead. It may also be caused at a young age due to exposure in family situations where explosive behavior, verbal, or physical abuse were frequent. Exposure to violence at an early age makes it more probable for them to show the same traits as they mature. A genetic factor may also be the cause, allowing the disorder to be passed down.

Empirically supported treatments

Few controlled studies involving treatments for IED exist. Some patients respond to treatments with certain medications such as anti-convulsion, anti-anxiety, mood regulators, anti-depressants, antipsychotics, beta-blockers, alpha(2)-agonists, or phenytoin. Also, some forms of group therapy, such as anger management, may be helpful. Treatment can include also cognitive behavioral therapy that helps the person identify triggers for outbursts and avoid them.

Cocaine Abuse and Dependence
(305.6)

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE

DSM-IV-TR CRITERIA

A maladaptive pattern of cocaine use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 month period:

1. Recurrent cocaine use resulting in a failure to fulfill major role obligations at work, school or home.
2. Recurrent cocaine use in situations in which it is physically hazardous
3. Recurrent cocaine-related legal problems

4. Continued cocaine use despite having a persistent or recurrent social or interpersonal problem caused or exacerbated by its use.

Or the symptoms have never met the criteria for Substance Dependence for this class of substance.

Associated features

- Intoxication of cocaine is accompanied with a number of symptoms. There is heightened alertness and euphoria associated with intoxication of cocaine. Behavioral changes such as hyperactivity, restlessness, impaired judgment and functioning, and anxiety are also associated with intoxication. People under a more severe intoxication will experience more agitation, confusion, and possibly seizures.
- Withdrawal symptoms can include a dysphoric or unpleasant mood, fatigue, unpleasant dreams, insomnia, psychomotor retardation, and increased appetite. When people are in this dysphoric mood, they think back to the euphoria they received from the cocaine high, which in turn increases their cravings to use cocaine again, to get out of the mood.
- Cocaine abusers experience a number of symptoms that affect every part of the body. First of all, cocaine affects the nervous system, which causes

euphoria. It can also cause symptoms like hallucinations and muscle jerks. Cocaine also affects the brain, which makes it so addictive. Since cocaine is mostly sniffed or snorted through the nose, this causes serious effects on the sinuses and nose. Smoking cocaine can affect the lungs, much the way smoking cigarettes affect the lungs and breathing. Cocaine also has an effect on the heart. One of the main effects of cocaine is stimulating the sympathetic nervous system which is directly related to the heart and the [“flight-or-fight” response](#). Cocaine abuse can cause increased heart rate, blood pressure, and decreasing the size of the blood vessels, which in turn restrict blood flow to the heart.

- People dependent to cocaine will do nearly anything to get cocaine. This can interfere with their job, schooling, and relationships. People dependent on cocaine have many of the same symptoms of intoxication. They have increased energy, weight loss, and not involved in normal activities, along with many other symptoms.

Child vs. adult presentation

There has not been much research done in the area of child vs. adult presentation. Children, however, can be affected by cocaine use in their parents. A fetus can be harmed when a mother is using cocaine while pregnant resulting in the baby

having withdrawal symptoms when born. Women who are pregnant and using cocaine experience more miscarriages. Cocaine can affect the development of the fetus. Cocaine can cause certain areas of the brain to develop abnormally. It can cause problems later on in life with being able to pay attention, processing information and staying focused, compared with those who are not exposed to the drug. Newborns born to mothers who used cocaine during the pregnancy have lower birth weight, smaller head circumference, and are shorter than those babies who were born to mothers not using cocaine. These effects have a great impact on the child throughout their life. Children can also be affected by the second-hand smoke from parents who smoke cocaine. Overall, there is no research showing that children use cocaine. Mothers who use cocaine can affect the development of their children. Cocaine use generally begins in adolescence and the symptoms are the same as those experienced by adults using cocaine.

Gender and cultural differences in presentation

- There are not many differences in the presentation of intoxication or withdrawal symptoms across genders; however it has been found that women typically use cocaine for different reasons. It is usually a response to stress, hoping that the drug will make them feel better. In men, it has been found that they use cocaine to feel even better when already feeling good. More specifically, a

study conducted in 2002, found that estrogen may have a role in sex-based addictions. The study found that women usually become dependent after using cocaine for shorter amounts of time as compared with men. Estrogen can affect the immediate response to cocaine as well as the long-term effects of the drug. Another study, published in 2005, tested women and men stress reactivity. These participants were dependent on cocaine. They were all given a psychological stress task, the Mental Arithmetic Task, and a Cold Pressor Task. The participants were measured on their physiological stress response (heart rate, etc.), their subjective stress responses (nervousness, etc.), and their cocaine cravings they experienced. The results showed that women demonstrated more subjective reactivity. They had higher ratings of nervousness, stress, and pain compared with the men in the study. The study showed that women seem to be more stressed overall when dependent on cocaine as compared to men. However, this was the first study that used the testing procedure that was used and none have been done since.

- Culturally there has been no research in the area of difference of presentation. The main differences that have been researched are differences in uses among different ethnic groups.

Epidemiology

In 2007, the [National Survey on Drug Use and Health](#) reported that 35.9 million Americans have used cocaine at least once in their life. In 2007, students who took the [Youth Risk Behavior Surveillance System](#), 7.2% reported trying cocaine at least once. While only 3.3% reported having used cocaine in the past month. Nearly half of federal and state prisoners have tried cocaine once in their life. Research shows that nearly 75% of people that try cocaine will become addicted. Only 25% of people that are using cocaine will be able to stop without any help at all. Throughout the 1990's to present-day, cocaine use has remained stable, with no significant increases or declines. The number of people trying cocaine has gone down since the 1980's, however it has not been that significant. Adolescents show high rates of cocaine usage. Hispanic adolescents show the highest rates of cocaine use in the 30 days prior to taking the Youth Risk Behavior Survey. Caucasian adolescents report the next highest rate, then African American adolescents. Newer research has shown that drug use in adolescents has gone down since 2001. However, Hispanic adolescent drug use is still an area of concern. Currently, Hispanic adolescents are using cocaine more than Caucasian and African American adolescents. Additionally, research has shown that cocaine use is rising in European countries. One group of researchers believes that to combat this, a public health approach is necessary.

Etiology

Research has shown that repeated exposure to cocaine can cause a change in genes and this leads to an altered level of a protein that regulates dopamine levels. Dopamine is associated with the euphoria received from cocaine use. This causes many people to become addicted or dependent on cocaine. Cocaine is addictive and changes genes, making it hard to stop the addiction. It has also been found that if one has a family member using cocaine, they are more likely to do the same. While the nature of the drug is addictive, one's environment can also have an effect on using cocaine.

Empirically supported treatments

While there is no cure for cocaine abuse or dependence, there are therapies and drugs that can help people be relieved of the symptoms of intoxication or help them make a life change to get off of the drug all together. However, there are no guarantees. First, psychosocial treatments provide support for behavioral change. About half of users in this setting can abstain from cocaine for about a month to a month and a half. However, the success of the program depends on the duration of the program and the specific designs of the program. Many use a 12-step approach to changing their behavior. This is based on getting help with being drug-free from a higher being. Another type of therapy is Relapse Prevention. This helps people understand their body and the cues they get so they can manage their use and relapse symptoms. Another

psychosocial treatment is a Matrix Neurobehavioral Model Treatment. This involves many types of therapies including individual therapy, family education, and relapse prevention groups. This is also a 12-step program that can include meetings with mandatory urine tests to see if members are actually improving. Next, much research has been done regarding pharmacological treatments. However, while some initially have shown success, most have failed to show similar results when tested again. Drugs can be helpful for cocaine intoxication, though. Benzodiazepines have shown to help people with intoxication symptoms that do not go away. Benzodiazepines are also helpful to treat the withdrawal symptoms. Roughly 20 drugs have been tested in helping with cocaine dependence. There is no current evidence for any effective pharmacological treatment for cocaine dependence. Psychosocial treatment proves to be the most effective treatment, currently. In 2005, a group of researchers developed a system, called Cocaine Rapid Efficacy Screening Trial (CREST) which is a randomized method for testing and comparing the effect of pharmacological treatments on cocaine dependence. The CREST started out with a 2-4-week period of gathering information, then the 8-week treatment period. The participants were given urine tests, cocaine craving ratings, mood test, along with a few other tests and measures to track the progress of their treatment and the drug. This study was done in 4 major United States cities and 19 total drugs were tested for their effectiveness in treating cocaine dependence. Their findings showed three

drugs (reserpine, cabergoline, and, tiagabine) that showed signs of effectiveness. These drugs were to be tested in a full-scale research experiment. No pharmacological treatments have been found to help people dependent on cocaine. They only help treat physical symptom associated with cocaine use. The only supported treatment is psychosocial therapy.

Links:

- Cocaine, Marijuana, Crack, Meth, Heroin Changes Brain Chemistry [Drugs Damaging the Brain](#)

DSM-V PROPOSED CHANGES: ADDING
“COCAINE-USE DISORDER”

DSM-V Cocaine-Use Disorder Criteria:

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by 2 (or more) of the following, occurring within a 12-month period:

1. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
2. recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
3. continued substance use despite having persistent or recurrent social or interpersonal problems caused or

exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

4. tolerance, as defined by either of the following:

- a need for markedly increased amounts of the substance to achieve intoxication or desired effect
- markedly diminished effect with continued use of the same amount of the substance

(Note: Tolerance is not counted for those taking medications under medical supervision such as analgesics, antidepressants, anti-anxiety medications or beta-blockers.)

5. withdrawal, as manifested by either of the following:

- the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
- the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

(Note: Withdrawal is not counted for those taking medications under medical supervision such as analgesics, antidepressants, anti-anxiety medications or beta-blockers.)

6. the substance is often taken in larger amounts or over a longer period than was intended

7. there is a persistent desire or unsuccessful efforts to cut down or control substance use

8. a great deal of time is spent in activities necessary to

obtain the substance, use the substance, or recover from its effects

9. important social, occupational, or recreational activities are given up or reduced because of substance use

10. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

11. Craving or a strong desire or urge to use a specific substance.

Severity specifiers:

Moderate: 2-3 criteria positive

Severe: 4 or more criteria positive

Specify if:

- With Physiological Dependence: evidence of tolerance or withdrawal (i.e., either Item 4 or 5 is present)
- Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither Item 4 nor 5 is present)

Course specifiers (see text for definitions):

- Early Full Remission
- Early Partial Remission
- Sustained Full Remission
- Sustained Partial Remission
- On Agonist Therapy
- In a Controlled Environment

Paranoid Personality Disorder

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Definition and Associated Features

Paranoid personality disorder (PPD) is characterized by an extreme level of distrust and suspicion of others; unjustified feelings of suspicion and mistrust of others, hyper sensitivity, expectation – without justification – that will be damaged and exploited by others and a tendency to find hidden meanings messages and comments that are in reality harmless behaviors as degrading or threatening. People with PPD often interpret even friendly gestures as manipulative or malevolent. They are often difficult to get along with, as they can be

confrontational and aggressive; therefore, they generally lack close relationships with other people because they are constantly waiting for negative outcomes such as betrayal. As a result of others reacting negatively to their hostility, their negative expectations are often confirmed; for example, they may suspect that their neighbor takes the garbage out early in the morning just to bother them.

People who suffer with PPD do not only suspect strangers, but people they know as well, they believe those they know are planning to harm or exploit them without evidence to support their suspicions. If a person with PPD does form a close relationship, the relationship is often accompanied by jealousy and controlling tendencies. These individuals typically do not have psychotic features, that is, they are in clear contact with reality and usually do not experience hallucinations. They may also have less cognitive disorganization, therefore they are able to function socially in the work environment, although somewhat effectively as the rest of society.


When people with PPD suspect exploitation, harm, or deceit, it is almost always associated with friends or close partners because these are the people they are near the most. For example: They may suspect their spouse or partner is involved in an affair. This is where loyalty and trust issues come in, They are reluctant to give out any information that will hurt them or be used to put them down in any way, so they tend to keep secrets from those who are close to them because of a paranoid idea they will be harmed in the process.

Since they have trouble with trusting others, people with PPD have an excessive sense of self-sufficiency and autonomy. They are often rigid, unable to collaborate, and often have difficulty accepting criticism and instead blame others for their shortcomings. They may frequently be involved in legal disputes because of their tendency to counterattack in response to perceived threats. Sometimes PPD may appear antecedent of Delusional Disorder or Schizophrenia. Those with PPD may develop Major Depressive Disorder, and Substance Abuse or Dependence is frequent.

Individuals who have PPD typically do not have psychotic features, that is, they are clearly in contact with reality, and they usually do not have hallucinations. However, they may experience brief psychotic episodes in response to stress. The important thing to remember is that these individuals do not have Schizophrenia, Paranoid Type because they do not have hallucinations, and their cognitive disorganization, typical of the Schizophrenias, is not present. In addition, they are able to function socially and in the workplace, although their functioning is affected by this disorder. These individuals are always guarded and alert for attacks from other people in areas of employment, social areas and home life.



One or more interactive elements has been

 excluded from this version of the text. You can view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=381#oembed-1>

DSM-IV-TR Criteria

Defined as stated above. This can begin by early adulthood and present in a variety of contexts, as indicated by four (or more) of the items listed below.

1. Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her.
2. Preoccupied with unjustified doubts about the loyalty or trustworthiness of friends, family or associates.
3. Reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.
4. Reads hidden demeaning or threatening meanings into benign remarks or events.
5. Persistently bears grudges, because they are unforgiving of insults, injuries, or practical jokes.
6. Perceives attacks on his or her character or reputation that are not apparent to others and is

quick to react angrily or to counterattack.

7. Has recurrent suspicions, without justification, regarding fidelity of spouse or partner.
 - Does not occur exclusively during the course of Schizophrenia, a Mood Disorder with Psychotic Features, or another Psychotic Disorder and is not due to the direct physiological effect of a general medical condition.
 - NOTE: If criteria are met prior to the onset of Schizophrenia, add “Pre-morbid,” e.g., “Paranoid Personality Disorder (Pre-morbid)”.

Child vs. Adult Presentation

According to the DSM-IV-TR, there are a few exceptions noting personality disorders are not generally diagnosed in individuals under the age 18. If the symptoms or behaviors, sometimes called features, have been present for at least 1 year, then the individual can be diagnosed with a personality disorder if he or she is less than 18 years of age.

Signs of Paranoid personality disorder can be seen in childhood, seen as having poor relationships, not doing well in school, odd thoughts, social anxiety, solitariness, hypersensitivity, and they may be seen as “odd” or “eccentric” by others and as a result may attract teasing by other children.

Gender Differences in Presentation of Disorders

- Paranoid Personality Disorder affects more males than females and contains a few co-morbid disorders. Co-morbidity often occurs with Schizophrenia, Avoidant, and Borderline Personality Disorders.
- Females are generally more associated with the disorders of Borderline, Histrionic, and Dependent.
- Males are generally more associated with the disorders of Paranoid, Schizophrenia, and Antisocial.
- Diagnosis for males and females are also different even if both present the same symptoms.
- Females are also more apt to seek help than males because they are more willing to acknowledge the symptoms, acknowledge the need for help, and are more influenced by their social group to seek help.

Cultural Differences in Presentation

Most of the disorders listed and reviewed are Caucasian based. However for different cultural groups, symptoms and treatment may not be the same.

Some behaviors influenced by culture or life circumstances may be mistaken for Paranoia. Members of minority groups, immigrants, refugees, or those of different ethnic backgrounds may be guarded or defensive because of

unfamiliarity or perceived as neglect by the majority society. These behaviors may produce anger in those who deal with these individuals, thus setting up a mutual mistrust, which would not be Paranoid Personality Disorder.

Epidemiology

The lifetime prevalence of Paranoid Personality Disorder is 0.5% to 2.5% of the general population. An increased prevalence of Paranoid Personality Disorder has a biological connection to relatives of chronic sufferers of schizophrenia and patients with persecutory delusional disorders, which is the presence of persistent delusions.

The prevalence rate for inpatient psychiatric hospitals is 10%–30%. Anywhere from 2% to 10% of patients in an outpatient treatment facility are also affected.

One study has found that 44% of those in treatment for alcoholism have Paranoid Personality Disorder, while other studies have only found it to be around 13.2% (SAMHSA, 2009).

Etiology

- The cause of Paranoid Personality Disorder is unknown, although there are some theories that it may be due to negative childhood experiences in a threatening domestic atmosphere or caretakers having PPD
 - In their childhood there was no way of

predicting or escaping their environment; therefore, they develop paranoid ways of thinking in order to cope with the stressful situations.

- In addition, the incidence of PPD appears to be increased in families with a member who suffer from Schizophrenia.
 - Having a familial factor means that they are more likely to get the disorder because it was in the family genetics, thus having a higher chance of developing the disorder rather than someone whose family has a no known genetic disorders.
- The developmental path of PPD predominantly involves environmental responses of criticism, blame, and hostility. Studies have linked this diagnosis to caregivers who treated the individual with PPD in a sadistic, degrading, or humiliating manner, imposing the belief that he or she was fundamentally bad. A process that restricts the individual's ability to trust, leads to an anxious withdraw from interactions that are later compensated for with rage and peremptory behaviors seeking to protect the individual from impending harm.
- Promotes belief that hateful criticism or abuse may result from interpersonal interactions. Leads to

withdrawal from such interactions that may later be compensated for with rage.

- According to the Encyclopedia of Mental Disorders, other possible interpersonal causes have been proposed. For example, some therapists believe that the behavior that characterizes PPD might be learned and might be traced back to childhood experiences. According to this view, children who are exposed to adult anger and rage with no way to predict the outbursts and no way to escape or control them develop paranoid ways of thinking in an effort to cope with the stress. PPD would emerge when this type of thinking becomes part of the individual's personality as adulthood approaches.
- Studies of identical (or monozygotic) and fraternal (or dizygotic) twins suggest that genetic factors may also play an important role in causing the disorder. Twin studies indicate that genes contribute to the development of childhood personality disorders, including PPD. Furthermore, estimates of the degree of genetic contribution to the development of childhood personality disorders are similar to estimates of the genetic contribution to adult versions of the disorders.

Medications

While individual supportive psychotherapy is the treatment of choice for PPD, medications are sometimes used on a limited basis to treat related symptoms. If, for example, the patient is very anxious, anti-anxiety drugs may be prescribed. In addition, during periods of extreme agitation and high stress that produce delusional states, the patient may be given low doses of antipsychotic medications.

Some clinicians have suggested that low doses of neuroleptics should be used in this group of patients; however, medications are not normally part of long-term treatment for PPD. One reason is that no medication has been proven to relieve effectively the long-term symptoms of the disorder, although the selective serotonin reuptake inhibitors such as [fluoxetine](#) (Prozac) have been reported to make patients less angry, irritable and suspicious. Antidepressants may even make symptoms worse.

A second reason is that people with PPD are suspicious of medications. They fear that others might try to control them through the use of drugs. It can therefore be very difficult to persuade them to take medications unless the potential for relief from another threat, such as extreme anxiety, makes the medications seem relatively appealing. The best use of medication may be for specific complaints, when the patient trusts the therapist enough to ask for relief from particular symptoms.

Prognosis

Paranoid personality disorder is often a chronic, lifelong condition; the long-term prognosis is usually not encouraging. Feelings of paranoia, however, can be controlled to a degree with successful therapy. Unfortunately, many patients suffer the major symptoms of the disorder throughout their lives.

Prevention

With little or no understanding of the cause of PPD, it is not possible to prevent the disorder.

Empirically Supported Treatments

Because those with PPD are very suspicious and untrustworthy of others, they are generally not likely to seek therapy on their own. Often, the legal system or the family of the person suffering from this disorder gets involved and encourages the person to seek treatment. However, it is extremely difficult to begin treatment with the person, as the therapist has to gain the trust of the patient.

The most successful form of treatment for this disorder is psychotherapy, which can be used to help the patient control his paranoid thoughts. Medications are sometimes used to treat related symptoms, such as anxiety or delusional states that some people with PPD suffer when under stress.

Some clinicians suggest that low doses of [neuroleptics](#) should be used for short-term treatment of PPD.

[Antidepressants](#) such as [Prozac](#) have been reported to make symptoms of PPD worse and people with PPD are often suspicious of medication and believe that others might try to control them through drugs. Although psychotherapy and medication can temporarily control symptoms of PPD, most patients experience the symptoms of PPD for their entire life and require consistent therapy in order to manage their paranoia.

Psychotherapy

According to the Encyclopedia of Mental Disorders, the primary approach to treatment for such personality disorders as PPD is [psychotherapy](#). The problem is that patients with PPD do not readily offer therapists the trust that is needed for successful treatment. As a result, it has been difficult to gather data that would indicate what kind of psychotherapy would work best. Therapists face the challenge of developing rapport with someone who is, by the nature of his personality disorder, distrustful and suspicious; someone who often sees malicious intent in the innocuous actions and statements of others. The patient may actively resist or refuse to cooperate with others who are trying to help.

Mental health workers treating patients with PPD must guard against any show of hostility on their part in response to hostility from the patient, which is a common occurrence in people with this disorder. Instead, clinicians are advised to develop trust by persistently demonstrating a nonjudgmental attitude and a professional desire to assist the patient.

It is usually up to the therapist alone to overcome a patient's resistance. Group therapy that includes family members or other psychiatric patients, not surprisingly, isn't useful in the treatment of PPD due to the mistrust people with PPD feel towards others. This characteristic also explains why there are no significant [self-help groups](#) dedicated to recovery from this disorder. It has been suggested, however, that some people with PPD might join cults or extremist groups whose members might share their suspicions.

To gain the trust of PPD patients, therapists must be careful to hide as little as possible from their patients. This transparency should include note taking; details of administrative tasks concerning the patient; correspondence; and medications. Any indication of what the patient would consider "deception" or covert operation can, and often does, lead the patient to drop out of treatment. Patients with paranoid tendencies often don't have a well-developed sense of humor; those who must interact with people with PPD probably should not make jokes in their presence. Attempts at humor may seem like ridicule to people who feel so easily threatened.

With some patients, the most attainable goal may be to help them to learn to analyze their problems in dealing with other people. This approach amounts to supportive therapy and is preferable to psychotherapeutic approaches that attempt to analyze the patient's motivations and possible sources of paranoid traits. Asking about a patient's past can undermine the treatment of PPD patients. Concentrating on

the specific issues that are troubling the patient with PPD is usually the wisest course.

With time and a skilled therapist, the patient with PPD who remains in therapy may develop a measure of trust. But as the patient reveals more of his paranoid thoughts, the clinician will continue to face the difficult task of balancing the need for objectivity about the paranoid ideas and the maintenance of a good rapport with the patient. The therapist thus walks a tightrope with this type of patient. If the therapist is not straightforward enough, the patient may feel deceived. If the therapist challenges paranoid thoughts too directly, the patient will be threatened and probably drop out of treatment.

Portrayed in Popular Culture

- George from Seinfeld
 - He is characterized by irrational suspicions and mistrust of others
- Cornelius Fudge from Harry Potter
 - He irrationally fears that Albus Dumbledore, and just about anybody, is trying to overthrow him as the Minister of Magic

DSM-V Changes

Paranoid Personality Disorder will be represented and diagnosed by a combination of core impairment in

STEPHANIE WEIGEL

personality functioning and specific pathological personality traits, rather than as a specific type.

(APA, 2010)

Links

- [The Encyclopedia of Mental Disorders](#)

Schizoid Personality Disorder

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DSM-IV-TR criteria

- A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
 1. neither desires nor enjoys close relationships, including being part of a family

2. almost always chooses solitary activities
 3. has little, if any, interest in having sexual experiences with another person
 4. takes pleasures in few, if any, activities
 5. lacks close friends or confidants other than first-degree relatives
 6. appears indifferent to the praise or criticism of others
 7. shows emotional coldness, detachment, or flattened affectivity
- Does not occur exclusively during the course of Schizophrenia, a Mood Disorder with Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder and is not due to the direct physiological effects of a general medical condition.
 - NOTE: If criteria are met prior to the onset of Schizophrenia, add “Pre-morbid,” e.g., “Schizoid Personality Disorder (Pre-morbid).”

Associated Features

Individuals with Schizoid Personality Disorder (SPD) have little to no contact with the outside world. They have no desire to have social relationships, and when they do have them they do not enjoy them. This is a reason that they have

few to no friends and to others these individuals seem to be cold and distant, often displaying a stoic expression. They are rarely able to express their emotion and often fail to have warm feelings for anyone. They have little to no interest in sexual activity and have very few things in their lives that give them pleasure. They tend to be loners and pursue activities and occupations where they do not have to interact with people.

There is highest Co-morbidity for Schizotypal, Avoidant, and Paranoid Personality Disorders. Thus, is it most likely that another Cluster A disorder will occur with SPD. Anhedonia is often expressed, that is a an inability to experience pleasure and joy in activities and life. People that suffer from SPD tend to show long-standing patterns of behaviors that are abnormal to their environmental norms. They may experience brief psychotic episodes resulting from stress. SPD may appear as a precursor to Delusional Disorder or Schizophrenia, and those with SPD may develop Major Depressive Disorder.

The person may have a stoic look most of the day and not respond to any comments or jokes; they just keep to their self and do what they want to do alone. They are somewhat shy of others, not knowing what is going to happen next.

Child vs. Adult Presentation

Typically, the onset of SPD is in early adulthood or late adolescence were the symptoms can be seen. These would

include performing badly in school, self-isolation, and bad relationships with their peers.

The symptoms that are needed for diagnosing SPD need to be shown by early adulthood. The earlier this is found, the better, because it will be more difficult to treat once the person gets older.

One issue that is known is the similarity between SPD, autism and Asperger's disorder. It is important to know that the personality traits of SPD are inflexible and cause impairment in functioning

Gender and Cultural Differences in Presentation

More males are affected by Schizoid PD than females. The disorder is uncommon in clinical settings because individuals with SPD do not perceive themselves as distressed and, therefore, are not inclined to seek out treatment. They see themselves as normal, but not when they interact with others; they do not know what to expect from other people they have not met because they are socially inclined to be quiet and reserved of mysterious people.

SPD may be more prevalent in individuals with schizophrenic or schizotypal relatives.

Those from a variety of cultural backgrounds may sometimes exhibit defensive behavior and styles which may be mistaken as schizoid.

Immigrants are sometimes mistaken as cold, hostile, or indifferent.

Epidemiology

Schizoid Personality disorder has a prevalence rates in the general population between 1% and 3% and prevalence in an outpatient psychiatric setting around 1%. There is some familial patterns but none that are very significant in general settings.

This is the least diagnosed personality disorder in the general population, and is uncommon in clinical settings.

The diagnosis is based on a clinical interview to assess symptomatic behavior. Other assessment tools that are helpful in diagnosing Schizoid Personality Disorder include:

- Minnesota Multiphasic Personality Inventory (MMPI-2)
- Millon Clinical Multiaxial Inventory (MCMI-II)
- Rorschach Psychodiagnostic Test
- Thematic Apperception Test (TAT)

Etiology

SPD shares many commonalities of depression, Avoidant Personality Disorder and Asperger's syndrome and can be difficult to distinguish from the others because of some of the same symptoms and behaviors that are displayed in the other disorders.

Family life seems to be the underlying cause of Schizoid PD. These families are reserved emotionally, have impersonal communication, and are very formal. The parents often did

not give very much attention to the person while they were growing up. This occurring in the first year of their lives, seems to have an impact on their lack of wanting to form close relationships because these children did not learn the necessary skills needed to form and maintain close relationships.

Schizoid Personality Disorder may have increased prevalence in the relatives of those with Schizophrenia and Schizotypal Personality Disorder.

Empirically Supported Treatments

Individuals with Schizoid PD do not usually seek out treatment because they generally do not feel as if they are in need of help, like some of the other disorders; they think they are pretty normal individuals with normal lives but need an intervention by a friend to reveal that the behavior is problematic. When they realize, for the few who do seek treatment, there are medications that treat only the negative symptoms, similar to those persons with schizophrenia.

Psychodynamically oriented therapies:

- A psychodynamic approach would typically not be the first choice of treatment due to the patient's poor ability to explore his or her thoughts, emotions, and behavior. When this treatment is used, it usually centers around building a therapeutic relationship with the patient that can act as a model for use in other relationships.

Cognitive-behavioral therapy:

- Attempting to cognitively restructure the patient's thoughts can enhance self-insight. Constructive ways of accomplishing this would include concrete assignments such as keeping daily records of problematic behaviors or thoughts. Another helpful method can be teaching social skills through role-playing. This might enable individuals to become more conscious of communication cues given by others and sensitize them to others' needs.

Group therapy:

- may provide the patient with a socializing experience that exposes them to feedback from others in a safe, controlled environment. It can also provide a means of learning and practicing social skills in which they are deficient. Since the patient usually avoids social contact, timing of group therapy is of particular importance. It is best to develop first a therapeutic relationship between therapist and patient before starting a group therapy treatment.

Family and marital therapy:

- It is unlikely that a person with schizoid personality disorder will seek [family therapy](#) or marital therapy. If pursued, it is usually on the initiative of

the spouse or other family member. Many people with this disorder do not marry and end up living with and are dependent upon first-degree family members. In this case, therapy may be recommended for family members to educate them on aspects of change or ways to facilitate communication. Marital therapy (also called [couples therapy](#).) may focus on helping the couple to become more involved in each other's lives or improve communication patterns (minddisorders.com).

Medications

Some patients with this disorder show signs of anxiety and depression which may prompt the use of medication to counteract these symptoms. In general, there is to date no definitive medication that is used to treat schizoid symptoms.

Prognosis

Since a person with schizoid personality disorder seeks to be isolated from others, which includes those who might provide treatment, there is only a slight chance that most patients will seek help on their own initiative. Those who do may stop treatment prematurely because of their difficulty maintaining a relationship with the professional or their lack of motivation for change.

If the degree of social impairment is mild, treatment might succeed if its focus is on maintenance of relationships related

to the patient's employment. The patient's need to support him- or herself financially can act as a higher incentive for pursuit of treatment outcomes.

Once treatment ends, it is highly likely the patient will relapse into a lifestyle of social isolation similar to that before treatment.

Prevention

Since schizoid personality disorder originates in the patient's family of origin, the only known preventative measure is a nurturing, emotionally stimulating and expressive care-taking environment

Portrayed in Popular Culture

- Mr. Freeze from Batman
 - Due to a long-time search for a cure for his wife's malady, he is an emotionless machine.
- Severus Snape from Harry Potter
 - He rarely expresses emotions and usually stays in his office or in the Potions chamber away from the company of others

DSM-V Changes

Schizoid Personality Disorder will be represented and diagnosed by a combination of core impairment in

personality functioning and specific pathological personality traits, rather than as a specific type
(APA, 2010)

Links

- [Schizoid Personality Disorder](#)

Narcissistic Personality Disorder

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Individual diagnosed with Narcissistic PD discusses his disorder.

DSM-IV-TR criteria

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
2. is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love (perfect marriage to the perfect spouse)
3. believes that he or she is “special” and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
4. requires excessive admiration
5. has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations (“You owe me because I’m that good”)
6. is inter-personally exploitative, i.e., takes advantage of others to achieve his or her own ends
7. lacks empathy: is unwilling to recognize or identify with the feelings and needs of others

8. is often envious of others or believes that others are envious of him or her
9. shows arrogant, haughty behaviors or attitudes

Other Symptoms:

- history of intense but short-term relationships with others; inability to make or sustain genuinely intimate relationships
- a tendency to be attracted to leadership or high-profile positions or occupations
- a pattern of alternating between unrealistic idealization of others and equally unrealistic devaluation of them
- assessment of others in terms of usefulness
- a need to be the center of attention or admiration in a working group or social situation
- hypersensitivity to criticism, however mild, or rejection from others
- an unstable view of the self that fluctuates between extremes of self-praise and self-contempt
- preoccupation with outward appearance, “image,” or public opinion rather than inner reality
- painful emotions based on shame (dislike of who one is) rather than guilt (regret for what one has done)

Associated features

Individuals with Narcissistic Personality Disorder are greatly lacking in empathy and are unwilling to recognize or identify with the feelings and needs of others. They see themselves as above others and feel a strong sense of entitlement and need for admiration. Narcissistic individuals do not perceive themselves as flawed and are not likely to seek treatment. Therefore, these individuals represent less than one percent of the clinical population.

Some people who suffer from NPD also have mood disorders. Narcissistic patients only pursue relationships that will benefit them in some way. Their inflated sense of self results in a devaluation of others and their accomplishments. Patients with narcissistic personality disorder exaggerate their achievements and talents and are surprised when they do not receive the recognition they expect. These patients are prone to be more envious of other people who possess knowledge, a specific skill, or some kind of belonging that they do not possess. Patients are very self-absorbed and have a hard time responding to the needs of others. Narcissistic individuals often exhibit a history of intense but short-term relationships with others, an inability to make or sustain genuinely intimate relationships, and an unstable view of self that fluctuates between extremes of self-praise and self-contempt. Criticism may haunt them and leave them feeling humiliated, degraded, hollow, and empty, although they don't show it. Because of the problems from entitlement and the need for admiration and their disregard for others, they have difficulty

with interpersonal relationships. They may be unwilling to take part in situations in which there is risk and a possibility of defeat. NPD is also associated with anorexia nervosa, substance-related disorders, and other personality disorders.

If parents are neglectful, and they show no empathy toward the child, or if they devalue the child, then the child will always be seeking out this ideal sense of self, a narcissistic viewpoint. The reverse of this treatment by parents has also received some support. Narcissistic Personality Disorder could arise from parental overindulgence that is relatively painless but research is a little scarce for that proposition.

Hitler as an Example:

- The first criterion for this disorder is the individual must have a lavish sense of self-importance, they over-estimate their abilities, and embellish their accomplishments. Hitler considered himself to be a very special person. He believed that he was an astounding artist and had no doubt that he was going to get into the art school in Vienna and when he didn't he was astounded. He let the people around him believe that he had been accepted to the Viennese Academy of Fine Arts when in fact he was rejected twice.
- The second criterion of Narcissistic Personality Disorder is the individual must be preoccupied with fantasies of unlimited success and power. In Hitler's earlier years he had fantasies about

becoming a great and powerful artist. Later he developed the fantasy of becoming the world's greatest and most powerful leader by exterminating Jews.

- The third criterion is that the individual believes that they are superior, special, or unique. Hitler believed that his opinions were more advanced than those around him. He insisted that everyone listen to him and he often quarreled with those who opposed him.
- Hitler met the fourth criterion as well by needing excessive admiration. He was admired by many he came in contact with. He was able to string his friend Gustl around for so long because of the admiration Gustl had for Hitler.
- The fifth criterion is the sense of entitlement. Hitler expected others to cater to his every need, especially his mother, sister, and aunt. Later in his life, he expected his servants and military men to serve and give him everything he wanted.
- The sixth criterion and one of the ones Hitler showed most prominently is the exploitation of others. In his business deals, he did whatever he needed to, in order to benefit himself, even if that meant hanging others out to dry or throwing them under the bus so to speak.
- The seventh criterion is the lack of empathy. Hitler

had absolutely no empathy for what he was doing during World War II. Killing Jews and anyone who aided their survival was something easy and painless for Hitler. However, he did have empathy for his mother.

- Envy is the eighth criteria. Individuals with Narcissistic Personality Disorder envy others and believe that others envy them as well. Hitler was very envious of Gustl's acceptance into the Vienna Conservatoire to practice his Grand Piano.
- The final criterion is an arrogant, snobbish, or patronizing attitude towards others. Adolf Hitler was to say the least arrogant, snobbish, and patronizing. He believed that he was the greatest artist, the smartest man, better than women, and anyone different from him was inferior.
- It is evident that Hitler possessed characteristics that fall under all nine of the criteria so it could be possible that Hitler had Narcissistic Personality Disorder
- (Kershaw, 2008)

Subtypes of NPD

- Personality Subtype
- Age Group Subtype:
 - According to the Encyclopedia of mental

disorders, ever since the 1950s, when psychiatrists began to notice an increase in the number of their patients that had narcissistic disorders, they have made attempts to define these disorders more precisely. NPD was introduced as a new diagnostic category in DSM-III , which was published in 1980. Prior to DSM-III , narcissism was a recognized phenomenon but not an official diagnosis. At that time, NPD was considered virtually untreatable because people who suffer from it rarely enter or remain in treatment; typically, they regard themselves as superior to their therapist, and they see their problems as caused by other people's "stupidity" or "lack of appreciation."

- psychiatrists have proposed dividing narcissistic patients into two subcategories based roughly on age: those who suffer from the stable form of NPD described by DSM-IVTR , and younger adults whose narcissism is often corrected by life experiences.
- This age group distinction represents an ongoing controversy about the nature of NPD—whether it is fundamentally a character disorder, or whether it is a

matter of learned behavior that can be unlearned. Therapists who incline toward the first viewpoint are usually pessimistic about the results of treatment for patients with NPD.

- Other psychiatrists have noted that patients who meet the DSM-IV-TR criteria for NPD reflect different clusters of traits within the DSM-IV-TR list. One expert in the field of NPD has suggested the following subcategories of narcissistic personalities:
 - Craving narcissists. These are people who feel emotionally needy and undernourished, and may well appear clingy or demanding to those around them.
 - Paranoid narcissists. This type of narcissist feels intense contempt for him- or herself, but projects it outward onto others. Paranoid narcissists frequently drive other people away from them by hypercritical and jealous comments and behaviors.
 - Manipulative narcissists. These people enjoy “putting something over” on others, obtaining their feelings of superiority by lying to and manipulating them.

- Phallic narcissists. Almost all narcissists in this subgroup are male. They tend to be aggressive, athletic, and exhibitionistic; they enjoy showing off their bodies, clothes, and overall “manliness.”

Child vs. Adult Presentation

- NPD has been seen in children, adolescents, and adulthood. There have been no further studies to determine the differences in age of this disorder. The presentation of the disorder in children and adolescents are similar to the adult presentation.

Gender and Cultural Differences in Presentation

- NPD is seen more in men than in women (7.7% for men and 4.8% for women) based on 34,653 face-to-face structured interviews that included DSM-IV diagnostic criteria. Black men and Hispanic women had higher rates compared with Hispanic men and Caucasians of either gender. 50%-75% of all patients are men.

Epidemiology

- The prevalence of Narcissistic Personality Disorder within the general population ranges from 2 to 16 percent in the general population, but is less than 1 percent in the clinical population. The fact that

these individuals represent less than 1 percent of the clinical population is not surprising because these individuals rarely, if ever, seek out treatment. The reason is quite clear: These individuals see themselves (and their lives) as nearly perfect and do not see any need for change.

- For NPD, there have been no known genetic or environmental factors. It is believed that this is seen when parents over-indulge in the amount of encouragement they display to their child, over-zealously praise the accomplishments of the child, tell their child that they are not responsible for their own wrongdoings or spoiling their child.
- However, additional evidence suggests a genetic influence may be at play in determining the character of NPD. These inherited aspects include hypersensitivity, aggression, low frustration tolerance, and problems in affect regulation.
- Some researchers believe that Narcissistic individuals don't grow out of the period when they don't see the viewpoint of others as a child.
- In the clinical practice for substance abuse, 10 to 15% have Narcissistic Personality Disorder (SAMHSA, 2009).

Etiology

- The Encyclopedia states that at present there are

two major theories about the origin and nature of NPD. One theory regards NPD as a form of arrested psychological development while the other regards it as a young child's defense against psychological pain. The two perspectives have been identified with two major figures in psychoanalytic thought, Heinz Kohut and Otto Kernberg respectively

- Both theories about NPD go back to Sigmund Freud's pioneering work *On Narcissism*, published in 1914. In this essay, Freud introduced a distinction which has been retained by almost all later writers—namely, the distinction between primary and secondary narcissism. Freud thought that all human infants pass through a phase of primary narcissism, in which they assume they are the center of their universe. This phase ends when the baby is forced by the realities of life to recognize that it does not control its parents (or other caregivers) but is in fact entirely dependent on them. In normal circumstances, the baby gives up its fantasy of being all-powerful and becomes emotionally attached to its parents rather than itself. What Freud defined as secondary narcissism is a pathological condition in which the infant does not invest its emotions in its parents but rather redirects them back to itself. He thought that secondary narcissism developed in what he termed

the pre-Oedipal phase of childhood; that is, before the age of three. From a Freudian perspective, then, narcissistic disorders originate in very early childhood development, and this early origin is thought to explain why they are so difficult to treat in later life.

- Kohut and Kernberg agree with Freud in tracing the roots of NPD to disturbances in the patient's family of origin—specifically, to problems in the parent-child relationship before the child turned three. Where they disagree is in their accounts of the nature of these problems. According to Kohut, the child grows out of primary narcissism through opportunities to be mirrored by (i.e., gain approval from) his or her parents and to idealize them, acquiring a more realistic sense of self and a set of personal ideals and values through these two processes. On the other hand, if the parents fail to provide appropriate opportunities for idealization and mirroring, the child remains “stuck” at a developmental stage in which his or her sense of self remains grandiose and unrealistic while at the same time he or she remains dependent on approval from others for self-esteem
- In contrast, Kernberg views NPD as rooted in the child's defense against a cold and unempathetic parent, usually the mother. Emotionally hungry and angry at the depriving parents, the child

withdraws into a part of the self that the parents value, whether looks, intellectual ability, or some other skill or talent. This part of the self becomes hyperinflated and grandiose. Any perceived weaknesses are “split off” into a hidden part of the self. Splitting gives rise to a lifelong tendency to swing between extremes of grandiosity and feelings of emptiness and worthlessness.

- In both accounts, the child emerges into adult life with a history of unsatisfactory relationships with others. The adult narcissist possesses a grandiose view of the self but has a conflict-ridden psychological dependence on others. At present, however, psychiatrists do not agree in their description of the central defect in NPD; some think that the problem is primarily emotional while others regard it as the result of distorted cognition, or knowing. Some maintain that the person with NPD has an “empty” or hungry sense of self while others argue that the narcissist has a “disorganized” self. Still others regard the core problem as the narcissist’s inability to test reality and construct an accurate view of him- or herself

Macrosocial Causes.

- One dimension of NPD that must be taken into account is its social and historical context. Psychiatrists became interested in narcissism shortly

after World War II (1939–45), when the older practitioners in the field noticed that their patient population had changed. Instead of seeing patients who suffered from obsessions and compulsions related to a harsh and punishing superego (the part of the psyche that internalizes the standards and moral demands of one's parents and culture), the psychiatrists were treating more patients with character disorders related to a weak sense of self. Instead of having a judgmental and overactive conscience, these patients had a weak or nonexistent code of morals. They were very different from the patients that Freud had treated, described, and analyzed. The younger generation of psychiatrists then began to interpret their patients' character disorders in terms of narcissism.

- In the 1960s historians and social critics drew the attention of the general public to narcissism as a metaphorical description of Western culture in general. These writers saw several parallels between trends in the larger society and the personality traits of people diagnosed with narcissistic disorders. In short, they argued that the advanced industrial societies of Europe and the United States were contributing to the development of narcissistic disorders in individuals in a number of respects. Some of the trends they noted include the following:

- The mass media's preoccupation with "lifestyles of the rich and famous" rather than with ordinary or average people.
- Social approval of open displays of money, status, or accomplishments ("if you've got it, flaunt it") rather than modesty and self-restraint.
- Preference for a leadership style that emphasizes the leader's outward appearance and personality rather than his or her inner beliefs and values.
- The growth of large corporations and government bureaucracies that favor a managerial style based on "impression management" rather than objective measurements of performance.
- Social trends that encourage parents to be self-centered and to resent their children's legitimate needs.
- The weakening of churches, synagogues, and other religious or social institutions that traditionally helped children to see themselves as members of a community rather than as isolated individuals

Empirically Supported Treatments

- For NPD, the treatment of choice is normally Psychotherapy, but this method may prove problematic because the patient may become envious of the therapist and not respond to them. Long -Term Care Individual Counseling for these patients is recommended to help manage not only the self-aggrandizement, hypersensitivity, and need for control and attention, but also their anger and depression.
- Group Therapy is another option for patients, but the therapist should set down boundaries and limits on time, interruptions, the respect of others' feeling, responding to other group members, and listening to others' responses and feedback.
- It's important to obtain treatment as quickly as possible to avoid the onset of other disorders. Also, treatment should be continued for as long as allowed as personality traits are often very difficult to change. The inability to change is even more of a problem for the narcissistic type because, after all, they have the best personality already

Psychotherapy

- Several different approaches to individual therapy have been tried with NPD patients, ranging from classical [psychoanalysis](#) and Adlerian therapy to

rational-emotive approaches and Gestalt therapy . The consensus that has emerged is that therapists should set modest goals for treatment with NPD patients. Most of them cannot form a sufficiently deep bond with a therapist to allow healing of early-childhood injuries. In addition, the tendency of these patients to criticize and devalue their therapists (as well as other authority figures) makes it difficult for therapists to work with them.

- An additional factor that complicates psychotherapy with NPD patients is the lack of agreement among psychiatrists about the causes and course of the disorder. One researcher has commented that much more research is necessary to validate DSM-IV-TR 's description of NPD before outcome studies can be done comparing different techniques of treatment

Hospitalization

- Low-functioning patients with NPD may require inpatient treatment, particularly those with severe self-harming behaviors or lack of impulse control. Hospital treatment, however, appears to be most helpful when it is focused on the immediate crisis and its symptoms rather than the patient's underlying long-term difficulties
- Read more: www.minddisorders.com

Medication

- As of 2002, there are no medications that have been developed specifically for the treatment of NPD. Patients with NPD who are also depressed or anxious may be given drugs for relief of those symptoms. There are anecdotal reports in the medical literature that the selective serotonin reuptake inhibitors, or SSRIs, which are frequently prescribed for depression, reinforce narcissistic grandiosity and lack of empathy with others

Prognosis

- The prognosis for younger persons with narcissistic disorders is hopeful to the extent that the disturbances reflect a simple lack of life experience. The outlook for long-standing NPD, however, is largely negative. Some narcissists are able, particularly as they approach their midlife years, to accept their own limitations and those of others, to resolve their problems with envy, and to accept their own mortality. Most patients with NPD, on the other hand, become increasingly depressed as they grow older within a youth-oriented culture and lose their looks and overall vitality. The retirement years are especially painful for patients with NPD because they must yield their positions in the working world to the next

generation. In addition, they do not have the network of intimate family ties and friendships that sustain most older people

Prevention

- The best hope for prevention of NPD lies with parents and other caregivers who are close to children during the early preschool years. Parents must be able to demonstrate empathy in their interactions with the child and with each other. They must also be able to show that they love their children for who they are, not for their appearance or their achievements. And they must focus their parenting efforts on meeting the child's changing needs as he or she matures, rather than demanding that the child meet their needs for status, comfort, or convenience

Portrayed in Popular Culture

- In Greek mythology, Narcissus was a very beautiful guy that all the girls wanted to date, but Narcissus wanted nothing to do with them. He would pass by the loveliest and the most beautiful girls, not even bothering to look at them. One of his spurned lovers prayed to the goddess Nemesis that "he who loves not others love himself". Nemesis granted that prayer, and when Narcissus bent over a clear pool to get a drink of water, he

saw a reflection of himself and fell in love with it. He could not leave his image, and so he pined away, leaning perpetually over the pool, fixed in one long gaze until he died. They say that when his spirit crossed the river that encircles the world of the dead, it leaned over the boat to catch one last glimpse of itself in the water (Hamilton, 1969).

- Wall Street (1987)
- To Die For (1995)
- The Scarecrow from Batman
 - A psychiatrist himself, highly intellectual and generally condescending
- Gilderoy Lockhart from Harry Potter
 - Self-indulgent and always expecting admiration and adoration, even where lacking

DSM-V Changes

- Narcissistic Personality Disorder will be represented and diagnosed by a combination of core impairment in personality functioning and specific pathological personality traits, rather than as a specific type.
- [Prominent Personality Traits](#)
- [Narcissism, Manipulativeness, Histrionism,](#)

Callousness

(APA, 2010)

For More Information, Please Read:

- [Narcissistic personality disorder – children, define, causes, DSM, functioning, effects, therapy, adults, person, people, used, medication, theory, women, health, traits, mood, Definition, Description](http://www.minddisorders.com/Kau-Nu/Narcissistic-personality-disorder.html#ixzz167dngnxo) <http://www.minddisorders.com/Kau-Nu/Narcissistic-personality-disorder.html#ixzz167dngnxo>

Links

- www.minddisorders.com
- [Narcissistic Personality Disorder](#) video:



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Schizotypal Personality Disorder

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DSM-IV-TR criteria

- A pervasive pattern of social and interpersonal

deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. ideas of reference (excluding delusions of reference)
2. odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstition, belief in clairvoyance, telepathy, or “sixth sense”; in children and adolescents, bizarre fantasies or preoccupations)
3. unusual perceptual experiences, including bodily illusions
4. odd thinking and speech (e.g., vague, circumstantial, metaphorical, over elaborate, or stereotyped)
5. suspicious or paranoid idealization
6. inappropriate or constricted affect
7. behavior or appearance that is odd, eccentric, or peculiar
8. lack of close friends or confidants other than first-degree relatives
9. excessive social anxiety that does not diminish with

familiarity and tends to be associated with paranoid fears rather than negative judgments about self

- Does not occur exclusively during the course of Schizophrenia, a Mood Disorder with Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder.
- NOTE: If criteria are met prior to the onset of Schizophrenia, add “Pre-morbid,” e.g., “Schizotypal Personality Disorder (Pre-morbid).”

Associated Features

The speech of individuals with this disorder is affected in such a manner that it may be distinguished by unclear and unusual usages. Language is impaired by different contexts and syntax, or the arrangement of words and how they are used, in other words the grammar. Schizotypal behavior is often linked to individuals with Schizophrenia. They tend to appear emotionless, showing flat or constricted affect in interpersonal situations.

Schizotypal PD is difficult to accurately diagnose because it is highly co-morbid with several personality disorders, such as: Narcissistic, Borderline, Avoidant, Paranoid, and Schizoid PD. Individuals with this disorder may experience brief psychotic episodes in response to stress. They often seek treatment for anxiety, depression, or other dysphoric symptoms rather than for the actual disorder.

The schizotypal individual has unusual thought patterns

that end up disrupting their ability to communicate clearly with others. In addition, his or her ties to reality are impacted but not completely severed as in Schizophrenia. Because of this, many of these individuals are not able to realize their potential and are unable to lead truly productive lives.

Symptoms pointing to Brief Psychotic Disorder, Schizophreniform Disorder, Delusional Disorder, or Schizophrenia may develop in clinical settings. Over half may have a Major Depressive Episode.

Child vs. Adult Presentation

Schizotypal Personality Disorder may be first apparent in childhood and adolescence with solitude-seeking behavior, poor peer relationships, social anxiety, underachievement in academics, hypersensitivity, odd thoughts and speech, and bizarre fantasies.

As adults, presentation is similar but probably less severe such as less solitary activities because of boredom onset, and peer relationships are essential to advance in a life, such as with careers, friends and family.

Gender and Cultural Differences in Presentation

Generally more males are affected by Schizotypal Personality Disorder than females. Presentation in different cultural aspects do favor males as more Schizotypal affected than females probably because of a tendency for females to relate or talk to others enabling them to make relationships easier.

Females are more social and emotional than males in

general, and they have the tendency to communicate more information to other people and to be more open about their feelings and emotions. Males tend to be more closed off and only share private information to those they trust the most.

Some distortions must be evaluated within the individuals cultural context, as some cultural characteristics may be mistaken as schizotypal.

Epidemiology

- The prevalence of Schizotypal Personality Disorder is approximately 3% of the general population and is believed to occur slightly more often in males.
- Approximately less than 1% in an outpatient clinical sample.
- The course is rather stable, and only a small portion go on to develop Schizophrenia or another Psychotic Disorder.
- Schizotypal Personality Disorder is generally stable across an individual's life.
- Schizotypal Personality Disorder appears to occur more frequently in individuals who have an immediate family member with [schizophrenia](#).

Etiology

There is a chance that genetic factors contribute to the cause of Schizotypal Personality Disorder. Familial patterns are not

major here but can be more likely to contract the disorder if it is prevalent in the family genetics.

Environmental factors are less likely to contribute to this disorder than interpersonal factors because of interactions with people are social activities and may involve suspicion of others, odd beliefs and weird thinking, unusual perceptions or distortions of reality.

Oddities in children with STPD are reinforced when they are shunned and rejected by others, thus increasing their social anxiety and suspicion.

An alternative pathogenic hypothesis suggests that the child was severely abused, limited in autonomy development and peer interactions while caregivers modeled illogical formulations of reality, leading the adult with STPD to claim an unusual ability of knowing or controlling events combined with paranoid withdrawal from others.

Other hypotheses suggest that the infant's needs were met, but without sufficient emotional intimacy or warmth. Which hindered subsequent childhood development by punitive criticism, fragmented communications, and humiliation by peers.

The diagnosis of schizotypal personality disorder is based on a clinical interview to assess symptomatic behavior. Other assessment tools helpful in confirming the diagnosis of schizotypal personality disorder include:

- Minnesota Multiphasic Personality Inventory (MMPI-2)

- Millon Clinical Multiaxial Inventory (MCMI-II)
- Rorschach Psychodiagnostic Test
- Thematic Apperception Test (TAT)

Empirically Supported Treatments

Individuals with Schizotypal Personality Disorder are generally difficult to treat, as they are not comfortable with forming new relationships and interacting with others (ie. psychologists). They want to keep to themselves and not develop new close friends, or even have communication on a regular basis with family members. They would rather stay inside all day and be alone.

For individuals that have a little bit of higher functioning compared to other Schizotypal individuals, there are various treatment options. Provided these individuals see that they have a problem and seek treatment. One option is psychodynamic oriented therapies. This helps the individual build trusting relationships. Therapies include:

Psychodynamically oriented therapies

- A psychodynamic approach would typically seek to build a therapeutically trusting relationship that attempts to counter the mistrust most people with this disorder intrinsically hold. The hope is that some degree of attachment in a therapeutic relationship could be generalized to other relationships. Offering interpretations about the patient's behavior will not typically be helpful.

More highly functioning schizotypals who have some capacity for empathy and emotional warmth tend to have better outcomes in psychodynamic approaches to treatment.

Cognitive-behavioral therapy:

- Cognitive approaches will most likely focus on attempting to identify and alter the content of the schizotypal's thoughts. Distortions that occur in both perception and thought processes would be addressed. An important foundation for this work would be the establishment of a trusting therapeutic relationship. This would relax some of the social anxiety felt in most interpersonal relationships and allow for some exploration of the thought processes. Constructive ways of accomplishing this might include communication skills training, the use of videotape feedback to help the affected person perceive his or her behavior and appearance objectively, and practical suggestions about personal hygiene, employment, among others.

Interpersonal therapy:

- Treatment using an interpersonal approach would allow the individual with schizotypal personality disorder to remain relationally distant while he or she "warms up" to the therapist. Gradually the

therapist would hope to engage the patient after becoming “safe” through lack of coercion. The goal would be to develop trust in order to help the patient gain insight into the distorted and magical thinking that dominates. New self-talk can be introduced to help orient the individual to reality-based experience. The therapist can mirror this objectivity to the patient.

Group therapy:

- may provide the patient with a socializing experience that exposes them to feedback from others in a safe, controlled environment. It is typically recommended only for schizotypals who do not display severe eccentric or paranoid behavior. Most group members would be uncomfortable with these behavioral displays and it would likely prove destructive to the group dynamic.

Family and marital therapy:

- It is unlikely that a person with [schizoid personality disorder](#) will seek family or marital therapy. Many schizoid types do not marry and end up living with and being dependent upon first-degree family members. If they do marry they often have problems centered on insensitivity to their partner’s feelings or behavior. Marital therapy ([couples](#)

[therapy](#)) may focus on helping the couple to become more involved in each other's lives or improve communication patterns.

Medications

According to the Encyclopedia of MD, there is considerable research on the use of medications for the treatment of schizotypal personality disorder due to its close symptomatic relationship with schizophrenia. Among the most helpful medications are the antipsychotics that have been shown to control symptoms such as illusions and phobic anxiety, among others. Amoxapine (trade name Asendin), is a tricyclic antidepressant with antipsychotic properties, and has been effective in improving schizophrenic-like and depressive symptoms in schizotypal patients. Other antidepressants such as [fluoxetine](#) (Prozac) have also been used successfully to reduce symptoms of anxiety, paranoid thinking, and depression.

Prognosis

The prognosis for the individual with schizotypal personality disorder is poor due to the ingrained nature of the coping mechanisms already in place. Schizotypals who depend heavily on family members or others are likely to regress into a state of [apathy](#) and further isolation. While some measurable gains can be made with mildly affected individuals, most are not able to alter their ingrained ways of perceiving or

interpreting reality. When combined with poor social support structure, most will not enter any type of treatment.

Prevention

Since schizotypal personality disorder originates in the patient's family of origin, the only known preventative measure is a nurturing, emotionally stimulating and expressive caretaking environment.

Portrayed in Popular Culture

- Kramer from Seinfeld
 - He is characterized by odd behavior and thinking
- Luna Lovegood and Sybill Trelawny from Harry Potter
 - They are both very eccentric with odd appearances and awkward in social settings

DSM-V Changes

- Be reformulated as the Schizotypal Type
- Individuals who match this personality disorder type have social deficits, marked by discomfort with and reduced capacity for interpersonal relationships; eccentricities of appearance and behavior, and cognitive and perceptual distortions.

- They have few close friends or relationships.
- They are anxious in social situations (even when they have the time to become familiar with the situation), feel like outcasts or outsiders, find it difficult to feel connected to others, and are suspicious of others' motivations, including their spouse, colleagues, and friends.
- Individuals with this type are eccentric, odd, or peculiar in appearance or manner (e.g., grooming, hygiene, posture, and/or eye contact are strange or unusual).
- Their speech may be vague, circumstantial, metaphorical, over-elaborate, impoverished, overly concrete, or stereotyped. Individuals with this type experience a limited or constricted range of emotions, and are inhibited in their expression of emotions.
- They may appear detached and indifferent to other's reactions, despite internal distress at being "set apart."
- Odd beliefs influence their behavior, such as beliefs in superstition, clairvoyance, or telepathy.
- Their perception of reality can become further impaired, often under stress, when reasoning and perceptual processes become odd and idiosyncratic (e.g., they may make seemingly arbitrary

inferences, or see hidden messages or special meanings in ordinary events) or quasi-psychotic, with symptoms such as pseudo-hallucinations, sensory illusions, over-valued ideas, mild paranoid ideation, or transient psychotic episodes.

- Individuals with this personality disorder type are, however, able to “reality test” psychotic-like symptoms and can intellectually acknowledge that they are products of their own minds.

(APA, 2010)

Antisocial Personality Disorder

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DSM-IV-TR criteria

- There is a pervasive pattern of disregard for and

violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

1. failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are groups for arrest
 2. deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
 3. impulsive behavior or failure to plan ahead
 4. irritability and aggressiveness, as indicated by repeated physical fights or assaults
 5. reckless disregard for safety of self or others
 6. consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
 7. lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
- The individual is at least age 18 years.
 - There is evidence of Conduct Disorder with onset before age 15 years.
 - The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a

Manic Episode.

Associated Features

- Most essential diagnostic feature of ASPD is the pervasive disregard for and violation of the rights of others (SAMHSA, 2009).
- They appear deficient in their ability to experience shared or reciprocal emotions such as guilt or love (SAMHSA, 2009).
- They have a disdain for society's rules. They know right from wrong, but they simply do not care (SAMHSA, 2009).
- Antisocial Personality Disorder (ASPD) is considered to be a chronic illness in which an individual's manner of thinking, perceiving situations, and empathizing with others is deemed morally wrong in his or her society.
- Antisocial Personality disorder is also sometimes called psychopathy or sociopathic personality disorder. Normally, an individual suffering from Antisocial Personality Disorder will display a pattern of lying, stealing, running away from home, and having difficulty upholding the law. They also tend to have problems with the abuse of illicit drugs and alcohol.
 - The fearlessness hypothesis states they

psychopaths have a higher fear threshold, or the frightening things for most people, like a burning building, or gunshots, have little effect on these individuals. It is possible there is no association with certain stimuli or cues with punishment or danger, such as an alarm going off.

- Psychopaths do not show normal anxiety reactions when anticipating a punishment response and they were slow at learning how to stop responding when punishment was inevitable.
- They were unable to avoid punishment because they have problems learning how to properly respond to anxiety-producing situations. Impulsive behaviors are unrestrained because the individuals do not successfully avoid punishment.
- These inhibited responses that can be learned in the face of cues that signal upcoming punishment or also known as passive avoidance learning, and appears to be deficient in psychopaths and in individuals with ASPD.
- A behavioral activation stem may, at the least, be normal, and at the most, be overactive in avoiding the punishment by

any means necessary. Psychopaths are persistent in situations where failure is likely, so they set sites on a goal and very little if anything will stop him or her from attaining their goal.

- The majority of people who have a substance use disorder in conjuncture with ASPD are not sociopathic except as a result of their addiction.
- Most people that are diagnosed with ASPD are not true psychopaths.
- Individuals with ASPD violate the rights of others through deceit or aggression.
 - They will lie repeatedly or will con other people for profit or pleasure.
 - They are impulsive and lack the ability to plan ahead.
 - Their behavior will generally be irresponsible, they will often be irritable, and they will often get into physical fights.
 - An important criterion is that they will be indifferent to having hurt or mistreated another person, or they will rationalize this behavior.
- They are also unable to hold down a steady job and will often renege on financial commitments or steal

from others.

Substance Use Among People with ASPD

They use substances in a polydrug pattern, meaning more than one drug at a time, involving alcohol, marijuana, heroin, cocaine, and methamphetamine.

The illicit drug culture can correspond with their view of the world as fast-paced and dramatic, which helps to support their need for a heightened self-image.

(SAMHSA, 2009)

Child vs. Adult Presentation

The disorder cannot be diagnosed until the age of 18, but symptoms must be present before the age of fifteen and diagnosed as Conduct Disorder. Studies show that 60% of all children who suffer from Conduct Disorder will later develop ASPD. It is when Conduct Disorder is left undiagnosed and untreated that it is most likely to develop into ASPD.

The rates of ASPD are much higher for young adults than for older adults.

A well known notion about ASPD is that these disorders begin early on in a child's life. The greater the number of antisocial behaviors the child demonstrates, the more likely that child will develop ASPD later on in life. This is the single best predictor of developing ASPD or psychopathy. Conduct disorder is closely related in behaviors, such as theft, truancy, and school discipline problems.

Gender and Cultural Differences in Presentation

- Men are more likely than women to be diagnosed with ASPD. Studies show that about 3% of males and about 1% of females receive this diagnosis.
 - Women are more likely to be misdiagnosed as Borderline Personality Disorder (SAMHSA, 2009).
 - Determining the type and extent of antisocial symptoms for women is not easy, but it is important due to the high prevalence of neglectful parenting in women with substance use disorders and ASPD (SAMHSA, 2009).
- Studies also show that in clinical settings, the prevalence rate of ASPD ranges anywhere from 3 to 30 percent of the clinical population, with an increased prevalence with substance abuse facilities and prisons.
- ASPD rates are much higher among young adults than older adults.
- Culture seems to play a large role in the prevalence rates of Antisocial Personality Disorder.
 - For example, in Taiwan the prevalence rate is 0.14% while in Canada it is 3.7%. The only reasonable explanation for the lower rate in Taiwan is that the

Taiwanese report antisocial behaviors more often than other countries.

- In contrast, Taiwan has a lower prevalence rate than the countries surrounding it. Studies show that rates in Hong Kong and South Korea are similar to those in the U.S. and Europe; studies also show that the countries with high rates in ASPD also have high rates in other disorders with which there is typically co-morbidity. This disorder is more common among individuals with a relatively low socioeconomic status within their culture.

Epidemiology

- 3% of males and about 1% of females in community samples show Antisocial Personality Disorder. Clinical settings can have between a 3% to 30% prevalence rate depending on the characteristics of the populations being sampled.
- Higher rates are seen with substance abuse treatment settings and forensic or prison setting. In the male prison populations, 20% or more have Antisocial PD (SAMHSA, 2009).
- Most recent epidemiology studies put prevalence rates in the general population between 1% and

4%, and prevalence in an outpatient psychiatric setting at around 3% to 4%.

- The course is chronic, but the disorder may become less evident or remit with age, especially about age 40. This remission tends to be particularly evident regarding criminal behavior, though there is likely a decrease in the full spectrum of behavior.
- 10 to 20% of homeless women, and 20 to 25% of homeless men receive diagnosis of Antisocial PD (SAMHSA, 2009).
- 34.7% of alcoholics, 27% of heroin addicts, 30.4% of cocaine addicts have Antisocial Personality Disorder
 - The percentage is in the mid 40s for those addicted to 2 of the 3 drugs listed above.
 - 59.8% of those addicted to all 3 of the drugs have Antisocial Personality Disorder

(SAMHSA, 2009)

Etiology

- Little is known about the causes of Antisocial Personality Disorder. There are several factors which complicate detecting the cause.

- First, most individuals with this disorder do not perceive any fault within themselves and, therefore, will not seek out clinical assistance.
- Another reason is because many of the disorders dealing with personality are similar to one another, making it difficult to differentiate one disorder from another.
- There seems to be a strong genetic link to ASPD development and criminality.
- Although researchers aren't entirely sure, they do believe that genetics have something to do with the development of Antisocial Personality Disorder.
 - Even though some researchers believe that genetics has some to do with a person developing ASPD, they mainly believe that a person's environment is the main cause.
 - One perspective looks at the parents for answers. Studies have shown that parents who passively give in to their children's whims and do not take disciplinary action can aid in the development of antisocial personalities. Their children may perceive their parents behavior as uncaring and

will continue to behave poorly because they have not been conditioned to behave otherwise.

- They often exhibit signs of antisocial behavior from 15 to 18 years of age, such as unlawful behavior, deceitfulness, consistent irresponsibility, and lack of remorse.
 - Evidence of similar behaviors even before the age of 15.
 - When antisocial behavior occurs without any signs of it during adolescence, the DSM-IV diagnosis is Adult Antisocial Behavior.
- A history of childhood abuse, including harsh and neglectful care giving, is believed to result in the adult individual with ASPD neglecting others' needs and feelings.
- Some suggest that individuals with ASPD exhibited difficult temperaments in childhood, eliciting hostile reactions in caregivers and reinforcing withdrawal from others.
- Developmental examinations of ASPD suggest that children who are repeatedly rejected by their normative peer group and who are more involved in deviant peer groups are more likely to develop ASPD.

- Also, the under-arousal hypothesis is given credit in that it states that individuals with personality disorders, in general, including ASPD have low levels of arousal in their brain's cortex and is one reason why these individuals exhibit antisocial behaviors.
- More research has been conducted on ASPD than any other Personality Disorder.
- Environmental factors help to influence the development of psychopathy, criminal behavior and other conditions.
- The fearlessness hypothesis states they psychopaths have a higher fear threshold, or the frightening things for most people, like a burning building, or gunshots, have little effect on these individuals. It is possible there is no association with certain stimuli or cues with punishment or danger, such as an alarm going off.
- Psychopaths do not show normal anxiety reactions when anticipating a punishment response and they were slow at learning how to stop responding when punishment was inevitable.
- Inability to avoid punishment because of problems learning how to properly respond to anxiety-producing situations.
- Impulsive behaviors are unrestrained because the

individuals do not successfully avoid punishment.

- These inhibited responses that can be learned in the face of cues that signal upcoming punishment or also known as passive avoidance learning, and appears to be deficient in psychopaths and in individuals with ASPD.

Empirically supported treatments

- There is currently no permanent treatment for Antisocial Personality Disorder.
- As stated above, individuals with ASPD rarely see themselves as having a problem and are not motivated to enter treatment willingly.
- Many therapists do not see significant improvement throughout the course of counseling, as the patients tend to be manipulative and uncooperative.
- The patients have also been known to fake improvement in order to end their treatment.
- Even if treatment is successful for a patient, relapse is very likely to occur shortly after treatment sessions have ceased.
- ASPD is still not completely understood, so the use of medications is not yet a safe treatment option.
- Also, since ASPD is resistant to treatment; suicide, alcoholism, vagrancy, and social isolation are very

common among these patients.

- Antisocial personality disorder is highly unresponsive to any form of treatment, in part because persons with APD rarely seek treatment voluntarily. If they do seek help, it is usually in an attempt to find relief from depression or other forms of emotional distress. Although there are medications that are effective in treating some of the symptoms of the disorder, noncompliance with medication regimens or abuse of the drugs prevents the widespread use of these medications.
- The most successful treatment programs for APD are long-term structured residential settings in which the patient systematically earns privileges as he or she modifies behavior. In other words, if a person diagnosed with APD is placed in an environment in which they cannot victimize others, their behavior may improve. It is unlikely, however, that they would maintain good behavior if they left the disciplined environment.
- If some form of individual [psychotherapy](#) is provided along with [behavior modification](#) techniques, the therapist's primary task is to establish a relationship with the patient, who has usually had very few healthy relationships in his or her life and is unable to trust others. The patient should be given the opportunity to establish

positive relationships with as many people as possible and be encouraged to join [self-help groups](#) or prosocial reform organizations.

- Unfortunately, these approaches are rarely if ever effective. Many persons with APD use therapy sessions to learn how to turn “the system” to their advantage. Their pervasive pattern of manipulation and deceit extends to all aspects of their life, including therapy. Generally, their behavior must be controlled in a setting where they know they have no chance of getting around the rules.

Counseling Tips for Clients with Antisocial Personality Disorders (SAMHSA, 2009)

- | | |
|---------------|---|
| Corral: | <ul style="list-style-type: none">• Coordinate treatment• Communicate with other providers• Make contracts with clients |
| Confront: | <ul style="list-style-type: none">• Be direct and firm• Identify antisocial thinking• Conduct random substance testing |
| Consequences: | <ul style="list-style-type: none">• Make clients responsible for their behavior• Record violations of rules• Allow clients to experience consequences of their behavior• Designate positive consequences for pro-social behavior |
-

Prognosis

APD usually follows a chronic and unremitting course from childhood or early adolescence into adult life. The impulsiveness that characterizes the disorder often leads to a jail sentence or an early death through accident, homicide or [suicide](#). There is some evidence that the worst behaviors that define APD diminish by midlife; the more overtly aggressive symptoms of the disorder occur less frequently in older patients. This improvement is especially true of criminal behavior but may apply to other antisocial acts as well.

Prevention

Measures intended to prevent antisocial personality disorder must begin with interventions in early childhood, before youths are at risk for developing conduct disorder. Preventive strategies include education for parenthood and other programs intended to lower the incidence of child abuse; Big Brother/Big Sister and similar mentoring programs to provide children at risk with adult role models of responsible and prosocial behavior; and further research into the genetic factors involved in APD.

ASPD and Brain Structures

- There is a subtle structural deficit in the prefrontal cortex of uninstitutionalized antisocial, violent persons with psychopathic-like behavior who live in community settings

- There is a much less observable volume reductions specific to the prefrontal gray matter that is associated with APD
 - APD had a 11% reduction in prefrontal gray matter when compared to a control group, a 13.9% reduction when compared to a substance-dependent group, and a 14% reduction when compared to a psychiatric control group
- APD also have reduced autonomic activity during social stressors
 - Those with APD who also had reduced prefrontal gray matter volume also had lower skin conductance activity during social stressors
- Prefrontal cortex is part of a neural circuit that plays a central role in fear conditioning and stress responsivity
 - Poor conditioning is theorized to be associated with poor development of the conscience, and those who are less autonomically responsive to aversive stimuli such as social criticism during childhood would be less susceptible to socializing punishments, and hence become predisposed to antisocial behavior

- Antisocial groups show poor fear conditioning
- Prefrontal cortex is involved in the regulation of arousal, and deficits in autonomic and central nervous system arousal in antisocial persons have been viewed as facilitating a stimulation-seeking, antisocial behavioral response to compensate for such under arousal
- Patients with prefrontal damage fail to give anticipatory autonomic response to choice options that are risky, and make bad choices even when they are aware of the more advantageous response option
 - Inability to reason and decide advantageously in risky situations is likely to contribute to the impulsivity, rule breaking, and reckless, irresponsible behavior that make up 4 of the 7 traits of APD
- Previous research has shown that patients with major damage to the prefrontal cortex show dysregulation of cognition, emotion, and behavior, which predisposes to antisociality
- Those who are antisocial have visually imperceptible but meaningful and significant reductions in prefrontal gray matter volume in addition to psycho-physiological deficits in

emotion reactivity

- It is unlikely that only one brain mechanism is compromised in APD
 - Functional imaging has indicated multiple cortical and subcortical deficits in violent offenders
- Limitations
 - It is possible that it is only those substance abusers who also have APD who show the prefrontal deficit since substance abusers have been shown to have lower than normal prefrontal gray matter volumes
 - No study of gray matter volume loss in schizophrenia has controlled for crime and violence
 - Only men were assessed, so cannot be generalized to women
 - Only an association has been shown, not any causality
 - Does not delineate which subregion of the prefrontal cortex is particularly reduced in volume
 - It is predicted that the orbitofrontal region would be

the most impaired and the dorsolateral region relatively spared

(Raine, Lencz, Bihrlé, LaCasse, & Colletti, 2000)

Portrayed in Popular Culture

- *The Silence of the Lambs* (1991)
- *American Psycho* (2000)
- The Joker from *Batman*
 - Anarchy is his guiding philosophy
- Lord Voldemort from *Harry Potter*
 - He is a classic model of a conduct disorder case developing into Antisocial Personality Disorder

DSM-V Changes

- Reformulated as the Antisocial/Psychopathic Type
- Individuals who match this personality disorder type are arrogant and self-centered, and feel privileged and entitled. They have a grandiose, exaggerated sense of self-importance and they are primarily motivated by self-serving goals.
- They seek power over others and will manipulate, exploit, deceive, con, or otherwise take advantage of others, in order to inflict harm or to achieve

their goals.

- They are callous and have little empathy for others' needs or feelings unless they coincide with their own. They show disregard for the rights, property, or safety of others and experience little or no remorse or guilt if they cause any harm or injury to others.
- They may act aggressively or sadistically toward others in pursuit of their personal agendas and appear to derive pleasure or satisfaction from humiliating, demeaning dominating, or hurting others.
- They also have the capacity for superficial charm and ingratiation when it suits their purposes.
- They profess and demonstrate minimal investment in conventional moral principles and they tend to disavow responsibility for their actions and to blame others for their own failures and shortcomings.
- Individuals with this personality type are temperamentally aggressive and have a high threshold for pleasurable excitement. They engage in reckless sensation-seeking behaviors, tend to act impulsively without fear or regard for consequences, and feel immune or invulnerable to adverse outcomes of their actions.

- Their emotional expression is mostly limited to irritability, anger, and hostility; acknowledgment and articulation of other emotions, such as love or anxiety, are rare.
- They have little insight into their motivations and are unable to consider alternative interpretations of their experiences.
- Individuals with this disorder often engage in unlawful and criminal behavior and may abuse alcohol and drugs. Extremely pathological types may also commit acts of physical violence in order to intimidate, dominate, and control others.
- They may be generally unreliable or irresponsible about work obligations or financial commitments and often have problems with authority figures.

(APA, 2010)

For More Information, Please Read

- Luntz, B.K., & Widom, C.S. (1994). Antisocial personality disorder in abused and neglected children grown up. *American Journal of Psychiatry*, 151(5), 670-675.

Links

- [Antisocial Personality Disorder](#)
- All Things Considered on [NPR](#) covers a story on

STEPHANIE WEIGEL

the brain of a psychopathic person.

Borderline Personality Disorder

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DSM-IV-TR criteria

A pervasive pattern of instability of interpersonal

relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts. This is indicated by having 5 or more of the following characteristics:

1. Being frantic to avoid abandonment, either real or imagined
 - NOTE: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
2. A pattern of intense, unstable interpersonal relationships characterized by alternating between extreme variances of idealization and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
 - NOTE: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
5. Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability,

or anxiety usually lasting a few hours and only rarely more than a few days)

7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation or severe dissociative symptoms

Associated features

- One of the most prominent features is instability in interpersonal relationships, self-image, and affects.
- Severe instability can be seen in their fluctuating views and feelings about him or herself. They often feel really good about themselves, their progress, and their futures to only have a seemingly minor experience turn their world upside-down with concomitant plunging self-esteem and depressing hopelessness (SAMHSA, 2009).
- Another prominent feature is marked impulsivity that begins by early adulthood and is present in a variety of contexts.
- Individuals with BPD will often give up on something just before the goal is attained.
- It is often difficult to maintain relationships, a job, or educational goals since their basic instability

extends to work and school.

- Psychotic-like symptoms may occur when an individual is under stress. These symptoms include hallucinations, body-image distortions, ideas of reference, and hypnagogic phenomena.
- They typically don't do well with personal relationships and may feel more comfortable with pets or inanimate objects. If they do have relationships, they are unstable, with reports of how wonderful an individual is one day and then the next expressions of intense anger, disapproval, condemnation, and even hate towards the same person (SAMHSA, 2009).
- The risk of suicidal, self-mutilating, and/or brief psychotic states increases when they are experiencing an emotional state that they cannot handle (SAMHSA, 2009).
 - The risk for suicide increases when the individual also has a co-occurring Mood or Substance Related Disorder.
 - 10 percent of adults with BPD commit suicide
 - A person with BPD has a suicide rate 400 times greater than the general public
 - 33 percent of youth who commit suicide have features of BPD

- (Kreger, 2008)
- Patients suspected of BPD also exhibit symptoms of Depressive mood disorders, addictions to various things from drugs to binge eating, and Anti-Social Behaviors. Other co-morbid disorders include Mood, Substance Related, Eating, Post-Traumatic Stress, Attention Deficit/Hyperactivity, and other Personality Disorders.
- To the sufferer, BPD is about deep feelings, such as:
 - If others really get to know me, they will find me rejectable and will not be able to love me and will leave me
 - I need to have complete control of my feelings otherwise things go completely wrong
 - I have to adapt my needs to other people's wishes, otherwise they will leave me or attack me
 - I am an evil person and I need to be punished for it
 - Other people are evil and abuse you
 - If someone fails to keep a promise, that person can no longer be trusted
 - If I trust someone, I run a great risk of

getting hurt or disappointed

- If you comply with someones request, you run the risk of losing yourself
- If you refuse someones request, you run the risk of losing that person
- I will always be alone
- I can't manage by myself, I need someone I can fall back on
- There is no one who really cares about me, who will be available to help me, and whom I can fall back on
- I don't really know what I want
- I will never get what I want
- I'm powerless and vulnerable and I can't protect myself
- I have no control of myself
- I can't discipline myself
- My feelings and opinions are unfounded
- Other people are not willing or helpful
- (Facing the Facts, 2009)

**BPD Traits Organized by Thoughts, Feelings, and
Actions (Kreger, 2008)**

	DSM Traits
THINKING: Impaired perception and reasoning	Spitting (extremes of idealization and devaluation) Brief moments of stress-related paranoia or severe dissociative symptoms (being very “out of it”) Intense, unstable moods and strong reactions to shifts in the environment. Irritability or anxiety, usually lasting for a few hours or days. Feelings of acute hopelessness, despair, and unhappiness Frantic efforts to avoid real or imagined abandonment A feeling of emptiness and a lack of identity, which complicate moods and emotions
FEELING: Poorly regulated, highly changeable emotions	Impulsiveness in at least 2 areas that are potentially self-damaging (spending, sex, substance abuse, reckless driving, or binge eating) Inappropriate, intense anger or difficulty controlling anger (frequent displays of temper, constant anger, or recurrent physical fights) “Pain management” behaviors such as overspending, aggression toward others suicide, self-harm, substance abuse, and eating disorders
ACTING: Impulsive behaviors	

Impaired Thinking (Kreger, 2008)

Cognitive Distortion	Cognitive Distortions in BPs
FEELINGS EQUAL FACTS: Emotions color interpretations of people and situations	The BP makes jaw-dropping interpretations, assumptions, and inferences that may bear little resemblance to reality
JUMPING TO CONCLUSIONS: Negative interpretation without supporting facts	The BP jumps to conclusions even when past experiences with the person/situation have been positive. The BP dismisses contrary supporting facts.
MIND READING: Assuming others think badly of you	The BP assumes others think she's scum on the garbage scow of the world
CATASTROPHIZING: Thinking the worst-case scenario will occur and nothing can be done to help the situation	The BPs catastrophizing can lead to poor, rash decisions or dangerous actions, such as self-harm or suicide attempts Small molehills become Mt. Everest
BLAME: Holding others totally accountable for negative situations	The BP not only dismisses contrary supporting facts but also thrashes, mutilates, and pummels them into submission The BP will not be held accountable for anything
DISCOUNTING THE POSITIVE	In a way similar to splitting, some BPs discount anything good in themselves and in others
MENTAL FILTER: Dwelling on criticism of the self while repelling compliments	For the BP, the soaking in is deeper – to the bone instead of the pores. Compliments are repelled faster and further away

Lower-Functioning vs High Functioning (Kreger, 2008)

	Mostly Lower-Functioning Conventional BPs	Mostly Higher- Functioning Invisible BPs
COPING TECHNIQUES	Acting in: Mostly self-destructive acts such as self-harm	Acting out: Uncontrolled and impulsive rages, criticism, and blame. These may result less from a lack of interpersonal skills than from an unconscious projection of their own pain onto others
FUNCTIONING	Low functioning: BPD and associated conditions make it difficult to live independently, hold a job, manage finances, and so on. Families often step in to help	High functioning: The BP appears normal, even charismatic, but exhibits BPD traits behind closed doors Has a career and may be successful
WILLINGNESS TO OBTAIN HELP	Self-harm and suicidal tendencies often bring these BPs into the mental health system (both as inpatients and outpatients) High interest in therapy	A state of denial much like an untreated alcoholic The BP disavows responsibility for relationship difficulties, refuses treatment; when confronted, he or she accuses others of having BPD. May see a therapist if threatened, but rarely takes it seriously or stays long

CO- OCCURRING (CONCURRENT) MENTAL HEALTH ISSUES	Mental conditions such as bipolar and eating disorders require medical intervention and contribute to low functioning	Concurrent illness most commonly a substance use disorder or another PD, especially Narcissistic PD
IMPACT ON FAMILY MEMBERS	The major family focus is on practical issues such as finding treatment, preventing/reducing BPs self-destructive behavior, and providing practical and emotional support. Parents feel extreme guilt and are emotionally overwhelmed	Without the diagnosis of an obvious illness for the BP, family members blame themselves and try to get their emotional needs met. They make fruitless efforts to persuade their BP to get professional help. Major issues include high-conflict divorce and custody cases

Substance Use Among People with BPD

- They are often skilled in seeking multiple sources of medication that they favor, such as benzodiazepines.
- They associate drugs with social interactions and use the same drugs of choice, method of administration, and frequency as the individuals that they interact with.
- They often use substances in a chaotic and unpredictable pattern.
- Polydrug use is common and may involve alcohol and other sedative-hypnotics taken for self-medication.

- At the beginning of a crisis episode, they will often take a drink or use a different drug in order to subside the growing sense of tension or loss of control.
- They usually have big appetites, and they often experience powerful, emotion-driven needs for something outside of themselves, such as drugs.
- When they stop using drugs, they are extraordinarily vulnerable to meeting their needs through other compulsive behaviors.
 - Some of these behaviors include:
 - compulsive sexual behavior
 - compulsive gambling
 - compulsive spending/shopping
 - other out of control behaviors that result in negative or even dangerous consequences

(SAMHSA, 2009)

Hitler as an example

The DSM-IV-TR describes Borderline Personality Disorder as a “pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five or more symptoms.

The first symptom is frantic efforts to avoid real or imagined abandonment.

The second is a pattern of unstable and intense, interpersonal relationships characterized by alternating between extremes of idealization and devaluation. When we look at most of the relationships in Hitler's life, Gustl, Geli, Eva, they go back and forth between stable and rocky. He somewhat cares, he does not care at all, he is happy with them, he is angry with them, he loves them, he hates them. This back and forth happens quite often throughout all of those relationship.

The third symptom is identity disturbance: markedly and persistently unstable self-image or sense of self. At times Hitler thought he was the greatest most prominent person in the world but others he thought of himself as a worthless failure. We can look at the period of trying to be an artist as an example, or the episode with the German film star. These switches between security were often.

The fourth is impulsivity in at least two area that are potentially self-damaging.

Recurrent suicidal behavior, gestures, threats, or self-mutilating behaviors is the fifth symptom.

The sixth symptom is the affective instability due to a marked reactivity of mood such as an intense episodic dysphoria, irritability, or anxiety. Hitler had affective instability quite often. At any given moment Hitler could 'fly off the handle' so to speak in fits of rage.

The seventh symptom is chronic feelings of emptiness.

The eighth is inappropriate intense anger or difficulty controlling anger. Like previously stated, Hitler had anger problem which he could not control. There are accounts in which Hitler has been reported not just yelling but throwing objects in his fits of rage.

The ninth and last symptom is transient, stress-related paranoid ideation or sever dissociative symptoms. Hitler was paranoid about a number of things. He was paranoid that people were out to get him. He was paranoid that the Jewish people were responsible for the evil, negative ambiance, and downfall of Germany. He was a hypochondriac who was paranoid that he was sick and had cancer any time something felt wrong or he was around a person he thought to be sick.

Hitler displayed five of the nine symptoms. If there were knowledge about psychology in Hitler's time like there is knowledge now, Hitler may have been diagnosed with Borderline Personality Disorder. (Kershaw, 2008)

Child vs. Adult Presentation

It should be noted that the DSM is not currently modified to diagnose patients under 18 with BPD. The generally accepted modifications to diagnosing underage patients are exhibitions of disruptive behavioral problems, and mood and anxiety symptoms. Adolescents and young adults with identity problems may display behaviors that could be mistaken as Borderline Personality Disorder. Such situations are characterized by emotional instability, anxiety-provoking choices, uncertainty, and dilemmas.

Gender and Cultural Differences in Presentation

- BPD is diagnosed most often in females (about 75%).
- There have been some studies which suggest that women with BPD are more likely to have eating disorders, as well as histories involving sexual or physical abuse that qualify them for PTSD (Post-Traumatic Stress Disorder).
- These studies also suggest that men are more likely to abuse substances, and have more defined antisocial personalities.
- 1 out of every 4 people with BPD are male (Kreger, 2008)
- We know very little about how BPD expresses itself in men or if treatment programs designed for women are as effective for men (Kreger, 2008)
- Men won't seek treatment. They see it as "unmanly" to acknowledge feelings, especially the vulnerability and abandonment fears associated with BPD (Kreger, 2008)

Clinician Bias

- Anger is interpreted differently depending upon whether it comes from a man or a woman
- Harder for clinicians accurately diagnose the

presence of BPD in males (Kreger, 2008)

Cultural influences

- Men are socialized not to expose their fear of abandonment or other emotional vulnerabilities
- Men are permitted anger (Kreger, 2008).

Borderline men and domestic violence

- Some men use the same outlets as borderline women do, such as making suicide threats
- A great many of them anesthetize themselves with alcohol and drugs such as cocaine or methamphetamine
- A subset channel their feelings into their more socially acceptable cousins: rage and aggression
- Both men and women can express their fear of abandonment as physical aggression
- Men's level of violence is often more lethal
- This aggression often results in a misdiagnosis of Antisocial PD or a conduct disorder in adolescents
- They are often incarcerated (Kreger, 2008)

Sexual acting out

- Men frequently engage in addictive, sexually compulsive behaviors, including:

- hiring prostitutes
- having serial affairs
- going to strip clubs
- obsessive viewing pornography
- engaging in voyeurism or exhibitionism
- compulsive masturbation
- (Kreger, 2008)

Epidemiology

- Borderline Personality Disorder affects about 1 to 2 percent of the population
- Recent research is showing that this number is much higher (Kreger, 2008)
- It is much more highly represented in the clinical population
- About 10 percent of outpatients and about 20 percent of inpatients in psychiatric settings are diagnosed with this disorder.
- About 75 percent of those diagnosed with Borderline Personality Disorder are females.
- Five times more common in first degree relatives of affected persons
- The course is decidedly variable. The most

common pattern is of chronic instability in early adulthood, with episodes of affective and impulsive dyscontrol and high levels of the use of health resources. Impairment and the risk of suicide are greatest in young adults and decrease with age. The tendency toward intense emotions, impulsivity, and intensity in relationships is often lifelong, though these areas improve with intervention within the first year. Greater stability is often attained during the 30s and 40s.

Etiology

- The actual cause or root of the disorder is not known.
- It is commonly believed that because the symptoms are long-lasting, that the symptoms primarily manifest in early adolescence, and may not show negative consequences until early adulthood.
- People with symptoms may have a history of unstable relationships and sexual/physical abuse or neglect.
- It also appears that a serotonin deficiency may be involved in the development of Borderline Personality Disorder.
- This could possibly explain why these individuals engage in self-mutilation and why these

individuals are impulsive, especially when it comes to aggressive behavior.

- Other research has implicated an irregularity of non adrenaline.
- Research also indicates that dopamine has been implicated in the etiology of Borderline Personality Disorder, which can be related to the fact that some borderline individuals demonstrate psychotic symptoms that are temporary.
- Research indicates that a complex interaction of environmental and genetic factors likely contributes to the presence of BPD. One environmental factor hypothesized to contribute to BPD has been pathological child experiences leading to trauma as indicated by a co-occurring diagnosis of PTSD.
- Another suggestion is that BPD is a dysfunction in the emotional regulations system that results from a combination of biological predisposition and environmental factors.
- There is also considerable research indicating that early childhood abuse such as emotional and verbal abuse maybe implicated in individuals with Borderline Personality Disorder, which account for 90% of individuals with Borderline Personality Disorder.

Older people with BPD

- Experts differ on whether people with BPD “grow out of BPD” when they get into their fifties and above
- Popular thinking is that they do
- More research needs to be done on this
- (Kreger, 2008)

Portrayed in Popular Culture

- Play Misty for Me (1971)
- Fatal Attraction (1987)
- Poison Ivy (1992)
- The Crush (1993)
- [Girl, Interrupted](#) (1999)
 - It is about a girl diagnosed with borderline personality disorder who is sent to a mental institution.
- Allein (Germany, 2004)
- Chloe (2009)
- Eliane from Seinfeld
 - She has extreme “black and white” thinking. She also has instability in relationships, self-image, identity, and behavior

- Anakin Skywalker from Star Wars
 - He shows signs of six out of nine criteria
 - He has unstable moods, interpersonal relationships, and behaviors
 - Infantile illusions of omnipotence and dysfunction experiences of self and others
 - Frantic efforts to avoid real or imagined abandonment
 - Shows impulsive behavior and has difficulty controlling his anger
 - Experiences two “dissociative episodes”
 - Exterminated the Tusken people after his mothers death
 - Killed all of the Jedi younglings
 - Has a disturbance in identity when he turns to the dark side and changes his name
 - (Landau, 2010)

- Catwoman from Batman
 - She is a woman of many moods and traumas
 - Her alter-ego, Selina Kyle, is typical of the impulsivity characterized by Borderline Personalities

- Moaning Myrtle from Harry Potter
 - Has expressed feelings of loneliness and abandonment mixed with the occasionally warm approach
 - Has very dramatic mood swings

Diagnostic Tests

Diagnostic Interview for Borderline Patients (DIB-R)

The Diagnostic Interview for Borderline Patients (DIB-R) is the best-known “test” for diagnosing BPD. The DIB is a semi structured clinical interview that takes about 50-90 minutes to administer. The test, developed to be administered by skilled clinicians, consist of 132 questions and observation using 329 summary statements. The test looks at areas of functioning that are associated with borderline personality disorder. The four areas of functioning include Affect (chronic/major depression, helplessness, hopelessness, worthlessness, guilt, anger, anxiety, loneliness, boredom, emptiness), Cognition (odd thinking, unusual perceptions, nondelusional paranoia, quasipsychosis), Impulse action patterns (substance abuse/dependence, sexual deviance, manipulative suicide gestures, other impulsive behaviors), and Interpersonal relationships (intolerance of aloneness, abandonment, engulfment, annihilation fears, counterdependency, stormy relationships, manipulativenness, dependency, devaluation, masochism/sadism, demandingness, entitlement). The test is available at no

charge by contacting John Gunderson M.D. McLean Hospital in Belmont Massachusetts (617-855-2293).

Structured Clinical Interview (SCID-II)

The Structured Clinical Interview (now SCID-II) was formulated in 1997 by First, Gibbon, Spitzer, Williams, and Benjamin. It closely follows the language of the DSM-IV Axis II Personality Disorders criteria. There are 12 groups of questions corresponding to the 12 personality disorders. The scoring is either the trait is absent, subthreshold, true, or there is “inadequate information to code”. SCID-II can be self administered or administered by third parties (a spouse, an informant, a colleague) and yield decent indications of the disorder. The questionnaire is available from the American Psychiatric Publishing for \$60.00.

Personality Disorder Beliefs Questionnaire (PDBQ)

The [Personality Disorder Beliefs Questionnaire](#) (PDBQ) is a brief self administered test for Personality Disorder tendencies.

Other

Other commonly used assessment tests are rating tests such as the Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD), and the McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD). In addition

there are some free, informal tests available. (Facing the Facts, 2010)

Empirically Supported Treatments

- Borderline individuals remain some of the most difficult to treat effectively in therapeutic situations, whether they are outpatient or inpatient. Personality traits are not left at entrance, so they are quite visible during treatment.
- The best treatment for BPD is [Dialectical behavior therapy](#), credited to [Marsha Linehan](#), a professor at [University of Washington](#).
- This treatment, established in 1993, focuses on helping the patient not only survive but to build a life that is meaningful to them by helping the patient to balance change and acceptance of the situations in their life.
- First, life-threatening or harmful situations are dealt with.
- Then they are gently pushed to experience emotions that are painful to them.
- Part three addresses living problems.
- The procedure is to help the patient feel complete as a person.
- Trust is a critical concern; it is difficult to create

and difficult to maintain when created. The therapeutic relationship is a teeter totter tilting back and forth the good and bad aspects of the therapist proclaimed by the patient. There is risk for suicide but the cries for help are difficult to separate out a true cry from a gesture that is not an emergency.

- Other types of therapies may be used also, including cognitive-behavioral therapy, group therapy, and family therapy, along with individual therapy. Therapy sessions should have specific, special strategies, and the therapists should set boundaries for the client. Therapists should be aware that clients with BPD can be difficult to manage even for experienced mental health professionals.
- A person with Borderline PD who seeks a mental health treatment is acutely emotionally distraught, and needs some relief from how she or he feels. Those that seek substance abuse treatment are probably only seeking treatment for the substance use disorder, and not the personality disorder (SAMHSA, 2009).
- An overwhelming number of clinicians do not have the training or experience to effectively treat those with the disorder (Kreger, 2008).
- Research-based therapies for BPD are not widely

available and are only appropriate for a subsection of those with the disorder (Kreger, 2008).

- 80 percent of psychiatric nurses believe that people with BPD receive inadequate care (Kreger, 2008)
- A 30 year old woman with BPD typically has the medical profile of a woman in her 60s (Kreger, 2008)
- Counseling a Client with Borderline Personality Disorder
- Anticipate that client progress will be slow and uneven
- Assess the risk of self-harm by asking about what is wrong, why now, whether the client has specific plans for suicide, past attempts, current feelings, and protective factors.
- Maintain a positive but neutral professional relationship, avoid over-involvement in the client's perceptions, and monitor the counseling process frequently with supervisors and colleagues.
- Set clear boundaries and expectations regarding limits and requirements in roles and behavior.
- Assist the client in developing skills (e.g. deep breathing, meditation, cognitive restructuring) to manage negative memories and emotions.
- (SAMHSA, 2009)

- Key Issues and Concerns in the Treatment of Borderline Personality Disorders
- slow progress in therapy
- suicidal behavior
- self-injury or harming behavior
- client contracting
- transference and counter transference
- clear boundaries
- resistance
- subacute withdrawal
- symptom substitution
- somatic complaints
- therapist well-being
- (SAMHSA, 2009)
- Types of Psychotherapy Used:
 - The psychotherapies that have been proved successful for BPD all strive to address underlying deficits in the ability of patients to relate to others, manage emotions, and confront longstanding problems that are typically rooted in childhood experience.
 - Cognitive-behavioral therapy (CBT):

- This therapy approach allows the patient to learn how to recognize and change their maladaptive thought patterns. The main focus is on restructuring the dysfunctional cognitions through a process of identifying, challenging, and reshaping the thoughts. The other focus is on changing the process to prevent, alter, or replace unhealthy behavior with a healthier, and more effective, behavior.
- Transference-focused therapy (TFP)
- TFP is a psychodynamic treatment that was designed especially for patients with BPD.
- It is a type of psychoanalysis that focuses on correcting the distortions in a patient's perceptions of significant others and the therapist.
- TFP places importance on the assessment and on the treatment contract between the client and therapist.
- The treatment contract has parameters that are established in order to deal with the most likely threats to the treatment and the patient's well-being that may or may not occur during the treatment.
- Dialectical-behavioral therapy (DBT)
- DBT targets suicidal and other dangerous, severe, or destabilizing behaviors. DBT strives to increase

behavioral capabilities, improve motivation for skillful behavior through management of issues and problems as they come up in day-to-day life, reduce interfering emotions and cognitions, and to structure the treatment environment in a way that reinforces functional rather than dysfunctional behaviors.

- DBT skills for emotion regulation include
 - identifying and labeling emotions
 - identifying obstacles to changing emotions
 - reducing vulnerability to emotion mind
 - increasing positive emotional events
 - increasing mindfulness to current emotions
 - taking opposite action
 - applying distress tolerance techniques
- Schema-focused therapy (SFT)
 - builds on CBT and is also known as CBT with a psychodynamic component
 - It is an active, structured therapy for assessing and changing deep-rooted psychological problems by looking at repetitive life patterns and core life themes, which are called schemas.
 - Schema therapists use an inventory to assess the schemas that cause persistent problems in a patients

life.

- To change the schemas, they use a range of techniques that include:
 - cognitive restructuring
 - limited re-parenting
 - changing schemas as they arise in the therapy relationship
 - intensive imagery work to access and change the source of schemas
 - creating dialogues between the schema side of the patients and the healthy side
- Mentalization-based therapy (MBT)
- Mentalization is the capacity to understand behavior and feelings, and how they are associated with specific mental states.
- One of the many theories about Borderline Personality Disorders is that those who are diagnosed with BPD have a decreased capacity for mentalization.
- The therapy itself seeks to help increase the capacity for mentalization, or the ability to perceive the mind of others as distinct from one's own.
- Mentalization is a component in most of the

traditional types of psychotherapy, but is usually not the main focus.

- (Facing the Facts, 2010)

DSM-V Changes

- Reformulated as Borderline Type
- Individuals who match this personality disorder type have an extremely fragile self-concept that is easily disrupted and fragmented under stress and results in the experience of a lack of identity or chronic feelings of emptiness. As a result, they have an impoverished and/or unstable self structure and difficulty maintaining enduring intimate relationships.
- Self-appraisal is often associated with self-loathing, rage, and despondency.
- Individuals with this disorder experience rapidly changing, intense, unpredictable, and reactive emotions and can become extremely anxious or depressed. They may also become angry or hostile, and feel misunderstood, mistreated, or victimized.
- They may engage in verbal or physical acts of aggression when angry.
- Emotional reactions are typically in response to negative interpersonal events involving loss or disappointment.

- Relationships are based on the fantasy of the need for others for survival, excessive dependency, and a fear of rejection and/or abandonment.
- Dependency involves both insecure attachment, expressed as difficulty tolerating aloneness; intense fear of loss, abandonment, or rejection by significant others; and urgent need for contact with significant others when stressed or distressed, accompanied sometimes by highly submissive, subservient behavior.
- At the same time, intense, intimate involvement with another person often leads to a fear of loss of an identity as an individual. Thus, interpersonal relationships are highly unstable and alternate between excessive dependency and flight from involvement.
- Empathy for others is severely impaired.
- Core emotional traits and interpersonal behaviors may be associated with cognitive dysregulation, i.e., cognitive functions may become impaired at times of interpersonal stress leading to information processing in a concrete, black-and white, all-or-nothing manner.
- Quasi-psychotic reactions, including paranoia and dissociation, may progress to transient psychosis. Individuals with this type are characteristically impulsive, acting on the spur of the moment, and

frequently engage in activities with potentially negative consequences.

- Deliberate acts of self-harm (e.g., cutting, burning), suicidal ideation, and suicide attempts typically occur in the context of intense distress and dysphoria, particularly in the context of feelings of abandonment when an important relationship is disrupted.
- Intense distress may also lead to other risky behaviors, including substance misuse, reckless driving, binge eating, or promiscuous sex. (APA, 2010)

Prognosis

- The disorder usually peaks in young adulthood and frequently stabilizes after age 30.
- Approximately 75–80% of borderline patients attempt or threaten [suicide](#), and between 8–10% are successful.
- If the borderline patient suffers from depressive disorder, the risk of suicide is much higher. For this reason, swift diagnosis and appropriate interventions are critical.
- Remitted borderline patients were significantly less likely than non-remitted borderline patients to meet criteria for a number of other personality

disorders, mostly anxious cluster disorders

- BPD decreases significantly over time, especially for remitted borderline patients
- (Zanarini, Frankenburg, Vujanovic, Hennen, Reich, & Silk, 2004)
- The most co-occurring personality disorders declined significantly over time
- Three exceptions were avoidant, dependent, and self-defeating PDs
- Anxious cluster of disorders are the Axis II disorders that are most strongly associated with BPD failing to remit (Zanarini et al., 2004)
- There may be subtypes of BPD patients and some of these subtypes are most likely to remit in the short- to mid-term, making them less temperamentally impaired than those whose borderline pathology remains relatively constant
- Treatment aimed at these subtypes needs to be developed (Zanarini et al., 2004)

Prevention

- Prevention recommendations are scarce. The disorder may be genetic and not preventable. The only known prevention would be to ensure a safe

and nurturing environment during childhood

Medications

- Medication is not considered a first-line treatment choice, but may be useful in treating some symptoms of the disorder and/or the mood disorders that have been diagnosed in conjunction with BPD. Recent clinical studies indicate that [naltrexone](#) may be helpful in relieving physical discomfort related to dissociative episodes
- No FDA-approved medication exists for BPD (although many medications are used to treat the symptoms (Kreger, 2008))

Medications Studied and Used in the Treatment of Borderline Disorder (Kreger, 2008)

ANTIPSYCHOTICS

Drug class	Medications	Symptoms Improved by One or More Medications in the Class
Neuroleptics	thiothixene (Navane)	anxiety, obsessive-compulsivity, depression, suicide attempts, hostility, impulsivity, self-injury/assaultive-ness, illusions, paranoid thinking, psychoticism, poor general functioning
	haloperidol (Haldol)	
Atypical	trifluoperazine (Stelazine)	anxiety, anger/hostility, paranoid thinking, self-injury, impulsive aggression, interpersonal sensitivity, low mood, aggressions
	flupenthixol	
	olanzapine (Zyprexa)	
	aripiprazole (Abilify)	
	risperidone (Risperdal)	
clozapine (Clozaril)		
	quetiapine (Seroquel)	

ANTIDEPRESSANTS

Drug Class	Medications	Symptoms Improved by One or More Medications in the Class
SSRIs and related antidepressants	fluoxetine (Prozac) fluvoxamine (Luvox) sertraline (Zoloft) venlafaxine (Effexor)	anxiety, depression, mood swings, impulsivity, anger/hostility, self-injury, impulsive aggression, poor general functioning
MAOIs	phenelzine (Nardil)	depression, anger/hostility, mood swings, rejection sensitivity, impulsivity
Mood stabilizers	divalproex (Depakote) lamotrigine (Lamictal) topiramate (Topamax) carbamazepine (Tegretol) lithium	unstable mood, anxiety, depression, anger, irritability, impulsivity, aggression, suicidality, poor general functioning

Economic Impact

- Up to 40 percent of high users of mental health services have BPD
- More than 50% of individuals with BPD are severely impaired in employability, with a resulting burden on Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and Medicaid and Medicare
- 12 percent of men and 28 percent of women in prison have BPD (Kreger, 2008)

Information for the Family

[Facing the Facts](#) when a loved one has Borderline Personality Disorder

- To the family members, BPD behavior is frustrating, and can feel unfair. Some common thoughts are:
- You have been viewed as overly good and then overly bad
- You have been the focus of unprovoked anger or hurtful actions, alternating with periods when the family member acts perfectly normal and very loving
- Things that you have said or done have been twisted and used against you
- You are accused of things you never did or said
- You often find yourself defending and justifying your intentions
- you find yourself concealing what you think or feel because you are not heard
- You feel manipulated, controlled, and sometimes lied to (Facing the Facts, 2010)

For More Information, Please Read:

- Linehan, M.M. (1993). Skills training manual for

treating borderline personality disorder. New York: Guilford Press.

- Kreger, R. (2008). The essential family guide to borderline personality disorder: New tools and techniques to stop walking on eggshells. Center City, Minnesota: Hazeldon Publishing.

Links

- APA: Borderline Personality Disorder Often Missed First Time Around
- [Borderline Personality Disorder](#)
- [Borderline Personality Disorder](#)
- www.minddisorders.com

Histrionic Personality Disorder

BILL PELZ AND HERKIMER COMMUNITY
COLLEGE



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=393#oembed-1>

What is a person with Histrionic Personality Disorder like?

The majority of cases of Histrionic Personality Disorder (HPD) are female. They may initially seem like average girls or young women, as their excessive focus on physicality can be seen in more reasonable quantities in most young ladies. At first this person may seem simply a little scattered, a little shallow, and a tad self-centered. However, a person with HPD exhibits far more than the normal amounts of all of these traits. Use of phrases that are ambiguous is frequent. “It was just like, you know, weird” would be a normative statement, or even “it was just like . . . you know?” This vague speech encompasses most of life, especially in regards to emotions and any cognitions. For example, one may see they have a distaste for something, and when inquiring as to why, simply get the response, “because it’s bad/yucky” or “I just don’t like it!” In this way, a person with HPD can often seem almost childlike in their speech patterns, as though they cannot introspect well enough to discern a more accurate description, or are too distracted or disinterested to even attempt to do so.

However, this vagueness does not mean they are unsure. People with HPD tend to be very sure of everything they think and do, even if what they think and feel changes moment to moment. This confidence can be seen in many of their actions, though they are often more than happy to act meek if it will acquire them attention. This confidence in the truth of their opinions seems to lead to them expressing

emotions as if they are incredibly severe. Though it is often debated whether the person with HPD experiences emotions more intensely, or simply reports them as more intense; we normally see expression of incredibly powerful emotions, but short lived, and very shallow. Though the term shallow may sound odd when referring to an emotion, when one converses with a person with HPD it usually becomes abundantly clear rather quickly. There is very little subtlety or shades of grey to the emotional spectrum of a person with HPD. If they are sad, they are distraught and the entire world is in peril; when they are happy, they are ecstatic, and euphoria barely expresses the joy they feel. In this way, such things as 'bittersweet' or simply doing pleasantly seems to be outside of the person with HPD's realm of experience. Even emotions like envy, which are distinct to most people, seem to get subsumed into a broader emotion, such as anger. And where an average person may be irritable with someone, a person with HPD often skips straight to blind rage, and will start a fight or throw a tantrum in response.

This extremity of expression is seen also in their conceptions, or at least their reports on their conceptions, of interpersonal relationships. A person is an enemy, or they are thick as thieves. A person with HPD may refer to you as their BFF (best friend forever) after only a couple of meetings. After four meetings, they may express that not only are they in love with you, you are in love with them! This confidence may seem to overlap with narcissistic personality disorder in many ways, and in this single aspect, the two do have

similarities, but expression in other symptoms is much more specific in HPD.

But, like the better known Narcissistic PD, people with HPD also crave the spotlight. They love, almost need to be the focal point of at least one person's attention at any given time, but the more, the better. Where the two disorders differ, is that HPD sufferers almost exclusively use physical attractiveness and sexuality to gain this attention. Though sometimes they resort to emotionality, often in the form of temper tantrums, more often than not they take on the role of seductress. A young lady with HPD may think nothing of taking off her shirt in a room full of people if she felt that focus was shifting somewhere else. Once again, though many people enjoy being the center of attention, and many normal young women may use their bodies or sensuality to become the center of attention (see the average spring break videos), these behaviors are exaggerated, more frequent, and occur in less appropriate situations in a person with HPD.

DSM-IV-TR criteria

- A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five or more of the following:
 1. Uncomfortable in situations where he or she is not the center of attention.
 2. Interactions with others are often characterized by

inappropriate sexually seductive or provocative behavior.

3. Displays rapid shifting and shallow expressions of emotions.
4. Consistently uses physical appearance to draw attention to self.
5. Has a style of speech that is excessively impressionistic and lacking in detail
6. shows self dramatization, theatricality, and exaggerated expression of emotion
7. is suggestible, i.e., easily influenced by others or circumstances
8. Consider relationships more intimate than they actually are.

Associated features

- Individuals have many emotional ups and downs. When not the center of attention in a social setting, individuals will find obvious ways to gain that attention back. They often, although unaware of it, act out a certain role, such as “victim” or “princess.” They often have trouble with their relationships with same-sex friends because of their sexually provocative style, and they may alienate friends because of their constant need for attention. They often easily become bored with routine and

are frustrated by situations that involve delayed gratification. They use flirtatious or sexually provocative behavior to get what they want, usually attention from others. The cognitive style of individuals with HPD is superficial and lacks detail. In their inter-personal relationships, individuals with HPD use dramatization with a goal of impressing others. The enduring pattern of their insincere and stormy relationships leads to impairment in social and occupational areas (Encyclopedia of Mental Disorders).

- Treatment for patients is difficult ultimately because most who suffer from HPD don't seek treatment because symptoms don't usually interfere with daily life.

Child vs. adult presentation

- HPD doesn't show development until the teenage years, approximately 15 years of age. Treatment for sufferers is usually amongst the more mature age groups, generally in the early 40's.

Gender and cultural differences in presentation

- Women are more likely to have HPD than men. Registered cases show that 65% are women and 35% are men that suffer from Histrionic Personality Disorder. Women tend to be over

diagnosed with this disorder. This is largely due to our culture. If a man brags about his accomplishment it is seen as being macho, If a woman seeks the same kind of attention, she is diagnosed with Histrionic Personality Disorder.

- According to the Encyclopedia of Mental Disordersm HPD appears primarily in men and women with above-average physical appearances. Some research has suggested that the connection between HPD and physical appearance holds for women rather than for men. Both women and men with HPD express a strong need to be the center of attention.
- HPD may be diagnosed more frequently in Hispanic and Latin-American cultures and less frequently in Asian cultures. Further research is needed on the effects of culture upon the symptoms of HPD.

Epidemiology

- HPD affects an estimated 1-2% of the general population, whereas only 1% are involved in outpatient programs.
- Prevalence rates are 10 to 15% in mental health settings (SAMHSA, 2009).
- The lower prevalence rate in psychiatric settings may be understood in the context of the culturally

adaptive qualities associated with the sex role stereotypes found in individuals with HPD.

- No evidence of significant familial patterns. (Not necessarily a genetic link).
- 10 to 15% of those in substance abuse treatment settings have HPD (SAMHSA, 2009).

Dual diagnoses

- HPD has been associated with alcoholism and with higher rates of [somatization disorder](#), [conversion disorder](#), and [major depressive disorder](#). Personality disorders such as borderline, narcissistic, antisocial, and dependent can occur with HPD.

Etiology

- The development of HPD illustrates a complicated interaction of biological predispositions and environmental responses. The temperament of extroversion and emotional expressiveness that underlie the character of an individual with HPD are recognized as having biological components. These factors interact with a lack of caregiver attention during formative years that led the child to develop strategies of attention grabbing presentation and shallow interaction that would elicit attention and connection

Neurochemical/Physiological Causes:

- Studies show that patients with HPD have highly responsive noradrenergic systems, the mechanisms surrounding the release of a neurotransmitter called norepinephrine. Neurotransmitters are chemicals that communicate impulses from one nerve cell to another in the [brain](#), and these impulses dictate behavior. The tendency towards an excessively emotional reaction to rejection, common among patients with HPD, may be attributed to a malfunction in a group of neurotransmitters called catecholamines. (Norepinephrine belongs to this group of neurotransmitters.)

Developmental Causes:

- Psychoanalytic theory, developed by Freud, outlines a series of psychosexual stages of development through which each individual passes. These stages determine an individual's later psychological development as an adult. Early psychoanalysts proposed that the genital phase, Freud's fifth or last stage of psychosexual development, is a determinant of HPD. Later psychoanalysts considered the oral phase, Freud's first stage of psychosexual development, to be a more important determinant of HPD. Most psychoanalysts agree that a traumatic childhood

contributes towards the development of HPD. Some theorists suggest that the more severe forms of HPD derive from disapproval in the early mother-child relationship.

Defense Mechanisms:

- Another component of Freud's theory, defense mechanisms are sets of systematic, unconscious methods that people develop to cope with conflict and to reduce anxiety. According to Freud's theory, all people use defense mechanisms, but different people use different types of defense mechanisms. Individuals with HPD differ in the severity of the maladaptive defense mechanisms they use. Patients with more severe cases of HPD may utilize the defense mechanisms of repression, [denial](#), and dissociation.

Repression.

- Repression is the most basic defense mechanism. When patients' thoughts produce anxiety or are unacceptable to them, they use repression to bar the unacceptable thoughts or impulses from consciousness.

Denial.

- Patients who use denial may say that a prior

problem no longer exists, suggesting that their competence has increased; however, others may note that there is no change in the patients' behaviors.

Dissociation.

- When patients with HPD use the defense mechanism of dissociation, they may display two or more personalities. These two or more personalities exist in one individual without integration. Patients with less severe cases of HPD tend to employ displacement and rationalization as defenses.

Displacement

- occurs when a patient shifts an [affect](#) from one idea to another. For example, a man with HPD may feel angry at work because the boss did not consider him to be the center of attention. The patient may displace his anger onto his wife rather than become angry at his boss.

Rationalization

- occurs when individuals explain their behaviors so that they appear to be acceptable to others.

Biosocial Learning Causes:

- A biosocial model in psychology asserts that social and biological factors contribute to the development of personality. Biosocial learning models of HPD suggest that individuals may acquire HPD from inconsistent interpersonal [reinforcement](#) offered by parents. Proponents of biosocial learning models indicate that individuals with HPD have learned to get what they want from others by drawing attention to themselves.

Sociocultural Causes:

- Studies of specific cultures with high rates of HPD suggest social and cultural causes of HPD. For example, some researchers would expect to find this disorder more often among cultures that tend to value uninhibited displays of emotion.

Personal Variables:

- Researchers have found some connections between the age of individuals with HPD and the behavior displayed by these individuals. The symptoms of HPD are long-lasting; however, histrionic character traits that are exhibited may change with age. For example, research suggests that seductiveness may be employed more often by a young adult than by an older one. To impress

others, older adults with HPD may shift their strategy from sexual seductiveness to a paternal or maternal seductiveness. Some histrionic symptoms such as attention-seeking, however, may become more apparent as an individual with HPD ages.

Prevention

- Early diagnosis can assist patients and family members to recognize the pervasive pattern of reactive emotion among individuals with HPD. Educating people, particularly mental health professionals, about the enduring character traits of individuals with HPD may prevent some cases of mild histrionic behavior from developing into full-blown cases of maladaptive HPD. Further research in prevention needs to investigate the relationship between variables such as age, gender, culture, and ethnicity and HPD.

Empirically supported treatments

- There are no known treatments for HPD, most patients use psychotherapy, but complications are commonly caused. Medication is not a wise decision due to the risk of the patient involving the medication in a self destructive way. There are no currently no self help groups for people with HPD. The exaggerated emotional activity of HPD patients tends them to develop relationships with

their therapist, severely limiting a psychologist's ability to help a HPD patient.

Psychodynamic therapy:

- HPD, like other personality disorders, may require several years of therapy and may affect individuals throughout their lives. Some professionals believe that psychoanalytic therapy is a treatment of choice for HPD because it assists patients to become aware of their own feelings. Long-term psychodynamic therapy needs to target the underlying conflicts of individuals with HPD and to assist patients in decreasing their emotional reactivity. Therapists work with thematic dream material related to intimacy and recall. Individuals with HPD may have difficulty recalling because of their tendency to repress material.

Cognitive-behavioral therapy:

- Cognitive therapy is a treatment directed at reducing the dysfunctional thoughts of individuals with HPD. Such thoughts include themes about not being able to take care of oneself. Cognitive therapy for HPD focuses on a shift from global, suggestible thinking to a more methodical, systematic, and structured focus on problems. Cognitive-behavioral training in relaxation for an individual with HPD emphasizes challenging

automatic thoughts about inferiority and not being able to handle one's life. Cognitive-behavioral therapy teaches individuals with HPD to identify automatic thoughts, to work on impulsive behavior, and to develop better problem-solving skills. Behavioral therapists employ [assertiveness training](#) to assist individuals with HPD to learn to cope using their own resources. Behavioral therapists use response cost to decrease the excessively dramatic behaviors of these individuals. Response cost is a behavioral technique that involves removing a stimulus from an individual's environment so that the response that directly precedes the removal is weakened. Behavioral therapy for HPD includes techniques such as [modeling](#) and behavioral rehearsal to teach patients about the effect of their theatrical behavior on others in a work setting.

Group therapy:

- is suggested to assist individuals with HPD to work on interpersonal relationships. Psychodrama techniques or group role play can assist individuals with HPD to practice problems at work and to learn to decrease the display of excessively dramatic behaviors. Using role-playing, individuals with HPD can explore interpersonal relationships and outcomes to understand better the process

associated with different scenarios. Group therapists need to monitor the group because individuals with HPD tend to take over and dominate others.

Family therapy:

- To teach assertion rather than avoidance of conflict, family therapists need to direct individuals with HPD to speak directly to other family members. Family therapy can support family members to meet their own needs without supporting the histrionic behavior of the individual with HPD who uses dramatic crises to keep the family closely connected. Family therapists employ behavioral contracts to support assertive behaviors rather than temper tantrums.

Medications

- Pharmacotherapy is not a treatment of choice for individuals with HPD unless HPD occurs with another disorder. For example, if HPD occurs with depression, antidepressants may be prescribed. Medication needs to be monitored for abuse.

Portrayed in Popular Culture

- Scarlett O'Hara from *Gone with the Wind*
- Blanche DuBois from *A Streetcar Named Desire*
- The Penguin from *Batman*

- He constantly compensates for his short stature and horrible appearance with an active sense of panache
- Constantly seeking attention to his small self
- Bellatrix Lestrange from Harry Potter
- The theatrical right-hand woman of the Death Eaters craves the approval and appreciation of her master
- Every movement of hers oozes sexuality

DSM-V Changes

- Histrionic Personality Disorder will be represented and diagnosed by a combination of core impairment in personality functioning and specific pathological personality traits, rather than as a specific type.
- [Prominent Personality Traits](#)
- [Histrionism, Emotional lability](#)

(APA, 2010)

Links

- [Histrionic Personality Disorder](#)

Obsessive-Compulsive Personality Disorder

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DSM-IV-TR Criteria

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the

major point of the activity is lost

2. shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)
3. is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
4. is over conscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
5. is unable to discard worn-out or worthless objects even when they have no sentimental value
6. is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
7. adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
8. shows rigidity and stubbornness

Associated Features

Obsessive compulsive personality disorder (OCPD) is a disorder in which the subject suffers from an obsession with control and rules and becomes so fixated on following these

rules or rituals that it becomes detrimental to their day to day lives. They believe that these rules and rituals keep them from harm. This harm is something they perceive out of their own warped perspective. People with OCPD experience things such as rigidity, indecisiveness, and depressed demeanor.

Relationships are hard to maintain due to their volatility. This volatility surfaces when this person is put in a situation where they have lost control. Some resort to aggressive behavior while others may simply withdraw from the situation completely. The subject generally does not express emotion very well. People who suffer from this disease tend to excel at school or work because of their devotion to rules. Though beneficial in some situations this dedication to rules often leads to failure because of their lack of flexibility when unexpected change occurs.

These individuals are preoccupied with maintaining control mentally and in their interpersonal relationships. They make sure they do not make a mistake, and often check for the presence of mistakes. Much attention to detail is observed, and this often causes homework to not get completed because of perfectionist qualities. They tend to be workaholics and are not involved in many leisure activities; there may be problems in relaxing or having any type of fun.

They demand everything be done their way and possess stubborn qualities. Individuals are usually serious, rigid, formal, inflexible, and tend to be extremely moral. They tend to be stingy and want to save useless stuff of no value. Basically, those that cannot let loose, are cold, and stiff with

anal tendencies most likely retentive. The OCPD is different from obsessive-compulsive disorder (OCD) in that the personality disorder does not include the obsessions and compulsions that define OCD. These disorders are contrary to popular belief that they are related on the same spectrum

- Co-morbidity is often seen with Dependent Personality Disorder, and Avoidant Personality Disorder.
- The most common types of obsessions in persons with OCD in Western countries are:
 - fear of contamination (impurity, pollution, badness)
 - doubts (worrying about whether one has omitted to do something)
 - an intense need to have or put things in a particular order
 - aggressive or frightening impulses
 - recurrent sexual thoughts or image
- The most common types of compulsions in persons with OCD in Western countries are:
 - washing/cleaning
 - counting
 - hoarding
 - checking

- putting objects in a certain order
- repeated “confessing” or asking others for assurance
- repeated actions
- making lists

Child vs. Adult Presentation

Once this disorder begins to manifest itself in early adulthood, there is no child presentation to compare with the adult presentation.

Unusual behaviors in children that may be signs of OCD include:

- Avoidance of scissors or other sharp objects. A child may be obsessed with fears of hurting herself or others.
- Chronic lateness or dawdling. The child may be performing checking rituals (repeatedly making sure all her school supplies are in her book bag, for example).
- Daydreaming or preoccupation. The child may be counting or performing balancing rituals mentally.
- Spending long periods of time in the bathroom. The child may have a hand washing compulsion.
- Schoolwork handed in late or papers with holes erased in them. The child may be repeatedly

checking and correcting her work.

Gender and Cultural Differences in Presentation

Men are twice as likely to suffer from this disorder as women. Some researchers theorize that the cause of the gender difference is due to the Western culture allowing men to act more controlling and stubborn.

Epidemiology

This disorder appears to only be present in approximately 1% of the United States population. It also seems to affect men more often than women. There is prevalence between 2% and 8% in the general population, and between 8% and 9% in outpatient psychiatric settings. And anywhere from 3% to 10% of individuals in mental health clinics have Obsessive-Compulsive Personality Disorder. There are no significant familial problems.

Etiology

The causes of OCPD are not well-known. Research leads us to believe that most sufferers are genetically predisposed. Another assumption is that OCPD is caused by things such as rigid parenting with young children. Children that are punished too harshly and receive little or no positive reinforcement for their good behavior are likely to develop this disorder. In most cases the children who develop OCPD are the oldest children in their families. Individuals were often

punished for failing to be perfect and received no rewards for success. Affection and emotions were expected to be controlled or remain unexpressed.

These individuals do not generally present themselves voluntarily to treatment settings, thus making these disorders more difficult to properly research. Those that do come in are in a debilitated state, and it becomes difficult to specify the causal factors because we have to go back and piece together the etiological pieces of the puzzle. The most critical problem is that many of the Personality Disorders are co-morbid with each other, making it very difficult to separate out which factors are unique to each disorder.

Individuals with OCPD expect others to judge and criticize them in the same way that caregivers did during their development. Therefore, individuals with OCPD judge others by the same strict standards and self-criticize in the same manner as the caregivers who once criticized them.

Psychosocial causes:

In the early part of the century, Sigmund Freud theorized that OCD symptoms were caused by punitive, rigid toilet-training practices that led to internalized conflicts. Other theorists thought that OCD was influenced by such wider cultural attitudes as insistence on cleanliness and neatness, as well as by the attitudes and parenting style of the patient's parents. Cross-cultural studies of OCD indicate that, while the incidence of OCD seems to be about the same in most

countries around the world, the symptoms are often shaped by the patient's culture of origin

Biological causes:

There is considerable evidence that OCD has a biological component. Some researchers have noted that OCD is more common in patients who have suffered head trauma or have been diagnosed with Tourette's syndrome. Recent studies using [positron emission tomography](#) (PET) scanning indicate that OCD patients have patterns of [brain](#) activity that differ from those of people without mental illness or with some other mental illness. Other studies using [magnetic resonance imaging](#) (MRI) found that patients diagnosed with OCD had significantly less white matter in their brains than did normal control subjects. This finding suggests that there is a widely distributed brain abnormality in OCD. Some researchers have reported abnormalities in the metabolism of serotonin, an important neurotransmitter, in patients diagnosed with OCD. Serotonin affects the efficiency of communication between the front part of the brain (the cortex) and structures that lie deeper in the brain known as the basal ganglia. Dysfunction in the serotonergic system occurs in certain other mental illnesses, including major depression. OCD appears to have a number of features in common with the so-called obsessive-compulsive spectrum disorders, which include Tourette's syndrome; Sydenham's chorea; eating disorders; [trichotillomania](#); and delusional disorders. There appear to be genetic factors involved in OCD. The families

of persons who are diagnosed with the disorder have a greater risk of OCD and [tic disorders](#) than does the general population. Childhood-onset OCD appears to run in families more than adult-onset OCD, and is more likely to be associated with tic disorders. Twin studies indicate that monozygotic, or identical twins, are more likely to share the disorder than dizygotic, or fraternal twins (www.minddisorders).

Empirically Supported Treatments

- Treatment for this disease is mostly limited to psychotherapy and self help treatments. Generally very difficult to treat, Cluster C seems most promising to treat and Cluster A least so.
- Medicine seems to only alleviate some depressive symptoms but doesn't seem to improve symptoms in the long term sense. Obsessions can be influenced with selective serotonin re-uptake inhibitors or mono amine oxidase inhibitors.
- In extreme cases [electro-convulsive therapy \(ECT\)](#) or neurosurgery are used.
- Prevention is also almost impossible. As stated earlier most cases are people who are genetically predisposed. Early detection and treatment offers the best results.
- Therapy for this disorder can be quite difficult. Because of patients obsession with rules and doing

things their own way it is difficult to teach them a new concept.

Medications

According to the encyclopedia of Menatal Disorders, the most useful medications for the treatment of OCD are the selective serotonin reuptake inhibitors (SSRIs), which affect the body's reabsorption of serotonin, a chemical in the brain that helps to transmit nerve impulses across the very small gaps between nerve cells. These drugs, specifically [**clomipramine**](#) (Anafranil), [**fluoxetine**](#) (Prozac), fluvoxamine (Luvox), [**sertraline**](#) (Zoloft), and [**paroxetine**](#) (Paxil) have been found to relieve OCD symptoms in over half of the patients studied. It is not always possible for the doctor to predict which of the SSRIs will work best for a specific patient. Lack of response to one SSRI does not mean that other drugs within the same family will not work. Treatment of OCD often proceeds slowly, with various medications being tried before the most effective one is found. While studies report that about half of those treated with SSRIs show definite improvement, relapse rates may be as high as 90% when medications are discontinued.

Portrayed in Popular Culture

- Jerry from Seinfeld
 - He is characterized by rigid conformity to rules, moral codes, and excessive

orderliness

- Monk from Monk
- Sheldon Cooper from Big Bang Theory
- Harvey Dent Two-Face from Batman
 - Has a preoccupation with coin-flipping
- Mr. Edward Nygma (The Riddler) from Batman
 - He has to leave riddles behind
 - In a 1999 issue of Gotham Adventures, he tries to commit a crime without leaving a riddle, but fails
- Dolores Umbridge from Harry Potter
 - The temporary Headmistress and Inquisitor of Hogwarts upon Dumbledore's disappearance is the perfect picture of obsessiveness and rigidity.
 - She has to maintain order at all times

DSM-V Changes

- Reformulated as the Obsessive-Compulsive Type
- Individuals who match this personality disorder type are ruled by their need for order, precision, and perfection.
- Activities are conducted in super-methodical and overly detailed ways. They have intense concerns

with time, punctuality, schedules, and rules.

- Affected individuals exhibit an overdeveloped sense of duty and obligation, and a need to try to complete all tasks thoroughly and meticulously.
- The need to try to do things perfectly may result in a paralysis of indecision, as the pros and cons of alternatives are weighed, such that important tasks may not ever be completed.
- Tasks, problems, and people are approached rigidly, and there is limited capacity to adapt to changing demands or circumstances.
- For the most part, strong emotions – both positive (e.g., love) and negative (e.g., anger) – are not consciously experienced or expressed.
- At times, however, the individual may show significant insecurity, lack of self confidence, and anxiety subsequent to guilt or shame over real or perceived deficiencies or failures.
- Additionally, individuals with this type are controlling of others, competitive with them, and critical of them.
- They are conflicted about authority (e.g., they may feel they must submit to it or rebel against it), prone to get into power struggles either overtly or covertly, and act self-righteous or moralistic.
- They are unable to appreciate or understand the

ideas, emotions, and behaviors of other people.

- [Instructions](#)

(APA, 2010)



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://fhsu.pressbooks.pub/abnormalpsych/?p=395#oembed-1>

<https://youtu.be/kBA6ACBFNqg>

An example of how Obsessive-Compulsive Personality Disorder is portrayed in pop culture. In the television show Big Bang Theory, Sheldon Cooper, a theoretical physicist who shows signs of Asperger Syndrome and Obsessive-Compulsive Personality Disorder, has a compulsive need to knock three times, say the persons name three times, and repeat for a total of three times.

Schizophrenia, Paranoid Type
(295.30)

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DSM-IV-TR criteria

- A. Characteristic symptoms:
 - Preoccupation with one or more delusions or frequent auditory hallucinations. None of the following is present: disorganized speech, disorganized/ catatonic behavior, flat/ inappropriate affect.

- Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.
- B. Social/occupational dysfunction:
 - For a significant portion of the time since the onset of the disturbance one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).
- C. Duration:
 - Continuous signs of the disturbance that persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only

negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

- D. Schizoaffective and Mood Disorder exclusion:
 - Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either
 - (1) no Major Depressive Episode, Manic Episode, or Mixed Episode have occurred concurrently with the active-phase symptom, or
 - (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.
- E. Substance/general medical condition exclusion:
 - The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
- F. Relationship to a Pervasive Developmental Disorder:

- If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated)
- For the paranoid subtype, the above criteria must be met, but one must have a preoccupation with one or more delusions or frequent auditory hallucinations and none of the following is prominent: disorganized speech, disorganized or catatonic behavior, or flat or inappropriate affect.

Hitler as an example

The DSM-IV-TR has 5 diagnostic criteria for schizophrenia.

The first is the characteristic symptoms in which two of the following five must be present: (1) delusions, (2) hallucinations, (3) disorganized speech, (4) grossly disorganized or catatonic behavior, (5) negative symptoms such as affective flattening, alogia, or abolition.

Hitler had two of these. He had delusions that people were out to hurt him; delusions that the Jews were evil, unclean, and the cause for all of chaos and downfall of Germany; delusions that he was a wonderful artist, possibly one of the best of the time; delusions that he was all powerful and deserving.

The second symptom Hitler demonstrates is negative

symptoms of affective flattening. The only time Hitler showed any type of appropriate emotion was when he was angry. The second criterion is social or occupational dysfunction. Hitler was able to gain millions of followers but he rarely had true good relations with friends or family. Also considered is the duration, continuous signs for at least six months with at least one month of straight symptoms. Hitler portrayed these symptoms from young adulthood onward. Other criteria considered are ones of exclusion, exclusion of schizoaffective and mood disorders, exclusion of substance or general medical conditions, and exclusion of pervasive development disorders.

It may also be possible that Hitler had Cyclothymic Disorder, which is a mild form of bipolar disorder where a person has mood swings from mild to moderate depression to euphoria, but stays connected to reality.

DSM-IV-TR states that the essential feature of Paranoid type Schizophrenia is the presence of prominent delusions or auditory hallucinations in relation to preservation. The delusions are usually of grandiose theme. Hitler had many delusions about the Jew being evil and out to harm and infect everyone. Hitler often believed that he was a better artist and architect than he was and was appalled when others did not find him so. He believed he was better than everyone else, even while homeless living in the Men's Shelter.

Associated features include anxiety, anger, aloofness, and argumentativeness, most of which Hitler displayed in almost

every way. According to the DSM-IV-TR it may have been possible that Hitler had schizophrenia paranoid type.

Associated features

The paranoid subtype is the most common of subtypes. Those with the paranoid subtype will have delusions and suspicions that increase during the course of the illness. Their delusions are mostly persecutory, grandiose, or feelings of inadequacy, and will tend to have interpersonal problems. The delusions may be multiple, but usually have a theme. Other features include anxiety, anger, aloofness, and argumentativeness. These features become increasingly suspicious of relatives and close friends. The individual may display a superior or patronizing manner, and may be extremely formal or intense in their interactions. They function at a higher level than most other schizophrenics because of the lack of negative symptoms. Their diagnosis is more stable than for the other types, and they respond better to treatment as well. Individuals suffering from the paranoid subtype also suffer from social withdrawal and persistently hold grudges and perceive attacks.

Child vs. adult presentation

The illness is presented much the same for adults as for children, except the symptoms appear before age 12. The illness manifests itself gradually in children and is often preceded by lags in motor development, speech development, etc. The paranoid subtype often manifests itself later than

the other subtypes. If there is an onset of Schizophrenia in childhood or adolescence, a failure to achieve an expected level of interpersonal, academic, or occupational achievement is thought to occur. His or her social and occupational functioning needs to be on a steady decline during the disorder.

Gender and cultural differences in presentation

Schizophrenia presents itself three to six years later in women than in men, but it presents itself the same way between genders. Schizophrenic disorders present themselves consistently across the world, but one must take into account cultural attitudes on the symptoms which typically make up schizophrenia. In other words, what we see as symptoms of paranoia may be normal behavior to different cultures. Recent studies show that men are more likely to receive treatment for the disorder. In fact, most research on the treatment of schizophrenia is conducted on samples ranging from 60% to 100% male. Misdiagnosis of mood disorders as schizophrenia is the most common problem with the diagnosis of ethnic minorities in the United States.

Epidemiology

Schizophrenia has a lifetime prevalence of about 1%, and that prevalence may differ greatly from country to country. It is diagnosed disproportionately among the lower class. There is very little epidemiological data for Paranoid Schizophrenia specifically.

When the diagnosis of Schizophrenia came in use, almost half were considered in the Paranoid category. Now, new drugs can help decrease the paranoia and this diagnosis is on the decrease.

Etiology

Etiological factors for schizophrenia include genetic factors, environmental factors, and physiological factors.

The more severe a parent's schizophrenia, the more likely it is that a child will have schizophrenia. Monozygotic twins have a 46% concordance rate for schizophrenia, and dizygotic twins have a 9% concordance rate. There is also a lower fecundity level (the ability to produce viable offspring) for schizophrenics: a 70% reduction in males and a 30% reduction in females.

Paranoid Schizophrenia does not seem to be as affected by genetics as the other subtypes.

There are also many environmental factors which could lead to schizophrenia.

Such factors include living in an urban environment, a lower social economic status, and childhood experience of abuse or trauma.

Since concordance rates are not at or near 100%, it is certain that there are many environmental factors which play into schizophrenia. Adoption studies have shown that a healthy family environment can serve as a protective factor from schizophrenia.

Poor parenting is not held responsible for schizophrenia, but might increase the risk.

The [diathesis stress model](#) is accepted by many psychologists as an explanation for the development of schizophrenia. This model states that the person is born with a genetic vulnerability to Schizophrenia and is afterward exposed to a traumatic event with which he/she cannot cope. If the person can effectively handle the stress brought about by the trauma, Schizophrenia may never develop.

There are also some prenatal factors which influence the development of Schizophrenia. These factors include prenatal exposure to influenza, malnutrition, and birth complications.

There are also some physiological factors to consider:

One hypothesis states that Schizophrenia is caused by excess levels of dopamine. Some say that the dopamine receptors may have become hypersensitive.

There are some problems with this hypothesis. There are schizophrenics who do not respond to dopamine-decreasing drugs. Also behavior changes in schizophrenics occur over time, while dopamine receptors are effective usually within a few weeks. Schizophrenics also have anatomical differences in their brains. The total brain mass is less than average, and the ventricles are enlarged.

Paranoid schizophrenics do not show these neuropsychological differences.

Empirically supported treatments

The two modalities of treatment for Schizophrenia are psychotherapy and anti-psychotic medication.

Psychotherapy for Schizophrenia focuses on making changes that will be effective over time. Family therapy has been shown to have a positive outcome on the schizophrenic and to help the family cope with the disorder. The family is educated about the disorder and taught what to expect and how to handle different situations that the illness may present. They also learn how to improve communication between each other and the schizophrenic.

Social Skill Training teaches the schizophrenic to improve on the social skills he or she may be lacking, and the difference between acceptable and unacceptable behavior. In Assertive Community Treatment, an interdisciplinary team provides skills training, rehabilitation, education, and support so that the schizophrenic can be kept in the community as opposed to being hospitalized. Schizophrenics are also taught to recognize indicators of stress and how to cope with them effectively. For those who cannot reach the point of being able to be without sheltered care, token economies have been shown to be useful. Tokens are given in return for desirable behaviors which have been laid out and are exchanged after a period of time for snacks or privileges. Inappropriate behaviors are ignored and are punished only when necessary. All of these treatments are used in combination with anti-psychotic medications

Anti-psychotic medications for Schizophrenia include:

Clozaril, Compazine, Etrafon, Haldol, DecanoateInapsine, Lidone, Loxitane, Mellaril, Moban, Navane, Orap, Permitil, Prolixin, Decanoate, Enanthate, Proketazine, Risperdal, Serentil, Sparine, Stelazine, Taractan, Thorazine, Tindal, Trilafon, and Vesprin.

Paranoid Schizophrenia responds very well to medication and has the best prognosis of all the subtypes.

Antipsychotic side effects include: motor side effects, for example pseudoparkinsonism (shake uncontrollably), bradykinesia, rigidity, & tardive dyskinesia, seizures, anticholinergic effects, antihistaminic effects, & neuroleptic malignant syndrome.

Links

- [“Schizophrenia May Be Linked To Immune System”](#): A short story about three genetic studies believed to show possible causes for Schizophrenia.
 - “Schizophrenia May Be Linked To Immune System.” All Things Considered. National Public Radio. July 1, 2009
- An interview with Patrick Tracey, who traced his family’s history with Schizophrenia back five generations
 - Family’s History with Schizophrenia
 - “Tracing the Roots of ‘Irish Madness.’” Talk of the Nation. National Public Radio. Aug. 28, 2008

- Radio contributor Scott Carrier tells the story of a job he had at a particularly bleak point in his life, interviewing people diagnosed with Schizophrenia. Story begins at minute 3, and ends at minute 18:30.
 - “The Friendly Man.” This American Life. Chicago Public Radio. April 24, 2009
 - [Interview with a paranoid schizophrenic](#)

Articles

- [New hope for people with schizophrenia](#)
- [A recipe for schizophrenia symptoms?](#)
- Murry (1943) also provided a psychological evaluation of Hitler for the Office of Strategic Services. He believed that Hitler showed signs of schizophrenia paranoid type. Along with Schizophrenia he believed that Hitler exhibited signs of panic attacks, irrational jealousy, and delusions of persecution, omnipotence, megalomania, and ‘messiah ship’. He is one of the many theorist who believe that these psychopathic symptoms derived from his stay at Pasewalk. He noted that Hitler was able to gain control over his hysterical and paranoia. He used them to enhance his own standing by inflaming the nationalistic passions of the German people and fan hatred. (Murry, H. A. (1943). Analysis of the personality of Adolf Hitler with prediction of his future behavior

and suggestion for dealing with him now and after Germany's surrender. A report prepared for the Office of Strategic Services, October, 1943. Retrieved from www.lawschool.cornell.edu/library/donovan/hitler.)

- Coolidge, Davis, and Segal (2007) did an experiment in which they had five academic historians, with 10 years of hitlerian studies, current or former university faculty appointment, and a published book or article about hitler or Nazi Germany, completed the CATI of Hitler. They found that Hitler would have most likely been diagnosed with schizophrenia paranoid type. The mean consensus T score for schizophrenia scale was almost two standard deviations above the normal mean. His scoring on the Psychotic Thinking and Paranoid scales also support this diagnosis. The researchers also found high scores for PTSD. He was three standard deviations above the normal mean.(Coolidge, F. L., Davis, F. L., & Segal, D. L. (2007). Understanding madmen: A DSM-IV assessment of Adolf Hitler. *Individual Differences Research*, 5(1), pp. 30-43.)
- A Beautiful Mind is a 2001 movie about a man who develops paranoid schizophrenia and experiences delusional episodes.



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Schizophrenia, Disorganized Type
(295.10)

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DSM-IV-TR criteria

- Schizophrenia in which the following criteria are meet:
- All of the following are prominent for a diagnosis to be made:
 - Disorganized speech
 - Disorganized behavior
 - Flat or inappropriate affect

- The criteria are not met for Catatonic Type

Associated features

The essential features of the Disorganized Type of Schizophrenia are:

- Disorganized speech, disorganized behavior, and flat or inappropriate affect.
- Having disorganized speech may be accompanied by madness and laughter that are not closely related to the content of the speech.
- The behavioral disorganization (i.e., the lack of goal orientation) may lead to severe disruption in the ability to perform activities of daily living (i.e., showering, dressing, or preparing meals).
- Those individuals suffering from the Disorganized Type of schizophrenia may also demonstrate improper “normal behaviors” including masturbating or defecating in public.
- Criteria for the Catatonic Type of Schizophrenia are not met, and delusions or hallucinations, if present, are fragmentary and not organized into a coherent theme. Associated features include grimacing, mannerisms, and other oddities of behavior. Impaired performance may be noted on a variety of neuropsychological and cognitive test.
- This subtype is also usually associated with poor

pre-morbid personality, early and insidious onset, and a continuous course without significant remissions.

- Historically, and in other classification systems, this type is termed hebephrenic, which is characterized by foolish mannerisms, senseless laughter, delusions, hallucinations, and regressive behavior.

Individuals with Disorganized Type of Schizophrenia might suffer from social deficits, which is an impaired ability to understand and solve social problems. They behave “silly” or seem weird to most people. For example, individuals suffering from Disorganized type laugh or giggle at inappropriate times.

Individuals might also suffer from emotional deficits, which some Schizophrenics might show abnormal expressions of emotions, or an impaired ability to recognize emotion in others. Sufferers of Disorganized type schizophrenia also have problems showing the correct emotion for example they might be the ones to laugh at a funeral.

Substance abuse is very prevalent in Schizophrenia cases. 80-90% use nicotine heavily. In many cases many are polysubstance abusers.

Most Schizophrenics are at a high suicide risk. (10% succeed)

Also if these individuals display hallucinations and

delusions, their behavior tends to be bizzare and poorly organized.

Individuals do not respond well to treatment.

Child vs. adult presentation

In recent research it has been shown that signs of schizophrenia may be present before clinical symptoms of psychosis appear. Normally schizophrenia develops in individuals sometime between adolescence and early adulthood. During childhood, symptoms can be minimal and discrete, however through adolescence and into adulthood these symptoms will gradually increase in number and severity. It is extremely rare for the onset of schizophrenia to occur before adolescence (before the age of 12). Studies suggest that adult onset schizophrenia and childhood development of the disorder both lead to similar, if not identical, symptoms and complications. The life of the symptoms reported is similar to that seen in adult cases with the predictable developmental variations. For example, delusions are less complex in children and reflect childhood themes.

Gender and cultural differences in presentation

Women often have a milder overall course and later onset of schizophrenia than men. Men are more likely to receive treatment for the disorder. Some research suggests that social skills training may be more helpful to men than to women. Because treatment studies usually sample persons with

schizophrenia who are currently receiving treatment it leads to more information gathered on males than in females. The prevalence of schizophrenia is comparable across different cultures. Several studies have shown that the course of the illness is more benevolent in developing countries compared to industrialized nations. Certain cultural interpretations of schizophrenia may promote more acceptance of people who display the symptoms. Without a clear understanding of the religious and cultural background, patients may be misdiagnosed. Knowledge of cultural norms appears critical to avoid the possible misinterpretation of culturally bound beliefs, experiences, and practices when arriving at a diagnosis. Stigma also plays an important role for cultural factors; this can greatly undermine the person's ability to recover from the effects of schizophrenia. Also, this can cause difficulties in integrating into society.

Epidemiology

- It is estimated that approximately 2.2 million persons in the United States have Schizophrenia at any given time.
- The annual incident rate of new cases of Schizophrenia has ranged from 16 to 40 per 100,000 persons.
- One- year prevalence rates of Schizophrenia have ranged from 1% to 4.6% per 1,000 persons.
- The lifetime prevalence of Schizophrenia lies

between 0.55% and 1% per 100 persons worldwide.

- The prevalence is believed to be remarkably stable across a wide range of: different populations, cultures, genders, races, and religions.
- People with the illness are especially affected in that they are less likely to marry or remain married, particularly males.
- Also people with Schizophrenia are less likely to complete higher levels of education.
- Only 14% to 20% of persons with Schizophrenia hold competitive employment.

Etiology

- Studies that have been done in the past 30 years are indicating that the risk of developing Schizophrenia in biological relatives of persons with Schizophrenia is greater than in the general population, even in the absence of any contact between relatives.
- The odds of developing Schizophrenia if one parent has the disorder is 13% and rises to 50% if both parents have the disorder, compared to only 1% risk in the general population.
- The rate of one identical twin developing Schizophrenia if his or her twin also has

Schizophrenia is between 25% and 50%, compared to about 6% and 15% for fraternal twins.

- It also appears that the risk of developing Schizophrenia is greater in more severe types of Schizophrenia.
- It is more likely that Schizophrenia is a polygenetic condition or arises from an interaction of multiple genes, which increase the receptiveness to the disorder. Chromosome 1 has been implicated in recent research (Hodge et al., 2009). Several studies have shown that single nucleotide polymorphisms associated with chromosome 1 are present in many varieties of schizophrenia. Future research conducted will need to focus on determining which single nucleotide polymorphisms in a person's DNA might alter genetic function and facilitate the development of schizophrenia.

Empirically supported treatments

Although no cures have been found yet for Schizophrenia, there are many treatment options to help a person with Schizophrenia cope with this disorder. Antipsychotic medication is the main biological treatment used in Schizophrenic cases. Antipsychotic medications block an excess of dopamine in the brain, but also effect other neurotransmitters as well as serotonin levels. Antipsychotic medications are usually grouped with psychosocial therapy

treatments in order to treat the patient as effectively as possible. Although antipsychotic medications are useful, they can be dangerous and lead to major side effects.

Another treatment option is Psychosocial Therapy which includes family therapy, social skills training, and cognitive therapy. The most widely used type of therapy for schizophrenics is family therapy. In family therapy, the patient's family is educated about what is happening to their loved one and are taught ways to help communicate and deal with the situations that arise. Social skills training and Cognitive therapy are also popular ways in trying to treat schizophrenia. In social skills training, the patient is taught basic social skills such as maintaining eye contact and engaging in small talk to help build relationships with those around them. This type of therapy is helpful because Schizophrenics tend to push people away, and become isolated. This type of therapy can greatly help disorganized schizophrenics since they mostly struggle with showing emotions, as well as not knowing how to behave properly in public. Cognitive therapy is also a popular therapy choice in treating persons with Schizophrenia because it aims to reverse how they perceive themselves, others, and the world around them.

Brief Psychotic Disorder (298.8)

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DSM-IV-TR criteria

- A. Presence of one or more of the following:
 - Delusions
 - Hallucinations,
 - Disorganized speech (e.g., frequent derailment or incoherence)
 - Grossly disorganized or catatonic behavior
 - NOTE:* You should not include these

symptoms if they are a culturally sanctioned response pattern.

- B. Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning.
- C. The disturbance is not better accounted for by a Mood Disorder With Psychotic Features, Schizoaffective Disorder, or Schizophrenia and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition
- Specify if:
 - With Marked Stressor(s) (brief reactive psychosis): if symptoms occur shortly after and in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture
 - Without marked Stressor(s): if psychotic symptoms do not occur shortly after, or are not apparently in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture
 - With Postpartum Onset: onset within 4

weeks postpartum

Associated features

People with brief psychotic disorder usually experience emotional problems as well as huge amounts of confusion. They usually experience dramatic shifts of intense mood.

The level of impairment for this disorder may be brief, but it could also be very severe. The individual needs to be protected from the consequences of cognitive impairment, acting on the basis of delusions, and poor judgment. Because of this, supervision may be required. Also, supervision is needed in order to make sure that nutritional and hygienic needs are met and kept.

There is a high risk of suicide among younger teens who have this psychotic disorder and a highly increased risk of mortality among them also.

Personality disorders such as paranoid, schizotypal, and borderline personality disorder, along with others, may increase the development of brief psychotic disorder.

People who suffer from this disorder often have just lost a loved one or recently experience some form of intense grief. Afterward, they might experience extreme symptoms such as hallucinations or delusions, memory loss/impairment, confusion, and other physical changes (sleeping and eating patterns etc.).

Child vs. adult presentation

Brief psychotic disorder is very rarely seen in children. On

average, it usually appears more in adolescence or early adulthood. The age of onset is usually around late 20's to early 30's.

Gender and cultural differences in presentation

Gender differences in brief psychotic disorder are rarely seen. There is, however, some evidence of a slightly higher rate of brief psychotic disorder in women than men.

Cultural differences, on the other hand, are very popular. For example, if a patient reported hearing voices in the United States, they may be put on medications for brief psychotic disorder. In other cultures, however, if a patient hears voices it could be seen as a normal thing. It is part of their culture and their community as a whole may be experiencing the same phenomenon.

Epidemiology

The epidemiology is usually considered uncommon. The exact prevalence, and/or incidence is not fully known, therefore making the cause of brief psychotic disorder a mystery as of right now.

Etiology

The cause of brief psychotic disorder, as stated earlier, is unknown. People who have this disorder may have a psychological or even a biological vulnerability to developing the disorder or simply the symptoms of the disorder. Having

other psychotic disorders makes the patient more prone to develop brief psychotic disorder.

Empirically supported treatments

There is no known way to prevent this disorder.

A few common medications used are Thorazine, Prolixin, Haldol, and Trilafon. The prognosis becomes better the soon the disorder is diagnosed and treatment can begin.

If the symptoms are severe, a person may be admitted into a hospital to try and treat brief psychotic disorder. Other than this, psychotherapy and medications are used often. Psychotherapy is a method used to help the patient deal with, or cope with the disorder and learn how to handle the stressor that signaled it. The medications that are given to the patients are called anti-psychotic drugs. The anti-psychotic drugs help decrease the symptoms of brief psychotic disorder and also may eliminate the symptoms.

Delusional Disorder (297.1)

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DSM-IV-TR criteria

- A. Non-bizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, deceived by spouse or lover, or having a disease) of at least 1 month's duration.
- Symptoms include:
 - Nonbizarre delusions for at least one month.

- image Absence of obviously odd or bizarre behavior.
- image [Schizoaffective Disorder](#) and [Mood Disorder](#) with Psychotic Features have been ruled out.
- image Absence of evidence that an organic factor initiated and maintained this psychotic disturbance.
- image Absence of prominent hallucinations of a voice for at least one week. Absence of visual hallucinations for at least one week.
- image Has never met the criteria for the active phase of [Schizophrenia](#).

Subtypes

- B. Criterion A for Schizophrenia has never been met.
 - *Note: Tactile and olfactory hallucinations may be present in Delusional Disorder if they are related to the delusional theme.
- C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and behavior is not obviously odd or bizarre.

- D. If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods.
- E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
- Specify type (the following types are assigned based on the predominant delusional theme):
 - 1. Erotomaniac Type: delusions that another person, usually of higher status, is in love with the individual.
 - 2. Grandiose Type: delusions of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.
 - 3. Jealous Type: delusions that the individual's sexual partner is unfaithful.
 - 4. Persecutory Type: delusions that the person (or someone to whom the person is close) is being malevolently treated in some way.
 - 5. Somatic Type: delusions that the person has some physical defect or general medical condition.
 - 6. Mixed Type: delusions characteristic of

more than one of the above types but no one theme predominates.

- 7. Unspecified Type

Associated features

People with Delusional Disorder often appear to be very “normal” and function in many areas of their life without any difficulty. Others such as family members, coworkers, or doctors are more likely to see a problem than the person themselves.

The person with Delusional Disorder may develop a particular mood in reaction to their delusion, such as gloomy, irritated, extreme anger, or violence. One may go for unnecessary medical tests on a regular basis.

According to Kendler and Manschreck, associated factors include being married, being employed, recent immigration, low socioeconomic status, celibacy among men, and widowhood among women (Kendler, 1982; Manschreck, 2000).

Child vs. adult presentation

The onset of this disorder ranges from adolescents to adulthood but appears more frequently later in life.

The age of onset ranges from 18 to 90 and the mean onset is around 40.

Gender and cultural differences in presentation

There is no specific culture that presents with Delusional Disorder more than any other culture.

Overall, there are no obvious gender differences with Delusional Disorder.

The ratio for males to females with the disorder is about 1:1; however, some delusion types such as Jealous Type can be seen more commonly in men than in women.

Typically, there is an excess of women with the disorder.

Epidemiology

An uncommon disorder, the prevalence of delusional disorder in the United States is estimated in the DSM-IV-TR to be around 0.03%.

The age of onset can range anywhere from 18-90 years, with an average of about 40 years.

Etiology

Many factors seem to play a part in the etiology of this disorder, but a clear etiology is unknown. Because it is generally difficult to diagnose this disorder and those with this disorder do not often seek treatment, the etiology has not been extensively studied.

However, there are several theories as to what causes this disorder including genetic/biological factors, cognitive processing errors, or defensive delusions.

In studies that have been conducted, it has been shown

that those persons with relatives with delusional disorder have higher rates of the disorder, suggesting that a genetic factor might play a part.

Additionally, persons with this disorder may have distorted views of people and life, which can lead to delusional interpretations of daily events.

Empirically supported treatments

Treatment for Delusional Disorder often involves both biological therapy, such as medications, as well as psychotherapy.

Medicinal treatments may involve anti-psychotics and antidepressants such as SSRI and Clomipramine. Agitation, a state of frantic activity experienced with anger or fearfulness can occur from some of these medications. When this situation occurs, haloperidol can be given.

Psychotherapy treatments involve supportive therapy and cognitive therapy.

Treatment should be explored and implemented on a case by case basis, as each client is unique and needs an individualized treatment. Combining the medications with cognitive therapy is generally the best solution.

Links

- [What is Delusional Disorder?](#)

Schizophrenia Undifferentiated Type

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DSM criteria

A type of Schizophrenia in which symptoms that meet Criterion A are present, but the criteria are not met for the Paranoid, Disorganized, or Catatonic Type.

- Criterion A
 - delusions
 - hallucinations
 - disorganized speech (e.g., frequent derailment or incoherence)

- grossly disorganized or catatonic behavior
- negative symptoms (e.g., affective flattening, alogia, or avolition)
- * Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

Links

- [A Young Lady with Major Depressive Disorder finds relief](#). She also was diagnosed with Undifferentiated Type as well as a child.

Major Depressive Disorder (296.xx)

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DSM-IV-TR criteria

296.2x Major Depressive Disorder, Single Episode

- A. Presence of a single Major Depressive Episode and a Unipolar disorder.
- B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode. NOTE: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.
- It is important to maintain a healthy lifestyle to avoid major depressive disorder in the following: avoid drugs and alcohol, eat well balanced meals, get regular sleep and exercise, and seek supportive relationships. This might seem like simple tasks to obtain, but for many each one might be an obstacle.
- If the full criteria are currently met for a Major Depressive Episode, specify its current clinical status and/or features:

Abnormal Psychology

- Mild, Moderate, Severe Without Psychotic Features/Severe With Psychotic Features
 - Chronic
 - With Catatonic Features
 - With Melancholic Features
 - With Atypical Features
 - With Postpartum Onset
- Beck's Depression Scale Inventory or other screening tests for depression can be helpful in making the diagnosis. More information available at: [Beck's Depression Scale](#)
 - If the full criteria are not currently met for a Major Depressive Episode, specify the current clinical status of the Major Depressive Disorder or features of the most recent episode:
 - In Partial Remission, In Full Remission
 - Chronic
 - With Catatonic Features
 - With Melancholic Features
 - With Atypical Features
 - With Postpartum Onset

296.3x Major Depressive Disorder, Recurrent

- A. Presence of two or more Major Depressive Episodes
 - NOTE: To be considered separate episodes, there must be an interval of at least 2 consecutive months in which criteria are not met for a Major Depressive Episode.
- B. The Major Depressive Episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode. NOTE: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.
- If the full criteria are currently met for a Major Depressive Episode, specify its current clinical status and/or features:
 - Mild, Moderate, Severe Without Psychotic Features/Severe With Psychotic Features

- Chronic
- With Catatonic Features
- With Melancholic Features
- With Atypical Features
- With Postpartum Onset
- If the full criteria are not currently met for a Major Depressive Episode, specify the current clinical status of the Major Depressive Disorder or features of the most recent episode:
 - In Partial Remission, In Full Remission
 - Chronic
 - With Catatonic Features
 - With Melancholic Features
 - With Atypical Features
 - With Postpartum Onset
- Specify:
 - Longitudinal Course Specifiers (With and Without Interepisode Recovery)
 - With Seasonal Pattern

Associated features

Most people complain most about a sad mood that won't go away. People that have MDD, experience a low mood over several days or weeks. Some of the symptoms are: depressed

mood, loss of interest in pleasurable activities, change in appetite, insomnia, psychomotor retardation, and sense of worthlessness or guilt, problems with clear thinking or concentration, thoughts of death or suicide, etc. "Depressed children often display an irritable rather than a depressed mood, and show varying symptoms depending on age and situation. Most show a loss of interest in school and a decline in academic performance. They may be described as clingy, demanding, dependent, or insecure. Diagnosis may be delayed or missed when symptoms are interpreted as normal moodiness." The appetite tends to fluctuate. Individuals with this disorder may engage in "comfort eating," and thus gain weight. The comfort foods they choose are easy to eat and are often addictive.

Major Depressive Disorder often co-exists with other disorders. [The National Comorbidity Survey](#) reports that 51% of people with MDD also suffer from anxiety. Anxiety symptoms can delay recovery, have an increased risk of relapse and an increase in suicide attempts. Also, increased reports of alcohol and drug abuse exist. Attention Deficit Hyper-activity Disorder and Post Traumatic Stress Disorder are also often comorbid with MDD. Anhedonia is often expressed which means a significantly decreased interest or pleasure in all activities most of the day. The change in appetite is usually varies from significant weight gain, a considerable decrease in food consumption, or everyday variation basis.

Child vs. adult presentation

- In childhood, boys and girls can be equally affected. But in adolescence and adulthood, it occurs twice as often in women than in males.
- The symptoms are the same in children and adults but the characteristic of the symptoms change.
- Children are usually associated with irritability and social withdrawal.
- Elderly are usually associated with disorientation, memory loss, and distractibility.

Gender and cultural differences in presentation

- It affects all races.
- Latinos and Mediterranean cultures complain about nerves and headaches.
- Chinese and Asian cultures complain about weakness, tiredness, or imbalance.
- Middle Eastern cultures complain about problems of the heart or heartbreak.

Epidemiology

MDD is a very common condition. In the United States, 17.1% of people will experience at least one episode of MDD in their lifetime. Worldwide, it ranges from about 8–12%. Only 4.9% of the general population actually meets the

DSM-IV criteria to be diagnosed with MDD. It is known to happen more to women than in men for reasons that are unknown. Before puberty, there is really no difference between the prevalence in males and females. It is documented that people commonly develop MDD in their late adolescence or early adulthood.

The lifetime prevalence for men and women vary in the general population. For women it is 10% to 25% and for men it is 5% to 12%. The prevalence rates are not prejudice in any way. It affects all races, sex, education, and income levels.

Etiology

Major Depressive Disorder seems to be highly inheritable. Researchers have studied twins, and found strong genetic influence in depression. Identical twins that were raised in the same environment have about a 50% chance of both developing depression whereas, fraternal twins that were raised in the same environment only have about a 20% chance of developing depression. Adoption studies have also been influences in determining whether depression is genetic. Researchers have found that children of depression are more susceptible to depression even when adopted. Environmental factors have also been known to influence depression. Early stressful life events can make children more prone to developing depression later on in life. Such as losing a parent, sibling or relative or parents getting divorced, etc. Other environmental factors include low socioeconomic status and/or frustrating or unpleasant relationships.

Empirically supported treatments

Successful treatment of patients with major depressive disorder is promoted by a complete assessment of the patient. Treatment generally consists of three phases: an acute phase, a continuation phase, and a maintenance phase. Psychiatrists treating patients suffering from this disorder often use a variety of medications, psychotherapeutic approaches, electroconvulsive therapy, and other treatments methods, such as light therapy. Regardless of the specific treatment selected, it is important that the patient is provided with psychiatric management throughout each phase of the treatment.

Medications include tricyclic antidepressants, monoamine oxidase inhibitors, selective serotonin re-uptake inhibitors (SSRIs), and some newer antidepressant drugs. Although antidepressant medications can be very effective, some may not be appropriate for everyone. For example, in 2007, the FDA proposed that all antidepressant medicines should warn of the risk of suicidal behavior in young adults ages 18 – 24 years. Lithium and thyroid supplements may be needed to enhance the effectiveness of antidepressants. People with psychotic symptoms, such as delusions or hallucinations, may need antipsychotic medications.

Antidepressant medications are often used as an initial primary treatment for mild major depressive disorder and psychotherapy alone is also used as an initial treatment for patients with mild to moderate major depressive disorder. A combination of psychotherapy and medication may also be

used as an initial treatment for patients with psychosocial issues, interpersonal problems or a comorbid axis II disorder with moderate to severe major depressive disorder. Most people benefit with a combination of the two treatments. Lastly, electroconvulsive therapy can be used for patients with major depressive disorder with a high degree of severe symptoms or in patients in which psychotic symptoms or catatonia are present.

Most Recent Episode Depressed

- Draft Criteria for Bipolar I Disorder– Retain structure, with changes limited to the definitions of mood episodes that define each.

Diagnostic criteria for Bipolar I Disorder, Most Recent Episode Depressed

1. Currently (or most recently) in a Major Depressive Episode (see [Criteria for Major Depressive Episode](#)).
2. There has previously been at least one Manic Episode (see [Criteria for Manic Episode](#)).
3. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Specifiers and/or current features have not yet been reviewed by the Workgroup for bipolar disorder. It is anticipated that specifiers and/or features that apply across the mood disorders will be consistent across major depression and bipolar disorder. The bipolar specific rapid cycling specifier is under review to consider whether to keep as is, eliminate, or modify the Bipolar Subworkgroup will maintain whatever definition of MDE is finalized by the MDD Subworkgroup, with the exception that our review of the literature suggests the need to recognize the subgroup of those with MDE and mixed (i.e. manic/hypomanic) features.

Links

- <http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=6&hid=13&sid=baf65d19-fe39-421e-b023-99de13dbbeb0%40sessionmgr12>
- <http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=7&hid=13&sid=baf65d19-fe39-421e-b023-99de13dbbeb0%40sessionmgr12>
- NIMHgov: Depression – <http://www.youtube.com/watch?v=mlNCavst2EU>

Additional Information

Finding of this study was that there does appear to be a discernable prodromal phase to depressive episodes as well as several symptoms that appear to be common to the depressive prodrome across individuals (Iacoviello, Alloy, Abramson, &

Choi, 2010). A prodromal phase is a clear deterioration in function before the active phase of a mental disturbance. It is not caused by a disorder in mood or a psychoactive substance and includes some residual phase symptoms (Iacoviello, et al., 2010). There were seven symptoms that were included: sad mood, decreased interest in or pleasure from activities, difficulty concentrating, hopelessness, worrying/brooding, decreased self-esteem, and irritability. These symptoms tended to be present in the prodromal phase and also could serve as warning signs that lead to an acute episode of depression (Iacoviello, et al., 2010).

[Cognitive behavioral therapy](#) is an empirically supported type of treatment that focuses on maladaptive ways of thinking and why people think the way they do (Warman & Beck, 2003). Cognitive behavioral therapy is said to be a successful form of treatment for individuals with major depressive disorder.

- In a study by Carlbring and colleagues (2009) conducted a study using an online form of cognitive behavioral therapy and results indicate that cognitive behavioral therapy is an effective type of treatment for individuals suffering from major depressive disorder when therapist interaction, through email and other forms of communication, was involved. Individuals participating in this study rated therapists on several different measures and results concluded that when asked about life satisfaction, all

participants showed improvement which was shown by significant amounts of clustering of therapists data. This study is an example of how cognitive behavioral therapy can be effective is combined with communication to help individuals with major depressive disorder.

- Research conducted by de Graaf, Hollon, and Huibers (2010) examined the short-term improvements of individuals with depression who used computerized cognitive behavioral therapy as a treatment for their depression. Individuals were divided into three groups; one group used the computerized cognitive behavioral approach only, the second used both CBT and regularly prescribed treatments, and the third group only used regular treatments. Results indicated that after 12 months, those individuals with high optimism improved using only the CBT approach, while those needing more support improved using both CBT and regular treatment. In most instances, individuals with mild to moderate depression gain the most benefits from cognitive behavioral therapies, but it is possible in some cases for individuals with severe depression to also benefit from computerized cognitive behavioral therapy. This research provides an example of the effective use of cognitive behavioral therapy as a means to improve symptoms of people suffering from depression.

- Stuhlmiller and Tolchard (2009) make the argument, in their research, that computerized cognitive behavioral therapy is just as effective as other forms of cognitive behavioral therapies, but is less expensive, easy to teach, and more readily accessible to patients. Using technology and other tools that are easily accessible to individuals suffering from depression may result in cognitive behavioral therapy being more beneficial and used by more individuals.
- According to Jungbluth and Shirk (2009), incorporating cognitive behavioral therapy in group counseling sessions that consist of adolescents with treatment-resistant depression, may result in several positive outcomes. Conclusions from research indicate that patient involvement and overall social functioning both show improvements as result of a cognitive behavioral approach. Research conducted by Matsunaga and colleagues (2010) also supports the results from the previous study that cognitive behavioral therapy can improve social functioning when added to a treatment plan for individuals with treatment-resistant depression.
- Another study conducted by Kennard and colleagues (2009) also explored the effects of cognitive behavioral therapy in adolescents with depression. This particular research examined the

effects of combining cognitive behavioral therapy with a medication regimen versus treatment using only medication. Early results reveal that when medication and cognitive behavioral approaches are combined, social skills and problem-solving are positively affected and improvements are made. Using cognitive behavioral approaches, in addition to medication, will hopefully lead to positive long-term benefits and reduce possible recurring depression in adult life.



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Dysthymic Disorder (300.4)

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DSM-IV-TR criteria

- A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years. NOTE: In children and adolescents, mood can be irritable and duration must be at least 1 year. The individual must have been depressed for at least 22 months during the past 2 years. This type of disorder is classified as unipolar, where there is only severe depression.

- B. Presence, while depressed, of two (or more) of the following:
 - poor appetite or overeating
 - insomnia or hypersomnia
 - low energy or fatigue
 - low self-esteem
 - poor concentration or difficulty making decisions
 - feelings of hopelessness
- C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.
- D. No Major Depressive Episode has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, In Partial Remission.
 - NOTE: There may have been a previous Major Depressive Episode provided there was a full remission (no significant signs or symptoms for 2 months) before development of the Dysthymic Disorder, there may be superimposed episodes of

Major Depressive Disorder, in which case both diagnoses may be given when the criteria are met for a Major Depressive Disorder

- E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder.
- F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.
- G. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Specify If:
 - Early Onset: if onset is before age 21 years
 - Late Onset: if onset is age 21 years or older

Specify (for most recent 2 years of Dysthymic Disorder):

- With Atypical Features

Associated features

Many of the associated features of Dysthymic Disorder are similar to features of Major Depressive Disorder. Changes in sleep patterns, appetite, significant weight gain or loss, and psychomotor symptoms are seen less than in those patients with Major Depressive Disorder. Some of the most common symptoms to be associated with Dysthymic Disorder are feelings with inadequacy; social withdrawal; general loss of interest or pleasure; feelings of guilt or brooding about the past; excessive anger; decreased activity; productivity; or effectiveness. Around 75 percent of people who develop Dysthymic Disorder without ever having Major Depressive Disorder will develop Major Depressive Disorder within the next five years. Problems can occur when treatment becomes necessary, as the individual at that time may have become so accustomed to his depressed mood, he may not see anything that needs discussing. Some researchers say that the studies show that the spontaneous remission rate for Dysthymic Disorder could be as low as 10%. Some evidence found over the last ten years suggests that the with active treatment the plausible outcome is significantly increased (meaning there is a higher chance of a spontaneous recovery.) Dysthymic Disorder is often comorbid with Borderline, Histrionic, Narcissistic, Avoidant, and Dependent personality disorders in adults. In children, it can be comorbid with Attention Deficit/Hyperactive Disorder, Conduct Disorder, Anxiety Disorders, Learning Disorders, and Mental Retardation.

Child vs. adult presentation

In children, Dysthymic Disorder occurs consistently equal in both sexes. Both Children and adolescents, who have Dysthymic Disorder, display moods of irritability, crankiness, and depression. These attributes of Dysthymic Disorder usually impair the individual's school performance and most social interaction. Children who display Dysthymic Disorder also show to have low self esteem, tend to be pessimistic and, have poor social skills. Most patients with dysthymia recall having feelings of unhappiness during their childhood but do not know why. First onset occurs during adolescence or early adulthood. Some people that develop dysthymia do not get treated if it occurs during adolescence because they do not know happiness, and they believe that is just the way life is. Symptoms in children may present as feelings of irritability rather than being depressed, and these symptoms only need occur for one year.

Gender and cultural differences in presentation

Women are 2 to 3 times more likely to develop this disorder. However, before puberty and after menopause, men and women are affected about the same. Females outnumber males 2:1 during childbearing years. Little research has been done to show differences between races, however, it is more common among African Americans and Mexican Americans.

Epidemiology

Dysthymic disorder, lifetime prevalence for many people, affects about 6% of the general population. In a year, about 3% of the general population has this disorder.

Etiology

The cause of dysthymia is unclear but there are several factors that may cause it. They are

- Genetic predisposition
 - Dysthymic Disorder is most prevalent among first-degree biological relatives of people with Major Depressive Disorder or Dysthymic Disorder than people out in the general population.
- Biological factors
- Chronic stress
- Chronic medical illness
- Psychosocial factors, such as isolation, loss

Empirically supported treatments

There has been little research conducted on Dysthymic Disorder. Medications that are used to treat Dysthymic Disorder have originated from studies that studied Major Depressive Disorder. Dysthymic Disorder is a milder but longer lasting form of Major Depressive Disorder.

Researchers have carried over the findings from the studies of Major Depressive Disorder to Dysthymic Disorder. Furthermore this treatment taken from Major Depressive Disorder has been shown to be very effective in treating and managing Dysthymic Disorder. The most effective treatments that have shown success are as follows: antidepressants, MAOI, and SSRI antidepressants. The only other treatments that have been found to be effective in the fight against Dysthymic Disorder are supportive psychotherapy and psychoeducation. This helps the patient and the patient's family to understand the illness, helps improve the patient's compliance and allows the family to be more cooperative with their loved one's recovery. Cognitive therapy is used to change the pessimistic ideas. It also helps a person realize which problems are truly problems and which ones are minor. Problem solving helps individuals identify which areas of life need to be changed so one can better cope with this disorder instead of sustain it.

Additional Information:

Dysthymia is a milder form of major depression. Periods of feeling normal can last up to a couple of months but usually go back to feelings of depression (2009). People who are diagnosed with this disorder before age 21 tend to have a higher rate of developing a personality disorder (2009). Dysthymic symptoms can often go unnoticed so this population becomes untreated as well. Some medical conditions, including neurological disorders (such as multiple

sclerosis and stroke), hypothyroidism, fibromyalgia, and chronic fatigue syndrome, are associated with dysthymia. Investigators believe that, in these cases, developing dysthymia is not a psychological reaction to being ill but rather is a biological effect of these disorders (2009). People who have recently encountered a high level of stress such as losing a spouse or divorce can increase the risk for dysthymia (2009).

Bipolar I Disorder (296.xx)

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image

Manic Depressive (referred to Bipolar Disorder)

DSM-IV-TR criteria

The required criterion for the disorder dictates that the afflicted individual must have at least one manic episode in their life time. Mania is often followed by periods of depression. There is a cyclic nature about the illness. Individuals will fluctuate between episodes of depression and mania; hence the original label “manic depressive.” Although,

it should be noted there are periods of normalcy between each episodes, where individuals are able to function. Onset of the disorder often develops in late teens to early twenties. Nearly all individuals with the disorder develop it before age 50.

Manic episodes can manifest themselves as either irritability or euphoria.

Diagnostic criteria for 296.0x Bipolar I Disorder, Single Manic Episode

- A. Presence of only one Manic Episode...and no past major Depressive Episodes.
 - Note: Recurrence is defined as either a change in polarity from depression or an interval of at least 2 months without manic symptoms.
- B. The Manic Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- Specify if:
 - Mixed: if symptoms meet criteria for a Mixed Episode...
- Specify (for current or most recent episode).
 - Mild, moderate, severe without psychotic

features or severe with psychotic features.

- With Catatonic Features.
- With Postpartum Onset.
- Specify the current clinical status of the bipolar I disorder or features of the most recent episode if the full criteria are not currently met for a manic, mixed, or major depressive episode.
 - In partial or full remission
 - With catatonic features
 - With postpartum onset

Diagnostic criteria for 296.40 Bipolar I Disorder, Most Recent Episode Hypomanic

- A. Currently (or most recently) in a Hypomanic Episode
- B. There has previously been at least one Manic Episode or Mixed Episode
- C. The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The mood episodes in Criteria a and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

- Specify:
 - Longitudinal Course Specifiers (With and Without Interepisode Recovery)...
 - With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes)...
 - With Rapid Cycling.

Diagnostic criteria for 296.4x Bipolar I Disorder, Most Recent Episode Manic

- A. Currently (or most recently) in a Manic Episode...
- B. There has previously been at least one Major Depressive Episode..., Manic Episode..., or Mixed Episode...
- C. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- Specify
 - Longitudinal Course Specifiers (With and Without Interepisode Recovery)...
 - With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes)...
 - With Rapid Cycling...

Diagnostic criteria for 196.6x Bipolar I Disorder, Most Recent Episode Mixed

- A. Currently (or most recently) in a Mixed Episode...
- B. There has previously been at least one Major Depressive episode..., Manic Episode..., or Mixed Episode...
- C. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- Specify (for current or most recent episode):
 - Severity/Psychotic/Remission Specifiers...
 - With Catatonic Features...
 - With Postpartum Onset...
- Specify:
 - Longitudinal Course Specifiers (With and Without Interepisode Recovery)...
 - With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes)...
 - With Rapid Cycling...

Diagnostic criteria for 296.5x Bipolar I Disorder, most

Recent Episode Depressed

- A. Currently (or most recently) in a Major Depressive Episode...
- B. There has previously been at least one Manic Episode or Mixed Episode
- C. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- Specify (for current or most recent episode)
 - Severity/Psychotic/Remission Specifiers...
 - Chronic...
 - With Catatonic Features...
 - With Melancholic Features...
 - With Atypical Features...
 - With Postpartum Onset...
- Specify:
 - Longitudinal Course Specifiers (With and Without Interepisode Recovery)...
 - With Seasonal Pattern (applies only to the pattern of major Depressive Episodes)...
 - With Rapid Cycling...

Associated features

- Suicide is very prevalent in individuals with bipolar I disorder. It is thought that somewhere between 10 and 15% of bipolar patients will actually complete suicide; many more may attempt it. Those with bipolar I are more at risk to have an alcohol or other substance use/abuse problem, and this can lead to a worse course for their bipolar disorder. They may also show violent behaviors during the course of their disorder.
- Many problems are associated with bipolar I disorder. Violent behaviors could include child abuse, spouse abuse, or other worse violent actions. Problems with school such as truancy or failure are common, and later in life occupational success is also very difficult to attain or maintain. Episodic antisocial behaviors may also present themselves in bipolar I individuals. Maintaining stable relationships is also a problem for individuals with bipolar I disorder, and divorce is common.
- A person with Bipolar Disorder will resist treatment.
- Include mood lability and depressive symptoms that may last moments or minutes or days.

Child vs. adult presentation

- 10% to 15% of adolescents with recurrent Major depressive episodes will develop Bipolar I disorder. Mixed episodes occur most often in adolescents and young adults.
- Bipolar disorder in children:

<http://www.youtube.com/watch?v=2OfNPiZz3Lw>image

Gender and cultural differences in presentation

- There has not been a reported difference in race or ethnicity and the presence of bipolar I. Some clinicians believe that bipolar I disorder is over-diagnosed in some ethnic groups and in younger individuals.
- Gender affects the order of which the disorder appears. Males are more likely to have manic episodes first. Women are most likely to have major depressive disorder first.
- It is equally common in men and women, even though they initially display symptoms differently.
- Manic episodes in men usually occur much more than major depressive episodes; in women, the major depressive episodes occur more frequently.
- The different episodes may be intensified in women during the premenstrual period.

- Rapid cycling is more common in women.
- The course of BD illness may be worse among African American patients, who are more likely to have attempted suicide and been hospitalized than white patients.
- African American adolescents with bipolar disorder are treated for longer periods with atypical antipsychotics than Caucasian adolescents, even after adjusting for the severity of psychotic symptoms.

Epidemiology

- Bipolar Disorder 1 is common in the United States with a lifetime prevalence between 0.4 and 1.6%. Initial onset of Bipolar 1 is between age 15 and 24. When properly diagnosed and treated, Bipolar Disorder 1 often has a remission period of 5 years. After 5 years a recurrence is common.

Etiology

- First degree biological relatives have a higher chance of getting this disorder from their relatives that have it. They have a 4% to 24% chance of getting it.
- Tests were done and twin and adoption studies show strong evidence of a genetic influence.

- Estimates of the heritability of BD range from 59% to 87%. A review of studies indicated that the concordance rates for monozygotic twins average 57%, whereas the concordance rate for dizygotic twins averages 14%.
- The risk of BD among children of bipolar parents is four times greater than the risk among children of healthy parents.

Empirically supported treatments

- The usual treatment for Bipolar I Disorder is lifelong therapy with a mood-stabilizer (either lithium, carbamazepine, or divalproex / valproic acid) often in combination with an antipsychotic medication.
- In mania, an antipsychotic medication and/or a benzodiazepine medication is often added to the mood-stabilizer.
- In depression, quetiapine, olanzapine, or lamotrigine is often added to the mood-stabilizer.
- Combination of supportive psychotherapy, psychoeducation, and the use of a mood-stabilizer.

Single Manic Episode- for the DSM-V

Draft Criteria for Bipolar I Disorder

- Retain structure, with changes limited to the

definitions of mood episodes that define each.

Diagnostic criteria for Bipolar I Disorder, Single Manic Episode

- A. Presence of only one Manic Episode (see Criteria for Manic Episode) and no past Major Depressive Episodes. Note: Recurrence is defined as either a change in polarity from depression or an interval of at least 2 months without manic symptoms.
- B. The Manic Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Specifiers and/or current features have not yet been reviewed by the Workgroup for bipolar disorder. It is anticipated that specifiers and/or features that apply across the mood disorders will be consistent across major depression and bipolar disorder. The bipolar specific rapid cycling specifier is under review to consider whether to keep as is, eliminate, or modify.

Links

- Washington Post journalist, [Pete Early talks about trying to get his son properly diagnosed and treated for Bipolar Disorder](#). His difficult

experience trying to understand the nation's mental health system led him to write: *Crazy: A Father's Search Through America's Mental Health Madness*.

- [Bipolar Treatment](#)

Both bipolar and unipolar disorders are said to be heritable. Pathological disturbances of mood may follow a 'bipolar' course, where normal moods may fluctuate between mania and depression or in a 'unipolar' course will be only depressive moods. These disorders could be heritable based on the factors of neurochemical, neuroendocrine, and automatic abnormalities. The basis for these abnormalities has not been established. Bipolar disorder can skip a generation in most cases.

Additional Information

The number of children and adolescents of being diagnosed with bipolar disorder is increasing. Along with the over diagnosis, the children and teens are being over treated with medications as well. Atypical antipsychotics have been diagnosed, and some are proven as an effective treatment for bipolar disorder (Singh, Ketter, & Chang, 2010). "The efficacy of an atypical antipsychotic is defined in terms of treatment response rates or remission of illness. Response rates are commonly reported as a change in a symptom score as determined by clinical assessments of mania from baseline to endpoint. The Young Mania Rating Scale (YMRS) is a

commonly used validated instrument to determine the degree of manic symptomatology (Singh, et al., 2010).” Olanzapine is used for the treatment of manic or mixed episodes in Bipolar I disorder, usually in adolescents 13 to 17 years old. The findings indicated that weight gain might be a possibility and outweigh the benefits of the drug (Singh, et al., 2010). “In 2007, risperidone became the first atypical antipsychotic to receive FDA approval as monotherapy for short-term treatment of acute manic or mixed BD episodes in youths aged between 10 and 17 years (Singh, et al., 2010).” This drug does indicate weight gain therefore physicians need to monitor the patients every six months.

Lithium was studied to determine the relevancy of the drug in cases of severe manic episodes and other disorders related to the manic episodes such as bipolar. Lithium is a relevant drug in the treatment of moderate to severe manic episode, with an efficacy similar to those of most other compounds (Storosum, Wohlfarth, Schene, Elferink, Van Zwieten, & Brink, 2007). The justification of lithium as a first-line treatment of the algorithm in the treatment of manic episode, however, does not only depend on the magnitude of effect in placebo-controlled studies but also on other short- and long-term efficacy and safety considerations (Storosum, et al., 2007). Nevertheless, the results from our meta-analysis may contribute to the discussion about the place of lithium in the treatment of manic episode (Storosum, et al., 2007).

Bipolar disorder (BP) is a debilitating mental illness that affects a significant number of individuals. In this study, there

are differences found between mixed versus manic bipolar disorder (Shah, Averill, & Shack, 2004). The primary diagnostic feature, according to DSM-IV criteria (1), is a distinct period of abnormally and persistently elevated, expansive or irritable mood lasting for at least one week. In addition, at least three of the following symptoms are present: grandiosity, decreased need for sleep, pressured speech, and flight of ideas, distractibility, hyperactivity, or risk taking behavior (Shah, et al., 2004). Subsets of BP patients are diagnosed with mixed episodes (BPX). These individuals meet the criteria for both a manic and a major depressive episode; however, the depressive symptoms need only to be present for one week. Individuals who develop BPX have a more inconsistent pattern in age of onset than those with BPM (manic bipolar). Among individuals with BPM, no gender differences have been reported in number of manic episodes; however, women were more likely to be hospitalized (Shah, et al., 2004). Among males with BP, their first episode is more likely to be manic, whereas women are more likely to experience a depressive episode. Men tend to be more hyperactive, grandiose, and to engage in risky behavior, and women tend to report more racing thoughts and distractibility. Studies report mixed findings regarding co morbid substance abuse, with either women or men being found to have more substance-related co morbidity (Shah, et al., 2004). Those diagnosed with BPX are more likely to be women and they tend to have a greater number of depressive symptoms during manic episodes. The most common co-

morbidity is substance abuse, followed by anxiety disorders and eating disorders. Co-morbid substance abuse is more common among adolescents and among individuals diagnosed with BPX (Shah, et al., 2004). Although there are differences shown, these disorders also have similarities.

Several people wonder if there are differences between child and adult onset of bipolar disorder. The pediatric bipolar disorder is different from the adult by classifying nine symptom classes. Firstly there is elated mood, defined by silliness, giddiness and feeling invincible. Children in this state are easily overwhelmed, and their affect may oscillate quickly from excitation to a state of anxious distress (Bradfield, 2010). Secondly, irritable mood (one of the cardinal features of pediatric bipolar disorder) manifests in aggressive, hostile behaviors with intense, inconsolable responses to stressors (Bradfield, 2010). Inflated self-esteem or grandiosity is the next category of reported symptoms. The child may make unsupportable statements such as “I am the cleverest boy in the whole world”, or “The teachers could learn a few lessons from me”. A decreased need for sleep is evident in children with bipolar mood disorder (Bradfield, 2010). They awaken from little sleep, feeling refreshed and energized. Pressure of speech is noted, with children constantly talking, dominating the interpersonal space, and seeking attention by being excessively entertaining. Constant goal-directed activity is observed as a central feature. Children may be overwhelmed by a frenzy of activity, with aims to achieve unrealistic goals. The constant search for

pleasurable activities is also observed, a feature that often manifests in children showing little awareness of the social surroundings (Bradfield, 2010) . The emergence of depression in children living with bipolar disorder is age-specific in its manifestation. Depressed children may report feeling “crabby”; their parents may describe “excessive whining” in the child; they may cry for no apparent reason, withdraw and isolate themselves, exhibit fluctuations in mood from irritability to tearfulness, and may engage in minor self-injurious behaviors such as skin-pinching (Bradfield, 2010). These children may develop a painful sensitivity to rejection, due to the incongruity of their behaviors compared with their peers. The final category of symptoms in bipolar children relates to the psychotic spectrum. Children presenting what could be called an atypical mania could exhibit auditory and visual hallucinations, usually in relation to mood-congruent delusions of grandiosity (Bradfield, 2010). In terms of thought form, the significance of flight of ideas, spontaneously, and excessive speed and production of thoughts has been noted (Bradfield, 2010).

The following can be considered as red flags pointing to heightened risk: Firstly, people with Bipolar Mood Disorder who have a family history of suicidal behaviour are more likely to attempt suicide than those who do not (Bradfield, 2010). Secondly, a history of physical or sexual abuse is positively correlated with suicide attempts. These two factors must be seen in combination with the specific clinical presentation of the bipolar child (Bradfield, 2010). The

majority of people with Bipolar Mood Disorder who attempt suicide frequently present with mixed manic states, multiple depressive episodes, co-morbid anxiety or panic disorders and/or substance abuse or dependence (Bradfield, 2010). Furthermore, children presenting with a history of mixed episodes as well as concurrent psychotic symptoms are more likely to evince suicidal ideation (Bradfield, 2010). The treatment of children with psychiatric medication is a sensitive process that requires nuanced judgements and considers each child in relation to his/her development (Bradfield, 2010).

Bipolar II Disorder (296.89)

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DSM-IV-TR criteria

- A. Presence (or history) of one or more Major Depressive Episodes.
- B. Presence (or history) of at least one Hypomanic Episode.
- C. There has never been a Manic Episode or a Mixed Episode.
- D. The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective

Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

- E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Specify current or most recent episode:
 - Hypomanic: if currently (or most recently) in a Hypomanic Episode
 - Depressed: if currently (or most recently) in a Major Depressive Episode
- If the full criteria are currently met for a Major Depressive Episode, specify its current clinical status and/or features:
 - Mild, Moderate, Severe Without Psychotic Features/Severe With Psychotic Features
 - NOTE: Fifth-digit codes cannot be used here because the code for Bipolar II Disorder already uses the fifth digit.
 - Chronic
 - With Catatonic Features
 - With Melancholic Features

- With Atypical Features
- With Postpartum Onset
- If the full criteria are not currently met for a Hypomanic or Major Depressive Episode, specify the clinical status of the Bipolar II Disorder and/or features of the most recent Major Depressive Episode (only if it is the most recent type of mood episode):
 - In partial remission, In Full Remission
 - NOTE: Fifth-digit codes cannot be used here because the code for Bipolar II Disorder already uses the fifth digit.
 - Chronic
 - With Catatonic Features
 - With Melancholic Features
 - With Atypical Features
 - With Postpartum Onset
- Specify:
 - Longitudinal Course Specifiers (With and Without Interepisode Recovery)
 - With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes)
 - With Rapid Cycling

Associated features

Suicide is also a risk for individuals with bipolar II disorder. Completion rates are somewhere between 10 and 15 percent, although many more may attempt it. Like bipolar I, issues with school and careers are also present. Truancy or failure in school and occupational failure are common. Divorce is also very common in bipolar individuals. Bipolar II is often comorbid with Substance Abuse or Dependence, Anorexia Nervosa, Bulimia Nervosa, Attention Deficit/Hyperactivity Disorder, Panic Disorder, Social Phobia, and Borderline Personality Disorder.

Individuals with bipolar 2 disorders tend to have some creativity. A large number of people with bipolar 2 are well involved in art. Also individuals with bipolar 2 disorders are characterized as outgoing and more daring than people without bipolar 2 disorders.

Child vs. adult presentation

Bipolar 2 disorder is often more severe, more chronic, and more rapid cyclers in children versus adults. Bipolar 2 is very uncommon late in life. However, neurologic impairment can be associated with some older adults. Furthermore, adolescents are confined more to substance abuse with bipolar 2 than with their counterparts.

Gender and cultural differences in presentation

- In general, bipolar disorders are equally in both

men and women. However, women may actually be more at risk than men. Women are known to have more rapid episodes than males. The average age for bipolar 2 disorder is age 22 and it is uncommon after the age of 40. Also with bipolar disorders, in general, women tend to report experiences of depression first whereas men report experiencing mania.

- Men have predominately Hypomanic Episodes, and women have mainly Major Depressive Episodes.
- Women with Bipolar II Disorder may have an increased risk of developing episodes in the postpartum period.

Epidemiology

- The average lifetime prevalence rate for Bipolar II Disorder is approximately 0.5 percent.
- The average age for children with bipolar 2 disorder is 10 which is found in 0.3%-0.5% of patients. Bipolar 2 disorder is less common in older adults.

Etiology

Genetics play a big factor of people with bipolar 2 disorder. Individuals with family members that have bipolar 2 disorders have a big risk of bipolar 2. Antidepressants may be a

potential risk for bipolar patients in that it could trigger more rapid cycling and antidepressants can induce hypomania. There are also brain abnormalities in that the neurotransmitters dopamine, serotonin, and nor epinephrine can be associated with mood disturbances.

Empirically supported treatments

There seem to be different alternatives methods in treating bipolar 2 disorders. However, in treating all bipolar disorders, lithium is the desired treatment. Therapy also tend to play a vital role in the treatment of bipolar disorders in that it helps the client to understand the importance of the illness and helps them to recognize when a hypomanic or a depressive episode is occurring.

DSM-V Revisions

Draft Criteria for Bipolar II Disorder

- A. Presence (or history) of one or more Major Depressive Episodes (see [Criteria for Major Depressive Episode](#)).
- B. Presence (or history) of at least one Hypomanic Episode (see [Criteria for Hypomanic Episode](#)).
- C. There has never been a Manic Episode (see
- D. The mood symptoms in Criteria A and B are not better accounted for by [Schizoaffective Disorder](#) and are not superimposed on

Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

- E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Specify current or most recent episode:
 - Hypomanic: if currently (or most recently) in a Hypomanic Episode
 - Depressed: if currently (or most recently) in a Major Depressive Episode

Specifiers and/or current features have not yet been reviewed by the Workgroup for bipolar disorder. It is anticipated that specifiers and/or features that apply across the mood disorders will be consistent across major depression and bipolar disorder. The bipolar specific rapid cycling specifier is under review to consider whether to keep as is, eliminate, or modify

Additional Information

Patients with Bipolar Disorder are at a higher risk than any other disorder on the listed on the axis I. 25-56% of patients are at risk of attempting suicide; this is a major problem in bipolar disorder (Valtonen, Suominen, Haukka, Mantere, Leppämäki, Arvilommi, et al, 2008). The suicidal behavior is related to the depressive aspects of the illness. The highest levels of suicide ideation were at the point when individuals

had mixed phases of the illness and then peaking off into the more depressive stages (Valtonen, et al., 2008). The suicide thoughts were more likely to occur in Bipolar Disorder II rather than Bipolar Disorder I. The reason for this is because the bipolar II disorder patients spend more time during the mixed phases of depression. However both bipolar I and II are at high risk for suicide (Valtonen, et al., 2008). Individuals with bipolar disorders are prone to substance abuse such as: nicotine dependence, and alcohol abuse. Nicotine is the highest drug used in bipolar disorder followed by alcohol. For illegal substances, marijuana was the highest found to be abused (Leventhal & Zimmerman, 2010).

Cognitive impairment exists in both subtypes of Bipolar I and II disorders. Research has found that performance levels in verbal memory, working memory, psychomotor speed, and executive function were reduced in bipolar I disorder patients, but that performance levels only in working memory and psychomotor speed were reduced in bipolar II disorder patients (Yih-Lynn, H., Yi-Syuan, W., Jo Yung-Wei, W., Min-Hsien, H., Hui-Chun, C., Sheng-Yu, L., et al., 2009). Bipolar I patients impaired across cognitive domains (except for visual memory), while Bipolar II patients were unimpaired on verbal memory measures (Yih-Lynn, et al., 2009). Two possible factors involved in bipolar I patients having more severe neuropsychological deficits than Bipolar II patients might be the presence of psychotic symptoms and the effect of medication. Bipolar I patients generally have a history of frequent psychotic symptoms; however, one

recent study reported no correlation between a history of psychotic symptoms and cognitive impairment (Yih-Lynn, et al., 2009). Moreover, the presence of psychotic symptoms is one of the DSM-IV criteria for diagnosing bipolar I. Antipsychotic treatments are used more frequently in patients with Bipolar I (Yih-Lynn, et al., 2009). Some studies have associated cognitive deficits with antipsychotic medication rather than with psychotic symptoms; however, the effect of medication is difficult to control for and to evaluate in a clinical setting (Yih-Lynn, et al., 2009). Other studies have reported cognitive deficits in the first-degree relatives of bipolar disorder patients; thus, people have questioned whether the neuropsychological functional impairments found in the patients were due to the antipsychotics or to other medication (Yih-Lynn, et al., 2009). Further studies are needed to provide additional evidence (Yih-Lynn, et al., 2009).

Cyclothymic Disorder (301.13)

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DSM-IV-TR criteria

- A. For at least 2 years, the presence of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet criteria for a Major Depressive Episode. Note; in children and adolescents, the duration must be at least 1 year..
- B. During the above 2 year period (1 year in children and adolescents), the person has not been without the symptoms in Criteria A for more than

2 months at a time

- C. No Major Depressive Episode, Manic Episode, or Mixed Episode has been present during the first 2 years of the disturbance.
 - Note; After the initial 2 years (1 year in children and adolescents) of Cyclothymic Disorder, there may be superimposed Manic or Mixed Episodes in which case both Bipolar 1 Disorder and Cyclothymic Disorder may be diagnosed) or major Depressive Episode (in which case both Bipolar 2 Disorder and Cyclothymic Disorder, Delusional Disorder may be diagnosed).
- D. The symptoms in Criteria A are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- E. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug abuse, a medication) or a general medical conditioned (e.g. hyperthyroidism).
- F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Associated features

- This is a chronic but a less severe case of Bipolar disorder. The individual experiences numerous hypomanic episodes and many periods of depression over a two year period. Some periods of moods may last as long as two months in some individuals. There will also be “normal” periods of time lasting up to two months. In the first two years, there cannot be any evidence of a Manic Episode or any history of major depressive episodes
- Cyclothymic Disorder is a chronic, fluctuating mood disturbance with numerous periods of hypomanic symptoms and depressive symptoms. These symptoms do not qualify for either a diagnosis of a full Manic Episode or Major Depressive Episode.
- Substance Related Disorders and Sleep Disorders can be comorbid with Cyclothymic Disorder.
- There is a 15 to 50 percent risk that an individual with Cyclothymic Disorder will later develop one of the Bipolar II disorders.

Child vs. adult presentation

- Presence of Cyclothymic Disorder early in life may increase the likelihood of developing other Mood Disorders later in life (especially the Bipolar

Disorders.)

- In children and/or adolescents, symptoms only need to be present for one year as opposed to two years in adults.

Gender and cultural differences in presentation

- Cyclothymic Disorder seems to be equally common in both men and women. However in clinical settings women are more likely to present for treatment.

Epidemiology

- General lifetime prevalence rates are from 0.4% to 1%. Prevalence rates for mood disorder clinics can range between 3% to 5%.

Etiology

Major Depressive Disorder and Bipolar I or II seem to be more common in the First-degree biological relatives of people with Cyclothymic Disorder than in the normal population. Also, Cyclothymic Disorder may be more common in first-degree biological relatives of those with Bipolar I.

Empirically supported treatments

There are various treatment options available for those patients with Cyclothymia Disorder. A simple change in

lifestyle could be a key component. An example would be getting plenty of exercise. Exercise has been known to regulate mood and also help with emotional stability. This will not cure Cyclothymia of course, but it may offer the patient some relief.

Medication is another option. Some possible medications that could be prescribed are lithium, anti-seizure medication, antipsychotics, and antianxiety medication. Some alternate medications are magnesium, hypericum perforatum, SAMe, and Omega-3 fatty acids.

There are also therapy options if the patient does not want a medication. These are also a little safer than medication. Some examples are cognitive behavioral therapy, interpersonal therapy, and group therapy.

DSM-V

There will be no change in this disorder in the DSM-V.

Substance-Induced Mood Disorder

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DSM-IV-TR criteria

- A. A prominent and persistent disturbance in mood predominates in the clinical picture and is characterized by either (or both) of the following:
 - depressed mood or markedly diminished interest or pleasure in all, or almost all, activities
 - elevated, expansive, or irritable mood
- B. There is evidence from the history, physical

examination, or laboratory findings of either (1) or (2):

- 1. the symptoms in Criterion A developed during, or within a month of, Substance Intoxication or Withdrawal
- 2. medication use is etiologically related to the disturbance
- C. The disturbance is not better accounted for by a Mood Disorder that is not substance induced. Evidence that the symptoms are better accounted for by a Mood Disorder that is not substance induced might include the following: the symptoms precede the onset of the substance use (or medication use); the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication or are substantially in excess of what would be expected given the evidence that suggests the existence of an independent non-substance-induced Mood Disorder (e.g., a history of recurrent Major Depressive Episodes).
- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- NOTE: This diagnosis should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the mood symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the symptoms are sufficiently severe to warrant indecent clinical attention.
- Code [Specific Substance]-Induced Mood Disorder:
 - (291.89 Alcohol; 292.84 Amphetamine [or Amphetamine-Like Substance]; 292.84 Cocaine; 292.84 Cocaine; 292.84 Hallucinogen; 292.84 Inhalant; 292.84 Opioid; 292.84 Phencyclidine [or Phencyclidine-Like Substance]; 292.84 Sedative; Hypnotic, or Anxiolytic; 292.84 Other [or Unknown] Substance).
- Specify type:
 - With Depressive Features: if the predominant mood is depressed
 - With Manic Features: if the predominant mood is elevated, euphoric, or irritable
 - With Mixed Features: if symptoms of both mania and depression are present and neither predominate

- **With Onset During Intoxication:** if the criteria are met for Intoxication with the substance and the symptoms develop during the intoxication syndrome
- **With Onset During Withdrawal:** if criteria are met for Withdrawal from the substance and the symptoms develop during, or shortly after, a withdrawal syndrome

Associated features

Individuals may suffer from both independent and substance-induced mental disorders, but substance-induced mental disorders are different because most all of the psychiatric symptoms are caused by substance use, abuse, or withdrawal. Substance-induced mental disorder symptoms can range from anxiety and depression to full psychotic episodes. Physical symptoms usually subside days after substance use has stopped, but some psychotic symptoms can have long-term effects due to toxins damaging the brain (Substance-Induced Disorders, 2009).

Differential Diagnosis:

Mood symptoms occur commonly in Substance Intoxication and Substance Withdrawal, and the diagnosis of the substance-specific intoxication or substance-specific withdrawal will usually suffice to categorize the symptom

presentation. A diagnosis of Substance-Induced Mood Disorder should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the mood symptoms are judged to be in excess of those usually associated with the intoxication or withdrawal syndrome and when the mood symptoms are sufficiently severe to warrant independent clinical attention. For example, dysphoric mood is a characteristic feature of Cocaine Withdrawal. Cocaine-Induced Mood Disorder should be diagnosed instead of Cocaine Withdrawal only if the mood disturbance is substantially more intense than what is usually encountered with Cocaine Withdrawal and is sufficiently severe to be a separate focus of attention and treatment.

If substance-induced mood symptoms occur exclusively during the course of a delirium, the mood symptoms are considered to be an associated feature of the delirium and are not diagnosed separately. In substance-induced presentations that contain a mix of different types of symptoms (e.g., mood, psychotic, and anxiety symptoms).

A Substance-Induced Mood Disorder is distinguished from a primary Mood Disorder by the fact that a substance is judged to be etiologically related to the symptoms.

Substances such as, stimulants, methamphetamines, and cocaine can produce manic, hypomanic, depressive, and mixed episodes. Substances such as alcohol are consumed by individuals with major depressive disorder as a means of self-medication, but this may worsen the effects of depression in those individuals who abuse large amounts of alcohol.

Benzodiazepines are said to have effects on the body similar to that of alcohol when consumed over the long-term (Mood Disorder, 2010).

Because individuals with general medical conditions often take medications for those conditions, the clinician must consider the possibility that the mood symptoms are caused by the physiological consequences of the general medical condition rather than the medication, in which case Mood Disorder Due to a General Medical Condition is diagnosed.

Child vs. adult presentation

Gender and cultural differences in presentation

Substance-induced mood disorder is equally prevalent in males and females. There are some cultural preferences on the other side of the globe but research is scarce in this area and uncertain. Different cultures view disorders in drastically different contexts, some religious aspects as well as to do with family and the lineage.

Epidemiology

Although substance-induced mood disorder is listed in the DSM-IV-TR, the DSM-IV-TR does not include any data regarding prevalence or incidence of this disorder (Nash, 2008).

Etiology

Mood Disorders can occur in association with intoxication

with the following classes of substances: alcohol; amphetamine and related substances; cocaine; hallucinogens; inhalants; opioids; phencyclidine and related substances; sedatives, hypnotics, and anxiolytics; and other or unknown substances.

Mood Disorders can occur in association with withdrawal from the following classes of substances: alcohol; amphetamine and related substances; cocaine; sedatives, hypnotics, and anxiolytics; and other or unknown substances.

Empirically supported treatments

Generalized Anxiety Disorder

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DSM-IV-TR Criteria

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days for at least six months about a number of events or activities (such as work or school performance).
- B. The person finds it difficult to control their worry.
- C. An unrealistic fear or worry, especially in new or unfamiliar situations.

- D. The anxiety and worry are associated with three or more of the following six symptoms (with at least some symptoms present for more days for at least the past six months). NOTE: Only one item is required in children:
 1. Restlessness or feeling keyed up or on edge
 2. Being easily fatigued
 3. Difficulty concentrating or mind going blank
 4. Irritability
 5. Muscle tension
 6. Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

- E. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a panic attack (as in panic disorder), being embarrassed in public (as in social phobia), being contaminated (as in obsessive-compulsive disorder), being away from home or close relatives (as in separation anxiety disorder), gaining weight (as in anorexia nervosa), having multiple physical complaints (as in somatization disorder), or having a serious illness

(as in hypochondriasis), and the anxiety and worry do not occur exclusively during post-traumatic stress disorder.

- F. The anxiety, worry, and physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
- G. The disturbance is not due to the direct psychological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder.

Associated Features

In addition to the diagnostic features above, people with GAD often report several other types of psychological and physiological symptoms. These can include trembling (particularly of the extremities), nervous twitching, feeling shaky, and muscle soreness (usually related to high levels of tension they are experiencing). They can also experience somatic symptoms such as sweating, hot flashes, nausea, diarrhea, or an exaggerated startle response. Symptoms of autonomic hyperarousal, like rapid heart rate, shortness of breath, and dizziness are not as common as in other anxiety disorders, such as panic disorder and post-traumatic stress disorder, but can be seen.

Comorbidity of other disorders and GAD is extraordinarily high, with epidemiological studies showing rates of 90% in the general population, and clinic studies showing rates between 45–98%. Major depressive disorder (MDD) is the single most common comorbid disorder, with some 60% of patients meeting diagnostic criteria for both. Other typical comorbidities include the other anxiety disorders, sleep disorders, and chronic pain. These high rates of comorbidity have led some to question if GAD should actually be classified as its own, separate disorder or if it is instead a prodrome (that is, a precursor to) or symptom of other disorders. It appears, based on current research, that it is properly classified as its own disorder for three primary reasons: it can be both reliably and validly diagnosed; non-comorbid GAD can be seen; and the high comorbidity rates may be an artifact of the DSM diagnostic criteria.

The impact of GAD on an individual can be devastating. Compared to the other anxiety disorders, individuals with GAD tend to show higher levels of social and occupational impairments. In terms of quality of life, GAD patients show decreases that are comparable to those with physical illness such as diabetes, hypertension, and congestive heart failure. Persons with GAD also tend to have much higher numbers of visits, and costs of visits, to physicians annually than do people without anxiety. In fact, over half of patients diagnosed with irritable bowel syndrome (IBS) have comorbid GAD diagnoses, and many of them are not aware of this.

Child vs. Adult Presentation

In children and adolescents, the anxieties and worries seen in GAD are often focused on their performance at school or in sporting events – situations when their performance is being evaluated or observed by others. There may also be a large concern about being punctual in social situations. Children with GAD may also show signs of being overly conforming, showing perfectionism, and being unsure of themselves. They may tend to redo tasks because they are dissatisfied with whatever they are trying to accomplish, which is generally an idea that realistically they cannot achieve, while constantly checking and changing things. Retrospectively, many diagnosed with GAD as adults report having felt anxious all their lives, and over half of those who present for treatment report onset in childhood or adolescence. Onset after 20 years old is not uncommon, though. The course of GAD has traditionally been considered to be chronic, but recent research shows that under 80% of those with lifetime diagnosis do not have chronic, clinical levels of worry.

Gender and Cultural Differences in Presentation

The diagnosed prevalence rate of GAD in females is over double that of males. Lifetime prevalence ratios are 1 male to every 1.9 females, with 12-month ratios of 1:2.2. There are different patterns of comorbidity seen between genders as well, with higher rates of substance use disorders (particularly

alcohol use) and antisocial personality disorders seen in males. Females, in contrast, show higher numbers of comorbid anxiety and mood disorders. Interestingly, even when controlling for comorbid problems, females also show higher rates of disability than males. The group at highest risk for having GAD are females who are middle-aged, not married, and of low income.

Culturally, persons living in the U.S. who are of Asian, Hispanic, or African descent are at lower risk for having GAD than Caucasians. Some studies have shown that those of minority status in the U.S., as well as persons living in Eastern Asia, experience more of the somatic symptoms of GAD and report fewer psychological or worry symptoms. There is some research, however, that shows psychological symptoms are as present in Chinese and Vietnamese people, but that they must be specifically asked about, as these populations are more likely to concentrate on somatic complaints.

Epidemiology

GAD prevalence rates are quite high across a number of studies. The Epidemiological Catchment Area Study reported that the lifetime prevalence rates range from 4.1% to 6.6% for DSM-III criteria. The National Comorbidity Survey Replication, which examined DSM-IV criteria in the United States, reported a lifetime prevalence rate of 5.7%, with 12-month rates of 2.7%. Very similar rates are reported in European samples, with rates between 1.2-1.9% for current and 4.3-5.9% for lifetime prevalence.

Etiology

It is not entirely known what causes generalized anxiety disorder, but a number of factors likely contribute. Evolutionarily, anxiety is highly useful, as it prepares the body for “fight or flight” by activating the sympathetic nervous system. In GAD, like in other anxiety disorders, this activation appears to be in response to what should be non-anxiety provoking stimuli. In other words, people with GAD display a specific cognitive bias that causes them to attend heavily to potentially threatening stimuli, as well as interpret ambiguous stimuli as if it were threatening.

While GAD does not necessarily run in families, that does not mean there is not a role that genetics play in the disorder. Instead of a propensity toward GAD, children instead inherit a greater likelihood of expressing high levels of neuroticism and anxiety sensitivity. Indeed, genetic studies show that there is a high genetic overlap between GAD and major depression. The environment may be responsible for how this vulnerability is then expressed. Intriguingly, one environmental risk factor may be smoking cigarettes, as teenagers who smoke are 5-6 times as likely to develop GAD as non-smokers. Trauma and stressful events like abuse, death of a family member, divorce, or changing careers may also lead to development of GAD.

At the level of the brain, several neurotransmitters have been found to be linked to GAD (as well as a number of other disorders). Serotonin and norepinephrine have both been implicated, with the causal mechanism seeming to be

a lack of receptor sensitivity to them. The amygdale is also disrupted in GAD, impacting the appropriate rely of sensory information to the rest of the brain. This may help to explain the threat-bias displayed by those with GAD.

Psychologically, the central and defining feature of GAD is worry (leading some to propose it actually be renamed “Generalized Worry Disorder). Where the typical, non-clinically anxious person spends approximately 15% of their day worrying, people with GAD may spend as much as 60% engaged in worry. For them, worry is an avoidant coping strategy which is maintained by two types of reinforcement. First, worry leads to decreased physiological and emotional reactivity in response to stressors, which means it is positively reinforcing. Second, it is also negatively reinforced, as the vast majority of worries and fears do not come true; people with GAD attribute these bad things as not happening because they worried about them. This not only maintains worry, but causes people to see it as a good, beneficial activity. Unfortunately, it also has negative consequences, particularly increasing the frequency of intrusive, anxiety-provoking mental imagery, which results in a sense of uncontrollability. This in turn makes the individual with GAD both more likely to worry and increasingly impaired by their worry. As for why people might worry more often in the first place, it appears to be due to a high degree of intolerance for uncertainty. Uncertain or ambiguous situations are often viewed as stressful and upsetting, unfair, negative, avoided at all costs, and interfering with one’s

ability to function. These negative association with uncertainty then cause people to begin worrying about encountering them in the future.

Empirically Supported Treatments

Treatment for GAD can be done both via psychotherapy and pharmacology. There are similar effect sizes seen for cognitive-behavioral therapies (0.7) and medications (0.6). Unfortunately, though, the majority of persons with GAD lack access to properly trained CBT clinicians, and other therapies (supportive, psychodynamic, humanistic) are just not effective. This leads to the majority of persons with GAD being treated with medication, which is actually less cost-effective and shows fewer long-term benefits than CBT.

In terms of medication, two primary classes of drugs are used: benzodiazepines (BZD) and antidepressants (AD). With BZD, such as alprazolam, bromazepam, lorazepam, and diazepam, are quite effective at relieving GAD in the short-term, but are discouraged for long-term use. This limitation is recommended due to potential for developing tolerance and subsequent abuse, as within 4-6 weeks of use they are generally no more effective than a placebo. The most common side effects of BZD are dizziness, drowsiness, decreased alertness, and poor concentration. The most commonly prescribed drugs for GAD are types of AD, such as fluoxetine, duloxetine, escitalopram, paroxetine, and sertraline. There is little evidence to suggest an enormous difference in efficacy between tricyclics (TCA), serotonin

reuptake inhibitors (SRI), or combined serotonin-norepinephrine reuptake inhibitors (SNRI). While these take considerably longer to show a response, sometimes up to six weeks after beginning taking them for full effectiveness, they have little risk of addiction and can be discontinued relatively easily using a gradually stepped-down dosage. Side effects often seen vary depending on the specific drug, with TCA often having more severe profiles. Common TCA side effects include sedation, dry mouth, postural hypotension, while common SRI side effects are dizziness, nausea, disturbed appetite, and sexual dysfunction.

Psychotherapeutically, CBT vastly outperforms other therapeutic modalities, at both immediate post-treatment and long-term follow-up. There is a very low (under 10%) rate of dropouts in CBT. Interestingly, shorter dosages (8-10 sessions) have been shown to be equally effective as longer ones, with treatment gains seen up to two years after treatment has been discontinued. This makes CBT superior to medication in relapse prevention, as well as more cost effective. It is important to note, however, that although there are large effect sizes, especially compared to wait-list controls (1.09), that only about half of patients will have their worry drop to non-clinical levels. There are four traditional components to CBT for GAD: self-monitoring, applied relaxation training, cognitive therapy, and the rehearsal of relaxation and cognitive restructuring in the real world.

Self-monitoring teaches patients to objectively observe their anxious responses and note the triggers of worry. This

is crucial because the earlier a patient can identify worry, the more effective the deployment of coping responses will be. In the relaxation training, patients are taught progressive muscle relaxation in session, then are required to practice it twice daily until they have mastered the ability to, on conscious demand, release muscle tension from their entire body. Once this mastery is obtained, they will then rehearse this skill in real-life situations. Cognitive therapy is used to help correct the negative, pervasive cognitive biases seen in GAD. This is done by 1) identifying how the patient is thinking and the beliefs about self, world, and future that underlie those thoughts, 2) evaluating the accuracy of those cognitions through examination of their logic, probability, and past evidence, 3) generating alternative, more accurate interpretations, predictions, and ways of believing, and 4) using these new perspectives whenever worry is detected and engaging in deliberate behavioral experiments to test if the worry is accurate or not. After relaxation and cognitive therapy are taught, the therapist will have the patient practice using these coping strategies in session by eliciting worry. In GAD, it is key to use intense imagery, not just verbal descriptions, to induce higher anxiety levels, as talking it out is analogous to worrying aloud, which suppresses the intensity of emotional reactivity.

Proposed DSM-5 Revisions

The proposed changes in GAD criteria for DSM-5 primarily reflect an increase and focus on worry as the defining factor

of the disorder. By drawing more attention to this key aspect of GAD, and putting less emphasis on physiological symptoms, it is hoped that the diagnostic criteria will become more reliable and better able to differentiate from other anxiety disorders. Other major changes include the decrease of duration of worry from 6 to 3 months, and the number of symptoms aside from worry decreased from 3 to 1. While the duration decrease will likely increase the number of people who qualify for this diagnosis, the symptom drops have not been shown to do the same in research trials. Finally, adding an avoidance criteria to the diagnosis brings the criteria more in line with the other anxiety disorders and is supported by both research data and clinical opinion.

image

Sleep disturbances (difficulty falling or staying asleep) are common with general anxiety disorder.

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Obsessive-Compulsive Disorder (OCD)

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DSM-IV-TR Criteria

- A. Either obsessions or compulsions:

Obsessions as defined by (1), (2), (3), and (4):

1. Recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress
2. The thoughts, impulses, or images are not simply excessive worries about real-life problems

3. The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
4. The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion).

Compulsions as defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
 2. The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive
- B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. NOTE: This does not apply to children.
 - C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1

hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

- D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an eating disorder; hair pulling in the presence of trichotillomania; concern with appearance in the presence of body dysmorphic disorder; preoccupation with drugs in the presence of a substance use disorder; there is some presentation of a preoccupation with having a serious illness in the presence of hypochondriasis, or thinking that one is ill the majority of the time; preoccupation with sexual urges or fantasies in the presence of a paraphilia; or guilty ruminations in the presence of major depressive disorder).
- E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
- Specify if with poor insight (if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable).

Associated Features

Although a diagnosis of OCD requires only that a person either has obsessions or compulsions, not both, approximately 96% of persons experience both. For almost all people with OCD, being exposed to a certain stimuli (internal or external) will then trigger an upsetting or anxiety-causing obsession, which can only be relieved by doing a compulsion. For example, I touch a doorknob in a public building, which causes an obsessive thought that I will get sick from the germs, which can only be relieved by compulsively washing my hands to an excessive degree. Some of the most common obsessions include unwanted thoughts of harming loved ones, persistent doubts that one has not locked doors or switched off electrical appliances, intrusive thoughts of being contaminated, and morally or sexually repugnant thoughts. Commonly seen compulsions include hand washing, ordering or arranging objects, checking, praying, counting, and thinking good thoughts to undo bad ones.

Given that obsessions almost always trigger a compulsion, there are certain patterns of the two seen together. For example, contamination obsessions are almost always followed by some sort of compulsive cleansing, such as washing hands, taking a shower, or using hand sanitizer. There is some disagreement in the literature about just how many dimensions OCD symptoms fall into, with some finding four factors and others five based on different analytic techniques.

Up to 75% of persons with OCD also present with

comorbid disorders. The most common in pediatric cases are ADHD, disruptive behavior disorders, major depression, and other anxiety disorders. In adults, the most prevalent comorbidities are social anxiety, major depression, and alcohol abuse. Interestingly, the presence of comorbid diagnoses predict quality of life (QoL) more so than OCD severity. Different primary O/C are also associated with certain patterns of comorbidity, in both adults and youth. Primary symmetry/ordering symptoms are often seen with comorbid tics, bipolar disorder, obsessive-compulsive personality disorder, panic disorder, and agoraphobia, while those with contamination/cleaning symptoms are more likely to be diagnosed with an eating disorder. Those with hoarding cluster symptoms, on the other hand are especially likely to be diagnosed with personality disorders, particularly Cluster C disorders.

Almost all adults and children with OCD report that their obsessions cause them significant distress and anxiety, as opposed to similar, intrusive thoughts in persons without OCD. In terms of QoL, persons with OCD report a pervasive decrease compared to controls. Youth show problematic peer relations, academic difficulties, and participate in fewer recreational activities than matched peers. Overall, there is a lower QoL in pediatric females than males, but in adults similar disruptions are reported. When compared to other anxiety disorders and unipolar mood disorders, a person with OCD is less likely to be married, more likely to be

unemployed, and more likely to report impaired social and occupational functioning.

Daily, there are a number of problems that people with OCD face. One is the avoidance of situations in which the objects of the obsessions are present. For example, a person may avoid using public restrooms or shaking hands with people because doing so will trigger their contamination obsession, which will lead to them having to do a cleansing compulsion. Some people will not leave their homes because that is the only way to avoid objects and situations that will trigger their obsessions. Frequent doctor visits may also occur because they fear that something is wrong with them physically, just like a hypochondriac would feel. Feelings of guilt can also be present, along with disrupted sleep patterns and extreme feelings of responsibility. Self-medication may also be present in adults, with alcohol and sedatives the most often abused substances.

Child vs. Adult Presentation

Presentation of OCD symptoms is generally the same in children and adults. Unlike many adults, though, younger children will not be able to recognize that their obsessions and compulsions are both unnecessary (e.g., you don't really need to wash your hands) and extreme (e.g., washing hands for 15-20 seconds is fine, but 5 minutes in scalding water is too much) in nature. In young children, compulsions often occur without the patient being able to report their obsessions, while adolescents are often able to report multiple

obsessions and compulsions. Children and adolescents are also more likely to include family members in their rituals and can be highly demanding of adherence to rituals and rules, leading to disruptive and oppositional behavior. As such, youth with OCD are generally more impaired than adults with the same type of symptoms.

Gender and Cultural Differences in Presentation

While OCD is equally present in males and females in adulthood (although some studies have found much higher rates in females), the disorder is heavily male in pediatric patients. There are some differences in comorbidity as well. Among men, hoarding symptoms are most often associated with GAD and tic disorders, but in women social anxiety, PTSD, body dysmorphic disorder, nail biting, and skin picking are more often observed.

There is strong evidence that cultural differences do not play a prominent role in presence of OCD, with research showing few epidemiological differences across different countries and even between European and Asian populations. Similar symptom categories are seen across cultures, but culture can impact the content of obsessions and compulsions. In Bali, for example, heavy emphasis on somatic symptoms and need to know about members of their social network is found. Perhaps the best example is in religious obsessions, which are very common. Type of religious upbringing has been related to different types of primary obsessions, such as emphasis on cleanliness and order in

Judaism, religious obsessions in Muslim communities, aggressive aggressions in South American samples, and dirt and contamination worries in the United States. Worries about blasphemy and going to hell might be common in evangelical Christian societies, but would not be seen in a Buddhist background. It is also important to note that many cultures have rituals that are deep-rooted in their history and do not indicate OCD. It is only when these rituals exceed the cultural norms that OCD may be a concern.

Epidemiology

In the U.S., the lifetime prevalence rate of OCD is estimated at 2.3% in adults and around 1-2.3% in children and adolescents under 18. The 1-year prevalence of OCD in adults is 1.2% in adults and around 0.7% in children. There is a fairly substantial number of “sub-clinical” cases of OCD (around 5% of the population), where symptoms are either not disturbing or not disruptive enough to meet full criteria. As noted above, pediatric OCD is heavily male dominated, with some studies showing that there is an evening out within the genders by adulthood, and some showing that the numbers reverse and females become predominant.

Etiology

Family studies have indicated that OCD is modestly heritable for adult onset (27-47% of the variance in symptoms), but shows a much higher heritability for child onset (45-65%). These numbers, though, emphasize that environment is still

a very important contributor to development of OCD. Biologically, dysfunctions of the neurotransmitters serotonin, glutamate, and dopamine are all implicated. Frontal cortico-striatal circuitry appears to mediate the presence of OCD, with over activity of the direct pathway from the ventromedial caudate to the globus pallidus and substantia nigra thought to be associated with OCD symptoms. This in turn disrupts functioning of the mediodorsal thalamus.

A recent field of inquiry has attempted to link sudden, pediatric onset of OCD to strep infections. Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcus (PANDAS) is a highly controversial area of research. Children with PANDAS are reported to develop obsessions, compulsions, and tics with no prodromal symptoms or indications during the course of a streptococcal infection, and these symptoms can be alleviated with treatment of the infection. As mentioned, this is an emerging and contentious idea, with many prominent researchers and clinicians not convinced by the evidence.

Psychologically, the most well-supported model for development of OCD is the cognitive-behavioral one. It proposes that obsessions and compulsions arise from dysfunctional beliefs that one holds; the greater the strength of the beliefs, the greater the chance that a person will develop OCD. One of the major research findings to support this idea is that unwanted cognitive intrusions are experienced by most people, with similar contents to clinical obsessions, but are not believed and as such cause little to

no distress. Conversely, in people with OCD, these intrusive thoughts can become obsession if they are appraised as personally important, highly unacceptable or immoral, or posing a threat for which the individual is personally responsible. These types of appraisals will lead to high amounts of distress, which one then attempts to alleviate via compulsions. These compulsions result in anxiety reduction, but it is only temporary and actually reinforces the maladaptive beliefs that led to the negative appraisal in the first place, thus perpetuating the cycle of obsessions and compulsions. This model is the basis for CBT for OCD, which attempts to break this cycle of reinforcement and correct those negative appraisals and maladaptive beliefs.

Empirically Supported Treatments

There are both pharmacological and psychological treatments for OCD that are supported by research evidence. Overall, pharmacology with serotonin reuptake inhibitors (SRIs) shows large effect sizes in adults (0.91), but only moderate effect sizes in youth (0.46). Even with effective medication, most treatment responders show residual symptoms and impairments. There is also a very high relapse rate seen across numerous studies (between 24–89%). SRIs can be supplemented with adjunctive antipsychotics, but only a third of patients will show improvements. Across subtypes of OCD, there are medication differences seen. For example, the presence of tics appears to decrease selective SRI effects in children, but it is unclear if it has the same effect in adults.

Another known difference is that OCD with comorbid tics responds better to neuroleptics than OCD without tics does.

The treatment of choice for OCD, in both adults and children and backed by numerous clinical trials, is cognitive-behavioral therapy, particularly the exposure with response prevention aspect of it (EX/RP). It is superior to medications alone, with effect sizes ranging from 1.16-1.72. There is a low (12%) relapse rate, but it is important to note that up to 25% of patients will drop out prior to completion of treatment due to the nature of treatment. The structure of treatment is very similar to what is used to treat phobias, but the course of therapy generally lasts between 12-16 sessions due to the larger number of anxiety/obsession triggering stimuli. It has been found that those with hoarding cluster symptoms respond less well to CBT, in part due to reluctance to engage in exposures. For them and others who are not engaging in exposures as needed, a treatment module focusing on motivational enhancement may be required. Research has also shown that individuals with comorbidity respond equally well to treatment, and that treatment of OCD often results in decreases of other anxious and depressive symptoms. Intriguingly, group therapy that uses CBT and EX/RP has been shown to be equally as effective as individual therapy and, for persons with mild OCD, computer-assisted self-treatment has been shown to be very effective (e.g., BT-STEPS).

As with OST for phobias, the first step is an assessment to determine maintaining factors (such as family

accommodation) and comorbid problems. Next, education about the causes (biological and psychological) of OCD is presented, and misattributions about causes are corrected, and patients are asked to keep track of all possible O/C symptoms over the course of a week, as this allows for construction of a fear hierarchy to begin. Different O/C symptoms are often interwoven in hierarchy, as most people will present with two or more symptom clusters (e.g., symmetry and contamination, or hoarding and forbidden thoughts). The therapist and patient work on hierarchy construction together, based on self-report, other-report (e.g. parents), and behavioral observations. Once the hierarchy is constructed, items on it begin to be addressed in therapy, starting with moderately difficult situations, as ones below will show decreases naturally with treatment of higher problems. During the treatment phase, the clinician makes use of EX/RP techniques, including both imaginal and in vivo exposures. Imaginal exposures are often used in the beginning to demonstrate that anxiety will decrease across time, or when the person has abstract worries and fears that are difficult to perform real-life exposures for.

This also allows for practicing coping skills (e.g., cognitive restructuring and thought challenging) before confronting the real situation or stimuli. In vivo exposures follow and are similar to those conducted for persons with phobias, with the incorporation of cognitive challenges, modeling, reinforcement, and education into each exposure. Between sessions, homework is critical to the success of CBT for

OCD, with the therapist helping the client to plan exposures to perform throughout the week, usually variations on what was accomplished during therapy. Ideal exposures are prolonged, repeated, prevent the use of distraction behaviors and show a SUDs decrease of at least 50% (with more being better). There may need to be shaping up to the more difficult situations, in terms of both time and use of distracters. For example, a person may need to move from just standing in a public restroom, to touching the door, then the door handle, then the floor, then the top of the toilet, to the toilet handle, the toilet seat, and finally into the bowl.

Proposed DSM-5 Revisions

Several changes have been proposed to the diagnosis of OCD, primarily just wording changes such as clarifying that the O/C are time consuming and impairing. The largest change is in the specifiers, which will move from the dichotomous “with poor insight” to a more continuum-based assessment rated from “good or fair” to “poor” to “absent” insight. In addition, the specifier of “tic-related OCD” will be used if the patient has a lifetime history of a chronic tic disorder or Tourette’s Syndrome. This has been proposed because this appears to be a distinct subtype of OCD and may account for up to 40% of pediatric cases. This category is often male-dominated, with a high incidence of symmetry/exactness/ordering and lower cleaning/contamination symptoms than seen in the general OCD population. In terms

of comorbidity, there are very high rates of trichotillomania and disruptive behavior disorders seen in this subtype.

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Post-Traumatic Stress Disorder (PTSD)

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DSM-IV-TR Criteria

- A. The person has been exposed to a traumatic event in which both of the following have been present:
 1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the

physical integrity of self or others

2. The person's response involved intense fear, helplessness, or horror. NOTE: In children, this may be expressed instead by disorganized or agitated behavior.
- B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
 1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. NOTE: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
 2. Recurrent distressing dreams of the event. NOTE: In children, there may be frightening dreams without recognizable content.
 3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). NOTE: In young children, trauma-specific reenactment may occur.

4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
 5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
 1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
 2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
 3. Inability to recall an important aspect of the trauma
 4. Markedly diminished interest or participation in significant activities
 5. Feeling of detachment or estrangement from others
 6. Restricted range of affect (e.g., unable to have loving feelings)
 7. Sense of a foreshortened future (e.g., does

not expect to have a career, marriage, children, or a normal life span).

- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
 - 1. Difficulty falling or staying asleep
 - 2. Irritability or outbursts of anger
 - 3. Difficulty concentrating
 - 4. Hypervigilance
 - 5. Exaggerated startle response
- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

In addition, clinicians specify if the PTSD is acute (duration of symptoms is less than 3 months) or chronic (duration of symptoms is 3 months or more) and if it was a delayed onset (if onset of symptoms is at least 6 months after the stressor).

Associated Features

In addition to the diagnostic criteria, individuals with PTSD often describe feelings of guilt about surviving when others did not survive or about the things they had to do to survive

a trauma. A number of other symptoms can occur, such as feelings of shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs, social withdrawal; impaired relationships with others; or a marked shift from the individual's previous personality. Especially problematic are the self-destructive behaviors that can develop with PTSD, such as alcohol and drug abuse, suicidal behaviors, and risky sexual behavior.

Avoidance of situations or activities that remind a person of the trauma can cause functional impairment, problems with interpersonal relationships, and lead to marital conflict, divorce, or loss of job. Some individuals become greatly limited in the places and activities that they are able to engage in due to avoidance. Compared to healthy controls, people with PTSD report having a greatly reduced quality of life, and are at an elevated risk of poor physical health.

Having PTSD also puts one at a greatly elevated risk of developing comorbid disorders, even when compared to people with other anxiety disorders. Data indicate that over 80% of people with PTSD meet criteria for at least one other diagnosis, with over 50% having two or more comorbidities. In persons with PTSD, high rates of simple (31%) and social phobias (27%) are seen, but the most commonly co-occurring disorders are non-anxiety ones, particularly major depression (48%) and substance abuse. Over 50% of males and almost 30% of females meet criteria for alcohol abuse or dependence, while other drug abuse is present in over 34% of males and 27% of females. In studies examining males

veterans, even higher comorbidity rates are found for major depression, with 86% meeting criteria, but similar rates of anxiety and substance abuse problems were found.

Child vs. Adult Presentation

Exposure to traumatic events can have major developmental influences on children. While the majority of children will not develop PTSD after a trauma, best estimates from the literature are that around a third of them will, higher than adult estimates. Some reasons for this could include more limited knowledge about the world, differential coping mechanisms employed, and the fact that children's reactions to trauma are often highly influenced by how their parents and caregivers react. These impact the development and presentation of PTSD, leading to differences not only from adults, but within different age groups of children. In the weeks after a trauma, up to 90% of children may experience heightened physiological arousal, diffuse anxiety, survivor guilt, and emotional lability. These are all normal reactions and should be understood as such (similar things are seen in adults. Those children still having these symptoms three or four months after a disaster, however, may be in need of further assessment, particularly if they show the following symptoms as well. In children under the age of six, these may indicate problematic adjustment to the disaster: generalized anxiety about separation, strangers, or sleep problems; avoidance of certain situations; preoccupation with certain symbols / words; limited emotional expression or play

activities; and loss of previously acquired skills. For older children, warning signs of problematic adjustment include: repetitious play reenacting a part of the disaster; preoccupation with danger or expressed concerns about safety; sleep disturbances and irritability; anger outbursts or aggressiveness; excessive worry about family or friends; school avoidance, particularly involving somatic complaints; behaviors characteristic of younger children; and changes in personality, withdrawal, and loss of interest in activities.

Gender and Cultural Differences in Presentation

Women are significantly more likely to develop PTSD after a traumatic experience than men, even when predominantly female victim traumas, such as sexual crimes, are taken into account, with lifetime prevalence rates well over double that for men (9.6% vs. 3.6%). The genders also show differential patterns of response to traumas. For example, only 1% of males threatened with a weapon will develop PTSD, but over 30% of females in similar situations will. Females also show higher rates after physical and sexual assaults.

The majority of studies have been done by Western researchers using Western populations. As such, we have only a small body of literature to draw cross-cultural comparisons. There has been some research showing that African Americans returning from the Vietnam War more at risk of developing PTSD than Caucasians or other minorities. Subsequent findings found that, for the overall population, African Americans and Native Americans are at a higher

risk than other minorities for developing PTSD. Much of the cross-cultural research around the globe has focused on differential rates of PTSD, with major findings indicating that (as in the U.S.) the more traumas one is exposed to, the greater likelihood of developing PTSD.

There have also been considerable critiques of the application of PTSD, with its inherent Western biases, to non-Western cultures. Twelve-month prevalence rates vary greatly between the U.S. (3.6%) and most other countries, such as urban China (0.2%), Japan (0.4%), Mexico (0.6%), and even Europe (0.9%) and Australia (1.3%). These large differences have led many to advocate for the use of more localized, culture-specific stress reactions (such as *ataque de nervios* in certain Latin and Hispanic cultures). Using biomarkers (such as exaggeration of startle response or physiological reactivity) has also been proposed, but there is only preliminary data so support their use at this time.

Epidemiology

The majority of people experience some sort of traumatic event at least once during their lifetime, with 25% of people experiencing multiple traumas. Rates are slightly higher for men (61%) than for women (51%), although types of trauma vary dramatically between genders. Women, for example, are much more likely to experience sexual assault or rape (9%) than males (1%), but men are much more likely to be involved in a serious accident (25% vs. 14%). Thankfully, though, the prevalence rate for PTSD is much lower than

these numbers, as the vast majority of those involved in traumatic experiences do not develop it. Lifetime prevalence rate for the general U.S. population is 6.8%, with 12-month rates of only 3.6%.

Not all groups are equally at risk of developing PTSD, however. In high- or at-risk individuals (e.g., combat veterans, disaster victims, or criminal violence), prevalence rates ranging from 3% to 58% have been found. In countries with high rates of civil war and internal strife, shockingly high rates of PTSD have been found. In one study, over 37% of Algerians in the late 1990s met criteria for a PTSD diagnosis, compared to 6.8% of Americans. Interestingly, the type of disaster a person experiences greatly impacts the chance of developing PTSD. For example, while only 4-5% of those who live through a natural disaster develop PTSD, studies have found that 30% or more of people involved in man-made disasters (shootings, bombings, and so on) develop PTSD.

In recent U.S. combat veterans, studies have found that lifetime prevalence is about 39% in males, above the rate of 30% seen in veterans of the Vietnam War. When compared to other types of traumas that males experience, being in combat results in higher lifetime PTSD prevalence, a greater likelihood of delayed onset, and a greater likelihood of unresolved symptoms. Several studies examining PTSD in military females have found similar rates, even without the front-line combat experience. These studies have been criticized, though, due to some methodological difficulties.

Etiology

Alone among all the disorders listed in the DSM, PTSD has a specific etiological event – experiencing a trauma. While it is highly adaptive to have a strong fight-or-flight response during a trauma and when your life is threatened, these reactions should decrease once the trauma has passed. In persons with PTSD, however, they do not. As such, PTSD can be seen essentially as a failure to adapt to differing situations. Why people’s reactions fail to return back to normal after can be influenced by a number of factors. Prior to the event, a number of factors will greatly increase risk. These include being female, of a minority race, having a lower level of education, and having a lower income level. Also, a history of previous psychiatric problems and childhood trauma make it more likely that one will develop problematic symptoms. In addition to the type of trauma experienced, certain factors about the trauma can increase risk, such as greater perceived threat or danger and helplessness, as well as the unpredictability and uncontrollability of traumatic event. Post-trauma, lack of social support, overall amount of life stress, coping mechanisms used, and type of attributions made for the disaster can all increase risk.

Empirically Supported Treatment

As with most anxiety disorders, both medications and therapy can be effective in treating PTSD, although certain

psychotherapies are much more effective. Meta-analyses show that CBT, particularly Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT), have much greater overall effect sizes than medications for both self-reported symptoms (1.2 vs. 0.65) and clinician ratings (1.5 vs. 1.05). Nonetheless, medication can certainly be a very useful adjunctive treatment, especially to assist in controlling comorbid problems such as depression, and is more widely available than therapists trained in PE or CPT. The SSRIs (such as citalopram, fluoxetine, paroxetine, and sertraline) are the most well-studied group of agents, and have been shown to significantly outperform placebos in both civilian and military populations. The drug with the highest effect sizes, though, is venlafaxine, a SNRI. It slightly outperforms the SSRIs in both populations.

The two most well-supported psychotherapies are both types of CBT: prolonged exposure and cognitive processing therapy. They both share general components of psycho-education, anxiety management, exposure with response prevention, and cognitive restructuring. Little is known about their relative efficacy, but there is some research showing that clients with strong guilt about the trauma may fare better in CPT. Dropout rates are similar and relatively low across treatments.

The first part of PE is psycho-educational and allows the client to learn about trauma and its effects on individuals, as well as understand the symptoms of PTSD. This also lays out the groundwork and rationale behind why exposing oneself

to the memories and to particular stimuli (both of which they are actively avoiding) is going to eventually lead to symptom reduction. Next, the client learns breathing skills to help control their anxiety and distress they will experience during the exposures. The third component is in vivo EX/RP, where a hierarchy of feared and avoided stimuli that are actually safe is developed, then increasingly anxiety-provoking stimuli are encountered and endured until they do not trigger anxiety in the individual. Finally, the fourth component of PE is mental exposure to trauma. This is accomplished by repeatedly having the person imagine the event as it occurred and experience all of the sights, the sounds, the smells, and perceptions of that event. This is often accomplished by writing trauma narratives, detailed descriptions of the trauma that would be read aloud repeatedly.

There are significant overlaps between PE and CPT, but also differences. The first CPT phase provides education about PTSD, but with an emphasis on the role of thoughts and how one's perceptions or beliefs influence the way that they feel. The second phase focuses on processing the trauma and can be done with or without a trauma account. There is a more historical focus in CPT, where the client is focusing on reflections of how they made sense of what happened to them and then being led to a different and more adaptive interpretation of the trauma. In the third component, cognitive restructuring is taught, allowing the client to challenge their own negative and maladaptive thoughts and interpretations. The fourth and final component is focused

on employing cognitive restructuring for both historical and current interpretations.

Proposed DSM-5 Revisions

In the DSM-5, it has been proposed that, given the differential presentation of PTSD across the lifespan, completely separate criteria be adopted for different age groups. In particular, distinctions between the presentation of PTSD in adults, adolescents, school-age, and preschool children have been discussed. This is primarily driven by the fact that the DSM-IV criteria were developed for and tested on older adolescents and adults. As such, the proposed criteria include large numbers of notes that describe developmentally appropriate symptoms (such as repetitive play reflecting the trauma or frightening dreams with no specific content), as well as lower number of symptoms required to meet diagnosis. The other major change proposed is the removal of DSM-IV Criterion A2 (“The person’s response involved intense fear, helplessness, or horror.”) as it has not been found to have either clinical or research utility.

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Social Phobia

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DSM-IV-TR Criteria

- A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. NOTE: In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety

must occur in peer settings, not just in interactions with adults.

- B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed panic attack. NOTE: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.
- C. The person recognizes that the fear is excessive or unreasonable. NOTE: In children, this feature may be absent.
- D. The feared social or performance situations are avoided or else endured with intense anxiety or distress.
- E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- F. In individuals under age 18 years, the duration is at least 6 months.
- G. The fear or avoidance is not due to the direct psychological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition

and is not better accounted for by another mental disorder (e.g., panic disorder with or without agoraphobia, separation anxiety disorder, body dysmorphic disorder, a pervasive developmental disorder, or schizoid personality disorder).

- H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in anorexia nervosa or bulimia nervosa.

In addition, the DSM-IV has the "Generalized" specifier, where the person's fear includes almost all social situations.

Associated Features

Also known as Social Anxiety Disorder, persons with SP are often hypersensitive to criticism, greatly fear negative evaluation, have increased perceptions of rejection, difficulty being assertive, and low self-esteem or feelings of inferiority. Test taking can be difficult for individuals with social phobia due to their fear of indirect evaluation by others. Observable signs of anxiety (poor eye contact, making sounds like "uh" and "um" during speech) are often present in individuals with this disorder. Attending school or work may also be difficult for people with social phobia and they tend to underachieve in these areas.

Comorbidity within persons diagnosed with SP is very

high, over 80% in clinical settings. In adults, the most commonly diagnosed comorbidities are major depression, dysthymia, panic disorder, GAD, specific phobias, and alcohol use disorders. In children, high rates of oppositional defiant disorder, conduct disorder, and ADHD are both present (all of which are unique among the anxiety disorders). SP most often develops prior to other comorbid problems, but relationship with substance use disorders is more uncertain. Some studies have found substance use causing SP, while others have found the reverse. Avoidant Personality Disorder (AVPD), which involves severe restriction and avoidance of situations in which one feels that they would be judged, shows high overlap with SP, with over 40% of people with SP also meeting criteria for AVPD. It is generally more severe than SP, and some researchers claim it is just an extreme variant of SP. Other research, though, shows that there are several distinctions between the two, and that it may be more related to schizophrenia spectrum disorders.

The impact of SP is wide-ranging, both in youth and adults. It is a common reason for school refusal in youth, and the only internalizing disorder highly associated with dropping out of school early. In adults, we find reduced workplace productivity and higher unemployment rates in those with SP. Reduced health-related QoL are also found. Other problematic areas are the high rates of being single or divorced, a wide range of reported sexual dysfunctions, smaller social networks and less social support, and a lowered amount of positive psychological experiences. Persons with

Sp are also at a greater risk for suicide than general population.

Child vs. Adult Presentations

SP is the anxiety disorder where the highest percentage of cases begin in childhood, with reliable and valid cases being seen as early as age six. Children are likely to show symptoms such as crying or throwing tantrums, freezing up, and staying close to a familiar person. They also can show inhibited social interactions, even up to the point of selective mutism, and may seem highly timid and uninvolved in group activities. As seen with college-aged adults, children show signs of underachievement in school settings compared to their academic and intellectual potential. Unlike adults, many children may be unable to identify the nature of their anxiety and often do not have the option of avoiding feared situations, as they are forced into them by adults.

Gender and Cultural Differences in Presentation

Community based and epidemiological studies find that SP is slightly more represented in females (13.0% lifetime) than in males (11.1%). In most clinical and treatment-seeking samples, though, the majority of clients are males. The most commonly avoided or anxiety-provoking situations are different for males and females. For men, eating in restaurants and writing in public are seen more frequently, while in women using public restrooms and speaking in public are more represented.

In the U.S., higher rates of SP are seen among those of lower socioeconomic status, as well as persons with lower levels of education. While Native Americans are at a higher risk than Caucasians for development of SP, other minority groups show lower rates. Interestingly, people living in urban areas in both the U.S. and abroad show lower levels of SP.

Cross-country comparisons show much higher rates in the U.S. (7.1% for 1-year rates) compared to non-Western nations, such as Japan (0.8%), South Korea (0.2%), urban China (0.2%), Mexico (1.7%), South Africa (1.9%). Even compared to Europe (1.1–2.3%) and Australia (1.3%), U.S. rates are much higher. When comparing Western and Asian populations, there appears to be a distinctive division between what is causing the social anxiety: fear of embarrassing self (Western) versus fear of offending others (Eastern). The culturally bound disorder of *taijin kyofusho* (TKS; translated as “fear of interpersonal relations) seen in Japan and Korea seems to exemplify this division. In TKS, people show similar avoidance patterns as SP, but do so because they fear doing something to offend another person (rather than embarrassing themselves, which is what is seen in SP). Also distinct from most cases of SP is what the individual fears they will do or present, such as having an unpleasant body odor or that they will stare at another person’s crotch or chest. These features, however, have been observed in Western samples.

Epidemiology

Best evidence indicates that, in the U.S., the lifetime

prevalence rate of SP for adults is 12.1%, with a 12-month prevalence rate of 7.1%. Prevalence decreases with age, from a 12-month rate of 9.1% among 18–29 year olds to 3.1% in those 60 years and above. Rates in children are relatively high due to the early onset of this disorder, with an under-18 prevalence of 6.8%. Over 50% of adults self-report retrospectively that they began having problems in childhood, and almost 80% report development of the disorder by age 20. Lower-level, non-clinical levels of SP are common, with one study showing that 20% of participants reported excessive fear of public speaking and performance, but only about 2% appeared to experience enough impairment or distress to warrant a diagnosis of SP. In the general population, most individuals with SP fear public speaking, where less than half fear speaking to strangers or meeting new people.

Etiology

As with all the other anxiety disorders, there has been significant progress in understanding the biological, psychological, and social causes of SP over the last several decades. Biologically, multiple gene variants and neurotransmitters seem to play a role in social anxiety, with no one “true” pathway to the disorder. There is only modest heritability seen in SP, less so than for OCD, but the research is still attempting to unravel if this is due to genetic linkage or shared environmental factors. What is likely is that genetics and other pre- and peri-natal biological influences are

responsible for the development of a behaviorally inhibited temperament, which then places an individual at a greatly increased risk for developing SP later in life. This risk factor (behavioral inhibition) then interacts with certain types of social environments to cause someone to become social anxious. For instance, studies have found that the family environments of people diagnosed with SP tend to be more overprotective and less affectionate than is typical. Their families also tend place a very high emphasis on other people's opinions and demonstrate a distinct lack of family sociability.

Cognitive-behavioral models emphasize the psychological and learning factors that assist in developing SP. The CBT model focuses on the role of negative self and situation interpretation and avoidance. When a person with SP encounters a social situation, such as having to speak in front of an audience, this activates certain negative assumptions about themselves ("I'm no good at this, I will look foolish, no one is interested in hearing what I say"). That then causes them to perceive the situation as dangerous, not physically but socially. This activates the sympathetic nervous system, causing the outward, observable manifestations of anxiety (e.g., sweating, increased heart rate, dry mouth, feeling flushed) and at the same time making them more focused inward on themselves. In turn, this provides evidence for them that they actually are socially awkward, as anxiety often inhibits performance and thus causes what was feared to come true (in this case, verbal blocking, not making eye contact, looking nervous). This will feed back into negative

evaluations of themselves and lead to escape and avoidance behaviors, which will cause a reduction in anxiety, negatively reinforcing those behaviors. This will also cause the person to feel that their negative cognitions concerning social situations are accurate, making them want to avoid such things in the future.

Empirically Supported Treatments

Only half of persons with SP ever seek treatment of any kind, and for those who do seek treatment, the average amount of time between onset of problems and seeking help is between 15-20 years. This is particularly sad due to the fact that both pharmacological and psychotherapeutic interventions are quite effective for this disorder. While combining the two does not appear to show benefit over either alone, the effect sizes are quite large for both medications (1.5) and cognitive-behavioral therapy (1.8). While medications tend to decrease symptoms more quickly than CBT, the effects of CBT are slightly greater and outlast medication significantly.

The first line medical treatments for SP are the SSRIs, with the exception of fluoxetine, and the SNRIs. In particular, escitalopram and paroxetine appear to show the highest response rates (54-71% and 55-72%, respectively). Both classes are well-tolerated and have similar effect sizes compared to placebos. While the MAOIs and benzodiazepines can both be effective at lowering symptoms, they have more dangerous side effect profiles, and both carry a risk of addiction. Recently, research has also examined the

use of D-cycloserine (a glutaminergic agent), but not as a standalone treatment. Instead, it appears that it may be useful as an adjunct to CBT incorporating EX/RP, increasing its effectiveness.

Treatment for SP is longer and involves more components than for specific phobias, as the feared situations tend to be more diffuse and more anxiety-based. Gains or even improvements are seen from 6-12 months post treatment, and there are low drop-out rates (10-20%) during treatment. Both group and individual formats both show large improvement rates, but individual is higher. Given the problems with access to trained therapists, though, researchers have also examined the use of minimal contact therapies that rely heavily on self-guided exposures. One study found that bibliotherapy plus only three hours of non-therapy contact with a therapist clinically improved 40% of clients with SP. Those with severe symptoms, however, did not improve much, so this may be good option for persons with mild to moderate SP.

Six components are used in CBT addressing social anxiety: psychoeducation, applied relaxation, social skills training, imaginal and in-vivo exposure, video feedback, and cognitive restructuring. The education component helps the client to better understand the nature of social anxiety and orient them to treatment. In applied relaxation, the therapist trains clients in the use of relaxation methods such diaphragmatic breathing and progressive muscle relaxation and then has the person use them while in social situations. Social skills

training focuses on improving use of verbal and nonverbal behaviors in conversations and other social situations. Video feedback involves taping the person doing a task (often public speaking) and then playing it back to them to help show them they are not acting as awkward as they believed during the task. The use of exposures appears to be the most important aspect of the treatment, as studies comparing the full CBT package to EX/RP alone have shown similar effect sizes.

Likewise, applied relaxation techniques are not effective by themselves, and the same seems to be true of social skills training. Video feedback can be seen as a kind of exposure, which leaves only one other component that may play an active role in change. Cognitive restructuring is often used to help prepare for engaging in the exposures. Exposures can thus be seen as the “test” of if automatic negative thoughts are correct or incorrect. So, as the key component, exposures must be done in a very controlled manner, taking care to catch and not allow subtle avoidance or distractor behaviors and instead and focus on the situation at hand. Dichotomizing the components of EX/RP and cognitive restructuring, though, may be misleading. Observation of expert therapists treating people with SP often mix the two, rather than strictly using one or the other. As such, SP treatment is a prime example of the CBT model of behavior causing changes in thoughts, but thoughts also causing changes in behavior.

Proposed DSM-5 Revisions

The first change is the name of the disorder. In the DSM-IV, it is referred to as “Social Phobia (Social Anxiety Disorder)” while in the DSM-5 it is proposed to be renamed “Social Anxiety Disorder (Social Phobia).” This is due to the fact that the disorder appears to be one not of fear, but of anxiety. Persons with SP do not overtly and actively avoid all social interaction (which is pervasive in society) as someone with a phobia would, but instead endure such situations with marked distress and discomfort. Another significant change is the addition of two more specifiers to the current Generalized one: Performance Only and Selective Mutism. This is less supported by the research data, though, particularly the “Performance Only” subtype.

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Panic Disorder and Agoraphobia

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DSM-IV-TR Criteria

Of all the anxiety disorders, panic disorder is set to undergo the most changes in the proposed DSM-5. In the DSM-IV, there are three separate diagnoses, Panic Disorder with Agoraphobia, Panic Disorder without Agoraphobia, and Agoraphobia without History of Panic Disorder, while the DSM-5 proposes to have only two: Panic Disorder and Agoraphobia. As such, this section will be a bit different from the other anxiety disorders, in that I will detail information about DSM-IV panic attacks, agoraphobia, panic disorder,

and then discuss the etiology, treatments, and DSM-5 changes that are proposed across all three.

PANIC ATTACK

DSM-IV-TR Criteria

NOTE: A panic attack is not a codeable disorder. Code the specific diagnosis in which the panic attack occurs (e.g., 300.21 Panic Disorder with Agoraphobia)

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

- 1. Palpitations, pounding heart, or accelerated heart rate
- 2. Sweating
- 3. Trembling or shaking
- 4. Sensations of shortness of breath or smothering
- 5. Feeling of choking
- 6. Chest pain or discomfort
- 7. Nausea or abdominal distress
- 8. Feeling dizzy, unsteady, lightheaded, or faint
- 9. De-realization (feelings of unreality) or depersonalization (being detached from oneself)
- 10. Fear of losing control or going crazy
- 11. Fear of dying

- 12. Paresthesias (numbness or tingling sensation)
- 13. Chills or hot flashes

Associated Features

Panic attacks (PA) are actually fairly common across all the anxiety disorders, but are especially prevalent in the phobias and post-traumatic stress disorder. They usually last several minutes and can mimic signs of a heart-attack to those not familiar with them. The most commonly reported PA symptoms are heart-pounding and dizziness, although there is great variability among PA, even in the same person (as indicated by the large number of possible symptoms). The least common symptoms (paresthesias, choking, and fear of dying) are indicative of more severe PA problems and likelihood of reoccurrence. Also, the higher number of symptoms, the more severe the PA will be. In fact, one's risk for suicide attempts and emergency room use was elevated by 20% for each additional PA symptom above the four. If a person has less than four of the PA symptoms listed above, it is referred to as a "limited panic attack."

Recent research has shown that, contrary to previous beliefs, there are not significant differences in people who are "early peakers" (symptom severity reaches highest level prior to 10 minutes) and "late peakers" (those who have highest severity after 10 minutes). This is reflected in the proposed changes for DSM-5, as discussed below. Having a PA actually puts one at an increased risk for developing other anxiety

disorders, even though they are relatively common (see “Epidemiology” below).

There are three types of PA: a) unexpected or uncued panic attacks, b) situational or cued panic attacks, and c) situationally predisposed panic attacks. Unexpected or uncued are PA where the individual cannot link the onset to specific situational trigger. In contrast, a situational or cued PA occurs either in anticipation of or exposure to a specific trigger (internal or external). Finally, situationally predisposed PA are similar to a cued PA, but a person may be exposed to the triggering stimuli and not have a PA.

Child vs. Adult Presentations

While children can experience panic attacks, it is fairly rare. Instead, rates of reported PA begin to increase sharply during the middle teenage years and then decline rapidly starting again at age 50. Presentation does not appear to differ among age groups, although adolescents have been found to be more reluctant to discuss PA symptoms, worrying that they may represent some sort of severe medical problem.

Gender and Cultural Differences in Presentation

Studies show that more women than men experience panic attacks, at a ratio of 2:1. Culturally, panic attacks can be seen in every ethnicity and social class. However, some studies reveal that there are differences in how the symptoms are expressed compared to Caucasians and Europeans. For example, paresthesias and fear of dying is more common

among African Americans, while trembling occurs to a higher degree in Caribbean Latinos. Dizziness is a predominant symptom among several East Asian groups, with fear of dying seen more in Arabs. Finally, depersonalization, derealization, and loss of control are more often reported by Puerto Ricans than Caucasians.

Epidemiology

Almost a third of the U.S. population, 28.3%, will have at least a single panic attack at some point in their life. The overall population 12-month rate is much lower, at 11.2%, but much higher in the college population, where over 22% of students report having a PA in the past year. About 3 to 4% of adults suffer from chronic, repeated panic attacks but do not meet the DSM-IV criteria for panic disorder.

AGORAPHOBIA

DSM-IV-TR Criteria

Agoraphobia is not a codable disorder. Code the specific disorder in which the Agoraphobia occurs (e.g., Panic Disorder With Agoraphobia or Agoraphobia Without History of Panic Disorder)

1. Anxiety about being in different places or situations from which escape might be difficult (or embarrassing), or in which help may not be available in the event of having an unexpected or situationally predisposed panic attack or panic-like

symptoms. Agoraphobia fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile. NOTE: Consider the diagnosis of a specific phobia if the avoidance is limited to one or only a few specific situations, or a social phobia if the avoidance is limited to social situations.

2. The situations are avoided (e.g. travel is restricted) or else are endured with marked distress or with anxiety about having a Panic Attack or panic like symptoms, or require the presence of a companion.
3. The anxiety or phobic avoidance is not better accounted for by another mental disorder, such as social phobia (e.g. avoidance limited to social situations because of fear of embarrassment), specific phobia (e.g. avoidance limited to a single situation like elevators), obsessive-compulsive disorder (e.g. avoidance of dirt in someone with an obsession about contamination), post-traumatic stress disorder (e.g. avoidance of stimuli associated with a severe stressor), or separated anxiety disorder (e.g. avoidance of leaving home or relatives).
4. At least four of the following symptoms developed during at least one of the attacks:
 1. Shortness of breath or a smothering

sensation

2. Dizziness, unsteady feelings, faintness
3. Palpitations or accelerated heart rate
4. Trembling or shaking
5. Sweating
6. Choking
7. Nausea or abdominal distress
8. Depersonalization or derealization
9. Flashes, hot flashes, or chills
10. Chest pain or discomfort

Associated Features

As noted above, the DSM-IV does not classify Agoraphobia (AG) as its own, distinct disorder, instead seeing it in the context of Panic Disorder. This is in sharp contrast to the ICD-10, which classifies AG as a distinct disorder. Regardless of the nosology, many agoraphobic people have fears of leaving their homes, resulting in their ability to perform normal everyday activities being severely limited. The principal symptom of AG is a fear that a panic attack will occur when the individual is in some sort of inescapable situation (e.g., crowds, tunnels, open spaces) and leave them helpless or embarrassed, even if they have never had a PA. As a result, the individual will try to avoid these situations unless

there are security measures, such as a spouse or friend with them.

While most people who have PA do not develop AG, the chance to do so tends to increase with the history and frequency of them. Intriguingly, population based studies show that between 46-85% of people with AG have not actually had a full-blown PA, although this number is much lower in clinical samples (0-31%). In addition, AG is not only seen with Panic Disorder, but can be comorbid with a number of Axis I conditions. Almost 78% of people with AG qualify for at least one other anxiety disorder (phobias and GAD being the most common), while 64% are diagnosed with comorbid mood disorders and over 31% have substance abuse or dependence problems. It is also not uncommon for people diagnosed with Axis II disorders, particularly avoidant and dependent personality disorders.

Child vs. Adult Presentation

Although AG usually has a first onset between 23 to 29 years, younger children and older adults can also develop it. When children develop AG, there tend to be more physical symptoms reported, so a diagnosis of an anxiety disorder may not be considered at first. Adults who are diagnosed with this disorder are commonly afraid of a future PA in public, and are therefore afraid of the attack itself occurring. Children, though, do not necessarily have the cognitive ability to project that far in the future, and instead may show avoidance of certain activities without a clear reason for doing so.

Gender and Cultural Differences in Presentation

There are approximately 50% more females than males that experience AG during their lifetime (1.6% vs. 1.1%), although 12-month rates are very similar (0.9% vs. 0.8%). There is some data to suggest that cultural perceptions of females is highly influential on AG, as cultures where females are viewed as more submissive and dependent on males show higher rates of AG.

Epidemiological study rates vary greatly across national studies, from a low of 0% in urban Chinese to a high of 4.8% in South Africans. In the U.S., Caucasians tend to show lower rates than minority groups, with Puerto Ricans displaying very high rates (6.0%). This is not consistent across all studies, though as some find similar rates for all groups. Minority groups do appear to have an earlier age of onset than Caucasians, as well as showing decreases in prevalence with age.

Epidemiology

Despite not being an official diagnosis in DSM-IV, best estimates are that AG has a lifetime prevalence of 1.3% in the general population. Rates of 12 month prevalence were only slightly lower at 0.9%. Other studies have found a point prevalence rate of 0.8% for panic attacks occurring with AG. Rates do not tend to decrease steadily with age, but instead show a pattern of decreasing slightly from 18-29 year olds

(1.0%) to 30–44 year olds (0.8%), the increasing until age 59 (1.2%), and finally greatly decreasing afterward (0.4%).

PANIC DISORDER (PD) WITH AGORAPHOBIA
(W/ AG) OR WITHOUT AGORAPHOBIA (W/O AG)

DSM-IV-TR Criteria

- A. Both 1 and 2:
 1. Recurrent, unexpected panic attacks
 2. At least one of the following:
 - i. Persistent concern about having additional attacks
 - ii. Worry about the implications of the attack or its consequences (e.g. losing control, having a heart attack, “going crazy”)
 - iii. A significant change in behavior related to attacks.
- B. Absence of agoraphobia (PD w/o AG) OR presence of agoraphobia (PD w/ AG)
- C. The panic attacks are not due to the direct physiological effects of a substance (e.g. hyperthyroidism).
- D. The panic attacks are not better accounted for by another mental disorder such as social phobia (e.g. occurring on exposure to a feared social

situation), obsessive-compulsive disorder (e.g. on exposure to dirt in someone with an obsession about contamination), post-traumatic stress disorder (e.g. in response to stimuli associated with a severe stressor), or separation anxiety disorder (e.g. in response to being away from home or close relatives).

Associated Features

Many individuals with PD report having occasional or constant feelings of anxiety that are not focused on any specific event or situation, while others become apprehensive about what might happen during routine activities. The negative impacts of PD are myriad. First, demoralization is common as the person becomes discouraged, ashamed and unhappy about the difficulties of living everyday life. They blame themselves, thinking that they are lacking in “character” or “strength”. Missing school or work because of medical visits is common, and can lead to dropping out of school or job loss. People with PD have very high rates of medical visits, procedures, and laboratory tests, both compared to the general public and persons with other anxiety disorders. They consistently report dissatisfaction with their medical treatment, and physicians rate people with PD as more difficult to care for. Medical visits over a 12-month period are especially common to the ER (43.9%), urgent care (48.8%), cardiologist (46.3%), and family practitioners (46.3%).

Comorbidity is higher for people who have combined PD and AG, compared to those with PD alone. In PD w/ AG, over 93% meet criteria for another anxiety disorder, while the overlap is only 66% in PD w/o AG. Similar differences are seen in comorbid mood disorder (73% vs. 50%) and substance abuse problem (37% vs. 27%) rates. Depression is a very comorbid, but can either precede (a third of cases) or occur after PD (two thirds of cases).

Child vs. Adult Presentation

While both children and adults can have PD, it tends to be very rare before puberty, gradually increases until middle age, and then decreases again. Youth and adults experience similar symptoms (trembling, breaking out in a sweat, heart, palpitations, nausea, and so on), although adolescents report worrying about subsequent PA less than young adults. It is crucial to note that some researchers have found that children who are later highly prone to developing PD display much higher rates of separation anxiety than same-age peers. Such children also tend to show other anxious behaviors, such as behavioral inhibition and anxiety-sensitivity.

Gender and Cultural Differences in Presentation

PD w/o AG is two times more common in women than in men, while PD w/ AG is three times more common in women. This gender gap begins to be observable by early adolescence, and just continues to widen with age. It is important to note that some cultural or ethnic groups restrict

women from being in the public life, and that this should be distinguished from agoraphobia. PD appears to be more debilitating to women than it is for men, as females tend to become more depressed, rate higher on fear tests, and spend more time avoiding social situations. Men are also more likely to hold down a steady job.

In the U.S., minorities tend to have lower rates of PD than Caucasians, although Native American groups have been found to have higher rates. Cross-culturally, lower rates of PD are seen outside the U.S., even in European samples. For instance, studies in the Ukraine have found rates of 1.27% and 1.94% for 12-month and lifetime, respectively. Germany had slightly higher 12-month rates (1.8%), but still lower than the U.S, while Australia was even lower (1.1%). In Japan (0.5% for 12-month), South Korea (0.2%), China (0.2%), PD is extremely rare, with similarly low rates in other non-Western countries (0.6% in Mexico, 0.8% in South Africa).

As noted earlier, certain symptoms of PA are more or less frequently seen in certain cultural groups. Directly related to PD are several culturally-bound disorders. For example, *khyâl* attacks in Cambodia are characterized by a mix of PA and culture-specific symptoms including tinnitus and neck soreness w/ dizziness. *Ataque de nervios* (“attack of nerves”) among Latin Americans and *trunggio* (“wind”)-related attacks in Vietnam also appear to be culturally-relevant variations on PD.

Epidemiology

Panic disorder (with or without agoraphobia) has a lifetime prevalence rate of 4.7% in the U.S., with a 12-month rate of 2.7%. Both lifetime and one year rates show an upside down U curve of distribution, with lower rates for 18-29 year olds (4.2% and 2.8%) and those over 60 years old (2.1% and 0.8%) compared to age groups of 30-44 (5.9% and 3.7%) and 45-59 (5.9% and 3.1%). Rates for children and adolescents are very low, likely due to the lack of development of cognitive abilities such as self-monitoring and metacognition.

In treatment-seeking clinical settings, the prevalence rates for panic disorder are noticeably higher, with some studies finding as high as 30%. In general medical settings, almost 10% of people referred for a mental health consultation were diagnosed with panic disorder. In specialty medical settings such as vestibular, respiratory, and neurology clinics the prevalence rates vary from 10% and 30%, while in cardiology clinics rates as high as 60% have been found. In community samples, a third to a half of individuals diagnosed with PD have AG as well. There is a much higher rate of PD w/ AG encountered in clinical samples than without AG.

Etiology

Genetic and family studies have found that both biology and environment are strong contributors to the development of both PD and AG. Twin studies have revealed that there is a genetic link to the development of PD. Individuals with a first

degree relative suffering from panic disorder are eight times more likely to develop panic disorder than people without. If onset is before age 20, though, the individual's risk increases to 20 times as likely to develop PD. Heritability for PD seems to be around 45%, with shared (10%) and unshared (45%) environments contributing significantly. For AG, heritability estimates are slightly higher, at around 60%. The temperament trait of behavioral inhibition (BI) is highly implicated in the development of both, and parents with PD or AG are more likely to have children who are behavioral inhibited. This, however, holds true across all anxiety disorders. For PD and AG specifically, anxiety sensitivity (believing anxiety is harmful and bad) is the key trait. Furthermore, we know that early trauma and maltreatment are risk factors for developing both later, and that development may be mediated by the presence of BI.

Neurologically, panic attacks are closely linked to amygdala function. The amygdala is the anxiety "way-station" that mediates incoming stimuli from the environment (thalamus and sensory cortex) and stored experience (frontal cortex and hippocampus). As such, it impacts the anxiety and panic response by stimulating various brain areas responsible for key panic symptoms based on both internal and external stimuli and past events. In particular, the periaqueductal gray in the midbrain could be especially important for mediating panic symptoms. Pharmacology and CBT can effectively treat PA, but they act on different systems. While pharmacology can target all areas of the above

described system, effecting amygdala and frontal-lobe interpretation of stimuli or output effects, CBT impacts the frontal-lobe areas, especially in the medial prefrontal cortex, which is known to inhibit input to the amygdala.

Psychologically, the major factor in the development of PD and AG seems to be anxiety sensitivity. This is the belief, which could be acquired in any number of ways, that anxiety could cause severe physical, social, and psychological consequences that extend beyond any discomfort during a PA. Examples of means of acquisition are direct experience, vicarious observations, information transmission, and parental reinforcement. Essentially, a person develops a “fear of fear.” This model posits that an individual who has a PA or PA symptoms may, through the process of interoceptive conditioning, learn to fear any change in physiological state that could signal the onset of panic. As such, they pay more attention to physical and bodily changes than most individuals, which ironically puts them at a higher risk of having panic attacks. For example, if you take the stairs to the third floor of a building, you may notice that you are flushed, breathing more heavily than usual, and sweating. For a person prone to PA, these signs would be seen as indicative of an oncoming PA rather than just being a sign of tiredness or being out of shape. This would make them nervous about the chance of having a PA, which activates the sympathetic nervous system and in turn makes it more likely they will actually have a PA. This can lead both to the avoidance of

situations likely to trigger such sensations (AG) as well as a high likelihood of having repeated PA (PD).

Empirically Supported Treatments

Pharmacology meta-analyses for PD and AG show similar medium to large effect sizes (0.48-0.55) for both the tricyclic antidepressants (TCA) and SSRI classes of drugs. Benzodiazepines (BZD) are also effective at reducing incidence of PA, but they and the TCA are prescribed less than SSRI due to side-effect reasons. In treatment-refractory patients, SSRIs can be supplemented with BZD, or MAOIs can be used. Again, these are not front-line treatments due to their larger side effect profile. Clients should be made aware that there is a substantial (25-50%) relapse rate within 6 months when medications are discontinued, though. This may be partially due to the high potential for withdraw symptoms (from any medication) to become interoceptive cues for a PA, thus reversing the progress made while on the medication.

Cognitive-behavioral therapy is the most well studied and validated treatment for PD, with effect sizes of 0.9-1.55. It has been found to be equally effective in individual or group format, as well as in standard (14-18 meetings) or brief (6-8) sessions. As with all CBT treatments for anxiety, though, there is a massive underutilization due to lack of properly trained mental health professionals. CBT for PD emphasizes psychoeducation about panic symptoms, cognitive restructuring focusing on reducing anxiety sensitivity,

interoceptive exposure to feared bodily sensations, and in vivo exposure to the previously avoided and feared situations. Similar to other treatments discussed above, retraining of breathing to help patients cope with their panic and anxiety has been found to be unnecessary. CBT for AG is very similar, but with a smaller focus on interoceptive exposures and greater emphasis on in vivo exposure to feared situations.

Although both medical and psychotherapeutic treatments are effective alone, CBT has a stronger initial effect size and yields larger long-term effect sizes (0.88-0.99 vs. 0.40-0.55). Research has found no benefit for combining the two, as controlled trials show that CBT alone is as effective as the combination. As with several other disorders, researchers have also examined self-guided therapies based on CBT, using both bibliotherapy and computer-mediated models. Results are generally supportive, with one study finding similar one-year effect sizes for 10 session live CBT (0.93) and 10 module internet self-help treatment (0.80).

Proposed DSM-5 Revisions

As mentioned earlier, there are major changes proposed for these disorders in DSM-5. First, Agoraphobia is recommended to be classified as a distinct disorder. There are three primary lines of evidence that have supported this change: psychometric evaluations supporting the construct of agoraphobia alone, epidemiological investigations of prevalence, and the impact AG has on clinical course and outcome. This change would also bring the DSM-5 and

the ICD (International Classifications of Disease) more into alignment, as Agoraphobia is already a separate disorder in that system. As such, Panic Disorder would no longer have the “with or without Agoraphobia” included in the diagnosis. It is also proposed that a specifier be added to all the anxiety disorders that would allow “with panic attacks” to be noted in the diagnosis, given the high rate of PA across the class.

In addition the disorders reviewed above, there are three others included in the DSM-IV anxiety disorder section. The first is Anxiety Disorder Due to a General Medical Condition. As expected from the name, this is where a person experience anxiety problems as a direct result of a medical problem, such as as hyperthyroidism, hypothyroidism, vitamin deficiencies, or brain lesions. People with cardiovascular problems, endocrine disorders, neurologic conditions, peptic ulcers, diabetes, and respiratory conditions are also at risk of developing anxiety as a result of their condition.

The second is Substance-Induced Anxiety Disorder, which is the direct result of either intoxication or withdrawal from a psychoactive substance. Common substances causing such problems include alcohol, cocaine, sedatives, hypnotics, and anxiolytics. The final is Anxiety Disorder Not Otherwise Specified. This is a “catch-all” category, where a person displays prominent anxiety symptoms or avoidance, but does not meet full criteria for any of the other, specific disorders.

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PART XVII

Additional
Information about
the Text

The following information is information about the text.

STEPHANIE WEIGEL

This is where you can add appendices or other back matter.